

Health Expenditure and Reimbursement in the Affordable Care Act: Relevant to the Shortage of Neurologists

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Editorial

The “Affordable Care Act” (ACA, also called “Obama Care”) is the name for the comprehensive health care reform law and its amendments [1]. The law addresses the coverage of health insurance, healthcare costs, and preventive care. The ACA features three main objectives: 1) to make affordable health insurance available to more people who are with household incomes between 100% and 400% of the federal poverty level (FPL); 2) to expand the Medicaid program to cover all adults with income below 138% of the FPL; and 3) to support innovative medical care delivery methods designed to lower the costs of health care generally [1]. In fact, the ACA has achieved a historic advancement in health-equity in the USA as the ACA has made health insurance more accessible [1, 2]. This landmark law improved the healthcare for women and families, children, elderly, disable people, LGBTQI+ and communities. However, there are still millions of Americans uninsured or underinsured due to high costs, even with subsidies potentially available [3]. Higher out-of-pocket expenses for private insurances and disrupted markets in some geographic locations chip away the affordability of the ACA-compliant plans [3]. Notably, the ACA-induced net gain in healthcare coverage was almost entirely due to an increase in Medicaid enrollment [4] and little or no change was recognized in quality, utilization, and the total costs of health care [5].

Medical care expenditure is the biggest issue in the US healthcare expenses, accounting for 90% of costs. These expenditures encompass costs for caring for people with disability, chronic or long-term medical conditions, particularly in the elderly population; in addition, the increased cost of new medications, technologies, and procedures [6]. National health expenditure (NHE) has costed \$4.3 trillion in 2021, or \$12,914 per person, and accounted for 18.3% of Gross Domestic Product [7]. The rate of NHE spending kept exceeding the rate of economic growth at an unsustainable pace. Notably, the expenditures were significantly increased by 4.4% in 2021 for hospitals (\$1,323.9 billion) and 5.6% for physician-clinical services (\$864.6 billion) [7]. On the other hand, the reimbursement rate for healthcare services continued declining.

There are gaps in reimbursement for healthcare providers and hospitals due to different rates conducted among private insurances, and Medicare and Medicaid. Notoriously, the current reimbursement methods are tedious and not transparent in the US health system. It was estimated that if Congress established a centralized claims clearinghouse, \$300 million could be saved annually [8] via simplifying procedures for reimbursement. A national survey disclosed current negative impacts of reimbursement and other predictors causing diminished access for the insured people to access to healthcare, partly due to compromised physicians' willingness to accept publicly insured continuing care patients [9]. Insurances deny coverage due to multiple reasons such as cost control or the services are not included in the written policies or insured plans, services outside the provider

Table 1: Neurology workforce.

	2010	2013	2015	2017	2019
PGY-1 positions	630	678	720	787	905
Neurologists	12,916	13,156	13,392	13,717	14,140
Ratio to population	23,928	24,029	24,001	23,746	23,429

PGY-1: 969 in 2021 and 1,005 in 2022.

Source: AAMC. Physician Specialty Data Report. 2022. <https://www.aamc.org/data-reports/data/2020-physician-specialty-data-report-executive-summary>.

network, missing detail due to insufficient information, questions about medical necessity or coverages, possibly paperwork errors, mix-ups, or a failure to follow the steps required by a health plan [10]. Additionally, tedious paperwork has shifted much work from secretaries to physicians and increased more patients-doctor direct communication resulting in decrease in efficiency for physicians to provide health care to patients. More secretaries and administrators are employed to appeal (and re-appeal) to negotiate reasonable reimbursement. To protect providers' interests, professional organizations continued lobbying Congress. Huge resources have been wasted in the current bloated and wasteful administrative system. It has been claimed that administrative spending accounts for 15% - 30% of the NHE in the US and at least half of the spending "does not contribute to health outcomes in any discernible way" [8, 11, 12]. Consequently, the unhealthy healthcare system was capable of shrinking physicians' willingness to accept "bad" insurances and worsening the disparity for patients to access health care. To make it worse, the reimbursement rate to healthcare providers has continuously been diminished and the US congress has passed the year-end omnibus legislation including a Medicare physician payment cut of 2.5% in 2023 [13] which will further adversely impact physicians' willingness to serve certain patients with "bad" insurances.

There are approximately 14,140 neurologists serving Americans in a ratio of 1/23,420 population [14]. Although the number of resident training position in Neurology have been increased gradually over the past decade, from 630 in 2010 to 905 in 2019 (more than 40% increase), it just kept the similar proportional ratio to the population (Table 1) [14]. The healthcare market continues strongly demanding more neurologists because more patients with increased incidence and prevalence of aging-related neurologic diseases seen in the circumstance of improved human-longevity with "baby-bombers" entering elderly. Notably, in 2021 healthcare workforce lost 333,942 providers and, in the fourth quarter, 117,000 physicians dropped out of services [15].

Efforts have been exercised in trying to resolve the barriers of consequences downstream, however, it should be more crucial to address the original sources upstream. Those "barriers" interfering with healthcare are fundamentally due to the causes that originated from the system or the structural deviation. There are many models in addressing the healthcare system, of which the Donabedian model is the standard approach in assessing quality. It has been concluded, and verified, that structure is the most important factor determining and influencing process and outcome [16]. The system or structural deviations including the ACA reimbursement have caused the current unfavorable circumstances for healthcare in the USA. To improve, it may be better to adopt a model of universal health

insurance for every American, i.e., to cover a major proportion of healthcare costs with options of additional private insurers to cover the rest proportion of healthcare costs. An estimated \$285 billion to \$570 billion in annual national health spending can be saved [8] if a universal health insurance coverage is employed. In this way it may simplify procedures for reimbursement and effectively reduce the wasteful administrative spending. Reduction in negative impacts of reimbursement could promote physicians' willingness to accept publicly insured continuing care patients [9] and improve shortages of physicians including neurologists.

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