HEALTHCARE REFORM:  
THE EFFECTS OF THE ELECTION

As the provisions of the PPACA are being put into effect, many questions and concerns remain among all sectors.

By Amy Scanlin, MS

President Obama has been re-elected, and the Patient Protection and Affordable Care Act (PPACA) has been declared constitutional. As such, changes in healthcare coverage and implications for insurance companies, drug and medical device manufacturers, physicians and patients are moving forward, amid many questions as to what is to be expected. With the plans and policies of the PPACA still evolving, it will be many years before the full implications are seen. However, there are some key effects of the election outcome that will prepare us for what to expect in the near term.

First, some facts:
• Health insurance exchanges will be fully in place by January 2014.
• In 2011, drug companies were taxed higher to the tune of $27 billion, and in 2013, it is expected that new taxes on medical devices will total approximately $20 billion.1
• An estimated 16 million to 18 million people, or anyone with incomes lower than 133 percent of the federal poverty level, will be added to the Medicaid system.
• The influx of patients will strain access to providers who accept Medicaid. According to a survey of providers conducted by Sermo and Athena Health, 66 percent of physicians have considered dropping out of government-run health programs.2
• High-risk insurance pools have not had the level of anticipated success so far, so changes to enrollment are being made. In addition, a proposed long-term care provision called the Community Living Assistance Services and Support program (CLASS Act) has been suspended due to an inability by officials to find a way to make it financially feasible.3

Universal Coverage
While the government estimates the PPACA will reduce the number of uninsured by 32 million by 2019, further estimates say that 23 million will continue to remain uninsured. Medicaid will see an increase of between 16 million and 18 million people, and 24 million people will become eligible to be insured through state-based exchanges beginning in 2014. Many predict that those seeking care through Medicaid will
have a tough time finding providers because low Medicaid reimbursement rates have reduced the number of physicians who accept it. Faced with a scarcity of providers, many Medicaid-eligible patients may seek healthcare through emergency room visits, by some estimates even more than the number of emergency room visits by the uninsured.

However, it is not just Medicaid patients who may have trouble finding care. With millions of newly insured patients in the system, appointments will become harder to find for most everyone. “There is not much the country can do about the shortage of primary care physicians in the near term,” says Marc Boutin, executive vice president and chief operating officer at the National Health Council. “However, federal and state legislators have been working on the idea of getting allied health professionals to take on more services under primary care, for example using physician assistants and moving responsibilities to other levels. There is certainly anxiety [about the vast numbers of new patients coming into the system], but we need to realign the delivery system in an appropriate way.”

Starting in 2014, unless exempt for financial hardship or religious reasons, those who can afford it will be required to have health insurance or pay a fine of 1 percent of their income or $95 for an individual in 2014 and increasing to 2.5 percent of their income or $695 by 2016. For families, the penalty would be 2.5 percent of household income or $2,085, whichever is greater. Subsidies to purchase insurance will be provided for those who need it, or they may qualify for Medicaid.

Children presently cannot be denied coverage for a pre-existing condition, and this will extend to adults in 2014.

Employers may choose to keep the insurance plans they currently offer, but they are under no obligation to do so, and they may also change premiums, deductibles and co-pays. However, in 2014, small businesses that employ 50 or more people, have at least one employee using subsidized healthcare, and choose not to provide healthcare insurance will be fined $2,000 per full-time employee. Tax credits will be offered to small businesses to help encourage them to provide insurance coverage.

The Supreme Court has ruled that states cannot be forced to require state-based exchanges or to provide Medicaid insurance to all those who fall 133 percent or more below the poverty level. As well, federal funding for Medicaid cannot be withheld from states that choose not to create their own state-based exchange. However, states must determine whether they will offer their own state-based exchange, default to a federally facilitated exchange or form a hybrid of the two. Those states that choose not to increase Medicaid coverage will continue to receive their Medicaid subsidies at their present rate. Those that choose to increase coverage will receive 100 percent coverage for all newly enrolled beneficiaries between 2014 and 2016, and 90 percent thereafter. In addition, states that choose to increase Medicaid coverage are also able to reduce that coverage after 2016 when the 100 percent coverage drops to 90 percent.

A lot of decisions about how to implement the new rules are being left to the states as well. “Right now, there is no uniform anti-discrimination language [and] no uniform appeals process. What we expect within a plan may vary from state to state. States may leave these things up to the insurance companies to define.” says Boutin. That becomes especially confusing for physicians who participate in multiple insurance plans, Medicare and Medicaid. “They will have a different definition within each plan. That lack of standardization within states has the potential for real challenge, and the physician’s ability to appeal on behalf of the patient is a great concern right now. We really think standard definitions and applications around medical necessities and the appeals processes are important. It [the essential health benefits package] will have diminished impact without it.”

The PPACA aims to improve healthcare in rural and underserved areas through a federally funded program (to the tune of $230 million over the next five years) called the Teaching Health Center Graduate Medical Education Program (THCG-MEP). Medical residents may participate in training at community-based health centers that operate a primary care residency program, such as federally qualified health centers, community mental health centers and health centers run by the Indian Health Service. While medical residents have always had the option to train in underserved areas, this provides additional federal funding to encourage them to do so.

Eleven THCG-MEP centers were federally funded in 2011, and in 2012, 22 resident programs received funding. The program is being expanded again this year in hopes that those in residency in primary care centers will stay in primary care, an area of medicine that currently has a shortage of physicians and projects a shortfall of 45,500 primary care providers by 2020, according to the American Colleges Center of Workforce Studies.

