Commentary

How the ACA Addressed Health Equity and What Repeal Would Mean

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Abstract This commentary reviews the many different ways the Affordable Care Act (ACA) explicitly and implicitly attempted to improve health equity, and then assesses how the Republican proposal to repeal and replace the ACA (the proposed American Health Care Act) would impact efforts to improve health equity. Although the American health care system still had a long way to go to achieve health equity, it may be argued that the ACA was a major step forward in creating new programs and regulations that had the potential to improve health equity. In stark contrast, Trumpcare makes no mention of health equity as a goal and—if passed—would result in an increase in health inequity. It would shamefully represent the first time in modern US history that a major federal health reform bill would actually move us further away from creating more equal access to health care coverage and toward reduced health equity.

Keywords Trumpcare, ACA, health inequity

In a bill that is 906 pages long one might think that the Affordable Care Act (ACA) would impact many different facets of our health care system, and of course it does, despite the media and political focus on the coverage components of the bill. While the coverage components are crucially important for improving health equity in the United States, the ACA provided new provisions across the policy spectrum to address health equity in a multipronged approach.

As discussed in the Introduction of this special issue, there are multiple ways to approach achieving health equity: from focusing on creating a more inclusive and fair decision-making process to improve health equity to focusing on direct investments in vulnerable communities to create a

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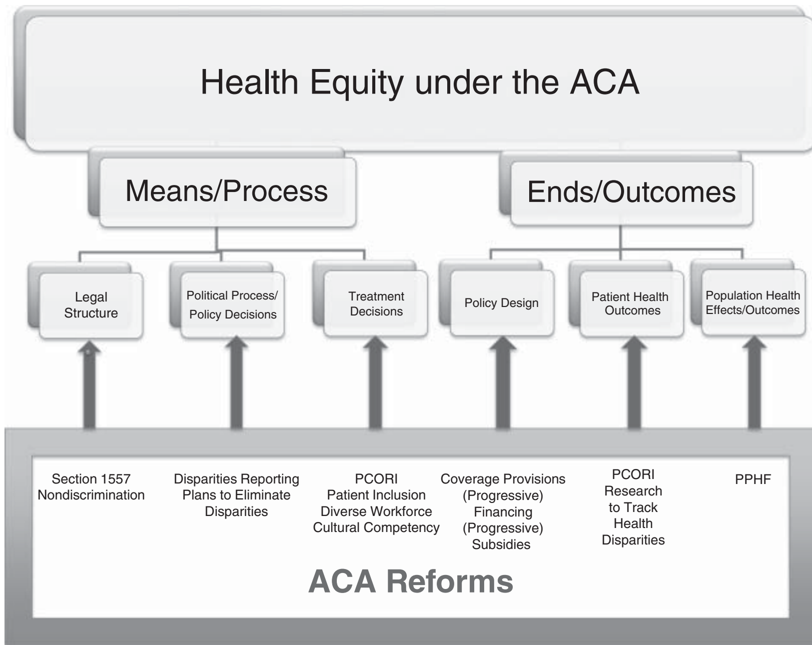

Figure 1 Health Equity under the ACA

more equal distribution of health outcomes. What should be fully appreciated about the ACA is that it indeed included provisions for improving health equity through creation of a fairer process and a more equal distribution of health outcomes, and also invested across multiple levels within the health care system (see fig. 1). In this short commentary I walk through some of the most important provisions of the law. This illustrates the magnitude of the ACA's intent to impact health equity. While we can debate how well various provisions would have improved health equity (or will improve equity in the absence of repeal), it is clear that improving health equity was (and continues to be) a central goal of the ACA, and a number of provisions were implemented to achieve that goal.

This is crucially important because you cannot begin to achieve a goal unless you place that goal in legislation, and create concrete implementation plans to begin the hard work. The ACA did that. Therefore, when the Congress debates total ACA repeal with or followed by a replacement bill (as is happening as this issue goes to press), it is important to grasp all that will be thrown out and how unlikely it is that health equity will be stated as a central goal of replacement legislation—much less the inclusion of provisions to achieve the goal.

