The Affordable Care Act: An Enigmatic Policy in a Period of Political Transition

ND Flex Program
CAH Board Members

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Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND

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**Why this Title for a session?**

**Political Transition (or Political Quagmire?)**

- YoYo-like elections – Dems in, Dems out, Reps in, Reps out
- Pushing and pulling – Tea Party and the Occupy Wall Street
  - Congressman LaTourette (R-OH) announced retirement on July 31st – no will to compromise, “acrimony”
  - Moderate Dems and Reps – endangered species – Demise of the Blue Dogs
- Pushing and pulling – Senate yes, House no/Senate no, House yes – or legislation simply does not move
- Pushing and pulling – Senate and a malfunctioning Filibuster process
- Primary election challenges are up, and so are upsets – normally safe incumbents running scared – UT, TX, IA, Dick Luger in IN
- Era of the “Super-Pac” – dollars dominate the political discourse

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**Why this Title for a session?**

**Political Transition (or Political Quagmire)**

- Simpson-Bowles Deficit Reduction Committee
- Gang of Six led by Senator Conrad
- Budget Control Act of 2011- “Super Committee” fiasco – now Sequestration and US credit rating downgrade
  - Sequestration impact in ND - $4.99 million in Medicare cuts to rural hospitals and negative economic impact in rural areas of a loss of $6.09 million and 115 jobs (Source: www.SanoCapitalGroup.com)
  - Sequestration Impact on other ND programs - Head Start, $1.5 million; Child Care Development Block grant, $324,000; MCH, $140,000; Breast and Cervical Cancer Screening, $645,000; Senior Nutrition, $316,000; Family Violence Protection, $75,000; Low Income Home Energy, $1.7 million
- Managed to get health reform – but strictly party-line vote – no bipartisan ownership of a solution
- Election of 2012 – choice, confusion, perplexed and frustrated voters
Why this Title for a session?

Enigmatic Policy

- While the policy may seem clear, the process to get it was very muddy and oblique covering many years of starts and stops
- Leaves a level of confusion, frustration (both winners and losers and a fine line between them)
- Winners not a real sense of winning; for the losers no real sense of defeat (party line vote magnifies this)
- Wait, wait, wait for the Supreme Court
- Wait, wait, wait for a new Congress and President? – Perpetual political battle
- Ideology is fluid – Dems moved from advocating for a single or all-payer system to a Republican idea to have insurance mandates (i.e. individual mandate) but Reps abandoned the idea
- Post 2012 Election – Continue ACA implementation but with appropriations? Repeal? Deficit Reduction, Sequestration?
Why the Need for Health Reform?

U.S. health system – **equity** issues

**Spend the most** but do not have the best health outcomes

Growing recognition that we can no longer **afford** what we have, how we distribute services and benefits, how we pay for care, and how we access care

**Rural communities** have **unique** issues
- Access to care and availability of providers, along with coverage
- Population that is poorer, older, and sicker
- Health care in a rural community is a community and economic resource – how we see ourselves – source of pride and identity not just health services

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**Center for Rural Health**

What Drives Health Reform?

- **US Census estimate** (2010) of **49.9 million Americans without health insurance or about 16.3% of population**
  - **ND** about 9.15% or 65,000-102,000 (various sources)
  - **ND American Indian about 33%** (2004 statewide survey)
- 12-14,000 Americans lose health insurance every day
- 2,500 file for bankruptcy everyday due to health and medical costs
- Health accounts for **17.9% of GDP** (2011) (9% in 1980, 16.2% in 2008, and forecast to be 20% by 2021)
  - France spends 11% (2008)
  - Germany 10.5% (2008)
  - Canada spends 10.4% (2008)
  - OECD average was 9.6% (Organization for Economic Cooperation and Development -34 countries)
- **U.S. Health care spending was $2.6 trillion** in 2010 ($1.4 T in 2000, and $0.7 B in 1990) and expected to grow to $4.64 trillion by 2020
  - In 2009, about $7,960 per person was spent on health care in the U.S.
- **U.S. spends about twice as much** per capita on health care as **other countries**
- U.S. health care spending averaged annual increase was 9.9% (1970-2008) or 2.5 times faster than GDP
- Health care spending is over 4 times that spent on national defense

Insurance coverage
- 55.3% (2010) of Americans have insurance from their employer\(^3\) (down from 64% in 2000)\(^4\) –
  - ND it is about 62%
  - 52% of ND farmers receive insurance through non-farm source
- 64% of Americans have private health insurance\(^3\)
- 31% have insurance that is government based (Medicare, Medicaid and military)\(^3\)
  - 15.9% - Medicaid
  - 14.5% - Medicare
- 16.3% are uninsured\(^3\)
  - 12% White (non-Hispanic)
  - 21% African American
  - 31% Hispanic American

