Health Reform: What's Old, What's New, and How Will it Affect you?

Presented by:

The Ca-Nv Public Health Training Center

Funded by:

HRSA Health Resources and Services Administration

1

California-Nevada Public Health Training Center

- **Collaboration of:**
  - San Diego State Univ., Graduate School of Public Health
  - Loma Linda U., School of Public Health
  - California State University Fullerton, Dept. of Health Science
  - Univ. of Nevada Las Vegas, School of Community Health Sciences
- **Goal:**
  - Strengthen performance in the core functions and delivery of essential services among public health workers in CA and NV
- **Website:**
  - http://www.CaNvPHTC.org

CALIFORNIA-NEVADA Public Health Training Center 2

Upcoming Trainings in San Diego

***In-Person Trainings* (all 8:30AM-noon)**

- ***8/27/12:*** *Health Disparities, Health Equity, and Social Determinants of Health*
- ***8/29/12:*** *Writing Grant Proposals for Health Programs*

Webinars

- ***TBA:*** *Fall Prevention: A Step-by-Step Guide to Reducing Falls in Older Adults (10-11AM)*
- ***9/13/12:*** *Health Policy for Program Planning (11:30AM-12:30PM)*

Go to CaNvPHTC.sdsu.edu/Trainings/default.asp to register

CALIFORNIA-NEVADA Public Health Training Center 3

Health Reform: What's Old, What's New, and How Will it Affect You?

August 21, 2012

Trainer:

Robert Seidman, PhD

Director, CaNvPHTC
Head, Division of Health Management and Policy
San Diego State University

4

Objectives

This training will help you to:

1. Understand the background leading to recent health reform initiatives.
2. Identify key features of the Patient Protection and Affordable Care Act (PPACA).
3. Describe how selected components of PPACA may affect the population's choices, health, and decisions by private and public health care organizations.
4. Understand the basis of the legal arguments and the Supreme Court's decision on constitutionality of the ACA.

CALIFORNIA-NEVADA Public Health Training Center 5

Topics

- **Background**
  - Why was there pressure for health reform?
  - Previous reform efforts
  - Desirable elements of health reform
- **Patient Protection and Affordable Care Act (PPACA)**
  - Political background
  - Major components
  - Phased in implementation
  - Financing ACA
  - Legal issues and challenges
- **Impact of PPACA on Individuals and the Community**
  - Access to care
  - Providers
    - Primary care workforce
    - Hospitals
    - Clinics
  - Public Health

CALIFORNIA-NEVADA Public Health Training Center

Class Guidelines

- Ask questions
  - Trainer does not know all details of ACA
- Ask: How does this affect
  - the organization where I work?
  - my job responsibilities?
  - me individually?

Why Health Reform Necessary?

- Large % of U.S. population uninsured
  - 2010: 49.9 million
    - 16.3% of entire population (all ages)
    - 72.8% of those 18-24 years of age
  - Limited access to care (except through costly ER)
    - Implications for
      - Individual health status?
      - Population health?
  - Why:
    - Health insurance usually provided by employer
      - Economic downturn --- lose jobs --- lose insurance
      - Cost shifting to employees --- more costly

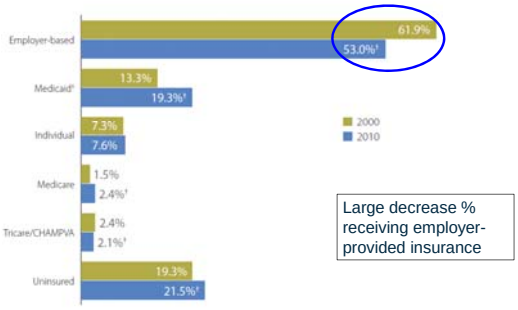
Uninsured in California

	TOTAL POPULATION IN MILLIONS	UNINSURED RESIDENTS IN MILLIONS	UNINSURED RESIDENTS SHARE OF TOTAL
United States	264.5	47.2	17.8%
HIGHEST PROPORTION STATES			
Texas	22.1	6.0	27.3%
New Mexico	1.7	0.4	24.8%
Florida	15.2	3.7	24.6%
Nevada	2.3	0.5	22.4%
Mississippi	2.5	0.5	21.4%
Arizona	5.8	1.2	21.2%
Arkansas	2.4	0.5	21.1%
California	32.7	6.9	21.0%