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How the ACA Addressed Health Equity

All ten titles of the Affordable Care Act contain some aspect concerning health equity.[1] There are thirty-five explicit mentions of "health disparities" in the Act—all specifying a particular effort to reduce or eliminate health disparities. Title I focuses primarily on reforms to the individual and group health insurance markets. There are numerous sections of Title I that deal explicitly with prohibiting various forms of discrimination.[2] As Rosenbaum and Schmucker discuss in this issue, Section 1557 (ACA § 1557[a]) is particularly important because it prohibits health insurers and health care providers not only from intentional discrimination, but also from engaging in unintentional behaviors that result in a disproportionate impact by race, ethnicity, gender, disability, or age (see also Watson 2012).

Title II deals primarily with specifications for improving access to the Medicaid program—what is now known as the Medicaid expansion. However, also included in this title is Section 2951, which details goals to improve maternal, infant, and early childhood home visiting programs for at-risk communities. This section not only requires states to submit a needs assessment to identify communities at risk, but also a plan for addressing these needs, which would "improve health care practices, *eliminate health disparities*, and improve health care system quality, efficiencies, and reduce costs" (p. 340, emphasis added).

Title III specifies a set of programs and principles for improving the quality and efficiency of health care where the goal of attempting to achieve health equity is clearly specified. Under directives to the Secretary of the Department of Health and Human Services (HHS) to develop a "National Strategy," one of the seven requirements listed states that "the Secretary shall ensure that priorities identified [will] . . . reduce health disparities across health disparity populations and geographic areas" (p. 378). Similar language is added for determining performance bonus payments for Medicare advantage plans, that is, that performance indicators would take into account reductions in health disparities (p. 448).

Particularly significant is the creation of the Prevention and Public Health Fund (PPHF) detailed under Title IV to "provide expanded and sustained national investments in prevention and public health, to improve

1. Title VIII, the CLASS Act, was officially repealed on January 1, 2013, so I will not discuss that title.

2. Section 2716, Prohibition of discrimination based on salary; Section 2704, Prohibition of preexisting condition exclusions or other discrimination based on health status; and Section 1557, Nondiscrimination.

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health outcomes, and to enhance health care quality" (APHA 2017). Although the PPHF never received the full funding initially specified under the ACA in 2010, the establishment of this fund is significant in representing the first mandatory funding stream for public health from the federal government (Pollack 2011). Many studies attempting to pinpoint how best to improve health outcomes and reduce disparities point to investments in population health as key. Thus, it is noteworthy that a core part of PPHF's funding has gone to bolster the country's public health infrastructure—to create the basic components of a healthy community—as well as to prevent the spread of infectious diseases and control their outbreaks. In addition, PPHF dollars have gone directly to support "programs at the local, state, and federal levels that fight obesity, curb tobacco use, and increase access to preventive care services" (APHA 2017).

Title IV also created community transformation grants administered by the CDC, with the expressed purpose of creating healthy communities that would prioritize "strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health" (pp. 564–65). In the first year alone (2011), the CDC provided sixty-seven grants across thirty-six states. Most grants funded private-public partnerships across multiple sectors including schools, transportation, private businesses, and faith-based and nonprofit community-based organizations (CDC 2017).

Title V of the ACA is devoted to improving the health care workforce with specific attention to improving cultural competency and public health proficiency training to reduce health disparities (p. 628). The Patient-Centered Outcomes Research Institute (PCORI) was established under Title VI of the ACA. Its purpose has been to assist patients, providers, purchasers, and policy makers in making informed health decisions by advancing the quality of evidence of comparative clinical effectiveness information through rigorous research. The ACA specified gaps in knowledge regarding health disparities as an important indicator to be used when identifying research priorities (p. 729). Title VII—improving access to innovative medical therapies—contains three sections devoted to improving access to affordable medicines for children and underserved communities. And, finally, Section 10334 is devoted to issues pertaining to "Minority Health" under Title X.

These provisions, while glossed over here for the sake of brevity, when taken together, convey the breadth of attention given to improving health equity under the ACA (see fig. 1).[3] And yet, although these provisions are

3. Note these are not even all the provisions that address health equity in the ACA. For a discussion of other provisions not discussed here, see Fiscella (2011).

