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POLICY FORUM

# Access to Rehabilitative Care in the Affordable Care Act Era

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The Patient Protection and Affordable Care Act of 2010 has certainly caused much discussion and debate in our country since its passage, now more than five years ago. Questions continue to arise in the public discourse as to whether one is "for" or "against" the Affordable Care Act (ACA). Yet when one looks closer at the 2,000-plus pages of the act and 10,000-plus pages of rules, one realizes this is a multi-layered law. One of the areas worthy of exploration and discussion is how the act affects provision and accessibility of rehabilitative care services. That discussion is the purpose of this article.

## A Brief History of Government-Sponsored Health Care Coverage in the United States

It was not until World War II that we began to consider as a society whether medical care should be treated as a right rather than a privilege. Society decided that serving in the military entitled one to health care. Care for those with disabilities acquired during military service was to be provided by the Veterans Administration [1].

Fostered by unions and encouraged by various federal government policies, health insurance coverage expanded significantly. In a mere ten-year period, from 1940 to 1950, the percentage of the US population with health insurance coverage, provided primarily by employers, expanded from 9 percent to 53 percent [2]. Access to medical care, including habilitation and rehabilitation for acute and chronic conditions, was now available to a majority of the population.

Medicare, passed by Congress and signed into law by President Johnson in 1965, expanded health care access to the retired and elderly population and eventually was extended to cover care for those who had certain chronic disabilities. There was to be "equal financial access," i.e., people in all financial situations would have equal ability to access medical care, and "equal treatment for equal need," i.e., the provision of services would be the same regardless of individual circumstances [3]. With the passage of Medicare, coverage for those aged 65 and over was to increase from roughly 55 percent to 99 percent essentially overnight [4]. Medicaid was passed at the same time, managed by states but jointly funded by the federal government, with the aim of attaining a "decent minimum" [3] level of care for all—the indigent (those who are poor) and the medically indigent (those who become poor because of their medical situation).

Despite these gains, patterns of behavior were established that were to repeat themselves. The American Medical Association fought vehemently against Medicare on the grounds that it was "socialized medicine" [5]. Only 26 states established Medicaid programs in the first year [6], despite the availability of significant federal subsidies. It took 17 years for all 50 states to implement Medicaid [6]. All this is much like the story unfolding around the ACA, which was designed to ensure equal access to health care for the US population at large. We are experiencing some of the same debate and raw emotions that we did 50 years ago when the Medicare and Medicaid programs were debated in the halls of Congress. States have been slow to implement the ACA despite the availability of federal funding, and opposition to the underlying aims of the program has been fierce [7]. But the numbers of the uninsured are dropping in the United States [7], from 48 million before the ACA's passage to 37 million today [8]. We may indeed be beginning to look like other countries in terms of slowly approaching universal coverage. Equal access, as envisioned by those who conceived of Medicare, is perhaps in sight [9]. Health insurance plans are no longer allowed to deny individuals coverage or raise their premiums due to preexisting conditions. Lifetime coverage maximums are no longer legal. In fact, the only variables that can legally affect insurance premiums today are geographic region, use of tobacco, age, the richness of the health care plan benefits, and whether the plan offers individual or family coverage [9].

**Does the Affordable Care Act Ensure Equal Access to Care?**

"Equal access" to health care—the intention of the ACA—is not, however, equivalent to "equal financial access" or "equal treatment for equal need," which served as the basis for the development of Medicare. It is true that individuals or families with incomes below 400 percent of the federal poverty level who purchase health insurance through a federal or state exchange may receive federal subsidies [10]. But there are limitations on what insurance plans provide through these exchanges.

*Barriers to equal access*. The exchanges were created to allow patients "choice," a mantra of the ACA. This refers to choice of health plans or levels of coverage—bronze, silver, gold, or platinum plans, each successive level providing more benefits and lower deductibles but with a higher monthly premium—as well as choice of clinicians within that insurer's network. The complexity of such choice is a barrier for the typical person seeking insurance. In one urban community, for example, 91 health plans were available to users of the exchange for 2015 [9]. Each plan comes with a different network of clinicians and different financial aspects: pharmaceutical formularies, costs and provisions for habilitation and rehabilitation, and rules for coverage. Those covered by employer-sponsored insurance do not confront this paralyzing level of complexity.