Values are for an **average** during 2008 – 2010; for age ≤ 65 only

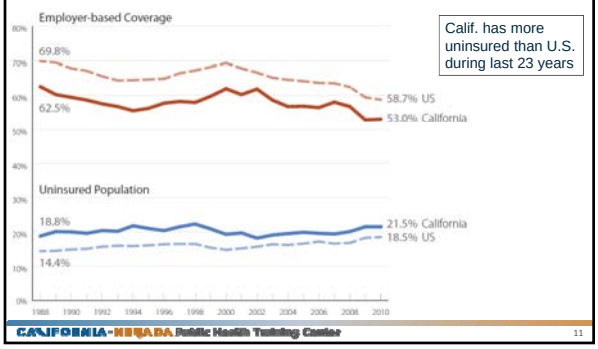
Source: California's Uninsured, CHFC, 2011

Uninsured in California



Large decrease % receiving employer-provided insurance

Uninsured in California



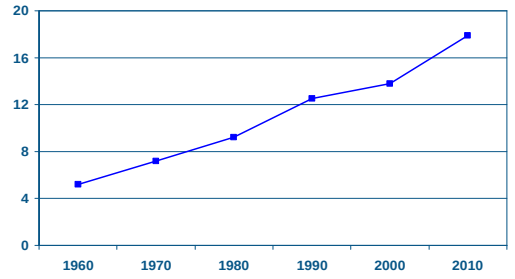
Calif. has more uninsured than U.S. during last 23 years

Comparisons: Life Expectancy and Per Capita Health Expenses

Country	Per Capita Health Expenditure in 2010 (US $)	Life Expectancy at Birth (2009, in years)
Australia	$4,774	82
Canada	$5,222	81
France	$4,691	81
Germany	$4,668	80
Switzerland	$7,812	82
United Kingdom	$3,503	80
United States	$8,362	79

Source: http://apps.who.int/ghodata/?vid=710

Health Expenditures as Share of Gross Domestic Product (GDP)



U.S. Health System

- Fragmented; not coordinated
  - Still largely employer-based
    - Large % uninsured
      - employer not provide health insurance or too expensive
      - Private insurance market excludes many of these
    - Other sources of insurance: private insurance; VA; Medicare, Medicaid, SCHIP
- High spending per capita; but health status lower than other countries spending much less
- Large % uninsured
  - Implications for access to care and health status
  - Hospitals/other providers shift costs

History of Health Reform

- 1912: Theodore Roosevelt champions national health reform in unsuccessful bid for presidency
- 1935: Franklin D. Roosevelt (FDR) favors creating national health insurance
  - » decides to push for Social Security first.
- 1945: Harry Truman calls asks Congress to create national insurance program.
  - » AMA denounces as "socialized medicine" and kills it.

History of Health Reform

- 1965: Lyndon B. Johnson twists arms in Congress to create Medicare and Medicaid
- 1974: Richard Nixon wants to require employers to cover workers; create federal subsidies to help everyone purchase private insurance.
  - » Watergate scandal occurs derailing this attempt

History of Health Reform

- 1976: Jimmy Carter supports mandatory national health plan
  - » Recession derails effort
- 1988: Congress passes bill expanding Medicare to cover Rx drugs and catastrophic care
  - » AARP-led "uprising" by older Americans upset at paying higher tax to finance it leads Congress to repeal law in 1989.
    - Tax levied on wealthy seniors only

History of Health Reform

- 1993: Hillary Clinton put in charge of developing plan for universal coverage
  - » Requires businesses to cover workers; includes form of individual mandate
  - » Extensive efforts to "educate" Congress & public; advocate for new plan
  - » Opposition from Republicans and business ("Harry and Louise"); Insufficient support to pass.
- 1997: SCHIP
- 2003: Rx coverage added to Medicare
- 2010: Affordable Care Act passed by Congress

Why Unsuccessful?