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the least recognized related to the ACA and therefore worth highlighting here, I would be remiss in not mentioning the enormous progress the coverage components have made toward improving health equity. Providing coverage through the Medicaid expansion and health exchanges not only has created more equal access to health care services, but also has significantly redistributed the burden of health care costs. In particular, the ACA coverage expansions moved the US distribution of premium costs from extremely regressive (where the poor pay a higher proportion of their income for premiums compared to higher-income Americans) to a much more progressive distribution. This is especially true in the expansion states where premium burdens—the amount that individuals are expected to pay—were made logically progressive starting at zero and gradually increasing at each higher income level (Grogan 2015).

On the revenue side as well, the ACA has made the tax system more progressive. Individuals at the very high end of the income distribution (2 percent of taxpayers) were required to pay higher federal taxes, higher Medicare payroll taxes (by 0.9 percent), and increased taxes on unearned income (largely investments) by 3.8 percent (Rice 2011: 492). These new taxes—all imposed on the very wealthy relative to the remaining 98 percent of Americans—covered a significant portion (about 17 percent) of total funding needed to pay for expansions contained in the ACA (Dorn, Garrett, and Holahan 2014).

Finally, the ACA also includes progressively rated cost-sharing subsidies for people who earn up to 250 percent of the poverty line in the health care marketplaces (from 6 percent to 27 percent cost-sharing levels) (Health Policy Brief 2013). And, the ACA sets limits on the total out-of-pocket costs for marketplace plans ($6,600 for an individual plan and $13,200 for a family plan in 2015). The financing of these coverage provisions significantly lowered the financial burden of health care costs for low-income Americans, while at the same time creating more equitable access to health care services.

While the ACA had a long way to go to eliminate health disparities, it is important to take stock of all that was put in place to help improve health equity, especially in light of current proposals in Congress to repeal and replace the ACA. If the chief bill now before Congress—the so-called American Health Care Act that passed the House (which is all that has passed as of this writing in February 2017)—is passed, what would be lost, and would any gains toward health equity be achieved?

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What Repeal and Replace Would Mean

Not surprisingly, repealing and replacing the ACA coverage provisions are the key foci of the reform proposal. The individual mandate, along with health care marketplaces and the subsidies for low-income individuals, would be repealed in favor of people purchasing health insurance *voluntarily* in the individual insurance market with the help of tax credits. While the Medicaid expansion would be an option for states to continue expanding coverage until the end of 2019, it also would then be repealed. At that point, Medicaid financing would be changed from a matching rate formula in which the federal government matches (50–82 percent of) the amounts that states contribute to the program to a per capita cap (PCC) in which the federal government provides a flat amount per person based on 2016 per-person expenditures. The bottom line is that switching to a PCC financing scheme will lower the amount of federal funding to the states for covering Medicaid expenses. The Center on Budget and Policy Priorities estimates that states would have to cover an additional $370 billion in Medicaid costs over the next ten years (Park, Aron-Dine, and Broaddus 2017). Finally, the taxation policies imposed on wealthy Americans to finance the ACA expansions would all be repealed with no tax policy replacements. The Joint Committee on Taxation estimates that repealing the ACA's tax directives will cost nearly $600 billion through 2026, and almost all of these savings would go to the very rich (Committee for a Responsible Federal Budget 2017; Mermin 2017) (see fig. 2).

There are many details that still need to be worked out, but the key takeaway messages from the proposed replacement bill are threefold: first, fewer people will have health insurance coverage because the tax credits will be insufficient to induce voluntary purchase, and because states will have less money and be forced to roll back Medicaid coverage. Second, the premiums and cost-sharing contributions of low-income Americans will increase sharply, not only because the plan eliminates cost-sharing subsidies but also because insurers would be allowed to sell catastrophic plans with high cost-sharing requirements. Third, the financing to pay for all expenditures associated with the replacement plan (e.g., the tax credits) will be far more regressive given the repeal of taxation on wealthy Americans. In stark contrast to the ACA, these coverage reforms will move the country toward greater health *inequities* and, as such, will exacerbate existing health disparities.

