Inside Obamacare

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"The challenge going forward is to be sure that care is integrated, effective, cost-effective and humane and that we as a nation can afford it," says Harry Selker. Credit: Alonso Nichols

Since it became law in 2010, the Patient Protection and Affordable Care Act (ACA) has been one of the most hotly debated pieces of legislation in recent years and continues to be controversial as it is implemented. For more than 15 years, Harry P. Selker, dean of Tufts University Clinical and Translational Science Institute (CTSI) and professor of medicine, worked closely on the issue with policymakers, including with

the offices of the late Sen. Edward M. Kennedy (D-Mass.), Sen. Max Baucus (D-Mont.) and Rep. Henry Waxman (D-Calif.).

Selker is a national leader in translational science, which aims to bring high-impact, cost-effective health care out of the lab and to the patient—an approach often called "bench to bedside." But translational science shouldn't stop there, says Selker. Good research, he says, makes for good public policy.

Selker and June Wasser, instructor of medicine and former Tufts CTSI executive director, are the editors of a new book, The Affordable Care Act As a National Experiment: Health Policy Innovations and Lessons (Springer), in which leading health policy experts examine the history, objectives and impact of the law that has become known as Obamacare.

Tufts Now talked with Selker about how the law will improve America's health-care system.

Tufts Now: What changes will consumers feel immediately as a result of the Affordable Care Act?

Harry Selker: The first thing we're going to notice is that millions more Americans will be able to get health-care insurance—ultimately 23 million. When I was a resident at Boston City Hospital (now Boston Medical Center), I took care of people who had no insurance. Not having access to routine care, their diseases progressed much further than they would have if these people had been insured. We as a nation, I think, have an obligation to provide health care as a basic need of life for our citizens. It's a profoundly important responsibility in support of health, welfare and fulfillment of potential.

As part of this expansion of coverage, there are other key changes that

most people already know about. People with pre-existing medical conditions now will be able to get coverage, and insurance can't be dropped as soon as a person gets sick, so that long nightmare is over. And for those covered by Medicare, Part D prescription drug coverage is enhanced so that the "donut hole" in payment coverage now is filled. This means that more people will be able to afford their medication because less will be required out of pocket.

What are some of the lesser-known elements of the new law?

Other parts of the law pertain to payment for medical care. The ACA has increased reimbursement for primary care physicians, which is crucial. Right now there aren't enough primary care physicians, in part because they aren't paid adequately. The financial incentives are greatly skewed towards the performance of procedures and the specialists who perform them. Thus young physicians with large debt loads from medical school feel they cannot afford to go into primary care. The ACA attempts to change this.

There are also important components of the ACA that crack down on insurance fraud and abuse and increase transparency in the flow of insurance funds and require that at least 80 percent of insurance dollars are used for patient care.

Ultimately by these and other measures, the ACA will change the way medicine is practiced. It will help change from care that is based on fee for service to a model of coordinated payment that should support care based on what is best for the patient and most efficient—a needed change that has been recognized for decades. In promoting this, the ACA provides for extensive evaluation by the Department of Health and Human Services and for independent research, including by health

services researchers such as are well represented at Tufts, to be sure that the new approaches are truly better. Another expansion of coverage is that the ACA has provisions that will allow people who are disabled to get some help at home so they can stay at home. It's much more humane. Right now, so many people have to go into assisted living or nursing homes, which are so much more expensive than at-home care and have many shortcomings for families.

Your book title suggests that the ACA is a great health policy experiment. Does the ACA do explicit research on the improvement of health-care delivery?

Embedded in the ACA is the creation of two research centers: the Patient-Centered Outcomes Research Institute and the Innovation Center at the Center for Medicare and Medicaid Services (CMS).

The newly created CMS Innovation Center was allocated $10 billion to spend over 10 years on projects to find ways to make health-care delivery more attractive, effective and efficient. For example, if Medicare paid for more home health-care services and attention to home conditions, might it avert illness or injuries that would lead to hospitalizations? Experiments of this type are being funded already—many here in Boston.

