Health Reform: 98 Years in the Making

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Connecting resources and knowledge to strengthen the health of people in rural communities.
Center for Rural Health

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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 Dates in Health Reform

• **1912** - *Teddy Roosevelt* and his Progressive party endorse social insurance as part of their platform, including *health insurance*

• **1915** - The American Association for Labor Legislation (AALL) publishes a draft bill for *compulsory health insurance* and promotes campaigns in several states. A few states show interest, but fail to enact as U.S. enters into World War I. The idea draws initial support from the AMA, but by 1920 AMA reverses their position.

• **1921** - *Women reformers* persuade Congress to pass the Sheppard-Towner Act, which provided matching funds to states for *prenatal and child health centers*. Act expires in 1929 and is not reauthorized.
1929 - Baylor Hospital introduces a pre-paid hospital insurance plan for a group of school teachers, which is considered the forerunner of future nonprofit Blue Cross plans.

1935 - Social Security Act passed by Congress. The Act includes grants for Maternal and Child Health. These grants restored many of the programs established under the Sheppard-Towner Act and extended the role of the Children’s Bureau to include not only maternal and child health services, but other child welfare services as well.

Key Dates in Health Reform

• **1939** - Physicians start to organize the first **Blue Shield plans** to cover the costs of physician care.

• **1944** - FDR outlines 'economic bill of rights' including **right to adequate medical care** and the opportunity to achieve and enjoy good health in his State of the Union address.

• **1946** - Truman sends health message to Congress. Revised Wagner-Murray-Dingell bill introduced to Congress again. An alternative Senate bill (Taft-Smith-Ball bill) **authorizes grants to states for medical care of the poor.** Neither bill gains traction.
Key Dates in Health Reform

- **1946** - Hill-Burton Act (Hospital Survey and Construction Act) to fund the construction of hospitals passes. It also prohibits discrimination on the basis of race, religion, or national origin in the provision of hospital services, but allowed for "separate but equal" facilities. The statute also required hospitals to provide a "reasonable volume" of charitable care.

- **1947** - Truman, in another special message to Congress calls for a National Health Program. Wagner-Murray-Dingell bill and Taft bill both reintroduced.

- **1948** - AMA launches a national campaign against national health insurance proposals.

Key Dates in Health Reform

• 1961 - White House Conference on Aging is held in Washington, D.C. Presidential task force recommends health insurance for the elderly under Social Security and President Kennedy sends special message to Congress on health. Rep. King and Sen. Anderson introduce a bill to create a government health insurance program for the aged; King-Anderson bill draws support from organized labor, intense opposition from the AMA and commercial health insurance carriers.

• 1962 - President Kennedy addresses the nation on Medicare that is televised from Madison Square Garden. AMA issues televised rebuttal.
Key Dates in Health Reform

• 1964 - President Johnson advocates for Medicare in a special message to Congress.

• 1965 - The Medicare and Medicaid programs are signed into law. Medicare Part A is to pay for hospital care and limited skilled nursing and home health care. Optional Medicare Part B is to help pay for physician care. Medicaid is a separate program to assist states in covering not only long-term care for the poor but also to provide health insurance coverage for certain classes of the poor and disabled. (Former President Truman sits next to President Johnson as bill is signed.)

• 1973 – Health Maintenance Organization Act – control cost and increase access – follow-up to wage and price controls for inflation
Key Dates in Health Reform

• **1983** - Medicare introduces **Diagnostic Related Groups (DRGs)** as a prospective payment system for hospital payment.

