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The Patient Protection and Affordable Care Act: The Impact on Urologic Cancer Care

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Abstract

In March 2010, the Patient Protection and Affordable Care Act as well as its amendments were signed into law. This sweeping legislation was aimed at controlling spiraling healthcare costs and redressing significant disparities in healthcare access and quality. Cancer diagnoses and their treatments constitute a large component of rising healthcare expenditures and, not surprisingly, the legislation will have a significant influence on cancer care in the United States. Because genitourinary malignancies represent an impressive 25% of all cancer diagnoses per year, this legislation could have a profound impact on urologic oncology. To this end, we will present key components of this landmark legislation, including the proposed expansion to Medicaid coverage, the projected role of Accountable Care Organizations, the expected creation of quality reporting systems, the formation of an independent Patient-Centered Outcomes Research Institute, and enhanced regulation on physician-owned practices. We will specifically address the anticipated effect of these changes on urological cancer care. Briefly, the legal ramifications and current barriers to the statutes will be examined.

Keywords

Patient Protection and Affordable Care Act; Health Care Education and Reform Act; Urologic Oncology; ACA; ACO; PCORI

Anne Morrow Lindbergh on Change-"Only in growth, reform, and change, paradoxically enough, is true security to be found."

Winston Churchill on Change-"There is nothing wrong with change, if it is in the right direction…"

In the United States, healthcare is delivered through a mixed public and private system that is the most expensive in the world per capita and amongst the highest as a proportion of gross domestic product. Despite this tremendous outlay, the American healthcare "system" consistently lags behind many developed countries in terms of quality and fair access. [1,2] Disturbingly, in 2010 the number of uninsured Americans surpassed 50 million persons or 16.7% of the population. Furthermore, 2010 represented the largest single-year increase in

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the number of uninsured Americans since the Census Bureau began tracking such information. Additionally, it is postulated that the high cost of insurance premiums may result in an additional 25 million people who are underinsured. [3] Simply put, there is a healthcare crisis in the United States that has the potential to bankrupt the country. This grave situation served as the backdrop for a national healthcare reform debate that ultimately resulted in President Barack Obama signing the Patient Protection and Affordable Care Act (PPACA) and the accompanying Health Care Education and Reform Act, known collectively as the Accountable Care Act (ACA), in March of 2010.

Support for the legislation, both within the medical community and among United States (US) citizens has been mixed, to put it mildly. The American College of Physicians, the American Cancer Society, the American Nurses Association, the American Academy of Pediatrics, the American Hospital Association and the American Medical Association supported the legislation, while the American College of Surgeons, American Academy of Opthalmology, the American Society of Anesthesiologists, the Congress of Neurological Surgeons and the American Urological Association (AUA) opposed it. [4] Interestingly, in a November 2011 Gallup poll, 47% of Americans favored a repeal of the healthcare law. [5] The PPACA and its subsequent amendments total over 2400 pages and represent the largest overhaul of the US healthcare system since Lyndon Johnson authorized the Medicare and Medicaid programs in 1965. [6] To this end, an exhaustive analysis is beyond the scope of this manuscript, however we will discuss several key components of the legislation and their hypothesized impact on urologic cancer care.

As a result of the ACA's inherent goal of improved integration of healthcare services, the fabric of the ACA is densely woven and as such, difficult to separate into exclusive themes. With that said, the statutes are tailored to provide coverage via three main motifs: Cost containment, quality improvement, and social justice.

Cost-containment Initiatives

The ACA will expand health care coverage to an additional 32 million US citizens that are currently uninsured. This will be accomplished through multiple mechanisms, most notably an individual health insurance mandate, whereby citizens are responsible for maintaining insurance coverage (either through their employer or their personal purchase) or be subject to a monetary penalty of 1% of income up to the cost of a basic health plan. These fines increase in 2016 to a maximum of $695 for individual adults and $2085 for families. In order to expand coverage to the "near-poor" and to avoid an unnecessary burden on those without the means to pay for health insurance, Medicaid coverage will be expanded to up to 133% of the US poverty line. Furthermore, for people with an annual income between 100% and 400% of the poverty line, tax credits will be available for the purchase of health insurance. In addition, businesses will be required to enlist employees in coverage programs. In order to minimize the economic impact of this mandate on small businesses, these firms may apply for a Small Business Health Care Tax Credit to defray the cost of insurance premiums. [4] The result of this expansion is to effectively enlarge the pool of at-risk, but insured individuals, resulting in a considerable offset via shared risk. Given that insurance companies stand to benefit from this increased pool of "customers" for their products, the legislation includes a clause that prevents underwriters from denying coverage on the basis of pre-existing conditions and to prohibit "cherry-picking" by these insurers.

