Morgan’s region is one of several across the country that have created hepatitis C dashboards featuring information from patients’ electronic medical records that is updated daily. The tool allows Morgan and colleagues to sort through patients by hepatitis C genotype, extent of liver disease, treatment status, and other factors. Last year, the Long Beach VA system used it to identify veterans with hepatitis C and advanced liver disease who hadn’t yet been treated and send a letter inviting these veterans to come in for potentially curative therapy.

“If they don’t call, we call them,” Morgan said. During the previous 2 years, nearly 40% of veterans treated for hepatitis C at the Long Beach medical center had been diagnosed with advanced liver disease. Nationally, that figure is 21% of the 174,842 veterans within the VA health system who have been diagnosed with hepatitis C. More than 76,000 of these veterans have already received treatment, and more than 60,000 have been cured.

**Educating Veterans**

Once veterans are in treatment, managing their need for ongoing monitoring and education about hepatitis C is yet another challenge. In San Francisco, a solution is monthly group visits, where 4 to 8 veterans have their blood drawn, pick up a 30-day supply of medication, talk about their latest test results, and provide each other with peer support. A psychologist is typically present to deal with emotional issues that accompany treatment and hope for a cure.

Veterans with drug or alcohol addiction aren’t automatically excluded from treatment at the VA, nor is there any specified abstinence requirement. But they won’t be offered antiviral therapy if adherence problems are suspected, Ross said. The VA has extensive experience in treating veterans with HIV infection who also struggle with substance abuse, and the agency understands the need to address social and psychological issues that can complicate medical treatment, he noted.

As many as 1 of 10 Vietnam veterans have chronic hepatitis C—a rate 5 times that of the general population—and Vietnam Veterans of America has begun holding educational sessions around the country to encourage them to get tested and seek care if necessary. All are in the age group the VA is targeting, but the hepatitis C virus wasn’t identified until 1989, years after the war ended. Meanwhile, the American Legion has also begun testing veterans for hepatitis C at community events through a partnership with AbbVie, which markets the Viekira Pak hepatitis C medication and has a financial interest in seeing more veterans treated for the disease.

Addressing the stigma associated with hepatitis C—which is closely associated with injection drug use and found disproportionately in people who are homeless and other marginalized populations—is an important part of these discussions. “When they came home, Vietnam vets were widely viewed as drug addicts or lazy good-for-nothings, and they haven’t forgotten,” said Berger. “Most of us were not involved in IV drug use; that’s not how we acquired hepatitis C. But that’s one of the reasons why so many of our people don’t get tested, because of the stigma.”

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**The Partisan Divide on Health Care**

**Larry Levitt, MPP**

Presidential elections rarely turn on debates over policy. They are typically influenced much more by the state of the economy, what is happening in the world, and the personal characteristics of the candidates. This year’s campaign, which is atypical in so many respects, may be even less about policy than usual and more about perceptions of the personal qualities of the candidates.

But elections always have consequences for the future direction of policy. Now that the party platforms for the 2016 campaign are written and posted online, we can see that Republicans and Democrats are as far apart on health care as they have been for quite some time. Platforms are never implemented as written, and not all candidates endorse every plank in them. However, they signal which issues are important to the parties and, broadly speaking, what candidates aim to do about them.

**Republican Platform**

Not surprisingly, the centerpiece of the Republican health care agenda (http://bit.ly/2aKyxxa) is repeal of the Affordable Care Act (ACA). The more contentious question has been what policies Republicans would put in place of the ACA and what changes they might propose for Medicare and Medicaid.

Key elements of the Republican health care platform include:

- Protection from insurance discrimination for people with preexisting conditions who maintain continuous coverage. This would be a weaker safeguard than what’s in the ACA, which guarantees access to insurance for everyone, even if they’ve had a gap in coverage, and requires that a minimum set of benefits be provided.

