Patient Protection And Affordable Care Act ("ACA")

Post-Election ACA in the U.S. and Ohio

**Introduction:**
As many readers may be aware, on June 28, 2012, the U.S. Supreme Court upheld a significant portion of President Obama's Act Healthcare Law — The Patient Protection and Affordable Care Act ("ACA"). Following that decision, this Journal published an article addressing the ACA's anticipated impact on physicians. Although the previous article analyzed the potential pros and cons of the ACA, there remained a significant degree of uncertainty as to how the ACA would be implemented, whether it would be supported by state governments, and whether the November election cycle would result in a change of leadership, which could have potentially caused the ACA to be rescinded.

Since the re-election of President Obama, and since the Democrats have remained in control of the Senate, it is increasingly clear that the ACA is here to stay. Accordingly, this article, as part of a series of articles, will further address the changes most immediately expected as a result of the ACA, as well as the State of Ohio's handling of its decisions related to the implementation of the ACA.

**National Implementation of ACA; Changes expected in 2013:**
Healthcare providers and patients alike are continually watching the federal government for more detailed information concerning the implementation of the ACA. To date, many questions remain unanswered. In a recent interview, economist, Gail Wilensky, Ph.D., the former chairwoman of the Medicare Payment Advisory Commission, stated, "watch out for anyone who tells you, this is what your future will look like, because they can't possibly know." Dr. Wilensky provided this commentary at an annual meeting for the Advocacy for Healthy Partnerships conference wherein she further expressed frustration over the ACA, and the lack of detail as to how the law will be carried out and/or impact physicians. Dr. Wilensky stated, "two thousand pages of legislation wasn't enough to say anything about reforming how we pay physicians." These frustrations are no doubt likely shared by many readers of this article. For that reason, over the next several months, this Journal will attempt to provide updates concerning the implementation of the new law and its impact on the health care industry. In the meantime, the remainder of this article will focus on the most transparent changes we are likely to see in 2013.

On November 1, 2012, in compliance with the mandates set forth in the ACA, the Centers for Medicare and Medicaid Services issued a final rule regarding Medicare reimbursements for primary care practitioners. Pursuant to the rule, effective January 1, 2013, Medicaid reimbursements will be brought on par with those of Medicare for primary care providers in 2013 and 2014. The federal government will pay 100% of the difference between Medicaid state plan payments and the applicable Medicare rate. The increase will most directly impact family medicine physicians, general internists and pediatricians. The Secretary of Health and Human Services Kathleen Sebelius says, "by improving payments for primary care services, we are helping Medicaid patients get the care they need to stay healthy and treat small health problems before they become big ones." This change in law has also come with great support by entities such as the American Academy of Family Physicians.

Also in 2013, the ACA requires implementation of authority to allow "bundle payments." The ACA established a nationwide pilot program designed to encourage providers to work with other providers to coordinate and improve the quality of patient care. Bundle payments allow the delivery of a flat rate for an "episode of care" to providers, rather than the current system of individually billing Medicare for each service provided. As an example, in the instance of a surgical procedure, instead of submitting multiple claims for payment, from multiple providers, the entire care team could be compensated with a bundled payment. The goal is that this program incentivize health services to be provided more efficiently, while still maintaining quality of care.

There is also a "Sunshine Act" component to the ACA that is expected to have impact beginning in 2013. A final rule regarding this provision has been drafted, but not yet approved by the Office of Management and Budget. Without all details yet available, the purpose of the rule is to create new transparency requirements. This law will likely take effect starting in March 2013, and will require pharmaceutical companies to report any single payment/transfer of $10 or more made to a physician. This is just one example of the requirements expected to be set forth in the final rule that seeks to create more transparency in financial relationships between health care providers and suppliers.