Added to this complexity is the trend toward increasingly narrow clinician networks, an attempt by health insurance companies to steer policyholders toward those practitioners with lower costs and higher value. Access to care is limited, geographically and

temporally, by restricted networks of clinicians, which can disproportionately affect patients who live in certain places by causing long waits for care in close proximity or time-intensive and expensive travel to obtain care.

Add, further, that thousands of dollars in payments are required by high-deductible health insurance plans before—and by coinsurance after—the coverage actually kicks in, which amounts to a significant financial barrier to access to care that particularly affects those without significant means. That the high costs of health care affect a large number of people is evidenced by their choice of health care plans: 85 percent of the 8 million people who subscribed in the first year of the health insurance exchange offerings chose either a bronze plan (with a deductible upwards of $4,500 for an individual) or a silver plan (with a deductible of at least $2,500 for an individual) [11].

Take all this together, and we see that the ACA may have limited success in providing equal access to health care.

*Barriers to habilitation and rehabilitation.* Finally, depending upon the plan chosen, there may be significant limitations on the amount of the habilitation and rehabilitation services covered, and coinsurance requires the patient to pay a significant proportion of the cost. Even though a plan might have limits on out-of-pocket costs to protect the policyholder, that does not mean there will be coverage for unlimited access to habilitation and rehabilitation services. And many patients tend not to look at the details of their benefit plans, leading to a rude awakening about the limits on benefits. All this limits access to rehabilitation care.

In the eyes of many, an injury or significant illness requires immediate attention and may reflect an "inelastic" demand for health care services, in the language of the economist—a demand that is unlikely to be altered significantly by changing prices. Habilitation and rehabilitation, however, tend to not be perceived as requiring immediate attention, and therefore demand is more "elastic." People without the means to pay for habilitative and rehabilitative care out of pocket may, therefore, put it off, with short- or long-term negative effects on health.

Furthermore, we seek transparency in the marketplace for health care coverage. But when "transparency" amounts to lengthy detailing of extremely complex systems, is it really achieving the intended goals? One may see the following actual language in insurance plan documentation: "Visit limit is a combined limit with Physical, Speech, Massage, Occupational, Cardiac and Respiratory Therapy. Outpatient Rehabilitation and Habilitation Services Visit Limits are a Combined Limit" [9]. Language in another plan indicates the benefits for habilitation and rehabilitation services as follows: "Speech Therapy, Occupational Therapy and Physical Therapy receive a combined maximum of 45 visits, including chiropractic care, sub-acute rehabilitation. Facility use is limited to 21

days per covered person per calendar year. Home Health Care Services is limited to 20 days per covered person per calendar year" [9].

Altogether, low coverage and confusing, overly complex explanations of benefits may be obstructing access to rehabilitation care in the post-ACA United States.

**Conclusion**

So have we achieved the goals underlying the establishment of Medicare and Medicaid? Equal access, as discussed in the context of the ACA, does not appear to mean the same thing that "equal financial access" did in the 1960s. High-deductible/high-coinsurance plans obstruct access to health care for those with limited financial means. Geographic barriers due to limited clinician networks may also obstruct access to care for residents of certain areas. Equality of access has decidedly not been assured.

Given that 22 states have not expanded their Medicaid programs, it could be argued that we have not even assured a decent minimum of care. In states that have not expanded their Medicaid program, state residents who have incomes below 138 percent of the federal poverty level—a significant proportion of people, since approximately 27 percent of the uninsured nonelderly population have incomes under 100 percent of it [12]—have fallen into the chasm between being able to afford health care and being eligible for Medicaid and/or federal subsidies to reduce health insurance costs.

Laws, rules, and regulations evolve over time. Perhaps legislators and policymakers will realize these shortcomings and make changes—we will see.

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