Supreme Court decision on the Affordable Care Act

What does it mean for neurology?

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Summary

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the Act or ACA), which is felt to be the most comprehensive reform to health care in the United States since the enactment of Medicare/Medicaid in 1965. Nothing this big happens overnight and without controversy. Numerous concerns were raised from all demographics and from both sides of the political aisle. Some of the concerns were legal questions regarding constitutionality and so legal processes began to address this issue. In June 2012, the Supreme Court decided in a 5-4 vote that the Act is constitutional. This has allowed the legislation to stand and over the next few years the more transforming parts will start to be implemented. It is important to understand the issues surrounding the Supreme Court decision and the impact this may have on health care and specifically the practice of neurology.

The Patient Protection and Affordable Care Act (ACA or the Act) is considered the most important legislation passed by the US Congress since the creation of Medicare and Medicaid in 1965. It is the direct result of rising health care costs in the United States and was a major initiative of President Obama's first term. During its passage there was much debate surrounding the legislation. While some of this debate continues today, on June 28, 2012, the Supreme Court of the United States (SCOTUS) put many of the legal questions to rest and paved the way for implementation of the Act. This article will review the issue before the Supreme Court and then discuss some of the areas that are likely to impact on neurology practices and patients.

The most important legal question about the Act before the Supreme Court was on the constitutionality of mandating all Americans to purchase health insurance or pay a penalty. If this

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section was determined to be unconstitutional, then the other legal questions would need to be addressed. The Act states that if a person cannot show proof of insurance, the Internal Revenue Service (IRS) will impose a tax on them. Some felt it was unconstitutional, and beyond the scope of Congressional power, to require Americans to buy a private market commodity. The Court decided that because the penalty was treated as a “tax” and Congress has a right to impose taxes, the Act was constitutional. Once this decision was made, it negated most of the other legal questions that were being raised, with one exception; federal funding of Medicaid.¹

The Supreme Court was also asked to address an issue related to the expansion of Medicaid. The Act provided for expanding Medicaid eligibility to 133% of poverty level and provided federal funding to states for this expansion. It directed that states that did not expand eligibility would lose all of their Medicaid funding. The Court decided in a 7–2 vote that states could not be coerced to expand their Medicaid offerings; therefore, if a state chooses not to expand its Medicaid program, the federal government cannot withdraw all Medicaid funding to that state. However, the Court did find that if a state chooses to expand coverage, they must accept all of the federal regulations attached to that expansion. They cannot pick and choose where they expand.¹

What are the implications of the SCOTUS mandate decision?

It is well accepted that the rising cost of health care in the United States is unsustainable and this is clearly the main driver for reforming the way health care is practiced and administered.² There are studies that show that despite higher spending on health care in the United States, we do not have better outcomes or healthier patients than in countries with lower spending on health care.³ So while most health care pundits accept that spending more does not mean better health, what remains unclear is how to fix these problems. Some believe that improved access to health insurance and therefore health care will correct some of the current burdens on the system. There are an estimated 48 million Americans who are currently not covered by health insurance.⁴ This puts financial pressures on the system at certain levels. Studies have shown that uninsured individuals experience delays in accessing health care and therefore access the system once they are sicker. This correlates with presentation at later disease stages requiring longer and more costly care.⁵

The cost of caring for the uninsured gets passed on to the public in a variety of ways, including higher cost for insurance and higher cost for providing care. Opening up the pool of premium paying, insured individuals provides more money to the entire system and also allows more individuals to access care earlier in their disease. It is believed this will lead to lower costs to the system.⁶

So which individuals are in the uninsured population and how can we get them insured? This is one of the questions addressed by the ACA. Clearly there are some individuals or small groups who could purchase health insurance but have chosen not to. It is estimated that of the

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48 million Americans who do not have health insurance, 18 million could and have chosen not to purchase it.⁷ In order to get some of the uninsured population to purchase insurance, the ACA created a penalty for not having it. Debate continues as to whether the intent was actually to be a penalty or a tax, but as it was set up as a tax under the Internal Revenue Service, the Supreme Court determined it was constitutional. There is also debate about how successful the provision will be. It is not clear that the penalty is enough to incentivize people to pay for insurance. There are estimates that the penalty will be at most around \$700 a year, whereas the cheapest health insurance will be around \$600–\$1,000 per month.⁷ The economics suggest this group would be better off paying the penalty. However, estimates suggest that of the 48 million uninsured, only 18 million may chose not to purchase insurance, and so there will still be a net gain for the covered pool.⁷

While the mandate addresses the population of uninsured who could afford insurance but choose not to purchase it, clearly there are many uninsured who cannot afford health insurance. The Act also provides for ways to help these groups become insured. There will be subsidies, tax breaks, and credits for individuals or small groups to now purchase insurance. Starting in 2014, individuals and small groups will have access to either state or federal insurance exchanges that will assist with obtaining affordable health insurance. The exchanges will provide summaries of new insurance products as well as summaries of what subsidies/tax breaks/credits might apply to assist with purchasing the insurance. These exchanges are currently under development and so the effectiveness remains to be seen.

How does the Medicaid expansion affect medicine?

