John I. Allen, Section Editor

Health Care Reform and the Road Ahead for Gastroenterology

EDWARD SHEEN,* SPENCER D. DORN,‡ JOEL V. BRILL,§ and JOHN I. ALLEN‖

*Division of Gastroenterology and Hepatology, Stanford University, Stanford, California; ‡Division of Gastroenterology and Hepatology, University of North Carolina, Chapel Hill, North Carolina; §Predictive Health, LLC, Phoenix, Arizona; and ‖Minnesota Gastroenterology, University of Minnesota, St Paul, Minnesota

Roadmap to the FUTURE of PRACTICE

The Supreme Court has weighed in on the constitutionality of the Patient Protection and Affordable Care Act (ACA). Few people predicted that the individual mandate to purchase insurance would be upheld because of Congressional authority to levy a tax. Fewer still predicted the ruling on Medicaid expansion. In this month's "Practice Management: The Road Ahead" segment, 4 of us have tried to outline (within editorial word limits) the potential implications of the Supreme Court ruling. Although we await election results, make no mistake—the ACA will move forward, and it will have profound implications for gastroenterology. Our training programs and safety net hospitals will suffer (see Taylor IL and Clinchy RM. Clinical Gastroenterology and Hepatology 2012;10:828–830), colorectal cancer screening paradigms may change as accountable care organizations develop, and each practice will be challenged to understand their State's reaction to Medicaid expansion. The American Gastroenterological Association will continue to monitor the national landscape, educate you about The Road Ahead, and advocate for our members and patients.

John I. Allen, MD, MBA, AGAF
Special Section Editor

The Patient Protection and Affordable Care Act, along with the Health Care and Education Reconciliation Act (collectively, ACA), was signed into law on March 23, 2010. The ACA is the nation's most sweeping health care legislation since the establishment of Medicare and Medicaid. Soon after its passage, numerous states, organizations, and individuals challenged the ACA in state and federal courts. The Supreme Court granted judicial review to portions of 3 cross-appeals of the Eleventh Circuit's opinion: one by the states (*Florida v U.S. Dept. of Health and Human Svcs.*), one by the federal government (*U.S. Dept. of Health and Human Svcs. v Florida*), and one by the National Federation of Independent Business (*Nat'l Fed. of Independent Bus. v Sebelius*), and dedicated 3 days in March 2012 to hear arguments, which is the most time allotted to a single case since *Brown v Board of Education* in 1954. This article briefly reviews the high court's ruling on June 28, 2012, and then considers the road ahead for health care reform and its impact on gastroenterology.

The Supreme Court Rules

In a 5 to 4 vote, Chief Justice John Roberts joined with the court's 4 more liberal members to uphold most of the ACA including the "individual mandate" that requires all Americans to purchase insurance or pay a penalty. In the majority opinion, Justice Roberts wrote, "The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax."[1] Roberts added, "Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness." By upholding the individual mandate, the Court ensured that the bulk of the ACA, which includes numerous provisions intended to expand access to care, control costs, and improve quality, would stand. Yet in a 7 to 1 decision, the court ruled that the federal government cannot require states to participate in the ACA's planned expansion of Medicaid, and that states electing not to comply with expansion may do so without being stripped of their existing Medicaid funds. Roberts emphasized that the court considers only the constitutionality and not the wisdom of legislation. "We do not consider whether the Act embodies sound policies," he wrote. These decisions "are entrusted to our nation's elected leaders, who can be thrown out of office if the people disagree with them."[1]

The Affordable Care Act

The ACA contains numerous provisions that will be implemented during the course of several years. To date, more than 40 ACA provisions have taken effect, many of which impact patients with digestive diseases and gastroenterologists. This article will focus on 4 specific areas of the law: patient protections, access, payment reform, and performance measure-

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Abbreviations used in this paper: ACA, Affordable Care Act; ACG, American College of Gastroenterology; AGA, American Gastroenterological Association; ASCs, ambulatory surgical centers; ASGE, American Society for Gastrointestinal Endoscopy; CMS, Centers for Medicare and Medicaid Services; CRC, colorectal cancer; FFS, fee-for-service; PCORI, Patient-Centered Outcomes Research Institute; PQRS, Physician Quality Reporting System; SGR, sustainable growth rate; VBPMs, value based purchasing modifiers.

© 2012 by the AGA Institute
1542-3565/$36.00
http://dx.doi.org/10.1016/j.cgh.2012.07.022

ment. After discussing how each will impact gastroenterology, we conclude by discussing how they further the 5 trends in health care reform introduced in "The Road Ahead" by John I. Allen.[2]

Patient Protections

Under the ACA, insurance companies are prohibited from rescinding coverage during illness or imposing annual or lifetime limits on coverage. Health plans are barred from basing premiums on medical history and imposing excessive premium rate increases and must now spend at least 80%–85% of collected premiums on medical care. Children may no longer be denied insurance coverage for preexisting conditions, and for adults, this protection will take effect in 2014.

