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ACA here to stay, retooling it will be the challenge for next president

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Former President Bill Clinton may have been right when he characterized the Affordable Care Act as the "craziest thing he ever heard of."

Unfortunately, Mr. Clinton's proposed solution to fix Obamacare, the oft-mentioned Medicare and Medicaid buy-in, does not come without its own set of complex financial challenges.

In this bizarre season of presidential electioneering, it is no surprise that the Affordable Care Act, tied to six years of constant controversy, has generated more than a few sound bites on the campaign trail.

Both Green Party candidate Jill Stein and Democratic nominee Hillary Clinton have posited numerous suggestions for health reform. Stein, as one might guess, is arguing in favor of Medicare for all, a single-payer system, reminiscent of another populist, Sen. Bernie Sanders.

Clinton, no stranger to health policy, has voiced several reform ideas building on the current ACA, including a major focus on reducing the costs of and expanding access to prescription drugs as well as advocating for lowering Medicare eligibility to age 55.

Libertarian Gary Johnson, on the other hand, wants the federal government out of health care and tempers the pain by advocating for legalization of marijuana.

And then, there is Donald Trump's pledge to repeal Obamacare — and he suggests that big savings can be had through the creation of robust interstate insurance markets.

Even with all the missteps, and bone-numbing complexities, the Affordable Care Act remains the signature domestic accomplishment of the Obama administration. The passage of the ACA in 2010 parallels other major legislative milestones in which complex variables momentarily align, thereby defying historical odds.

Scrapping Obamacare may be politically appealing to some, but with no viable alternative, its repeal would jeopardize health insurance coverage for millions.

House Speaker Paul Ryan's plan that proposes to fill the void with tax credits and increased use of health savings accounts is simply inadequate to meet the needs of low-income Americans.

The clear message that emerges from the presidential posturing is that, at best, the ACA remains a work in progress. Laden with so many untested ideas, Obamacare will require ongoing

remodeling, a lesson that Medicare has taught us for more than 50 years. Required changes need to go beyond the candidates' calls for containing costs and increasing competition.

At the top of the ACA reform list sits state insurance exchanges. Although the early days of enrollment glitches may be gone, there are simply not enough choices in state marketplaces to spark competition.

The shift from underwriting to managing risk seems too great a haul for insurers, as demonstrated by the demise of most co-ops. Measures like capping enrollment and increasing prices may not rescue exchanges from evolving into a type of public option, heavily buttressed by ever-expanding federal subsidies.

Another reform focal point concerns prescription drugs. Pharmaceutical spending is a chief contributor to rising health-care costs, continuing to elude meaningful regulatory control.

Candidate Clinton has called for Medicare to negotiate drug prices and expand rebates. But the politics of Big Pharma are dicey. Without a total sea change in November, an agenda for prescription drugs maybe better focused on optimizing utilization and where appropriate deprescribing.

Policies underpinning health data systems need tending. Pre-ACA, the dream of a seamless electronic medical record system was launched, and although progress has been made, the goal of interoperability remains elusive.

Without harmonized data systems, the ACA's so-called triple aim (better care for patients, better care for populations, reduced costs) can't be accomplished. Virtually all of the law's quality initiatives rest on the ability to collect and analyze detailed sets of clinical data across competing health systems.

Other highly visible areas for reform include the fate of the pending "Cadillac tax" and enforcement of the individual mandate. A perennial ACA challenge will be the need for the Congress to make deep cuts to Medicare, beyond provider reimbursement, as the program is just beginning to confront a new wave of demands with the emergence of personalized medicine.

In addition, state Medicaid redesign efforts must continue, with pursuit of strong measures that go beyond simply shifting public responsibilities to privately managed-care conglomerates.

The difficult tight rope act of improving quality and simultaneously reducing costs at the center of ACA innovations must be actualized outside the pages of the Federal Register. Not all value-based schemes, including accountable care organizations, will be sustainable, short of continuous reinvention.

The massive new regulations in the name of quality, such as the 2,000-page rule on physician reimbursement, may only serve to dampen practitioner participation in public insurance programs. Speaking of physicians, they are part of a health-care workforce whose numbers are woefully inadequate to meet growing access demands. The daunting task of health-care human resource planning largely remains a back-burner issue.

Perhaps the biggest challenge surrounding the ACA is the unfinished business of long-term care, where legislative shortcomings have been replaced by unrealistic expectations about community care and volunteerism.

Speaking of the aging bubble, it may be encouraging that two seniors are healthy enough to run for president.

One of these baby boomers will inherit the ACA. It may not be a "disaster," but certainly will need robust oversight, making the task of the executive branch in health policy, simply "huge."