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EDITORIAL COMMENT

Affordable Care

More Than Just an Act*

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CENTRAL GOALS OF THE AFFORDABLE CARE ACT

In 2010, Congress passed the Affordable Care Act (ACA), with the goal of providing Americans with universal, affordable, high-quality health care coverage (1). **Table 1** enumerates key elements of the law. During the ensuing 6 years it has seen several successes, including assurance of coverage for individuals with pre-existing conditions; coverage of approximately 20 million previously uninsured individuals (2); safety improvements, such as reduced hospital-acquired conditions; and standardization of basic coverage plans across multiple payers. It has also seen significant challenges, including rising premiums and reduced insurance choice in many parts of the country (3). At present, few, if any, public figures would disagree that significant changes are needed (regardless of whether the name "ACA" is kept or abandoned). But, it is essential that the successes of the bill be retained, with continued movement toward achieving its central goals.

In this issue of *JACC: Heart Failure*, Breathett et al. (4) report the effect of Medicaid expansion on the availability of heart transplants to African Americans, a step toward reducing our nation's health care disparities. They contrast "before" and "after" listings for heart transplants among Caucasians, African Americans, and Hispanics, as a percent of the census population for states that did versus did not implement ACA Medicaid expansion by January 2014. Their clearest finding is a 30% increase in monthly per capita heart transplant listing following Medicaid expansion among African Americans within 23 "early adopter" states plus the District of Columbia. In contrast, there was no such increment within 20 "nonadopter" states. The authors conclude that implementing ACA Medicaid expansion was associated with increased access to heart transplantation for African Americans, and they suggest that further broadening of Medicaid expansion may further reduce health care disparities.

The authors consider alternative explanations for the increased listing rates within selected states for African Americans during this time frame, including the preponderance of state-based marketplace programs in early-adopter states. However, other lines of evidence support improved coverage and a favorable effect on health services utilization among low-income individuals following Medicaid expansion (5).

HEALTH CARE DISPARITIES AND ALLOCATION OF TRANSPLANT SERVICES

African Americans are known to have both a disproportionately high prevalence of heart failure (HF) and its consequences and a disproportionate underutilization of certain health care services (6–8). Within the MESA (Multi-Ethnic Study of Atherosclerosis) database (6), African Americans without a baseline history of cardiovascular disease were estimated to have a HF incidence of 4.6 per 1,000 person-years, which is almost twice that of whites. Yet, African Americans may have disproportionately low rates of listing for heart transplants, due to disparities in insurance coverage and socioeconomic factors (8).

Heart transplantation, a limited resource, is reserved for a small proportion of patients with HF. Factors that drive transplant eligibility include a high level of morbidity and anticipated mortality, a low

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TABLE 1 Selected Components of the Affordable Care Act

Guaranteed issue ◦ Requires uniform premium, regardless of sex or pre-existing conditions.
Individual mandate ◦ In absence of employer health plan, Medicaid, Medicare: buy insurance or pay penalty.
Health insurance exchanges ◦ Offers a marketplace for comparison and purchase of insurance policies.
Subsidies ◦ Low income individuals and families (1–4× poverty level) to receive federal subsidies.
Medicaid expansion ◦ Eligibility to include all individuals and families up to 1.38× poverty level. (States can opt out.)
Minimum standards ◦ Established for all policies, with ban of coverage caps. Children covered to age 26 years.
Employer shared responsibility ◦ Firms with ≥50 employees not offering coverage will share subsidy burden.
Subsidy for very small business ◦ If they purchase insurance through an exchange.
Copayments, coinsurance, and deductibles ◦ Eliminated for benefits considered preventive care.
Fee restructuring ◦ Transitions Medicare reimbursement away from fee-for-service toward value-based and bundled payments. Creation of accountable care organizations

level of comorbidity that might limit post-transplant survival, and access to health insurance. There is little doubt that heart transplantation saves lives. According to the most recent report of the Scientific Registry of Transplant Recipients, 1- and 3-year survival following heart transplant in the United States are 90% and 85%, respectively. At the same time, transplantation is resource-intensive and costly. Yet, given the substantial decrement in mortality risk for patients receiving heart transplants, compared with expected rates with medical therapy alone in transplant-eligible patients, recent analyses have concluded that these procedures fall within an acceptable cost-effective range. In 1 analysis (9), 1-year survival for heart transplant-eligible patients treated medically was 39%, with transplantation increasing average life expectancy from 1.1 to 8.5 years and an estimated cost of <$100,000 per quality-adjusted life-year gained. (Cost-effectiveness is less favorable when a ventricular assist bridge-to-transplant strategy is deployed.)