Expanding Access to Care

The ACA will enable many currently uninsured patients to obtain health coverage and care for digestive diseases. Under the individual mandate, every citizen must obtain health insurance through their employer, the private market, or Medicaid. Low-income individuals not qualifying for Medicaid will receive federal tax credits and cost-sharing subsidies on a sliding scale. The ACA will also establish insurance exchanges to enable individuals and small businesses to pool risk and purchase health coverage at a lower cost. It was originally projected that these measures would expand health coverage to 32 million of the currently 50 million uninsured Americans. However, much uncertainty about the individual mandate, insurance exchanges, and Medicaid expansion remains after the Supreme Court ruling, and the actual number who will receive insurance coverage will probably be lower than previously estimated.

It is not clear how effective the individual mandate will be. ACA protections against insurance industry abuses will certainly lower barriers to health insurance. However, if the financial penalty for not obtaining insurance under the individual mandate is not sufficient to motivate healthy individuals to comply, a significant number may choose to remain uninsured. Without the contributions of these individuals to help finance the insurance pool and spread risk, premiums would rise and push other individuals out of the insurance market.

As of July 2012, states have made variable progress toward establishing health insurance exchanges. Fourteen states and the District of Columbia have passed legislation authorizing exchanges, and more than 20 states have authored similar bills. Several states including California and Maryland have not only passed legislation but are moving forward to install computer systems and set up administrative structures for their exchanges. Other states including Louisiana, Florida, Wisconsin, and Alaska are refusing to set up any insurance exchanges. In between are states that are debating how quickly to move and whether it would be easier to wait until after the November 2012 elections or simply allow the federal government to establish and operate exchanges as permitted by the ACA. Under current law, insurance exchanges must be operational by January 1, 2014, but because implementation was stalled while waiting for the Supreme Court decision, many states may not meet this deadline.

The most uncertainty surrounds Medicaid, the major source of new coverage. With the Supreme Court barring the federal government from removing existing funding from noncompliant states, some states will decide to opt out of Medicaid expansion for budgetary, cultural, or political reasons. Individuals in these states who do not qualify for Medicaid under current eligibility criteria but with incomes still below the ACA's cutoff for receiving federal subsidies (133% of federal poverty level) may remain uninsured.[3] Thus, the number of uninsured Americans who will obtain health coverage under the ACA's Medicaid expansion may end up being significantly lower than the 17 million originally predicted before the Supreme Court ruling.

From the gastroenterology perspective, the ACA will lower barriers to colorectal cancer (CRC) screening and expand health coverage to millions of currently uninsured Americans. Medicare, Medicaid, and private health plans are required to cover CRC screening without charging patients deductibles or copayments. The law waives cost-sharing for colonoscopy, sigmoidoscopy, and fecal occult blood testing. However, under Medicare's current payment rules, if a patient is referred for a positive fecal immunochemical test or undergoes polyp removal during a screening colonoscopy, the procedure becomes reclassified as a therapeutic procedure, and beneficiaries must pay an out-of-pocket cost. Cost-sharing for polyp removal may discourage usage of CRC screening.

With regard to coverage expansion, although the actual number of patients obtaining health insurance will probably be lower than first estimated, the newly insured will have greater opportunity than ever before to access care from gastroenterologists. Low-income patients with debilitating chronic diseases including chronic liver disease, hepatitis B and C, inflammatory bowel disease, and gastrointestinal malignancies will experience the greatest benefit.

Gastroenterologists practicing in low-income areas, safety-net hospitals, or academic medical centers, which generally see the highest number of uninsured patients, will experience the greatest benefit from the ACA's coverage expansions. However, gastroenterologists practicing in states refusing to participate in Medicaid expansion will encounter a higher number of uninsured individuals. Because reimbursement rates for many newly insured patients, particularly those covered by Medicaid, will be low, many gastroenterologists may be unable to accept them.[4] In addition, a nationwide shortage in the supply of gastroenterologists predated the ACA. For these reasons, there may not be enough gastroenterologists to fully meet the increased demand for services, which may lead to greater acceptance of the use of mid-level providers to perform CRC screening.[5]

Payment Reform

The fee-for-service (FFS) model will remain the primary reimbursement system for most gastroenterologists in the short-term. The ACA does not address the sustainable growth rate (SGR) formula that guides FFS reimbursement for Medicare and most other insurance plans. The SGR was introduced in 1998 with good intentions to control Medicare spending but attempts to reduce reimbursement without accounting for growth in the complexity and volume of health services and does not incentivize individual providers to control costs. The SGR is simplistic; if actual medical spending exceeds a preset

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