The Affordable Care Act: Do No Harm

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If medicine's watchword is "do no harm," physicians have many reasons to resist the plans of the incoming Trump administration and Republican-controlled Congress to repeal and replace the Patient Protection and Affordable Care Act (ACA). The 2010 health reform law is far from perfect, in either its structure or its execution; in a less dysfunctional political era, the flaws would have been addressed through subsequent changes. Now, amid the drive not to amend the law, but to repeal it—and absent a definitive replacement plan—physicians, as stewards of the nation's health care, should be up at arms about the potentially dangerous impact.

Out of political expedience, the ACA was designed not to provide universal health insurance coverage but to take a major step toward it through the expansion of both private health insurance and Medicaid for low-income populations. By that standard alone, the law has succeeded: An estimated 20 million people have gained coverage through the law's various aspects, and the nation's overall rate of uninsurance is now estimated at 8.9%, a historic low (1). Although gaining health coverage does not guarantee access to care, without coverage access is almost certainly compromised. A 2003 Institute of Medicine study calculated that 18 000 Americans died each year due to lack of health coverage alone (2).

To a large degree, those who have gained coverage under the ACA include millions who were already sick but either were denied coverage or could not afford it in the prereform insurance market. A study of health claims of persons who enrolled in Blue Cross Blue Shield individual insurance plans once the ACA was fully in effect showed that they had higher rates of hypertension, diabetes, depression, coronary artery disease, HIV infection, and hepatitis C virus infection than those who had individual coverage before health care reform (3). Once insured, they also received significantly more medical services than those previously enrolled in individual plans. Such studies tell the story of a health care system that was largely closed to these sick people before the ACA but embraced them—and delivered needed care—once coverage was in place.

A similar story emerges from the Medicaid expansion in the 31 states and the District of Columbia that chose to institute that part of the ACA. Early results showed that far more adults were being diagnosed with type 2 diabetes in states that had expanded the program versus those that had not (4). A recent New York Times/Kaiser Health News story reported that across the country, many previously uninsured gunshot survivors—including a Chicago man shot 10 times in a case of mistaken identity—were receiving needed care through the Medicaid expansion (5). A trauma surgeon quoted in the story acknowledged that she felt "deeply ashamed" that, before the ACA, uninsured patients shot in the abdomen were frequently denied costly bowel diversion surgery and were instead forced to wear colostomy bags for months or years.

With no firm plans to replace the law and suggestions that crafting a substitute could take several years, repeal by itself could be disastrous. The nonpartisan Congressional Budget Office estimated that Republican-backed repeal legislation adopted by both houses of Congress in 2015 but vetoed by President Obama would have caused 22 million people to lose coverage (6). A study for the American Hospital Association predicted that repeal would result in "an unprecedented public health crisis" as people lost coverage and could not "follow their prescribed regimen of care" (7).

Prototypical Republican plans to replace the ACA, such as the House Republicans' "A Better Way" blueprint (8), offer no comfort. Whatever the ACA's imperfections, it assembled a complex set of interrelated provisions to make coverage comprehensive and meaningful. It covers people with preexisting health conditions through a "guaranteed issue" requirement; provides for 10 categories of health benefits deemed "essential," including mental health coverage; and bans limits on lifetime payouts on health insurance policies. These provisions function in tandem to protect the sickest and to make private health coverage for individuals far more reliable than before.

Consider what could happen under Republican plans to strip most, if not all, of these insurance reforms. Even if ACA replacement plans nominally "covered" people with preexisting conditions, those with serious mental illness could lose coverage because that essential benefit would be abolished. "Guaranteed issue" would be replaced with an arrangement that would cover those with preexisting conditions only if they stayed continuously enrolled in health coverage. If their coverage lapsed—which it might well, if subsidies available under Republican plans are less generous than the ACA's—they would have to seek costly coverage through state "high-risk" pools. These arrangements existed in just 35 states before the ACA; were notoriously underfunded; and, in some instances, were closed to new entrants for years at a time.

In truth, no extant Republican plan has assembled a suite of insurance provisions, subsidies, Medicaid coverage, and other assistance that would offer as much protection as the ACA. America's physicians need to resist repeal and demand to see a full-blown replacement plan first, with the same cold-eyed rigor they would apply to any claim that the latest snake oil offering on the market was a better cure for patients.

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