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Research Article

How the Affordable Care Act Impacts on Health Care Specifically to Kidney Dialysis Patients

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Abstract

The American Health Care System has become a very complicated world. In the 1960s, Medicare was created to ensure Americans over 65 years old and Medicaid was created to protect poor people or people with long-term chronic illnesses such as kidney dialysis and mental health issues. At that time, most full-time employees received medical insurance from their employers and accepted what was offered to them, but this has changed over time. Most Americans are responsible for paying for their own medical insurance, but those who did not have insurance depended on Medicaid. Since the 1960s, the cost of hospitalization has become very expensive, and Medicaid has been abused. However, the Affordable Care Act (ACA) provides extra opportunities for Americans to obtain health care insurance, as well as inflicts penalties for those who do not obtain it. Today, nearly 90% of Americans have health care coverage [1]. Government, formal and professional websites provide necessary information to help people obtain health insurance. As an administrator in the age of New Public Management (NPM), I must keep my knowledge current to help people navigate this complex system. This essay will use this information to explain the changes created by the ACA and will focus on kidney dialysis as an example.

Introduction

Having health care coverage is necessary for people who are sick, hospitalized or chronically ill. Patients with kidney failure who must undergo dialysis need to go to a health care setting three times a week to stay alive. Treatments for kidney failure are very expensive. Government programs for healthcare came into existence during the1960s. Medicare provides support for those over 65 and Medicaid provides support to those with low incomes. Since that time, many American businesses phased out paying the premiums of healthcare insurance for their employees, forcing Americans to pay for their own healthcare insurance, if they wanted it. However, even the least expensive healthcare insurance is not cheap. Technological advances like ultrasound, dialysis, MRI and CT scans, have made tremendous progress in the medical field as well as increasing the costs of hospital services. Additionally, the increased costs of medical education, real estate, and unionization of medical workers, added to the normal rate of inflation, have all contributed to the growth of hospital bills. In the 1990s, President William Clinton proposed a healthcare bill to address the costs of healthcare, but it did not succeed in the legislature. President Barack Obama succeeded in having the Affordable Care Act (the "ACA") pass in 2010, despite some objections from members of Congress and the Senate.

The ACA provides assistance for low-income individuals and families to purchase private health insurance and not depend solely on Medicaid. It is not available for those Americans on Medicare, but it does cover people with pre-existing conditions including kidney failure. The ACA does penalize those Americans without medical insurance because its goal is to have all Americans insured.

New public management (NPM) is a set of constructs emphasizing a customer driven platform, fiscal responsibility,

market exploration and effectiveness, and a private sector mentality toward efficiency. It focuses on defined standards for quality, clarity of goals and teamwork, and an evaluation of products output versus bureaucratic procedures. NPM's goal is to bring a private sector marketplace mentality into the public sector.

Background

President Obama is not the first president to present a healthcare plan. In 1971, Republican President Richard Nixon proposed one of the most liberal health care plans America to ensure quality insurance coverage. It was considered a radical liberal approach and was met with opposition from the Democratic Party. The plan was extreme compared to the ACA, but three years after it was shut down, Nixon proposed a revision with stalwart precision. However, Nixon's plan failed to pass. It would be a very different country if the Nixon plan had passed in the early 1970's. Without a doubt, the ACA was one of the most intensely debated and carefully honed plans in the history of legislature. It continues to be debated and is an intense source of controversy among Republican governors. While President Obama passed his compelling piece of legislation in 2010, the Affordable Care Act, there was an undeniable polarization within the American people. Even with all of the potential economic problems that may arise from the new health care policies, it is legislation that the United States should continue to uphold and support.

The Republican Argument of the ACA

The Republicans argue that the ACA places a large financial burden upon the federal government. For example, ninety-three percent of Tennessee's citizens are insured but the state is practically bankrupt in accomplishing this feat, as most of its needy citizens receive care under the nation's Medicaid programs. As a result, many politicians employ Tennessee's predicament to illustrate how the ACA is potentially a fiscal disaster. Furthermore, employers also make sacrifices when purchasing health care for their employees, resulting in a perpetuating state of high cost and low-quality care. Congress claims that the ACA expands the role of the government to an unnecessary degree, becoming too involved in the lives of its constituents. Many politicians in the United States feel apprehensive about the ACA or oppose a nation-wide health care system. They employ these arguments as motives for maintaining the previous health care system.