In addition to the coverage reforms, the bill also would eliminate the Prevention and Public Health Fund. This would mean a reduction of at least $1 billion per year in public health funding (based on the last two years

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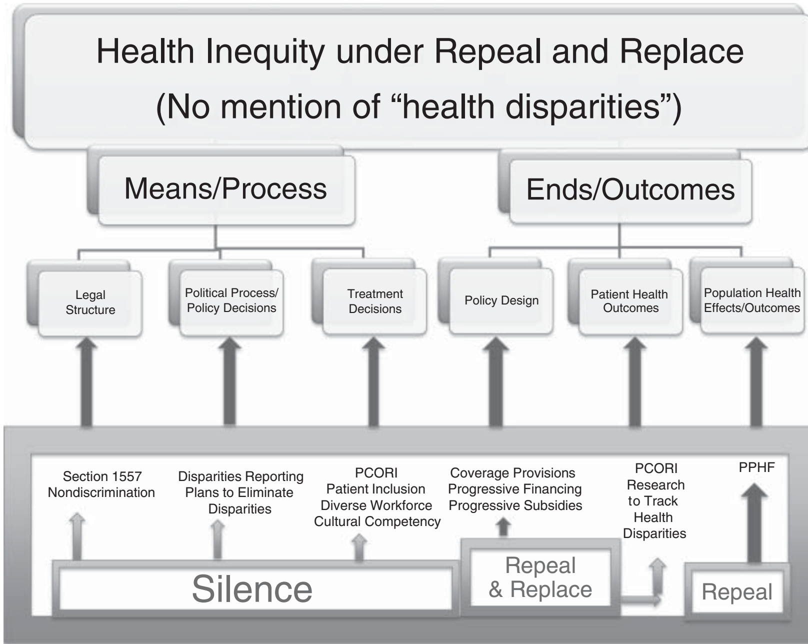

Figure 2 Health Inequity under Repeal and Replace

of appropriations), since the bill specifies no replacement. Local and state health departments would suffer enormously at a time when investment in basic public health infrastructure is arguably already too low, especially in light of ongoing threats of bioterrorism and difficulties in maintaining healthy local environments. Chrissie Juliano, director of the Big Cities Health Coalition (BCHC), a membership organization of twenty-eight urban governmental public health departments, reported: "I cannot underscore the importance of these funds enough . . . . [These funds are] essential to core public health programs that keep Americans healthy and safe every day . . . supporting disease tracking, access to immunizations for those most in need, and preventing and addressing lead poisoning, among other priorities" (Juliano 2017).

The absence of any mention of "health disparities" in the replacement bill is also deafening. While there is no reference to Section 1557 that disallows discrimination, or to any of the provisions calling for reporting on health disparities or creating a plan to eliminate disparities, or to the continued funding for PCORI, most of the changes apply to the coverage provisions—how do we implement better reporting on health disparities

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when more people are left out of the system? There were new expectations for addressing health disparities, for example, under the Medicaid expansion, but with expansion curtailed, efforts to address health disparities also would go away. While the incentives for delivery model reforms, which also emphasized reducing disparities, will hopefully remain intact, the lack of any mention of a goal to reduce health disparities sets forth a strong signal that the health equity goal that was clearly emphasized in the ACA is no longer valued.

Perhaps of greatest concern is the underlying philosophy of the repeal and replace proposal that so clearly is at odds with moving toward greater health equity. Although the ACA never achieved universal coverage (undocumented immigrants were excluded from the ACA due to another contentious partisan debate), it brought the United States closer to this goal than at any other time in American history, owing to the belief that all Americans deserve access to health care coverage regardless of their circumstances. In striking contrast, the repeal and replace proposal takes us back to beliefs espoused in 1965 when Medicare and Medicaid were enacted—that only certain people are deserving of health care coverage: the elderly under Medicare; the "truly deserving" aged, blind, and disabled under Medicaid; and those who cannot work—under Medicaid. The rest of the population should purchase private health insurance with their earnings. The assumption then was that if one were working, private health insurance would be affordable. That has never been true, and is even less so today. But, for those promoting the replacement bill, it remains their core belief. They want to place the blame for lack of coverage back onto the individual, and remove any sense of public or communal obligation to make sure that everyone has access to health care coverage. If that is truly the belief structure for the new American Health Care Act (if passed by Congress), then we are, sadly and pitifully, moving very far away from achieving health equity.

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