- Allowing people to buy insurance across state lines. This would likely have the effect of insurers setting up shop in states
with the least stringent regulations. It would not address the main impediment to insurers expanding their service areas, which is negotiating contracts with physicians and hospitals. • Ending “tax discrimination against the individual purchase of insurance.” Historically, this has generally meant allowing people who buy insurance on their own to deduct the cost of their premiums on their taxes, which would put individual insurance on equal footing from a tax perspective with employer-provided coverage. This idea, which Donald Trump proposed earlier (http://bit.ly/2aVVoA0), would benefit higher-income people in higher tax brackets. But it would little help lower-income people—who would make up the bulk of the uninsured if the ACA is repealed—because they are in low tax brackets and generally don’t itemize deductions. • Capping federal spending on Medicaid and giving states more leeway in administering the program through a block grant (http://bit.ly/29ZixX0). The precise effects would depend on the details, but block granting Medicaid would likely lead to lower federal spending over time. It would shift the risk of rising health care costs to states and could lead to reductions in Medicaid eligibility and coverage as states respond to the increased risk. • Providing people under age 55 years with the option of traditional Medicare or a premium support system of competing insurance plans once they enroll in Medicare (http://bit.ly/2aKzupv). The platform also proposes to raise the age of eligibility for Medicare. Democratic Platform In their platform (http://bit.ly/29YL9Vu), Democrats propose to build on the ACA toward the goal of achieving universal health care. The ACA has brought the share of the population uninsured to the lowest level recorded (http://bit.ly/2aKzh5s), yet 28.6 million people were still uninsured in 2015 (http://bit.ly/29ZYvzU). Specific health care proposals in the Democratic platform include: • Providing the option to enroll in a “public option” plan and allowing people over age 55 years to buy-in to Medicare. These mechanisms have the potential to lower costs for the federal government and consumers by decreasing administrative overhead and reducing rates paid to physicians and hospitals, which also helps to explain why the ideas have been quite controversial. • Making premiums more affordable and reducing patient out-of-pocket costs. Although the platform does not provide any detail on how this would be accomplished, Hillary Clinton has proposed to increase the ACA’s income-based premium subsidies and create a refundable tax credit for people with private insurance who have high out-of-pocket costs relative to their incomes (http://bit.ly/2abRQ6W). The platform also calls for an end to surprise medical bills (http://bit.ly/2aul6CS). • Targeting prescription drug costs. Monthly out-of-pocket costs for drugs would be capped, which would help some patients but not address the underlying prices for drugs. Importation of lower-priced drugs from other countries would be permitted, and “pay for delay” arrangements that postpone the introduction of generic drugs would be prohibited. Medicare would be allowed to negotiate drug prices directly with manufacturers (though the platform is silent on whether Medicare could also create a drug formulary in order to gain leverage with manufacturers). • Expanding funding for community health centers. Clinton has proposed $40 billion in additional funding for health centers over 10 years, which would represent a substantial increase in resources (http://bit.ly/2avWzjG). As their platforms illustrate, Democrats and Republicans have “fundamentally different” aims in health care (http://on.wsj.com/1ZWFuO9).

Democrats have sought to expand the use of government spending, regulation, and purchasing power to increase the number of people with insurance, reduce the growth in health care costs, and protect patients from discrimination and high out-of-pocket expenses. That has meant higher taxes and a more expansive role for government. Republicans are focused more on lowering federal spending, reducing taxes, and minimizing regulation, which would in turn lead to more people uninsured and less protection for people with preexisting medical conditions. The ACA has increased insurance coverage by 20 million people (http://bit.ly/2a4Z1Xs), and it is now the status quo in our health care system. Fully repealing it would be very disruptive. At the same time, the public remains divided on the law (http://bit.ly/29YD2f), so building on it will also be controversial. Regardless of who wins in November, neither party will get everything it wants. In fact, the experience of recent years suggests that any meaningful policy change in health care is exceedingly difficult in this political environment. Still, it is safe to assume that who controls the White House and Congress after November will heavily influence the future direction of the ACA and government health programs in general. ■

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