The Affordable Care Act: Impact on Nursing

UND Student Nurses Association

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- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country’s most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity

Focus on
- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

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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
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)
  - Netherlands spends 12.0% (2009)
  - France spends 11.8% (2009)
  - Germany 11.6% (2009)
  - Canada spends 11.4% (2009)
  - United Kingdom 9.8% (2009)
  - 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, $256 B in 1980) 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. 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 (down from 64% in 2000)
  - ND it is about 62%
  - 52% of ND farmers receive insurance through non-farm source
- 64% of Americans have private health insurance
- 31% have insurance that is government based (Medicare, Medicaid and military)
  - 15.9% - Medicaid
  - 14.5% - Medicare
- 16.3% are uninsured
  - 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)

Source: United Health Foundation – America’s Health Rankings 2011
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)?
  □ 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? (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) 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?
• Higher administrative costs due to private health plans? (ACA attempts to lower)
• Tort and Defensive Medicine? (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
Key Features of Patient Protection and Affordable Care Act (PPACA)

- **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 **recession** 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

- 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

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
\(^2\) Medداد Cov_rotation_correction:age 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.

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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
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 July 2012 over 350 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

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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
ACA Direct Impact on Nursing

- **Nursing Student Loan Program** -provides updates to the loan amounts for the Nursing Student Loan program and specifies that, after 2012, the Secretary has discretion to adjust this amount based on cost of attendance increases.

- **Nurse Loan Repayment and Scholarship Programs (NLRP)** - expands the Nurse Loan Repayment and Scholarship Programs (NLRP) to provide loan repayment for students who serve for at least two years as a faculty member at an accredited school of nursing.

- **Nurse Faculty Loan Program** -increases the Nurse Faculty Loan Program amounts from $30,000 to $35,000 in fiscal years 2010 and 2011 and declares that the amount of these loans will thereafter be adjusted to provide for cost-of-attendance increase for yearly loan rate and the aggregate loan. The legislation also creates a new sections for masters and doctorate level agreeing to spend 4-6 years as full time faculty.

- **Nurse Education, Practice, and Retention** - “Nurse Education, Practice and Quality Grants”. adds two new grant programs specifically for nurse retention, the first of which would authorize HHS to award grants to accredited nursing schools or health facilities (or a partnership of both) to promote career advancement among nurses. The second new grant program would permit HHS to make awards to nursing schools or health facilities that can demonstrate enhanced collaboration and communication among nurses and other health care professionals, with priority going to applicants that have not previously received an award.

- **Mandatory Funding Stream for Title VIII Programs** - authorizes $338 million in appropriations to carry out nursing workforce development programs including the advanced education nursing grants, workforce diversity grants, and nurse education, practice, quality and retention grants in FY 2010. For FY 2011 through 2016, HHS may use “such sums as may be necessary” to carry out such programs.

- **Public Health Workforce** -establishes a Public Health Workforce Loan Repayment Program to assure an adequate supply of public health professionals to eliminate workforce shortages in public health agencies. Under the program, HHS would repay up to one-third of loans incurred by a public health or health professions student in exchange for that student’s agreement to accept employment with a public health agency for at least 3 years. Individuals who service in priority service areas may be eligible for additional loan repayment incentives.

- **Allied Health Workforce** - authorizes an Allied Health Loan Forgiveness Program to assure there is an adequate supply of allied health professionals to eliminate critical allied health workforce shortages. The ACA authorizes HHS to make grants to accredited educational institutions that support scholarships for mid-career public health and allied health professionals who seek additional training in their respective fields.

- **Nursing Workforce Diversity Grants** - expands the workforce diversity grant program by permitting such grants to be used for diploma and associate degree nurses to enter bridge or degree completion programs or for student scholarships and stipend programs for accelerated nursing degree programs.
ACA Direct Impact on Nursing

- Change or Restructuring of the U.S. Health Delivery System – Fundamental Focus of the Affordable Care Act
  - Renewed focus on Wellness, Health Promotion, Disease Prevention, Disease Management (Population Health/Health Status)
  - But with a significant re-focus on the relationship of these factors to organizational performance, health outcomes and payment, cost factors (“lowering the cost curve”)
  - “Marry the two”
    - health behavior/health outcome
    - organizational performance/cost/payment/finance

Contact us for more information!

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