The SCOTUS decision on the Medicaid expansion deserves some further exploration as the implications of this remain unclear. The Court decided that states were not required to expand their Medicaid programs and if they chose not to expand they did not risk their current levels of federal funding. The Act provides for expansion of Medicaid eligibility to 133% of poverty level and would provide 100% funding for this expanded group until 2020, at which point federal funding drops to 90%. This means that states have a number of options regarding Medicaid. One option is to fully implement the defined expansions and receive 100% federal funding until 2020 followed by 90% funding. However states may decide, for political or financial reasons, not to participate in the expansion and continue their Medicaid programs as they are now and still receive current funding levels. But there is ambiguity as to whether states could decide on partial expansions and still receive federal funding for that expansion. For example, a state could expand its Medicaid program to 115% or 125% of the poverty level. There is nothing in the legislation or the SCOTUS decision that prevents a state from a smaller expansion and still being eligible for the 100% federal coverage to that expansion level. States may make compromise choices in this way.⁸ As the Act moves through regulatory channels, more guidance may come regarding these alternative options. The net effect of the expansion of Medicaid eligibility is to allow more people to be covered under Medicaid. While expanding the insured population broadens the pool and this may be good for getting patients on the covered side of the equation, it is unclear if this is good for providers given the traditionally low reimbursement rates for Medicaid.

What else does the ACA do for health care reform?

Since the ACA appears to be here to stay, it is important to understand some of the other provisions it creates. There are some that are good for patients and perhaps for neurology practices.

What are some positives of the Act for neurology patients?

1. Lifetime limits and preexisting condition exclusions go away (2014)⁹

By removing lifetime limits and existing condition restrictions, patients with chronic diseases such as multiple sclerosis or epilepsy no longer face losing access to care or medications by arbitrary time or dollar limits.

2. Children up to age 26 can remain on their parent's medical insurance (2010)⁹

Children will be covered longer, allowing them to finish schooling and get employment and hopefully their own access to insurance.

3. Medicare part D limits ("donut hole") are phasing out⁹

- a. 2010 insured receive \$250 rebate
- b. 2011 gap decreased by 50%
- c. Continued phase-out through 2020

The enactment of Medicare part D provided seniors coverage for medications; however, it included limits that caused them to lose coverage after a certain dollar amount was spent. This resulted in many seniors having to pay the full cost of medication part of the year and effectively led to many stopping or decreasing their medicines. The Act phases out this limit and eventually provides ongoing coverage of medications for seniors on Medicare.

4. Recommended preventive care must be covered by insurance (2012)⁹

Additionally, in order to shift costs from so-called "rescue care," which results from delayed access to care/treatment, insurance is required to cover preventive care. Hopefully this will address the issue of higher costs when care is delayed and patients are sicker.

5. A total of 85% of insurance premiums must go to medical care or patients get rebate (2011)⁹

Finally, insurance companies must keep overhead expenses to a minimum and use the bulk of insured premium dollars for providing health care (85%) or they must refund premium dollars to the insured. In the first year of this requirement, this provision was estimated to have saved consumers approximately \$1.5 billion.¹⁰

What are some positive effects of the ACA on neurology businesses?

1. Tax credits for small businesses offering health insurance (2011)

Practices currently offering health insurance can take tax credits for some of the cost of the premiums.

2. Small businesses will have access to purchasing health insurance for employees through exchanges (2014)

Many neurology practices across the country are small businesses. It is harder for small businesses to provide health insurance to employees than for the larger corporations. Access to cheaper insurance options through exchanges provided by the ACA may also help this situation and thereby insure more Americans.

3. Incentive payments for quality measure reporting and electronic health record (EHR) use (2010, ongoing)

Another way that neurology revenue may be helped is through the incentive offerings, including participation in certain reporting programs—e-prescribing, quality measure

reporting, and use of EHR. Ultimately there are penalties for not participating in these programs. However, there are potentially significant barriers to participate in these incentive programs. Most of these require up-front costs in equipment, staff, and training that smaller practices may not be able to afford. The financial incentives may not balance out the cost of implementation, making it a financial challenge for small businesses that are already struggling with declining revenues. Also, changes to workflow can be disruptive to busy practices that are already functioning at their limits of volume and efficiency.

What does the future hold?

While the bulk of the ACA tends to focus on insurance reform and not really health care reform, there are sections that attempt to change the way health care is provided. The Act provides for pilot programs and incentives to develop new models of care including Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH). Some organizations have been officially identified on the Center for Medicare and Medicaid Services (CMS) Web site as ACO¹¹ and have agreed to the reporting and payment requirements associated with this designation. They have also agreed to take on a certain amount of financial risk if they do not meet targets. Initially any money saved on care is shared by the insurers and the providers. However, if costs are not lowered, the groups will be penalized and lose money.¹² Physician groups are also getting involved with the PCMH or networks of care models. These focus on disease states and organize a patient's care around teams and what the specific needs of the patient may be. Many of these groups are collaborating with insurance companies and are focusing on using electronic resources, guidelines, and registries to improve care and lower costs. PCMH models are trying to engage patients in their health care decisions.¹³ With both of these models, there are plans for greater public reporting of cost and outcomes. Those groups, hospitals, or physicians providing the lowest cost for care with the best outcomes will be designated by some preferred ranking and patients will be encouraged to use these providers.

The goal for most new models of care is to eliminate the current fee-for-service payment programs and replace them with cheaper, more effective ways of providing care. However, these new models have not been proven to reduce cost or provide better care or outcomes.¹⁴ Most of the new models focus on incentivizing primary care providers, defined as internal medicine, pediatrics, and family practice, but not specialists. Specialty groups argue that for certain diseases such as multiple sclerosis, dementia, congestive heart failure, or diabetes, a specialist may be functioning as the patient's primary (main) provider and therefore should be eligible for these incentives. At this time, it remains unclear how specialists will fit in to these new models.

It also is not clear that any of these changes will improve the health of Americans. The talk is all about improving quality and there are programs focusing on reporting of measures related to this. Whether focusing on these measures actually makes people healthier remains to be seen. Clearly change is here and change is always difficult. Now that the Act has been found to be constitutional by the Supreme Court, the health care industry is moving forward with the implementation. Time will tell if we are building a system that is more cost effective and provides better quality and healthier outcomes for our patients.

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