Legislative Procedure Shapes Legislative History

Researchers from the University of Michigan suggest that the Democrats' opposition to the Nixon plan, compared with the Republican insurgency against the ACA, demonstrates that health care debates are more about political opportunism than a rational discussion to improve the financial health of the nation. In another words, policymakers of both political parties should think about what the policy is trying to accomplish for the American people, not oppose healthcare plans simply because they are proposed by the opposite party.

What is the Affordable Care Act (ACA)?

In 2014, President Barack Obama signed the Patient Protection and Affordable Care Act into law. This is a large, complex act that has been phased in over time. Initially, it mandates that every citizen obtain health insurance or pay a tax. This federal healthcare law is the largest change to American healthcare system since the creation of Medicare and Medicaid in the 1960s. The law solves a practical problem for American people, the problem of one-third of the American population being uninsured. The ACA was created to provide affordable health insurance for all U.S. citizens and to reduce the growth in health spending. Since the ACA took effect in 2014, 16.9 million more Americans now have health insurance (ObmaCareFacts.com).

Methods

For this analysis, the team used peer review articles from the American Journal of Kidney Dialysis, the Medical Education Institute, online resources, as well as articles from the Center of Medicaid Services, Blood Purification, the American Journal of Law and Medicine and the National Kidney Foundation.

How does the ACA change the expenses and costs of our current healthcare?

Americans spend 23 trillion dollars on healthcare annually. The ACA is planning on cutting the national deficit by over two hundred billion dollars in its first 10 years, and it's already working. The rate of uninsured Americans decreased from 16.3% to 15.7%. Americans have already saved 2.1 billion dollars through the ACA. The ACA bill states that affordable insurance is paying no less than 8% of your annual income on insurance. Through many phases, the ACA is continuing to reduce the growth of healthcare spending. The ACA also gives 47 million women access to preventative healthcare services. Lowering the cost of healthcare will help the 45.7 million Americans currently without health insurance. Along with lowering the costs, the ACA mandates that Medicaid workers and primary care physicians will receive an average 73% pay increase. This payment increase will help in finding doctors willing to take Medicaid patients. OmamaCareFacts.com states; "No one truly knows what Obama Care will cost. Common estimates for an average family of 4 range from around $7,000 a year to $30,000 a year depending on factors such as age, health status and region." Our current health care system costs, on average, $9,000 for every man, woman, and child each year. Currently, we don't have an exact answer if the ACA will cost Americans less or more money annually (ObamaCareFacts.com).

The pros and cons of the ACA

Since the enactment of the ACA, many arguments, both pros and cons, have been presented through the media, social media, and political groups. Those citizens who support the ACA feel that it will help the poor and uninsured citizens save money on medical expenses. The ACA can fund many more preventative tests for older citizens as part of Medicare. The logic behind this demonstrates that citizens who are proactive in their healthcare can avoid or delay major health problems in the future. Additionally, citizens who already have private coverage and wish to keep it can keep it under the ACA. The ACA extends coverage to young adults up to the age of 26 under their parent's insurance policies.

The other side of the argument outlines many cons of the ACA. Enrolling in the ACA can be complicated. Many consumers have complained that signing up for the right family and business coverage can be difficult. Benefits were cut for some of the elderly who have a very high annual income. Many companies could also drop coverage for their employees under this plan. Citizens against the ACA also see the implementation of an annual $95-dollar federal tax on those who do not have insurance of any kind as unfair. For some, they also argue, the ACA increases taxes on all citizens over the next few years in order to pay for healthcare for those who sign up for the ACA.

How does the Affordable Care Act (ACA) impact on Kidney Dialysis patients: How do patients get essential coverage under the ACA? How does the ACA provide benefits and coverage for kidney dialysis patients?

