

Health Care Reform: How Are We Doing?

Although by some measures the PPACA has improved the state of US health insurance, other indices show downward trends in efficacy and increases in care.

BY GEORGE A. WILLIAMS, MD

The Patient Protection and Affordable Care Act (PPACA) of 2010 created a fundamental restructuring of US health care delivery. The PPACA required that all health insurance plans provide coverage for a defined set of essential health benefits, proscribed health-based underwriting, eliminated policy rescissions and lifetime benefit caps, and limited insurance companies' underwriting profits.

A primary goal of the PPACA was to decrease the number of uninsured citizens through the creation of health insurance exchanges and expansion of Medicaid. Starting in 2014, individual and family plans (termed nongroup plans) were available for purchase through exchanges, and some citizens were eligible for premium and cost-sharing subsidies on an income-based sliding scale. In some states, individuals with incomes up to 133% of the federal poverty level became eligible for Medicaid. Also, the PPACA instituted alternative payment models. By the end of 2014, 8 million people signed up for health insurance through the exchanges and 3 million people were added to Medicaid. Starting in 2015, approximately 9 million people have been added to either the exchanges or Medicaid, with approximately 6 million people renewed automatically from 2014. Recently, the Congressional Budget Office predicted that 13 million people will be enrolled by the end of 2015.

So far, so good. What could possibly go wrong?

WHAT WENT WRONG

The first thing that went wrong was the impact of the essential health benefits requirement on existing individual policies that were no longer compliant, resulting in mass plan cancellations. The Kaiser Family Foundation estimated that approximately 43% of the 8 million people who will enroll through the exchanges by June 2015 were previously insured.¹ For many of

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these people, the president's promise about being able to keep their insurance rang hollow. The disruption in the individual market was so severe that the Centers for Medicare and Medicaid Services (CMS) delayed the implementation date for small employers until 2016. How these employer-based policies will be affected is uncertain, but the history with individual policies is likely to be repeated.

A crucial problem with the PPACA is the effect of the insurance mandates on premiums, deductibles, and copayments. The PPACA did not repeal the rules of actuarial science that prices insurance based on the risk of the covered population. Risk is a function of the cost of the required benefits and the health of the covered population. The less-than-expected enrollment of healthier, younger people compounded the risk. The Kaiser Family Foundation reported that enrollees in nongroup plans purchased in exchanges are likely to be in fair or poor health.¹ As a result, there were predictions of significant growth in premiums for 2015.¹

However, premium growth was flat for 2015, so the PPACA must have cut costs, right? Not exactly: It turns out the PPACA provided all exchange health plans with reinsurance that limits exposure. In other words, the

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taxpayers guaranteed that health exchange programs would not lose money between 2014 and 2016. For 2014, these reinsurance costs totaled \$10 billion. The American Academy of Actuaries estimated that the reinsurance payments cut premium growth by 10% to 14% in 2014 and 6% to 8% for 2015.² The reinsurance program expires in 2016. The effect on premium growth without reinsurance is unknown.

Even with the reinsurance program, the insurance exchanges have relied upon high deductibles and copayments to limit premium costs. Since the inception of the PPACA, there has been a steady increase in the growth of high-deductible insurance plans.³ When the small employer mandates go into effect in 2016, this trend will probably accelerate. The impact of high-deductible plans has already created problems for both patients and doctors. Patients often do not understand the implication of high-deductible plans and are stunned when they realize the insurance they have purchased does not cover their expenses. (For more information on high-deductible health plans, see “High-Deductible Health Plans: Implications for the Retina Specialist” in the July/August 2014 issue of *Retina Today*.)

Some of the costs and premiums may be covered via an income-related subsidy program administered by the Internal Revenue Service. However, the legality of this program for federal exchanges has been challenged and is now before the US Supreme Court in the case *King v Burwell*. Should the Supreme Court decide against the subsidies, many observers believe that the PPACA will not survive.

HITECH ACT

In 2009, Congress passed the Health Information for Economic and Clinical Health Act, or the HITECH Act, which established the concept of *meaningful use* for electronic health records (EHRs). In the same year, the American Recovery and Reinvestment Act incentivized physicians to install EHRs, and now a majority of retina specialists have EHRs.

The implementation of EHRs for most practices has been challenging and frustrating, with decreased productivity and increased costs the rule. Perhaps no aspect of the transition to EHRs has been more frustrating than meaningful use. Conceptually, meaningful use is designed to facilitate the clinical utility of EHRs to improve clinical outcomes. Practically, most clinicians, myself included, find meaningful use to be a useless exercise with no demonstrable clinical benefit. No other feature of health care reform has been as derided by physicians as meaningful use. Recently, CMS announced that 257 000 physicians—a majority of eligible physicians—will receive a 1% penalty on Medicare payments in 2015 due to failure to meet meaningful use requirements.

The obvious question is whether it is the incompetence of physicians or the meaningful use process that is failing. The American Medical Association has declared the meaningful use program a failure and recommended extensive changes going forward. Most of these changes are based on physicians' real world experience with this poorly designed, inefficient, and cumbersome bureaucratic nightmare. Because the meaningful use program advances to stage 3 this year, these changes are critical to physician practice. Hopefully, CMS will listen.

CONCLUSION

This year promises to be a seminal one for health care reform. Recent congressional changes and the upcoming Supreme Court decision will determine the future course and continued relevance of the PPACA. However, whether the PPACA survives or not, retina specialists can anticipate a challenging year. ■

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1. Hamel L, Norton M, Levitt L, et al. Survey of non-group insurance enrollees. The Henry J. Kaiser Family Foundation. <http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees>. Published June 19, 2014. Accessed February 13, 2015.

2. Meaningful use program is failing physicians. InsideHealthPolicy.com. Published December 17, 2014. Accessed February 13, 2015.

3. Pulling it together: The falloff in utilization: "There's something happening, here, what it is ain't exactly clear." The Henry J. Kaiser Family Foundation. <http://kff.org/health-costs/perspective/pulling-it-together-the-falloff-in-utilization>. Published April 10, 2014. Accessed February 27, 2015.