Will the
AFFORDABLE
CARE ACT
DELIVER

An Interview with Marshall Kapp, JD, MPH
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Marshall Kapp is an authority when it comes to the intersection of medicine and law. Presently he is the Director of the Florida State University Center for Innovative Collaboration in Medicine and Law, where we had the opportunity to chat with him about how the Affordable Care Act (ACA) is impacting people living with diabetes.

There was a lot of excitement among people with diabetes (PWD) when the Affordable Care Act was enacted, especially considering the struggles that PWD have had over the years with trying to obtain and keep insurance coverage with a pre-existing condition. Six years in, where are we today with the ACA?

Enactment and implementation of the Affordable Care Act since 2010 has been accompanied by high hopes on the part of advocates for persons with diabetes. Specifically, proponents of this legislation and its accompanying plethora of implementing regulations have promised that the ACA will create or foster improvements in the quality, accessibility, and affordability of medical care for individuals with diabetes and that, in turn, improvements in those aspects of medical care will directly produce improved health status and quality of life for affected individuals. Clearly, such improvements are sorely needed by a burgeoning patient population burdened by a very high-cost chronic disease. Whether the positive diabetes-specific expectations associated with the ACA actually end up being achieved remains to be seen over the coming years. That said, there are structural components of the health reform law that create the potential for progress.

Many people with diabetes see the Affordable Care Act as their first opportunity to finally obtain health insurance after repeatedly being denied due to their pre-existing condition. What are the key takeaways on the provision of health insurance with the ACA?

Many of the key provisions in the ACA are aimed at changing the American health insurance system. Prior to the ACA, many people with diabetes lacked sufficient health insurance, if they had coverage at all. Uninsured individuals, including those with diabetes, report poorer access to medical services (for example, lacking a regular source of preventative or therapeutic care) than insured persons. It is presumed by ACA proponents that, as the ACA enhances coverage for this population, it will reduce the gap between care needed and care provided, and that the resulting enhancement of health care utilization will lower the incidence of diabetes complications and improve the health of people with diabetes. Expanded health insurance coverage for persons with diabetes may occur under several specific ACA provisions.

Are you referring to the expansion of private insurance?

Precisely. Under the ACA, many individuals with diabetes who are not covered by Medicare, Medicaid, or other public/governmental insurance plans will have expanded access to private insurance coverage. Many of those individuals will be covered under employer-provided plans, which large employers are required to provide for full-time (30 hours per week or more) employees or pay a financial penalty. However, smaller employers do not fall under this “Play-or-Pay” mandate. To further complicate the matter, employers who do fall under the mandate may elect to pay the penalty rather than incur the costs of insuring their respective workforces. People without public health insurance or private employer-provided insurance are mandated, with some exceptions such as illegal immigrant status or inability to purchase an insurance policy whose premium would cost less than 8% of household income, under the ACA Shared Responsibility Provision to purchase a private individual insurance policy or pay a tax on non-compliance with the law. These private policies are available for purchase on the health care exchanges/marketplaces that are run either by individual states or the federal government. For individuals with incomes between 100-400% of the federal poverty line, government tax credits or direct financial subsidies are available to assist the consumer and make the insurance premium more affordable.
What about the expansion of public insurance? How does the ACA impact or influence programs like Medicaid?

As interpreted by the United States Supreme Court in National Federation of Independent Businesses v. Sebelius, 132 S.Ct. 2566 (2012), the ACA offered the states a financial incentive (through increased federal dollars) to expand their individual Medicaid programs to cover individuals with income below 138% of the federal poverty level. Some states have expanded their Medicaid coverage populations accordingly, others have negotiated different variants of expansion with the federal Department of Health and Human Services (DHHS), and others (included several states with the highest prevalence of diabetes) have declined to take advantage of this opportunity. Early data seem to suggest a positive correlation between Medicaid program expansion and the number of newly diagnosed and treated persons with diabetes. This finding is not surprising, as people with diabetes are disproportionately covered by Medicaid.

Are there other ACA provisions relating to diabetes that haven’t gotten as much attention as some of those that you’ve already mentioned?

In addition to the insurance-related ACA reforms, the legislation contained several other provisions intended to improve the quality of health services available to individuals with diabetes. For example, the ACA authorized the creation of a National Diabetes Prevention Program at the Centers for Disease Control and Prevention (CDC) for the purpose of eliminating “the preventable burden of diabetes.” Moreover, the Catalyst to Better Diabetes Care Act was incorporated into the body of the ACA, which directs the DHHS and the CDC to enhance diabetes surveillance and quality standards across the country. Among other things, DHHS must prepare a publicly available national diabetes report card for each state every two years.

There has been a lot of argument and controversy over the provisions and implementation of the Affordable Care Act. Given the polarizing effect of the act, will the ACA be successful?

The ACA, in both theory and practice, remains controversial. Its future success in addressing quality, accessibility, and affordability challenges for both the general population and for persons with diabetes is far from guaranteed. Specific provisions continue to be open to actual or potential political change, compliance dates and enforcement mandates have been malleable to the point of unpredictability (if not outright ignored when politically convenient), administra-
ative implementation remains problematic, and sufficient funding of implementation expenses is less than assured. Even with federal subsidies available to assist people to purchase insurance exchange products, the inevitable escalating costs of the private insurance policies offered on the exchanges, as well as substantial deductible and co-insurance liabilities, may impede the affordability of coverage for patients of moderate economic means with diabetes.

Ramifications of much higher individual and corporate taxes, both overt and hidden, to pay for promised ACA benefits may bring about negative results for the nation’s economic well-being (for example, weaker job creation) that are poorly anticipated or acknowledged today. Navigation of the staggering complexity enveloping the emerging health care system wrought, in large part, by the ACA necessitates much greater health literacy on the part of patients with diabetes, their families, and advisors. It is improbable that any of the ACA reforms will exert much noticeable impact on the availability of health care providers in primary care and endocrinology.

On September 9, 2009, President Barack Obama confidently told a Joint Session of the United States Congress, “I was not the first President to take up this cause [of health reform], but I am determined to be the last.” This expression of confidence has not been borne out by subsequent events. The challenge of translating recent legislative and regulatory health reform exercises into tangible accomplishments, let alone significantly improving on those exercises, means that advocates for the diabetes patient community and their governmental and private partners still have much work to do.

FURTHER READING