Minimum Essential Coverage is defined under The Affordable Care Act (The ACA) as healthcare coverage that fulfills all the necessary requirements for an individual to comply with the individual mandate. This basic coverage is used to fund the program, subsidize health insurance for tens of millions of Americans, improve Medicare, and expand Medicaid to cover 15 million people. The biggest factor in premium cost is income, due to the fact that cost assistance is based on income. The less a family earns, the less it pays. The Affordable Care Act also makes plans more affordable by reducing these cost sharing mechanisms through cost sharing reduction subsidies. The ACA mandates that health care plans offered in the individual and small group exchange markets offer a comprehensive package of items and services, known as Essential Health Benefits. Additionally, the following ten (10) Essential Health Benefits must be offered at no dollar limits on every plan under the ACA: 1. Ambulatory patient services. 2. Emergency Services. 3. Hospitalization. 4. Maternity and newborn care. 5. Mental health services and addiction treatment. 6. Prescription drugs. 7. Rehabilitative services and devices. 8. Laboratory services. 9. Preventive services, wellness services, and chronic disease treatment. 10. Pediatric services. For patients with kidney disease or kidney failure, denial of coverage for preexisting conditions is currently prohibited. The routine dialysis services are paid based on the dialysis facility's monthly composite rate of cost report (CR). The CR varies somewhat depending on a person's gender, age, and body size and is adjusted by a geographic wage index (the CR is higher in an expensive wage city and lower in an inexpensive wage rural area).

How are co – pays determined between the ACA and different health insurance programs regarding kidney dialysis patients?

Under the ACA certain covered services will have a copayment amount. This is the amount due to the insurance company when that service is rendered; the insurer picks up the difference between the actual cost and the copayment amount. Copayments usually only comprise a fraction of the actual cost of a service (for example the service is $100, and your copayment is $10). This helps to ensure that citizens seek medical attention when they are ill or drugs when they need them. It also helps to inspire citizens not to put off treatment due to its cost, and to encourage them not to overuse services due to the comparatively low cost. Approximately three-quarters of all US dialysis patients have Medicare as their primary insurance. For them, Medicare sets the reimbursement amount and pays 80% of that amount and the patient pays 20% of coinsurance.

Medicaid helps pay medical costs for people with low income and little savings. Medicaid can pay your Medicare premiums, deductibles, coinsurance, and some costs Medicare doesn't cover. Medicare-Inpatient dialysis treatments: Medicare Part A (Hospital Insurance) covers dialysis if you're in a Medicare-approved hospital. Outpatient maintenance dialysis treatments: Medicare Part B (Medical Insurance) covers a variety of services if you get routine maintenance dialysis from a Medicare-certified dialysis facility. Medicare Advantage is a type of Medicare health plan offered by a private company that contracts with Medicare to provide citizens with Part A and Part B benefits. If a citizen gets Medicare Part A, he can also get Part B; enrolling in Part B is by choice. Kidney dialysis patients may need both Part A and B in order for Medicare to cover some dialysis and kidney transplant services. With Original Medicare (Part A, or Part A and B), patients can go to any doctor in the U.S. who sees Medicare patients. It expands eligibility for Medicaid under age 65 with incomes up to 133% of the federal poverty level, (approximately $14,000 for an individual and $29,000 for a family of four) allowing more individuals to qualify for Medicaid assistance. Citizens qualify for Medicare if they need dialysis or a kidney transplant for end stage renal disease (ESRD). In states that have expanded Medicaid under the ACA, patients whose monthly income is below the poverty line ($958, or $1,293 for couples) are eligible for Medicaid without regard to assets.

How to manage or choose coverage from the perspective of different health insurances relating to kidney dialysis patients, for example: Private /Medicaid / Medicare

Under the ACA, your existing guaranteed Medicare-covered benefits won't be reduced or taken away. Patients reserve the ability to choose their own doctor. About 10% of all dialysis patients are covered through employer group health plans or other private insurance. Private insurance holders are actually less satisfied with health care and more concerned about costs than Medicare beneficiaries. Medicare has lower administrative costs than private insurance (less than 3% compared to an average 15% for private insurers) and has also lower per capita (per person) spending increases. Over the last decade, Medicare spending grew at a rate of 5.1% and Medicaid spending grew at rate of 4.6%, while private insurance per capita spending grew at a rate of 7.7%. Over the next decade, Medicare per capita spending is projected to increase by 3.1% and Medicaid by 3.6%, compared to 5% for private insurance. Important information can be found on following general websites: Dialysis Patient Dialysis; American Kidney Fund; National Kidney Foundation; Medicare; The ACA Facts. These sites provide kidney dialysis patients, healthcare professionals and Americans at risk with useful information about awareness, prevention, and treatment of kidney disease.