• **1986** - Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare to screen and stabilize all persons who use their emergency rooms regardless of ability to pay.
Key Dates in Health Reform

- **1993** - Within his first week in office President Clinton convenes White House **Task Force on Health Reform**, and appoints First Lady Hillary Clinton as chair. President Clinton's proposal, named the Health Security Act, is introduced in both houses of Congress in November, but gains little support. Every American would have a "Health Security Card" to ensure access to care. Clinton proposed a "managed competition" approach that called for **universal coverage, employer and individual mandates, competition between insurers, with government regulation to control costs**. Support from key stakeholders was often limited and conditional. The opposition was led largely by two groups: the Health Insurance Association of America and the National Federation of Independent Businesses, both believing reform would create hardship for their smaller members.
Key Dates in Health Reform

• 1994 - Health Insurance Association of America begins airing "Harry and Louise" television advertisements portraying a middle-class couple worried about health care under the Clinton health plan. Other national health reform proposals are introduced in Congress, but also fail to garner sufficient support for passage -- the McDermott/Wellstone single payer health insurance proposal and Cooper's proposal for managed competition without a guarantee of universal coverage. By mid-1994 even a bipartisan bill to expand coverage without comprehensive reform is unable to pass.

• 2002 - President Bush launches Health Center Growth Initiative significantly expanding the number of community health centers serving the medically underserved. Federal spending on rural health “zeroed-out” in Bush Administration budget 3 years in a row. Conrad adds back in to budget authorization.
Key Dates in Health Reform

• **2003** - **Medicare Drug, Improvement, and Modernization Act (MMA)** passes, creating a voluntary, subsidized prescription drug benefit (Medicare Part D) under Medicare, administered exclusively through private plans, both stand-alone prescription drug plans and Medicare Advantage plans, which are Medicare Part C and grew out of the Medicare + Choice concept.

• **2009 – 2010** – **Patient Protection and Affordable Care Act (PPACA)** introduced and enacted. Debate on public option but support for incrementalism via private insurance market and increased role for public sector (e.g., Medicaid); significant focus on quality of care improvements and prevention; change in delivery particularly payment systems, keep focus on employer role in providing insurance; add about 31 million to receive insurance; pre-existing conditions and lifetime insurance caps
Why the Need for Health Reform in 2010?

- 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
Why the Need for Health Reform (continued)

- US Census estimate (2009) of **50.7 million Americans without health insurance or about 17% of population** – ND about 11-16% or 65-68,000
- 12-14,000 Americans lose health insurance every day
- 2,500 file for bankruptcy everyday due to health and medical costs
- **Health care spending was $2.5 trillion** in 2009 and expected to grow to $4.5 trillion by 2019
- Health accounts for **17.3% of GDP** (was 16.2% in 2008 and forecast to be 20% by 2018)
  - France spends 9.5%
  - Canada spends 9.7%
- In 2008, about $7,900 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) or 2.5 times faster than GDP
- Health care spending is over 4 times that spent on national defense
Why the Need for Health Reform (continued)

• **Insurance coverage**
  - 60% of Americans have insurance from their employer (down from 66% in 2000) – *ND it is about 62% - 52% of ND farmers receive insurance through non-farm source*
  - 28% have insurance that is government based (Medicare, Medicaid and military)
  - 9% have insurance they purchase themselves
  - 17% are uninsured

• **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
Why the Need for Health Reform (continued)

• Health Status
  o U.S. ranked 28th in life expectancy (2008) in comparison to other countries*
  o 21st in age standardized mortality rate for cardiovascular disease (2008)*
  o 14th in age standardized mortality rate for cancer (2008)*
  o The Commonwealth Fund rates the U.S. last in health care system performance when compared to a group of six countries that include Australia, Canada, Germany, 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 access, patient safety, efficiency and equity.*
  o Fewer physicians per capita (2.4:1000 U.S. vs. 3.1:1000 other industrialized countries)
  o 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)

* United Health Foundation – America’s Health Rankings 2008
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) have 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 15,600 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
- 106,000 ND **Medicare** beneficiaries eligible for **free, annual wellness visit** and no cost sharing for prevention services
- Lower Medicare costs for 98,600 beneficiaries not enrolled in Medicare Advantage
- Eliminates **recession** on existing coverage (effective in 6 months)
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.
Key Focus: Payment Changes and Quality of Care