- **Cost of insurance** increasing at rapid rate – 120% increase since 1999
- About **1.5 million families lose their homes** every year due to unaffordable medical costs

Health Status Indicators

- U.S. (in 2011) ranked 32nd in life expectancy (28th in 2008) in comparison to other countries.
- 21st in age-standardized mortality rate for cardiovascular disease (2008)*
- 14th in age-standardized mortality rate for cancer (2008)*
- The Commonwealth Fund rates the U.S. last in overall health care system performance when compared to a group of six countries that include Australia, Canada, Germany, Netherlands, New Zealand, and the United Kingdom. The U.S. spends twice as much as these six countries on a per-capita basis, yet it is last on dimensions of efficiency and equity and 6th on quality and 6.5th on access.
- Fewer physicians per capita (2.4:1000 U.S. vs. 3.1:1000 other industrialized countries)
- 54% of U.S. patients do not seek recommended care, fill prescriptions, or visit a doctor because of health costs (7-36% in other countries)

Why Is U.S. Health System So Costly?

- Chronic Disease
  - Account for 75% of the over $2.5 trillion spent on health care
- Higher level of Per Capita Income (about 34% of cost differences)\(^7\)
  - Highest in the world, associated with higher health care costs (more money more spending)
  - Yet, not associated with medical outcomes (spend more, higher Per capita, but lower outcomes)
- Discretionary Medical Decisions\(^7\) (i.e. Practice Variation - Will Evidenced-based Medicine Help?)
  - Higher costing advanced care with medical specialists and availability of high tech treatment; less reliance on Primary Care - Significant regional variation (treatment process) \(^7\) about 21% of the cost differences may be associated with higher costing treatment decisions
  - Overall, U.S. spending on physicians is 5 x higher than peer countries (accounts for about 37% of spending gap)
  - 3-6 x higher costs for specialty physicians than peer countries
  - PC physician salaries roughly half specialty physicians
  - U.S. public and private payers pay more for specialty providers than other countries, and more for specialty over PC
- Higher pharmaceutical costs\(^7\)
- Higher administrative costs due to private health plans\(^7\) (ACA attempts to lower)
- Tort and Defensive Medicine\(^7\) (ACA does not address this)

The Three Goals of Health Reform

**Universal coverage** – “shared responsibility” – private and public instruments with incentives and subsidies

**Improve quality and overall public health** – restructure health delivery system, emphasize “comparative effectiveness,” care coordination, prevention and wellness, and provider accountability

**Reduce costs** – restructure fee-for-service, reimbursement linked to outcomes, comparative effectiveness, emphasis on prevention and wellness, chronic disease management, provider accountability and other interventions – **slow the rate in growth of health costs**
Key Features of Patient Protection and Affordable Care Act (PPACA)

- Immediate elimination (2010) of denial of coverage to children with pre-existing conditions – 11,800 children in ND
- Close “donut hole” in Medicare prescription drug benefit (2010)– 4,350 North Dakotans (December 2010) received checks for $250
- Donut hole closed to 50% payment in 2011 and entirely in 2020 when they will be responsible for standard deduct. + co-pay (25%)  
- Eliminates annual and lifetime limits on insurance coverage (cap on benefits) (2010) – bankruptcy protection
- Elimination of denial of coverage to adults (non-Medicare) with pre-existing conditions (2014) – 132,000 North Dakotans impacted
- Affordable coverage options for 70,000 uninsured North Dakotans and 63,000 who purchase insurance through individual market
  - Access to affordable insurance options for 8,200 uninsured North Dakotans with pre-existing conditions
- Tax credits for up to 17,700 ND small businesses (up to 35% for businesses with 25 or fewer employees or 92% of all businesses in the state, about 95% nationally)
- Medicaid expanded (133% of FPL) with first three years covered by feds, then sliding cost share
- Lower Medicare costs for 98,600 beneficiaries not enrolled in Medicare Advantage
- Eliminates recission on existing coverage (being dropped by insurance company)
Key Features of Patient Protection and Affordable Care Act (PPACA)

- In 2010 insurers must spend at least **85% of premiums** (large group) or **80%** (small group/individual) **on medical costs** or provide rebates to enrollees
- Rural **payment inequities** in Medicare reimbursement – IOM study
- Reauthorized **Rural Hospital Flexibility** program – expanded role
- Pilot program for coordinated care in rural – **Medical Home demonstration**
- **Pay rural physicians** at same rate as urban physicians
- Increased funding ($15 B over 5 years) to address **rural health disparities** in diabetes, obesity, tobacco use, and substance abuse
- Expands access to **340b** drug program (CAHs to have access like CHC – did not address RHC)
- Pays CAHs for reasonable costs associated with **clinical lab tests**
# Key Features of Patient Protection and Affordable Care Act (PPACA)