A novel and crucial aspect of the role of the CMS Innovation Center is that as its research provides ways to deliver care better, these findings can be directly implemented to improve nationwide health-care policy. The law allows the Secretary of Health and Human Services to implement the new policies immediately rather than waiting for congressional action—or inaction—as has been the case for Medicare policy changes in the past. This way, the nation can have a so-called "learning health-care system" across our entire nation. Rather than the

tradition of research being published, read and perhaps eventually implemented, and of local best practices not being adopted widely, now there is an immediate and direct route to impact care nationally. The nature and pace of health-care improvement nationally should be transformed—a revolution in health-care research and policy.

What will the patient-centered outcomes institute do?

Those of us involved in writing the legislation creating the Patient-Centered Outcomes Research Institute (PCORI) saw it as a way to support research that will inform patients, doctors and the public about the comparative effectiveness of various treatments. It was framed to provide information that will help people make critical health-care decisions, with a focus on what is best for the patient.

The trade-offs made in creating PCORI illustrate some of the "sausage making" that characterizes writing legislation. In assessing the financial impact of the ACA—which was a critical aspect of the overall legislation, as there were limits to how much it would be allowed to cost—the non-partisan Congressional Budget Office identified PCORI as one of the parts of the ACA that would save money. By conducting comparisons between treatments, when two or more treatments were found to be equivalent, then the least expensive one could be chosen, thereby saving money. However, this led to concern on the part of the pharmaceutical industry. If generic versions of drugs were shown to be as effective as the brand-name versions, drug companies would make less profit. Thus, one of the compromises needed to keep PCORI in the ACA was that the legislation prohibits PCORI research from explicitly doing cost-effectiveness analyses that are seen as threats to the sales of profitable drugs.

What were some of the other compromises?

In trying to assuage the concerns of the pharmaceutical, medical device and insurance companies, a late draft of PCORI not only had the new institute outside the government, it also had its governing board dominated by industry stakeholders. A group of us in academia and research worked hard to counter this, meeting with legislative staff, working with coalitions and publishing articles and op-eds. It was after we published a commentary in the *New England Journal of Medicine* that the bill's balance of the governing board was shifted to include more researchers and care providers and less industry influence.

On the other hand, our preference that PCORI be within the government, such as NIH, where we thought it would be most effective and independent, was not adopted. Its ultimate configuration is as a private nonprofit institute outside the government, but with funding streams, including taps on industry, mandated by the ACA. Ultimately, having to be set up as an entirely new research institute meant that it took a long time to ramp up, because it didn't have the research infrastructure in place. However, most of us now feel that being outside the government, with guaranteed funding not subject to the annual congressional appropriations process, and with a diverse governing board with academics and clinicians, has led to an excellent result for research, and ultimately for the nation.

It sounds like both sides actually made a lot of compromises.

Not only in the creation of PCORI—every aspect of creating the ACA was a compromise. Probably the most fundamental compromise was related to the fact that in this nation, unlike others, we had to build upon the existing features of our current health system. So, rather than making a single-payer national health-care system that covers all citizens, or even just expanding Medicare to cover all Americans, which might have been

simpler and ultimately less expensive, the ACA is built upon our nation's existing private insurance system. The failure of health-care reform in the Clinton administration made clear that reforming health-care delivery without the cooperation of the insurance industry is just not a realistic option in this country. Insurers had an enormous business stake in design of the ACA and needed to be engaged and involved in the compromises built into the new system. Likewise, medical device and pharmaceutical companies needed to be carefully engaged, because they stood to lose control of their markets and to have their profits curtailed. They pushed back, too, even though they are going to have a broader market of people who can afford their products.

What was the late Sen. Kennedy's influence on the process?

Ultimately, much of the success of getting the ACA passed was because all stakeholders were engaged as much as possible. That's one of the things I learned from watching Ted Kennedy. There was no more passionate advocate for the needs of the poor, sick or disabled, or for medical research. Yet he made carefully constructed compromises all the time, knowing that if he did not compromise, in the end, nothing would get done. He had so much wisdom in this. It was his passion for this undertaking, his implacable articulation of its importance and his example of how it needed to happen that remained the guiding light for this historic legislation. Although he did not survive to see it finished, he really was the central figure in the work.

The challenge going forward is to be sure that care is integrated, effective, cost-effective and humane and that we as a nation can afford it. There will be more changes down the road. If what we did here in Massachusetts was health-care reform 1.0, the ACA is health-care reform 2.0. There will be many more versions; we still have a lot more to

do.

Provided by Tufts University