The impact of this coverage expansion on the practice of urologic oncology will be significant. More patients will be diagnosed with genitourinary cancers and they will require the care of well-trained urologic oncologists. Whether our specialty has the capacity to meet this increased demand is an unanswered question. Numerous reports from Massachusetts, a

state that implemented universal coverage in 2006, indicate increasing wait times and burgeoning administrative needs after the implementation of their health plan. [7] The ACA does not include a specific mechanism to increase the pool of oncologic specialists to meet this heightened demand.

Needless to say, this coverage increase will be expensive. The Congressional Budget Office estimated the cost of the expansion to be $1 trillion. In order to generate the funds to cover this massive expenditure, the ACA includes reductions in: Medicare reimbursements to providers ($196 billion); payments within the Medicare Advantage program ($132 billion); and Medicare and Medicaid Disproportionate Share Hospital payments ($36 billion). These cuts are accompanied by: increased taxes on high-cost health insurance plans ($32 billion); new tariffs on Medicare payments (incorporating investment revenues from those with income of at least $200,000; $210 billion); new fees on insurance companies ($60 billion); and charges for pharmaceutical importation and manufacture ($32 billion). [8] Within the field of urologic oncology, all stakeholders (Physicians, Hospitals, Pharma, etc.) will feel the effects of these cuts across the spectrum of care. Simply put, we can expect to get paid less for our services in the future.

However, the ACA will not only influence reimbursement. It will also likely affect our organizational structure, primarily by making specialists direct employees of hospitals and healthcare systems. Currently, the reimbursement pattern of our healthcare system often rewards volume and intensity of treatments, rather than efficient or integrated care. In an effort to improve this coordination, the ACA allows for entities such as Accountable Care Organizations (ACO). These bodies will be comprised of networks of healthcare providers with an emphasis on primary care that work in synchrony with inpatient and outpatient facilities. The goal of the ACO is to manage and coordinate care for at least 5000 Medicare patients in an efficient and efficacious manner. Remuneration to the organization will be realized through CMS directed shared savings payments, adherence to and reporting of quality standards, bonuses, as well as efficiencies of care and scale. Effectively, this reimbursement structure will result in shared risk between CMS and the ACO, with more efficient and higher quality care resulting in lower costs and increased revenue for the ACO. ACOs are intended to streamline medical care with particular emphasis on primary care and chronic diseases. While cancer diagnoses are not explicitly noted in the statute, the legislation does provide for expansion of coverage for longstanding illnesses. Pilot programs are to begin no later than January 1, 2012. [8]

Given the ubiquitous and chronic nature of malignancies like prostate and bladder cancer, it is very likely that many of our patients will have their care provided through ACOs. It remains to be seen how urologic oncologists will interact with ACOs. Will they simply contract with these organizations? Will these organizations employ specialists to provide urologic oncology care? We believe the only entities currently in the healthcare system that will have the resources to form an ACO will be hospitals or multi-specialty clinics (MSC). To this end, it is our opinion that the creation of ACOs will result in more urologists being employed by hospitals or MSCs. An important caveat to this, however, is that large urology group practices will be well situated to negotiate contracts with ACOs, which may counteract this probable trend toward increased employment by hospitals or MSCs. At this point, the exact effect of ACOs remains to be seen.

A further component of the ACA legislation that is focused on cost containment is the notion of “bundled payments” or “episode-based payments”. Essentially, these can be considered “outpatient diagnostic-related groups” that function to capitate healthcare payments. Urologic cancer care requires a multi-disciplinary approach that often results in wide variation in resource utilization and costs. In an effort to control these factors, bundled

payments would be tied to specific outpatient diagnoses and would include all of the care particular to a treatment for a pre-specified period of time. Providers would receive a single payment explicitly linked to an episode and tied to quality metrics assigned by the Secretary of Health and Human Services. [8] Incentives will leverage quality standards and evidence-based practices to ensure optimal utilization of services. How reimbursement would be distributed among the responsible providers has not been clearly defined and a number of different models have been proposed. This clause may similarly increase the formation of MSCs and expand employment of urologic oncologists by healthcare systems, because larger groups are better positioned to collectively absorb the inherent risk of capitated payments for episodes of care. Going forward, it will be critical for urologic and medical oncologists to participate in the development of these payment schemes to ensure appropriate allocation of resources and care for our patients with urologic cancers. Pilot projects are slated to begin January 1, 2012. [8]

