The Patient Protection and Affordable Care Act (PPACA) of 2010 was signed into law by President Obama on March 23. This legislation has elicited much debate among policy experts and the public alike. No one knows exactly how this new complex law will play out, and objective evaluation of its effects is important. The American College of Physicians hopes that the legislation will advance key priorities on coverage, workforce, and payment and delivery system reform. The goal of the PPACA is to help provide affordable health insurance coverage to most Americans, improve access to primary care, and lower costs. This article discusses what the chances are that it will accomplish these objectives. It also explains many of the key provisions in the legislation and how they will affect both physicians and patients. Despite considerable uncertainty about the effects of this act, when compared with the status quo, it is an extraordinary achievement that will continue to evolve through its implementation.


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some 160 million according to the CBO (6)—will continue to be insured through their employers. For them, the biggest change is that insurance companies will no longer be allowed to cancel or deny coverage or increase premiums because a person has a preexisting condition or gets sick. People who lose or change jobs will have the security of being able to buy coverage through an exchange.

Patients in the traditional Medicare program will benefit from expanded coverage of preventive care and regular checkups with no coinsurance or deductibles. The legislation phases out the Medicare prescription drug “doughnut hole” over 10 years, beginning with a $250 rebate in 2010 (8). The law prohibits cuts in mandated Medicare benefits, but reductions in payments to Medicare Advantage plans could result in such plans dropping some optional benefits (9).

Whether all of these policies will work as intended depends on many factors, including the ability and willingness of state governments to organize the health exchanges, handle increased Medicaid enrollment, and police insurance companies. Although the legislation will not cover everyone, it will probably extend coverage to most legal residents and make insurance more secure, portable, and comprehensive for those who already have it. People who remain without health care will include undocumented workers, young people who decline to buy coverage despite the penalty, and people who earn too much to qualify for tax credits but still find the premiums too expensive (10).

### Table. The Patient Protection and Affordable Care Act Versus the Status Quo

<table>
<thead>
<tr>
<th>Patient Protection and Affordable Care Act</th>
<th>The Status Quo</th>
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<tbody>
<tr>
<td>Ninety-five percent of legal residents have health insurance; 32 million fewer uninsured, leaving about 25 million without coverage</td>
<td>More than 60 million people—1 out of 5 residents—will have no health insurance coverage</td>
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<tr>
<td>Insurers prohibited from excluding, canceling, or charging more to persons with preexisting conditions</td>
<td>Insurers continue to deny affordable coverage for people with preexisting conditions</td>
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<tr>
<td>Insurers cover evidence-based preventive services</td>
<td>Insurers exclude evidence-based preventive services</td>
</tr>
<tr>
<td>Adults up to age 26 years covered by parents’ health insurance</td>
<td>Young adults often lose their health insurance if covered under their parents’ policy at age 19 years or upon graduation from high school or college (18); this varies with the parent’s health insurance plan</td>
</tr>
<tr>
<td>Medicare Part D doughnut hole phased out</td>
<td>Medicare Part D doughnut hole remains</td>
</tr>
<tr>
<td>Medicare increases primary care payments for visits by 10%</td>
<td>Continued Medicare payment rates; no increase for primary care</td>
</tr>
<tr>
<td>Medicaid payments for primary care visits and vaccines increased to Medicare rates</td>
<td>Medicaid payments continue to pay far less than Medicare</td>
</tr>
<tr>
<td>Increased funding for training of primary care physicians; unused graduate medical education funds redistributed</td>
<td>Current levels of authorized funding; no increase in graduate medical education for primary care</td>
</tr>
<tr>
<td>Medicare hospital trust fund stays solvent until 2026</td>
<td>Medicare hospital trust fund goes bankrupt in 2017</td>
</tr>
<tr>
<td>Medicare and private insurers cover preventive services with patient, no cost sharing</td>
<td>Medicare and private insurers exclude coverage of preventive services</td>
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<tr>
<td>Deficit potentially reduced by $143 billion in 10 years and $1 trillion over 20 years according to the CBO; other provisions may begin to bend the cost curve</td>
<td>By 2017, health spending doubles to $4.3 trillion (19); a middle-income family that earns $80 000 ends up spending 40% of gross wages on health care, putting it out of reach for many (20)</td>
</tr>
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CBO = Congressional Budget Office.

### WILL THE PPACA IMPROVE ACCESS TO PRIMARY CARE?

The United States faces a shortage of 35 000 to 44 000 primary care physicians for adults by 2025. Population growth and aging will increase the workloads of family physicians and general internists by 29% between 2005 and 2025 (11). As more people obtain health insurance under the new law, the demand for primary care physicians will probably increase, exacerbating the primary care shortage (12).