How does the ACA relate to public administration?

When people have kidney disease and are on dialysis, education is a key part of treatment, and that includes knowing how insurance works. The ACA represents an effort to reframe the financial relationship between Americans and the health-care system to stem the health insurance crisis that has enveloped individuals, families, communities, the health-care system, and the national economy as a whole. New Public Management (NPM) stresses sensitivity to changes in the marketplace as well as state regulations. In such areas as American Kidney Society, NPM becomes politically mobilized to make sure that regulatory administration relevant to their interest such as care centers, does serve their needs rather than primarily the desires of the regulated industries. Patients who are hampered by age, language, access, and/or education level may be unable to use electronic applications for enrollment. Because of these impediments they are forced to ask for help from an agent to get coverage or to see eligibility requirements for benefits. In some cases, e – gov cannot facilitate the public's interaction with public administration in this context, especially as client and customer.

How does the ACA impact on kidney dialysis patients?

According to National Kidney Foundation [2], 468.000 patients are on kidney dialysis in the United States. While this number seems high, it is not that high considering the size of the country. If all these patients were located in one city or one state, proper care would probably be concentrated, specific and highly effective. But spread out across this big country, proper care is not always provided. The Accountable Care Organization (ACO), a network of medical professionals, was designed under the ACA to improve quality of care, lower the medical costs, and share the savings, create better cooperation in the network, reduce bureaucratic waste and lower risk prevention among patients. ACOs can be used for patients with all illnesses but not specifically patients with renal failure [3,4]. An ACO is designed to save money through a variety of increased efficiency procedures, but in any one geographic location, you will obviously not find a large population of end stage renal dialysis patients (ESRDs). It does not seem feasible that an ACO would be efficient for such small populations. ESRDs have more needs than patients with other illnesses, because without a transplant these patients are basically never cured and are always in need of treatment. They are, in fact, permanent patients. Very few illnesses require this kind of permanent need for treatment. Cancer patients may receive a variety of treatments (radiation, chemotherapy, surgery) in a central cancer specific treatment center, but at a certain point, the treatments end. Other illnesses come with a set of therapies that treat the illness, but only a kidney transplant can save ESRDs, and these are not readily available in this country.

One of the ACA solutions implemented on January 1, 2011, was the Medicare ESRD Prospective Payment System (ESRD PPS). This implemented a bundle payment system that combined composite and fee for service payments into a single lump payment. The result of this system should give the provider greater savings as it encourages more ESRDS to participate in home dialysis. Additionally, it should optimize the use of related medications as well as ESRD related clinical laboratory tests [4]. An additional related program was implemented a year later on January 1, 2012. This was the ESRD Quality Incentive Program (QIP), which sets patient benchmarks and measures patient outcomes to establish a basic level of care. Failure to meet criteria can result in reduced payments. These two solutions create a similar type of ACO needed to address the high costs associated with ESRDs.

While these were proposed to address costs, the KDQOL-36 survey targets ESRDs/kidney dialysis patients with specific inquiry of quality of life to chart the progress of patients and make recommendations for future care [5]. The results of this survey can be limited due to the patients who have no access to a computer or the internet, poor language skills, and/or poor educational backgrounds. ESRDs/kidney dialysis patients receive a payment of $2 when they participate in this survey, but not all the states and kidney dialysis clinics or hospitals are using this measurement. Results from these surveys are used to make propositions to help ESRDs achieve better quality of life while they are continuing life with multiple dialysis treatments every week. Ultimately, the needs of low scoring patients can be addressed as the information becomes apparent to the surveyors. Specific problems can be addressed and improved through a variety of measures.

In conclusion, portions of the ACA directly address ESRDs' and kidney dialysis' issues by lowering costs, increasing effective treatments, and creating a more efficient service delivery system. While some savings have been observed, the value of these systems will be seen more clearly as time passes and micro-adjustments can be made as results become known and are analyzed. And although the materials look good on paper, only savvy administrators and careful attention to the results will provide greater savings and better service in the future by improving the models thus far seen [6-15].

Acknowledgment

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Conflict of Interest

No conflict of interest.

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