The Affordable Care Act, Kidney Transplant Access, and Kidney Disease Care in the United States

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Disparities in access to health care, including in access to kidney transplantation, are widespread in the United States (1). Although the Medicare ESRD program is one of the few examples of a single-payer system in the United States, most people with kidney disease under age 65 years old cannot receive Medicare coverage until they require dialysis. This creates a scenario where, particularly for younger individuals with advanced kidney disease, access to optimal treatment may be limited, including transplant waitlisting before dialysis initiation and preemptive kidney transplantation as well as care to slow the progression of kidney disease and prepare individuals for kidney replacement therapy.

After the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and widespread implementation of its provisions in January 2014, millions of United States residents gained access to insurance coverage, with much of this increased access reflecting expanded Medicaid eligibility as well as expanded access to commercial insurance. Because Medicaid is largely administered by the states and not all states expanded Medicaid eligibility, uptake of Medicaid expansion varied widely across the United States. Given the disproportionate number of socioeconomically disadvantaged individuals with kidney failure, improved access to health care through Medicaid expansion could have major implications for kidney disease care in the United States.

In this issue of the *Clinical Journal of the American Society of Nephrology*, Harhay and colleagues (2) use United Network of Organ Sharing data to examine whether Medicaid expansion affected preemptive kidney transplant waitlisting, comparing changes in preemptive waitlisting between states that expanded and those that did not expand Medicaid. From 2011 to 2016, there were 59,265 individuals preemptively listed, including 32,670 in 24 expansion states and 18,288 in 19 nonexpansion states. From the pre- to postexpansion period (2011–2013 versus 2014–2016), states that fully implemented Medicaid expansion had a 59% relative increase in Medicaid-covered preemptive listings for kidney transplantation, rising from 1094 to 1737 listings, compared with a 9% relative increase, from 330 to 359 listings, in nonexpansion states. The adjusted portion of preemptive waitlistings with Medicaid coverage remained essentially unchanged in nonexpansion states (4.0%–3.7%) while increasing from 7.0% to 10.0% in expansion states. Critically, the total number of patients preemptively waitlisted rose in both expansion states and nonexpansion states across the time periods, and there is no analysis by Harhay and colleagues (2) as to whether individuals who would have received Medicaid in expansion states were able to obtain commercial insurance in nonexpansion states to facilitate preemptive waitlisting. Medicaid expansion was associated with larger percentage absolute increases in preemptive listing in ethnic minorities (4% increase among blacks, 5.9% increase among Hispanics, and 5.3% increase among "other" listings compared with a 1.4% increase among whites).

Prior studies have shown an association of socioeconomic status and type of insurance with kidney transplant waitlisting and transplantation. Keith *et al.* (3) reviewed Scientific Registry of Transplant Recipients data from 2001 to 2004 and showed a 78% lower likelihood of preemptive listing with Medicare only compared with commercial insurance. Similarly, in a single-institution study, Schold *et al.* (4) showed that patients with noncommercial insurance were less likely to receive a transplant evaluation relative to patients with commercial insurance and that there was no difference in transplant waitlisting between black and white individuals with commercial insurance. Critically, prior analyses also show better access to CKD care, including transplant waitlisting, in states with broader access to Medicaid coverage, suggesting that both having insurance and the type of insurance may be important factors for kidney disease care (5).

This study has important limitations, most notably that there were other policy and macroeconomic changes concurrent with Medicaid expansion in some states that also improved access to health care. These include increased access to commercial insurance through federal and state insurance marketplaces in all states, the exclusion of preexisting conditions as a determinant of insurance eligibility, and the ongoing economic recovery (6). Notably, enrollment in commercial insurance plans rose more in nonexpansion states than in Medicaid expansion states. Given the relatively small proportion of Medicaid patients among those who were preemptively listed, it is possible that improved access to all insurance coverage, including private insurance, may have resulted in similar overall listings in both expansion and nonexpansion states, and given prior reported advantages with private insurance compared with

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noncommercial insurance, those able to obtain commercial insurance may have had advantages in accessing kidney care.

Concurrent with expanded insurance access after implementation of the ACA, be it Medicaid or commercial coverage, the new Kidney Allocation System (KAS) was implemented in December 2014 with a goal of improving equity and access to transplantation for minorities (7). With previous studies showing that late referral and listing for kidney transplantation in blacks was a factor in lower transplantation rates, the new KAS included time from dialysis initiation rather than from registration on the transplant waitlist. Publicity associated with the new KAS also may have highlighted other aspects of the kidney transplant waitlist: a recent analysis of Organ Procurement and Transplantation Network data showing an increase of 4.9% in preemptive listings from the pre-KAS period to the post-KAS period, with this trend persisting through 2016 (8).

Although both the new KAS and the expansion of access to Medicaid and commercial insurance begin to address disparities in kidney disease care in the United States, major issues remain, particularly with regard to access to kidney transplantation. These include declining living kidney donation rates, low organ utilization with frequent discards, and uncertainty regarding living donor protections. To date, not enough has been done on a policy level to address these issues. The Living Donor Protection Act was reintroduced in Congress in 2017 after the failure of the 2016 iteration to gain sufficient support. This act protects donors by prohibiting insurance companies from altering or denying coverage to individuals on the basis of their status as an organ donor, and it specifies that living organ donation would entitle an individual to work leave under the Family and Medical Leave Act of 1993 (9). Other needed policies to address disparities in kidney care and access to kidney transplantation include guaranteed lifetime access to transplant immunosuppression.

The ACA succeeded in improving access to health care, with increases in insurance coverage in all states but more marked rises in insurance coverage occurring in states that either expanded Medicaid or expanded access to commercial insurance for low-income adults. Interestingly, coverage expansion itself, rather than whether expansion was accomplished through Medicaid or better access to commercial insurance *via* marketplace exchanges, had similar effects on utilization of preventive care (10). After the implementation of the ACA, insurance coverage rose slightly more for black and Hispanic individuals with chronic conditions than for whites, perhaps beginning to address some of the disparities in health care; of note, this was not accompanied by a similar increase in accessing care for minorities, and many individuals, particularly those with commercial insurance, where copays may be a barrier to utilization of care, still struggled to afford physician visits (11). Critically, the ongoing uncertainty surrounding the future of the ACA after multiple congressional repeal attempts, the failure of the federal government to pay cost-sharing reduction payments to insurers to subsidize commercial insurance for lower-income adults, the expansion of short-term health insurance plans with variable coverage of preexisting conditions, and the repeal of the ACA's individual mandate to obtain insurance threaten the viability of expanded health care access, particularly for individuals with chronic conditions, including kidney disease.

Preemptive transplant listing is one quantifiable marker of improved access to medical care before dialysis initiation, potentially serving as a proxy for other valuable care before dialysis initiation, including management to slow kidney disease progression, discussions of kidney replacement therapy, and dialysis access planning and creation. The critical link is increased access to insurance coverage, regardless of whether it is through Medicaid or other payers. Without access to care, patients go undiagnosed and untreated, crashing onto dialysis without having prepared for kidney replacement modalities. Particularly in conjunction with population education about kidney disease and kidney donation and with awareness of the need to improve equity in all stages of kidney disease care, policies that improve access to care can have a tremendous effect on the delivery of medical care. Harhay and colleagues (2) elegantly quantified this by describing the effects of access to Medicaid on preemptive kidney transplant listing. Much harder to quantify but likely far more numerous are the patients who, because of earlier diagnosis and treatment of their kidney disease, may never need to be listed for a kidney transplant but rather, will be able to maintain kidney health with better access to medical care.

Disclosures

None.

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