- Accountable Care Organizations (ACO)
- Value-based purchasing (VBP)
- Bundled payments
- CMS Innovation Center
- Comparative Effectiveness Research or Evidenced Based Medicine
Key Focus - Payment Changes and Quality of Care 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
- 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 - Payment Changes and Quality of Care 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 - Payment Changes and Quality of Care
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
Key Focus – General Quality of Care (and Prevention)

- **Evidenced Based Medicine** or Comparative Effectiveness Research – new Patient Centered Outcomes Research Institute
- Secretary to develop a “**national strategy**” for improving the delivery of health care services, patient health outcomes, and population health
- Establishes a **National Prevention, Health Promotion, and Public Health Council** to coordinate federal initiatives and to develop a “national strategy” on prevention and health promotion
- Creates a **Prevention and Public Health Fund** - $500 million for FY 10; $750 million for FY 11; $1 billion for FY 12; up to $2 billion, FY 15
- School based health centers
- Oral health care prevention
- Community Transformation grants
- **Free Medicare consultation for seniors for wellness** – health risk assessment and personalized prevention plan – (new benefit)
Key Focus – General Quality of Care (and Prevention)

- **States may** provide **Medicaid assistance** to persons with **chronic conditions** who designate a provider or a team of professionals as their **health home**; a health home could include a rural clinic, a community health center, a physician, a clinical practice, or a clinical group practice.

- During FY 2010 through 2014, the Secretary will **develop quality measures** to assess health outcomes and functional **status**, management and coordination across episodes and care transition, use of information provided to and used by patients, and meaningful use of health information technology. Authorized at $75 million.
Key Focus - Impact on Small Business and Farmers

- **Businesses are not required to offer insurance, if they employ fewer than 50 full time equivalent workers.** They are not subject to any penalties and fines.
- About **96%** of all U.S. business are “small” – 50 or < (ND about 92%)
- **Tax incentives** from 2010-2014 (transition into Small Business Health Option (SHOP) Exchange to purchase insurance – 100 employees).
- Businesses (including farms) with 10 or fewer FTE employees earning on average less than $25,000 eligible for a tax credit of 35% of health insurance premium where employer pays 50% of premium starting in 2010 tax year (increases to 50% by 2014 for 2 years as part of transition to purchasing insurance through the business exchange)
- 11-25 employees and average wage of $50,000 eligible for partial credits and then 26-50 have smaller credits- set up to address the needs of the smallest employer
- Over 50 employees business could pay **$2,000 penalty per employee** not covered (concern of a disincentive to not cover) – no enforcement
Key Focus - Impact on Small Business and Farmers

- Establishes an **Internet portal** with information about affordable and comprehensive coverage options (e.g., credits, retirees,)

- Ensures small businesses are aware of the insurance options available to them by making **Small Business Development Centers** and all **Small Business Administration partners eligible for awareness grants**, including Women’s Business Centers, SCORE, Minority Business Centers, Veteran Business Centers, and others.

- Requires the Government Accountability Office (GAO) to specifically **review the impact of Exchanges on access to affordable health care for small businesses** to ensure that Exchanges are indeed making a difference for small business owners.

- Authorizes **grants** to help small business employees access **comprehensive workplace wellness programs**.
Key Focus - Role of Medicaid in Health Reform

• **Expands Medicaid coverage** to 133% of FPL ($29,300 family of 4)
• Transitions children on S-CHIP in families between 100-133% of FPL to Medicaid
• State-based Exchanges to serve people over 133% to 400%
• **100% federal funding** of Medicaid expansion for first 3 years from 2014-2016
• **Tiered decrease** from 2017-2020
  ➢ 95% covered by federal dollars, 2017
  ➢ 94% covered by federal dollars, 2018
  ➢ 93%, 2019
  ➢ **90% 2020 and beyond** (90/10 federal/state match going forward on expansion)
• Increases Medicaid payment for Primary Care –FFS and Managed Care Primary Care services to be 100% of current Medicare rates for 2013 and 2014 – covered by federal dollars
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.
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.
Expert Estimates of ACA Impact

- 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% (RUPRI # 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%
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