- Special interests
  - Potential losers vs. potential winners
    - AMA opposition
  - Advocacy/advertising to sway public opinion
    - Harry and Louise
- Bad economic timing; competing interests
  - Other problems more important
- Reform Complex; difficult to explain to public
  - Misinformation campaigns by potential "losers"
- Philosophical
  - Government intervention

Important Elements of Health Reform

- What are desirable features of health reform?
- What criteria would be useful in evaluating current and future health reform?

Desirable Features or Criteria for Health Reform (discussion)

- Prevention
- % resources needed to implement reform
  - $ expenses per capita
- Incentives for MDs to have positive outcomes
- Care coordination
- Reduced error rates
- Electronic records
- Improved health outcomes
- Control prescription drug costs
- Holistic emphasis: the whole person
- Educate MDs/providers re: benefits of prevention

Implementation and Cost

- For each feature or evaluation criterion offered:
  - Expected impact(s) on
    - access to care?
    - quality?
    - Cost/expenditures?
  - How implemented? Barriers anticipated?
  - How to finance?
    - Are any cost-saving?

Criteria for Evaluating Health Reform Proposals

- **Access to care**
  - How comprehensive is coverage?
    - Individuals
    - Services
  - How do they acquire insurance coverage?
    - Employers?
  - Autonomy to select provider(s)?
    - Use of gatekeeper to limit access?
  - Copays that restrict access overall or to certain providers?

Criteria for Evaluating Health Reform Proposals

- **Cost**
  - How much does it cost individuals?
    - Incentives to minimize utilization and cost?
  - How does reform affect health costs overall?
    - Cost containment to control future cost increases?
  - Affordable for business? Population? Govt?

Criteria for Evaluating Health Reform Proposals

- **Financing**
  - How will reform be financed? Where will the money come from?
    - Taxes? Who pays?
  - Change payments to hospitals and MDs?
    - Provider response to these changes?
  - Subsidies to low-income populations?

Criteria for Evaluating Health Reform Proposals

- **Equity**
  - Is reform fair to all individuals?
    - How do we judge fairness?
  - Equity in financing?
    - Ex: regressive vs. progressive tax?
- **Sustainability** (long run)
  - Designed to live within budget so programs don't go broke?
  - System to monitor regularly; make changes

Criteria for Evaluating Health Reform Proposals

- **Quality of care**
  - Emphasis on providing high quality care?
    - How to measure quality?
    - Value-based purchasing?
- **Responsibility for own health**
  - Incentives or penalties?
- **Use of electronic information**
  - Implications for cost & quality of care; H outcomes
  - Incentives (e.g., "meaningful use")

Quiz on PPACA

- The PPACA includes elements that will have roughly similar impacts that increase the % of those with insurance coverage and reduce health care costs

True or False

While there are a number of components designed to reduce the rate at which health costs increase, most of the provisions in the ACA are designed to increase insurance coverage.

Quiz on PPACA

- The PPACA will require nearly all Americans to have health insurance starting in 2014 or else pay a fine.

True or False

Starting in 2014, most U.S. citizens and legal residents will be required to obtain health coverage, or pay a penalty. Some exemptions will be granted (e.g., those with religious objections or where insurance would cost > 8% of income)

Quiz on PPACA

- The PPACA provides for government panel to make decisions about end-of-life care for people on Medicare.

True or False

While early versions of the law did contain provisions that would allow Medicare to reimburse physicians for voluntary discussions with patients about end-of-life, these provisions were dropped from the final legislation.

Quiz on PPACA

- The PPACA will reduce benefits that were previously provided to all Medicare beneficiaries in order to decrease costs.

True or **False**

The law reduced payments to privately administrated Medicare Advantage plans (i.e., Medicare HMOs). But they will still be required to provide all benefits that are covered by traditional Medicare.

Quiz on PPACA

- The PPACA will expand the existing Medicaid program to cover low-income uninsursed adults regardless of whether they have children.

True or False

Medicaid will be expanded to cover nearly all individuals under age 65 with incomes up to 133% of the federal poverty level.

