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Affordable Care Act Needs Adjustments- Not Wholesale Elimination

Mario J. Paredes
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IF DONALD TRUMP gets his way and the Supreme Court invalidates the Affordable Care Act (ACA), millions of people will feel the impact: at least 23 million Americans will lose their health-care coverage, and 130 million will lose their pre-existing conditions protection. The repeal of ACA would leave some 50 million Americans without insurance.

As the President's critics have charged, targeting ACA for elimination is unconscionable, particularly when the coronavirus pandemic is still wreaking havoc throughout the country. In April and May alone, 500,000 people who lost their health-care coverage along with their jobs signed up for ACA. Meanwhile, 22.4 million Americans have been infected by the coronavirus and many will likely face longer-term health issues that, some observers suggest, may or may not be considered pre-existing conditions, leaving them potentially vulnerable to rejection by private insurance plans, or facing limited benefits.

For the President, the demise of ACA would fulfill a campaign promise. Democratic leaders, including the presumptive Democratic presidential nominee Joe Biden, were quick to unleash a barrage of statements condemning the Administration—clearly also with an eye on the November elections.

However, health-care—in particular health care for the poor and for all those at the margins of society—should never be a political football. Access to adequate health care is a human right. Recognition of, and respect for, that right should transcend the political divide.

Article 25 of the United Nations' 1948 Universal Declaration of Human Rights holds that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services." The World Health Organization echoes this position: "The right to health for all people means that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship. No one should get sick and die just

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because they are poor, or because they cannot access the health services they need." A safety net for many millions of people, especially during the pandemic, the ACA should not be dismantled before Republicans and Democrats arrive at a genuinely bipartisan consensus as to what mechanism can take the place of the ACA. Such a dialogue would have to wait until after the elections, when cooler heads can prevail and political rancor can be put aside—hopefully, to a significant degree.

Access to health care for the most vulnerable patients should not be subject to the vicissitudes of bitter political polarization. For now, the ACA should stay in force, even as it is clear that adjustments are in order to accommodate Republicans' legitimate concerns about big government getting involved with health care and people with private insurance plans paying higher premiums and rates to help underwrite insurers' participation in ACA.

What's called for above all is smart public spending. The experience of SOMOS Community Care over the past five years points to a way forward. SOMOS is one of 25 Performing Provider Systems (PPS) mandated by New York State's transformative Delivery System Reform Incentive Payment program (DSRIP). SOMOS is a network of 2,500 providers serving a largely minority (Hispanic, African American, and Chinese American) population of 800,000 vulnerable patients in New York City. The bulk of SOMOS doctors share the ethnic and cultural background, as well as the language of the people they care for. In many cases, SOMOS providers—most of them primary care physicians—live and work in the same neighborhoods as their patients.

That cultural affinity between doctor and patient, providers' cultural competence, is one of the hallmarks of DSRIP, a key aspect of the Value-Based Payment (VBP) system. The VBP formula stipulates that doctors are compensated not according to transactions performed—office visit, test, procedure, etc.—but according to the longer-term health outcomes of their patient. The traditional Medicaid transactional payment model is prone to waste and fraud, while VBP encourages doctors to really become invested in the well-being of their patients, which is not the case for traditional Medicaid.

In this process, SOMOS doctors are assisted by Community Health Workers, who visit patients' homes as needed, to get a sense of their social circumstances.

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Doctors and their staff next engage community-based organizations that address the Social Determinants of Health (SDH)—factors such as poor housing, lack of employment, limited access to healthy food, etc.—that have an impact on patients' health. Taking into account patients' medical, behavioral and social needs, doctors are in an optimal position to provide holistic, preventive care. Success hinges on the quality of the doctor-patient relationship, which ideally is one of mutual trust.

And that success is measurable: the key objective of DSRIP has been to significantly reduce the number of preventable, highly costly hospitalizations. SOMOS achieved a 20.4 percent reduction in the number of potentially preventable hospital admissions, a 25.7 percent reduction in the number of readmissions. In the process, SOMOS saved New York State taxpayers some $300M.

Value-Based Payment holds great promise for the care of vulnerable minorities, those with broken lives, addicts, as well as undocumented migrants—patients that often fall through the cracks in the traditional Medicaid system. Surely, VBP—better care and significant savings—deserves broader application; the formula could be a powerful driver of reform for Medicaid-sponsored health-care delivery under the ACA umbrella. It would be smart spending all parties could agree upon.

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