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High-risk patients also stand to benefit from the PPACA. Just recently, President Obama signed into law the Medicare IVIG Access Act (HR 1845) as part of the PPACA, which provides for a three-year demonstration project to address expanding access for Medicare patients with primary immunodeficiency diseases to intravenous immune globulin (IVIG) treatments administered at home. Prior to signing the bill, the cost of the IVIG drug was covered under Medicare Part B, but not the associated costs of administration, which effectively made the ability for at-home treatments ineffective. One note of caution, however, is that more clarification is needed on the specifics of the law, specifically with regard to pre-existing conditions, because some IVIG treatments are warranted for conditions not covered under Medicare.7

One provision for those with high-risk conditions that has been adjusted since the inception of the PPACA is that of high-risk insurance pools, or the pre-existing condition insurance plan. It was expected that between 200,000 and 400,000 would join these pools designed for those with pre-existing conditions who are unable to purchase insurance through private carriers. However, enrollment has been much lower than expected.7 Therefore, the requirements to join the pools, as well as the premiums, have been adjusted to encourage enrollment, and advertising has been increased, particularly through the Social Security Administration insurance application receipts. These efforts are working, with enrollment increasing in recent months.8

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Job Satisfaction

The future of the PPACA is a big question mark for many physicians, who are concerned about the industry. Based on results from surveys conducted in 2012, the Physicians Foundation has published its top-five concerns facing doctors in 2013:

- uncertainty about the specifics of how the PPACA will be fully implemented
- the consolidation of private practices into hospitals and medical groups and how this will affect quality of care and costs
- how 30 million newly insured patients will be cared for (In addition to the 45,500 projected shortage of primary care physicians by 2020, it is expected that there will be a shortage of more than 90,000 physicians in total, and a 130,000 shortage by 2025.)
- the decline in autonomy due in part to a decrease in payments and an increase in regulation
- an increase in administrative burdens due to increasing regulation on healthcare, which is causing a reduction of time spent with patients7

Reimbursement is also a concern. On average, Medicaid pays only 66 percent of Medicare rates. But, there is a PPACA provision that requires states to pay primary care doctors providing services to Medicaid-insured patients 100 percent of Medicare rates for the next two years. While this is only a short-term solution, it is a welcome one, especially for physicians in California, Florida, Michigan, New Jersey, New York and Rhode Island, all of which expect to see their payments increase significantly, on average 73 percent. Some argue, though, that this increase is merely due to the fact that their reimbursement rates were much too low to start with. For instance, physicians in Rhode Island, the state that is seeing the biggest increase in pay rates of 200 percent, were being paid only a third of what Medicare pays, which often didn’t cover the cost of seeing the patient. Eleven other states will see smaller increases because they already are being paid closer to Medicare rates. However, there is some concern that this short-term pay increase will be eliminated due to budget cuts. As a consequence, many physicians are not yet making plans for their practices based on the increase until it is sure to remain.10

Enrolling new patients in the healthcare system remains an issue. The PPACA has mandated certain practices to help get the word out to new patients, including online tools that Boutin anticipates could look something like that of the Medicare Part D calculator. Navigators, who will help patients find the right tools for their needs, are being established at the state level, and, of course, there will be insurance brokers selling their products. With both nonprofit and for-profit people working on behalf of consumers, Boutin believes enrollment will go pretty well: “People are expecting this,” he says of the fact that changes to insurance are right around the corner. “It’s not dissimilar to the Medicare Part D uptake, which at the time was one of the largest expansions.”
Funding the Law

The question of how to pay for those newly insured at both the federal and state level, without reducing physician payments and patient benefits to the point of severity, has many proposing options, all of which are controversial.

The Alliance on Healthcare Reform’s report, titled High and Rising Costs of Healthcare in the U.S. — The Challenge: Changing the Trajectory,11 points out that if healthcare’s increasing costs are funded by tax increases, the marginal tax rate for high-income earners could be 70 percent by 2060, and these increased expenses coupled with increased taxes could cause the gross domestic product to decline by 11 percent. Five percent of patients represent about 50 percent of the costs of healthcare, and 20 percent of patients represent around 80 percent. Patients costing the most tend to have chronic diseases such as diabetes, arthritis and high blood pressure, and the obesity epidemic is a major culprit.

With higher Medicare taxes (2.35 percent) on high earners, higher taxes on medical devices (though a repeal has already passed in the House) and brand-name drugs on the table, a novel proposal has been submitted by the National Coalition on Healthcare, which includes members such as the American Heart Association and CVS pharmacy. The proposal includes, in part, a controversial plan that calls for taxing sweetened beverages a penny per ounce, higher taxes on tobacco and alcohol, as well as penalties for underperforming hospitals,12 to earn revenue to help pay for the rising costs of healthcare.

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The proposal also spells out numerous possible spending cuts, as well as savings and restructuring of payments such as rewarding physicians for value rather than volume and utilizing market competition to lower costs, in part by expanding competitive bidding for medical devices for Medicare services, and enhancing quality and better coordinating care of high-cost patients (with the implementation of MedPAC’s recommendations of expanding PACE [Program for Accelerated College Education] and supporting meaningful-use incentive payments for behavioral health providers).

More to Come

Much of the PPACA is taking shape: Preventive services are more accessible, health insurance can’t be cut if you become sick and the doughnut hole in Medicare Part D coverage has begun to close, saving seniors $4.8 billion on prescription drugs so far.7

However, much remains to be done, including solidifying expectations of doctors, states, manufacturers, patients and taxpayers. For instance, questions persist about what will be required of the medical industry in order to meet the growing demand of the newly insured and how we will collectively pay for it all. This is shaping up to be an interesting year, and as more of the PPACA plan rolls out, more will be revealed. ∗

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References