An additional means by which the PPACA will contain costs is through reductions in the growth rate of Medicare spending via the Independent Payment Advisory Board (IPAB). This federally appointed committee is directed to maintain Medicare spending below specific growth targets. If these goals are missed, the Board is empowered to reduce expansion via policy mechanisms up to 1.5% of the Medicare budget. However, the IPAB is prevented from reducing Medicare benefits, raising premiums or taxes, and rationing care. Yet, payments to the prescription drug plan and Medicare Advantage remain viable targets for cost reductions. Prior to PPACA, Medicare cost-containment required Congressional approval. Under the current strategy, IPAB can recommend adjustments independent of Congress and those changes must be tied to the Consumer Price Index or Gross Domestic Product. [4] Critics, including the AUA, have denounced this addition, claiming the IPAB reductions would be would be “in addition to the $400-500 billion savings in provider payments already included in health care reform legislation” and may further hinder “access for Medicare beneficiaries and even infrastructure for the entire healthcare system.” [9]

The ACA does not *explicitly* aim to increase cost savings through cuts to physician reimbursement. In fact, the Act creates a 10% payment bonus for primary care physicians and ensures that they are compensated no less than 100% of Medicare allowable rates, a significant windfall for physicians in some states. As of yet, there are no direct provisions for increased specialty care reimbursement. However, there are financial inducements for physicians to report their quality data (and penalties for those who do not) to the Center for Medicare Services (CMS) under the Physician Quality Reporting Initiative (PQRI). Perhaps most germane to urologists, the ACA will restrain revenues generated from ancillary services such as in-office imaging and via a bolstered Stark law that will prohibit physicians from referring Medicare patients to a hospital in which they have an investment or ownership interest. [4]

Quality Measures

In many respects, it is difficult to separate the cost-containment strategies of the ACA from its quality improvement initiatives, as many of these quality measures are used to leverage subsequent cost control. Nonetheless, there are several key policy measures that promote effective healthcare delivery as well as formulate metrics and reporting mechanisms for these provisions. HHS is tasked with creating assessments of health outcomes; care transitions; and measures of efficiency, safety, equity, timeliness, and patient satisfaction. [8] These tools will be developed in conjunction with the National Quality Forum (NQF). The NQF is an independent, non-profit organization of multiple stakeholders with the expressed mission of improving healthcare quality by generating consensus on national healthcare priorities, advocating performance improvements, creating quality measures, and

promoting goals through education and outreach. [10] Information gleaned from these metrics will be combined in an HHS database that will ultimately be used for the public reporting of physician and hospital performance. In 2019, provisions within the ACA allow for possible financial incentives to Medicare beneficiaries who receive care by high quality physicians. [8] While it is not certain that HHS will enact this statute, the effect on urologic patients and providers could be profound. In short, public reporting will allow patients to identify physicians with higher (or lower) compliance with quality measures, which may influence individual provider practice patterns. This tension will be further heightened if beneficiaries are able to realize financial rebates for seeking care from physicians who demonstrate higher compliance. The danger of this policy is that hospitals and providers will spend undue time ensuring that they are compliant with the measures, potentially creating perverse incentives and affecting patient care.

As a first step toward public reporting, on December 30, 2010 HHS unveiled the Physician Compare Internet site, which currently contains physician demographic information, but will eventually disclose public information on patients' ratings of satisfaction as well as evaluations of treatment efficacy, safety, and outcomes. [11] As noted previously, CMS has introduced the PQRI to deliver incentives to providers that submit quality data for review. In 2015, the PQRI will begin penalizing physicians that do not report their quality outcomes. Ultimately, trial programs will be deployed in 2016 that enact strict pay-for-performance measures to specialized, free-standing cancer centers. If these measures prove effective in terms of enhanced quality and economic benefits, HHS may expand the scope of these pay-for-performance processes in 2018. [8] Undoubtedly, the previously described measures will represent significant improvements in transparency for cancer patients of all types, however, their exact mechanisms and efficacy will not be realized for many years.