Government agencies (as well as private insurers) have often focused on "cost" and ignored "effectiveness" in formulating both coverage and payment decisions for their plan members. A flagrant example of lethally simplistic health policy was Arizona's 2010 decision, later rescinded, to decline provision of all transplants to its Medicaid population (10). Presently, the ACA utilizes a montage of solutions to drive toward universal coverage (Table 1). These include requirements for employer coverage, tax penalties to uncovered individuals, and commercial plan premium subsidies for individuals of modest means, as well as expansion of Medicaid coverage to a broader range of low-income individuals and families. Although the ACA attempts to level the playing field by requiring coverage for certain basic care, it should not be assumed that each pathway to coverage yields equivalent care. Beyond coverage decisions, Medicaid fees vary substantially from state to state, in many cases driving provider institutions to either withhold expensive treatments or lose money. Kapoor et al. (11) showed divergence in delivering proven heart failure treatments, with Medicaid-covered individuals receiving low prescription rates of guideline-driven treatments, including implantable cardioverter-defibrillators (11,12). In our own experience this past year, there was a 7-fold differential in payment for heart transplants for Medicaid beneficiaries from 2 New England states. In 1 case, our hospital sustained a substantial financial loss in performing the procedure. Unless we believe it appropriate for state governments to divide our country into pockets of health care "haves" and "have-nots," we must maintain national standards for what represents basic coverage, and we must make sure that we provide it.

MOVING DECISION-MAKING TO PROVIDERS AND PATIENTS

Withholding coverage and ratcheting down payments are not the way to drive quality and efficiency. Neither are government-generated utilization metrics, such as the ill-conceived 30-day readmission penalty, the right way to drive down cost (13). We need to move decision making away from the payer—government or commercial—and back into the hands of the provider and patient. The present trajectory of Medicare and Medicaid payment is away from fee-for-service, toward fee for value and provider risk. Medicare payment structure is rapidly moving toward adoption of "bundled payments," wherein providers receive lump sums for longitudinal services surrounding a particular procedure or diagnostic group. Independent of the ACA, The Medicare Access and CHIP Reauthorization Act of 2015 (14), the new Medicare physician payment structure, will soon require each provider to participate in either an "alternative payment model" or a "merit-based incentive system," incentivizing improvements in quality and resource use. These directions should not be abandoned, but rather refined and advanced.

The government can play a central role in driving oversight of the health care dollar toward the provider, while encouraging accountability and transparency. With greater provider system consolidation and vertical integration, there should be less need for arbitrary penalties and rewards. Rather, whether we pay for health care as taxpayers or as private customers, we will be better served with those funds offered to integrated delivery systems, competing with others in their marketplace for the premium dollar on the basis of transparent cost and quality, the latter to be delivered equitably, regardless of ethnicity or socioeconomic status.

TIME FOR ACT 2?

The ACA needs fixing. However, the abandonment of government exchanges and increases in premiums by some insurers is not attributable to fundamental flaws in the program. Rather, the key shortcomings are the ACA's failure to achieve universal coverage and the failure of government formulas to mitigate the variance of actuarial risk from plan to plan. The law's incentives and penalties have been inadequate to achieve enrollment of a sufficient proportion of low-risk individuals to provide for the 80% of health care cost driven by the 20% of the population who are at highest risk (15). This shortcoming leaves the viability of commercial carriers to stopgap programs, including federal reinsurance, which expires this year, and 2 additional government-directed financial safety net formulas: "risk corridor" and "risk adjustment." However, Congress inexplicably eviscerated the risk corridor prior to its expiration, and the risk adjustment formula has been widely criticized for disproportionately penalizing start-up companies by underestimating new enrollees' risk and disadvantaging companies with premiums below the market median (16). These factors have perversely driven down market competition—the opposite of the desired effect—and are the subject of several lawsuits against the federal government (16). Far from mandating a death sentence for the ACA, these flaws are eminently fixable.

The political winds have taken a seismic shift. The liberal solution of a broader "government option" is now dead on arrival, in favor of a conservative drive for a greater private sector role. But the central question is whether we will we now regress and abandon the 3 core societal goals of universal coverage, cost containment, and pursuit of quality. Also, any efforts to advance these goals are hollow without a focus on eliminating health care disparities. The findings of Breathett et al. (4) suggest that we are seeing some success in this direction, with reduction in the disparate allocation of high-reward interventions such as heart transplant. Shall we now forsake those successes?

If we achieve consensus around our core goals, then there is no escaping a role of government in subsidizing health care for our least fortunate citizens. But beyond this fact, there are other legitimate choices to make: the relative roles of the private versus public sectors; service-based versus value- and population-based payment models; and payer-focused versus provider- and patient-focused decision-making and risk-bearing. Let us hope that as this next round of the debate unfolds, it focuses less on the name of the act and more on serving the health care needs of our entire population.

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