The PPACA aims to ameliorate the primary care shortage through increased funding for National Health Services Corps and Title VII health professions programs and creates a new program to provide grants and graduate medical education dollars to primary care residency programs at teaching health centers. The law requires residency programs to redistribute at least 65% of unfilled slots in non–primary care programs to primary care residency or general surgery residency programs. The PPACA also establishes the Primary Care Extension Program to support best practices in primary care (13) and will train more advanced-practice nurses, although states will continue to govern the services that they can provide.

Financial incentives for primary care include increased Medicare payments for primary care encounters by 10% starting in 2011 and continuing through 2016, and increased Medicaid payments for visits and vaccines by primary care physicians to no lower than the Medicare rates for years 2013 and 2014. The increases would “sunset” after these dates unless they were extended by Congress. The PPACA also accelerates pilot testing and implementation of new models like the patient-centered medical home, which will reimburse primary care physicians in qualified practices for instituting best practices to improve outcomes for patients with chronic illnesses.

These programs, over time, may help increase the availability of primary care clinicians. But the long training pipeline means that it will be at least 4 years before one might see an appreciable increase in the numbers of graduating primary care physicians. As a result, newly insured patients can anticipate difficulties gaining access to primary care, particularly in underserved communities. The PPACA will not solve the primary care crisis. Further changes are necessary to ensure adequate access to primary care physicians.
**Will the PPACA “Bend the Cost” Curve, and Can the Country Afford It?**

This is the $64 000 question—or actually, the $2.4 trillion (14) question, which is the amount that the United States now spends on health care. The CBO estimates that the law will reduce the deficit by $143 billion over the next decade (15) and by more than $1 trillion over 20 years (6).

The PPACA increases Medicare payroll taxes, imposes a tax on “Cadillac” insurance plans, and imposes new fees on medical device manufacturers and tanning booths. The revenue raised, when combined with $500 billion in Medicare “savings,” will be greater than the cost of the program, according to the CBO. The Medicare savings come principally from reducing payments to Medicare Advantage plans, reducing disproportionate share payments to hospitals because they will treat fewer indigent patients, reducing payments to hospitals with high readmission rates, and lowering the annual “inflation” updates to nonphysician providers.

Many of the potential cost-saving programs created by the PPACA will be initially implemented on a pilot basis, so the CBO generally didn’t count them as saving money. The law creates a new Medicare Center on Innovation, which will fund pilot tests of new payment and delivery models that aim to align incentives with efficiency and better outcomes, such as accountable care organizations that reward physicians and hospitals for collaboration toward shared savings. The PPACA creates an independent payment advisory board charged to make recommendations for altering payment policies to achieve savings. These recommendations will automatically go into effect unless Congress enacts an alternative with equivalent savings. Many hope that the PPACA’s requirement for comparative effectiveness research funding will also lead to more efficient use of resources, although the law specifically prohibits use of such research to deny care.

Critics question whether the CBO’s estimated cost savings will be realized. Columnist Robert Samuelson wrote:

> Even with highly optimistic assumptions, health spending remains out of control. It absorbs more of government, business and family budgets. Higher health spending would put pressure on future budget deficits, already projected to total about $9 trillion over the next decade. If new taxes and Medicare “savings” are real, they could be used exclusively to pay down deficits, not finance new spending. (16)

Others argue that the CBO may have underestimated the impact of the cost-saving measures. In a recent interview, Massachusetts Institute of Technology health economist Jonathan Gruber, said:

> I’m sort of a known skeptic on this stuff. My summary is it’s really hard to figure out how to bend the cost curve, but I can’t think of a thing to try that they didn’t try. Everything is in here. I can’t think of anything I’d do that they are not doing in the bill. You couldn’t have done better than they are doing. (17)

In other words, even the experts cannot tell if the PPACA will do enough to bend the cost curve. Long-range budget forecasting is notoriously fickle, so it is prudent to view with some wariness the CBO’s conclusion that the law will lower the deficit. Yet by Congress’s own rules, agreed to by both parties, PPACA will pay for itself. Hopefully, the pilot tests of alternative payment and delivery models will identify ways to both optimize care and achieve savings.

**Compared With What?**

Rather than asking whether the PPACA does everything to improve access and lower costs, we should ask how it compares with the status quo. By this measure, the PPACA is an extraordinary achievement (Table [18–20]). The health reform law is a work in progress, not the end of the story. As it is implemented, changes will be inevitable. Yet that the United States, for the first time in its history, has enacted legislation offering the promise of providing most Americans with access to affordable health care is a cause for celebration.

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**References**


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