- Continues existing increase in Medicare reimbursement to **rural ambulances**
- Provides a 3% add-on payment for **home care services**
- Extension of the **Medicare Dependent Hospital** program
- **Expand Community Health Centers**
- **Frontier amendment** - $650 million over 10 years to the state’s PPS hospitals – indirect, yet, significant impact to CAHs
- **Community Transformation Grants** – evidenced-based community preventive health activities
- Commits $15 billion over ten years to a **Prevention and Public Health Fund** for prevention and wellness activities and community-based public health services.
Health Reform Impact in North Dakota

- Overall, for hospitals decrease uninsured decreases bad debt and uncompensated care – AHA and AMA both supported the ACA
- Health Workforce Improvements (more detail in later slide)
- Focus on payment reform – outcome based
- Focus on prevention, disease management, individual responsibility
- Smaller and more focused areas, yet important to rural health
  - 340 B Drug Pricing Program – CAH but not RHC (yet)
  - Frontier Amendment – “Big 6” hospitals – benefits rural hospitals through outreach services provided by tertiary hospitals
  - Community Health Needs Assessment to retain non-profit status – stay connected to the community – learn what community thinks/wants from the local system
  - Community Transformation Grants – focus on evidenced-based health prevention, community engagement – physical activity and nutrition, chronic disease
  - Extension of the Medicare Rural Hospital Flexibility Program (Flex)
  - Strengthening of the Indian Health Services – protection for cost sharing in state exchanges – income level

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Health Reform Impact in North Dakota

- 340,000 ND residents protected against ceiling on annual insurance coverage limits
- 2,630 North Dakotans covered under parents insurance
- 11,800 children protected due to elimination of denial of insurance coverage to children with pre-existing conditions
- 106,000 ND Medicare beneficiaries eligible for free, annual wellness visit and no cost sharing for prevention services
- 17,700 small ND businesses eligible for tax credits

1The Affordable Care Act: Immediate Benefits for North Dakota. HealthReform.gov
http://www.healthreform.gov/reports/statehealthreform/northdakota.html
Health Reform Impact in North Dakota

- 9,050 Medicare recipients helped with “closing the donut hole” – totally closed by 2020\(^1\)

- **28,864** North Dakotans covered under increased Medicaid expansion from 100% of FPL to 133% of the federal level (cuts ND uninsured by 45.1%)\(^2\)

- **132,000** North Dakotans with pre-existing conditions protected from insurance denial\(^3\)

\(^1\)The Affordable Care Act: Immediate Benefits for North Dakota. HealthReform.gov
http://www.healthreform.gov/reports/statehealthreform/northdakota.html

\(^2\)Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Kaiser Commission on Medicaid and the Uninsured. May 2010.

\(^3\)Health Reform a Closer Look. Families USA. May 2010.
http://www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions/north-dakota.pdf

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Health Reform Impact in North Dakota

Workforce

- National Health Service Corps – increases funding significantly
- National Workforce Commission – strategy and plan
- State Health Care Workforce Development grants - $150,000/yr
- Health Care Workforce Assessments – national and state based centers
- Rural Physician Training Grants – to recruit students most likely to practice in rural
- Primary Care Extension Program – educate providers on prevention, health promotion, CDM, mental and behavioral health, and evidenced-based practices
- Mental and Behavioral Health Education and Training Grants – target increasing students in psychology and social work
- Distribution of Additional Medical Residency Positions – re-allocate unfilled urban residency slots to Primary Care – High population in HPSA would include ND
- Interdisciplinary Community-based Linkages – Strengthens AHECs
- Nursing Student Loan Program – increases funding
- Nurse Education, Practice, and Retention grants – can support rural hospital and
Health Reform Impact in North Dakota

Workforce

- Public Health Workforce Recruitment and Retention Program – rural is included
- Allied Health Workforce Recruitment and Retention Program – new loan program
- Training Opportunities for Direct Care Workers – targets LTC staff development
- Alternative Dental Health Care Providers Demonstration Program – awarded to 15 entities as demonstrations to test new dental provider models to address rural and underserved dental needs
- Bonus Payments to Existing Providers in Rural and/or Underserved Areas – 10%
- Geographic Practice Cost Index – rural physicians on par with urban for Medicare
- Payments to Primary Care Physicians – 2013 Medicaid fees for primary care to equal Medicare – helps RHCs

Key Changes to the Overall Health Delivery System:

Payment Changes
and Quality of Care
Accountable Care Organizations (ACO)
Value-based purchasing (VBP)
Bundled payments
CMS Innovation Center

Key Focus - Accountable Care Organizations

Definition: A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Payment and quality – linking payment to outcomes, not payment to activity (value vs. volume)
Start date is January 1, 2012 (end of May 2012 over 220 ACO’s established)
Legal structure, and ability to commit for minimum of 3 years
Integrated into the Medicare system first, followed by demonstrations with Medicaid and private pay
ACO incentives originate from sharing in cost savings which are also linked to improved patient outcomes (3 yr. Medicare benchmark)
Base of 5,000 patients – hurdle for rural?
ACA calls for CMS to develop a demonstration involving CAHs
Key Focus - Value Based Purchasing

• A value-based purchasing program (VBP) is instituted by October 2012, covering five conditions in Medicare, affecting prospective payment system (PPS) hospitals, including sole community hospitals, Medicare dependent hospitals, and small rural PPS hospitals. Develop a 3 year CAH VBP demonstration within 2 years of enactment. Pay hospitals based on performance on quality measures (VBP = P4P)

• This is another example of integrating payment and quality whereby the “buyers” of health services (employers) hold providers of health care accountable for both cost factors and quality factors

Key Focus - Bundled Payments and CMS Innovation Center

A national, voluntary bundled payment systems (Medicare) pilot program, which will be developed and piloted for inpatient and outpatient hospital services, physician services, and post-acute care services (by 2013) to improve patient care and reduce spending - Sec. to consult with small rural hospitals, including CAHs

Creation of a Center for Medicare and Medicaid Innovation within CMS. The purpose of the center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients. Successful models could be expanded nationally. Can include medical homes, coordinated care, integrated care for dual eligible, HIT, and CDM. Rural not specifically identified, but not excluded

Payment penalty applied to hospitals with high levels of readmissions and hospital-acquired conditions
Expert Estimates of ACA Impact

Congressional Budget Office (CBO), a non-partisan Congressional research unit has estimated that the state health insurance exchanges (to purchase insurance) would ease small business insurance costs, albeit only marginally: premiums in the small-group market are forecast to fall between 1% and 4% under the exchanges, while the amount of coverage would rise by up to 3%.

CBO estimates that due to the law’s small business tax credits, the average premiums per person in the small group market will decline by up to 8-11% in 2016. The tax credit system, over those 6 years, will help small businesses and farmers to be able to provide health insurance to their employees, meet the “shared responsibility” obligation of the law, but to do so without a mandate or a federal requirement to do so, and without fear of fines and penalties.

CBO estimates that the CMS Center for Innovation provision will lead to an additional savings of $1.3 billion over 10 years.

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Expert Estimates of ACA Impact

Business Roundtable estimated that provisions in the legislation could save $3,000 per person in health costs.

Rand Corporation (published in NE Journal of Medicine) estimates that the proportion of U.S. workers who will have access to health insurance through their jobs will jump from 84.6% to 94.6%. That works out to 13.6 million additional workers having the option to buy affordable health plans. Most of this will be in the 50 and less employer category.

Commonwealth Fund state that prior to the passage of the ACA, family premiums were expected to increase from $13,305 in 2010 to $21,458 in 2019.36 Under reform, premiums will increase only three-quarters as much. By 2019, it is estimated that family premiums will be nearly $2,000 lower as a result of the ACA.
**Expert Estimates of ACA Impact**

**Commonwealth Fund** finds that the small business tax credit is estimated to provide new coverage or stabilize existing coverage for about **3.4 million** workers and family members employed in small firms by 2013. Small firms eligible to offer their employees health insurance through the insurance exchanges will provide new coverage or stabilize existing coverage for about **5 million** workers and their families by 2019. The combination of the **individual requirement to health insurance and the employer penalties for not offering coverage** are expected to provide employer-based health insurance to **6 million to 7 million** people who are currently without employer health insurance.

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**Robert Wood Johnson Foundation** in analysis performed by the **Urban Institute** (simulation model), issued December 2010:

- Number of uninsured to decline by 28 million to 8.3% (Rural Policy Research Institute or RUPRI estimate is higher with a decline of about 31 m)
- Costs of uncompensated care to uninsured to decline from $70 billion to $27 billion
- 30% of uninsured covered by Medicaid and S-CHIP (RUPRI – 30% adults and 24% children)
- 20% of uninsured covered through exchanges
- 10% of uninsured covered through other changes for private market access to insurance
- Of remaining uninsured about 40% would be eligible for Medicaid or S-CHIP but refuse to enroll
- Spending for non-elderly acute services would increase by 4.5%
Contact us for more information!

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