Another change coming in 2013 as a result of the ACA is the new Internal Revenue Service ("IRS") provision related to medical devices. According to a final rule issued in December 2012, the IRS will impose a "Device Tax" on the sale of any taxable medical device at a rate of 2.3%. The tax is effective as of January 1, 2013. The government's justification for this tax is that the durable medical equipment industry is one set to gain business as a result of the expansion of health care coverage under the ACA — and since demand is increasing, the costs associated with the tax will be offset by increases in product sales.

In addition to the several provisions/changes highlighted above, the other most notable changes coming in 2013 relate to the way in which state governments respond to the ACA.

**Ohio's Response to the ACA:**
There are two primary issues of focus relative to the Ohio government's implementation of the ACA. The issues include the handling of: 1) the "insurance exchange" program, and 2) the optional expansion of Medicaid.

On the first issue, the federal government has extended its deadline until December 16, 2012, for states to decide if they will allow the insurance exchange program to be run by federal agencies, instead of state agencies. Ahead of this deadline, Ohio has already made its decision. Lieutenant Governor Mary Taylor announced in November, 2012, that Ohio plans to let the federal government run the new health insurance exchange program.

Healthcare markets, called exchanges, are designed to help people and small businesses find affordable care coverage. The exchanges will help low income Ohioans enroll in Medicaid, as well as to set rules for premiums and provide consumer protection guidelines. The markets are a key element of the health care law, where millions of individuals are expected to shop for coverage and find out if they are eligible for government subsidies or Medicaid. The law requires the federal government to build and operate the markets, if states do not.

For the federal administration, one of the most difficult decisions will be to decide how insurance policies must be designed, priced, and sold, starting next October, 2013, when open enrollment begins for the new online marketplaces, called exchanges. For example, the ACA allows insurers to alter their prices for people based on their age, family size, where they live, and tobacco use. The Department of Health and Human Services has to determine how insurers can go about setting prices relative to these demographics.

The second primary consideration for states, such as Ohio, is whether the state government will decide to “expand” its Medicaid program. Pursuant to the U.S. Supreme Court’s ruling this summer, states that do not want to expand Medicaid eligibility up to 133% of the federal poverty guidelines, or about $30,000 for a family of four, could opt out in 2014, without losing current Medicaid dollars. The federal government has not set a date in which the states must decide if they will expand their Medicaid program. Ohio has not yet made this decision. Ohio officials have indicated that a decision on whether to expand Medicaid eligibility is likely to coincide with the drafting of the state's biennium budget next spring.

A report released in November, 2012, by Kaiser Family Foundation estimates that if Ohio participates with implementation of the Medicaid expansion, it will reduce the number of uninsured in Ohio by 991,000, by 2022. Importantly, the federal government, pursuant to the ACA, would pick up 100% of the tab for the expansion until 2017. After that, however, federal funding decreases annually down to 90% in 2020 and beyond. State leaders have estimated that Ohio's

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share in 2017 and 2018 would be $457 million to pay for the newly enrolled.

The expansion of Medicaid was designed to be a major part of President Obama’s health care law, originally expected to account for half of the 32 million people who were to gain coverage under the ACA. Whether states, including Ohio, choose to expand the program, will have a significant outcome on the overall impact of the ACA.

In a statement made in June 2012, Governor Kasich said his administration is “very concerned that a sudden, dramatic increase in Medicaid spending could threaten Ohio’s ability to pursue needed reforms in other areas.” Although Ohio has not decided whether it will expand its program, many believe this statement is a clue that it will not.

**Conclusion:**
In closing, although there still remains much uncertainty over the anticipated impact of the ACA, the federal government has issued several rules in recent months, which are starting to give us a better picture of what to expect in the immediate future.

For further information regarding the ACA and/or issues that may be specific to your practice, please do not hesitate to contact David Valent, at Reminger Co., L.P.A., dvalent@reminger.com, with your questions or thoughts. Also, please feel free to contact the AMCNO editorial staff at ebiddlestone@amcno.org with your thoughts regarding specific issues of the ACA that you would like to see addressed in the series of articles this Journal intends to publish regarding the ACA. ■