While measures of quality and efficacy are important, ultimately, many of the treatments we offer provide some degree of benefit. The critical issues are: "How do different management strategies compare?" and "How do treatments relate to a patient's wishes and health perspectives?" With these questions in mind, the ACA creates the Patient Centered Outcomes Research Institute (PCORI), a non-profit, independent entity of 19 stakeholders representing various healthcare interests. The expressed goal of this organization is to promote comparative effectiveness research (CER) through improvements in "healthcare delivery and outcomes, by producing and promoting high-integrity, evidence based information that comes from research guided by patients, caregivers, and the broader healthcare community." [12] CER has been an area of considerable focus within the Obama administration. How this will affect urologic oncology remains to be seen but we can expect that CER will have significant effect on our practices in the coming years.

Social Justice and Legal implications

While the cost containment and quality improvement measures of the ACA are irrefutable, redressing the racial, gender, fiscal, and regional disparities in healthcare coverage is perhaps its most noble aim. While a majority of urologic cancers present in patients who are 65 or older, and therefore are covered under Medicare, a significant proportion of malignancies occur in patients without health insurance coverage. In fact, uninsured patients with cancer represent a particularly vulnerable population, with demonstrated differences in incidence, prevalence, burden, and mortality. [13] Through the mechanisms presented previously, the ACA will provide enhanced coverage, processes for integration, improved screening and surveillance, federally subsidized high-risk pools, and importantly, will prevent insurers from denying coverage based on pre-existing conditions. [14] Although increased access to care will benefit those without coverage, it is questionable that simply expanding coverage, in itself, will result in improved health since there is considerable

evidence that cancer patients with Medicare coverage still demonstrate poorer outcomes. [15,16]

Whereas the ACA provides considerable benefits in the realm of social justice, it also brings to bear substantial legal weight via enhanced prosecution of Medicare fraud. In 2010, via increased funding for enforcement, enhanced penalties for false claims, and expanded congressional oversight, the Department of Justice and HHS recovered $2.5 billion in judgments and settlements against perpetrators of Medicare fraud. This represents a nearly 7 to 1 return on the government's investment. [17] Regrettably, the PPACA currently provides no commensurate measures for tort reform.

Despite the tremendous strides and political capital invested in its passage, the ACA still faces considerable legal challenges. Recently the Supreme Court agreed to hear actions against the constitutionality of the proposed legislation. The principal foundation for the lawsuits against the ACA stem from claims that Congress exceeded its constitutional authority by ratifying the Act and that the individual mandate for coverage is untenable on legal grounds. [18] A Supreme Court ruling on the constitutionality of the legislation is due as early as the Spring of 2012.

Regardless of the outcome of the Supreme Court ruling, it is worth repeating an earlier point: The ACA is constructed in such a way that wholesale repeal of the legislation is extremely difficult, if not impossible. Opponents of healthcare reform, therefore, will likely use a piecemeal approach to repeal, targeting individual elements of the law through the budgetary and legislative process. This approach could have unintended consequences which might inadvertently increase costs and decrease quality. Politicians and policy makers will need to be cognizant of this fact in the coming years.

Conclusions

In the broadest sense, it is our opinion that the role of government is to provide for its citizens what those individuals are not able to realistically provide for themselves. Whether this sentiment applies to healthcare delivery or the notion that medical coverage is an inalienable right is open for debate. Nonetheless, one could certainly make a rational argument that the burgeoning healthcare expansions that have allowed $15,000 daily intensive care unit charges, $4,000 MRI scans, and $100,000 proton beam therapies are beyond the means for the average US citizen. Beginning with President Truman in 1945, and culminating with President Johnson's entitlements, the US government has taken a sponsoring role in the healthcare of a significant proportion of our lives. However, unlike Medicare and Medicaid, whose provisions were nearly instantaneous, the PPACA will expand over the next 5 years to achieve its principal ambition of increasing health insurance coverage to the uninsured. The time horizon for many of its subsidiary provisions is even further afield. The forthcoming impact on urologic oncology is equally cloudy, though changes in access, cost, reimbursement, and the organization of urologic cancer care are imminent. Given its breadth, complexity, and the up-coming legal hurdles, it remains to be seen whether the aims set out by the ACA will be achievable, and whether the changes brought about by this legislation represent our "true security" or are even "in the right direction".

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