Quiz on PPACA

- Under PPACA, state Medicaid programs that refuse to expand coverage to include those with FPL less than 133% will lose the federal matching contribution for their current Medicaid population.

True or **False**

The legislation passed in 2010 did include this provision, but the Supreme Court ruled recently that it was unconstitutional.

Quiz on PPACA

- The PPACA will provide financial help to low and moderate income Americans who don't receive insurance through their jobs to help them purchase insurance privately.

True or False

Individuals without access to affordable coverage who purchase coverage through the new insurance exchanges and have income up to 400% of FPL will be eligible for tax credits.

Quiz on PPACA

- The PPACA will create a new government-run insurance plan to be offered along with private plans.

True or **False**

Allowing for a "public option" insurance plan did have substantial support among Democrats, but vocal opposition to this forced Congress to eliminate it from the final legislation.

Quiz on PPACA

- The PPACA will allow undocumented immigrants to receive financial help from the government to buy health insurance.

True or **False**

Undocumented immigrants are not eligible to receive financial help from the government to buy insurance, nor are they eligible for Medicaid or to purchase insurance with their own money in the new Exchanges.

Quiz on PPACA

- The PPACA will prohibit insurance companies from denying coverage due to a person's medical history or condition.

True or False

Starting in 2014, all health insurers will be required to sell coverage to everyone who applies, regardless of their medical history or health status.

Political Backdrop for Health Reform

- Highly divided and partisan Congress
- Public perceptions
  - Government takeover of insurance market
    - Perceived infringement on personal liberty and freedom
    - Threatening ("socialized medicine")
      - Irony: already many government insurance programs
  - Misinformation (e.g., "death panels")
- Economic downturn
  - Impact on future deficit? Job growth prospects?

The Patient Protection and Affordable Care Act (PPACA)

- Often referred to as Affordable Care Act (ACA)
- Legislation passed 1st quarter 2010
- Very complex legislation; many individual components
  - Some challenged in court
- Goals
  - Expand health insur. coverage; decrease uninsured
  - Improve coverage for those with insurance
  - Control rising health care costs

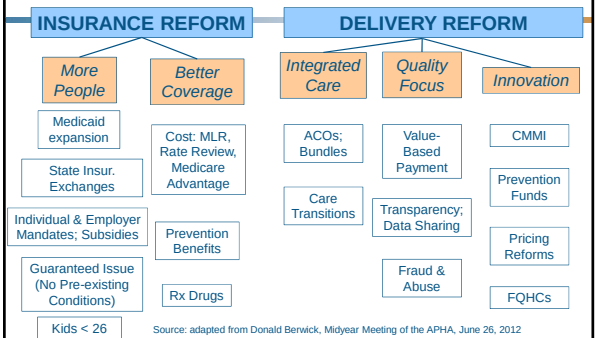
The Patient Protection and Affordable Care Act (PPACA)

- First – short video, good summary (9 minutes):
  - http://healthreform.kff.org/The-Animation.aspx
- Let's examine most important components of the ACA

Framework for ACA

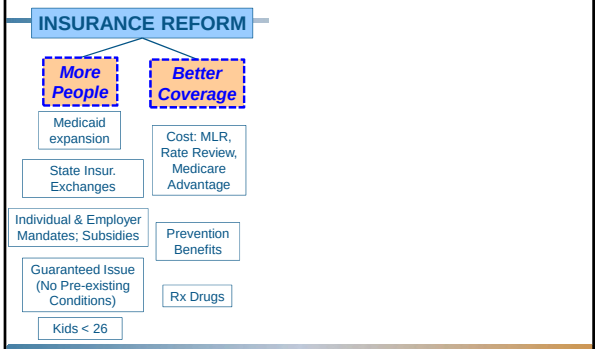
- Donald Berwick viewed ACA as consisting of components related to 2 important changes in health sector
  - Reform Insurance Market
    - Increase population with insurance coverage
    - Change insurance policies so better coverage
  - Reform Delivery System
    - Increase quality of care & better health outcomes
    - Incentives to provide high quality services
    - Reduce health costs through innovations in how and what types of services provided

Structure of Changes in ACA

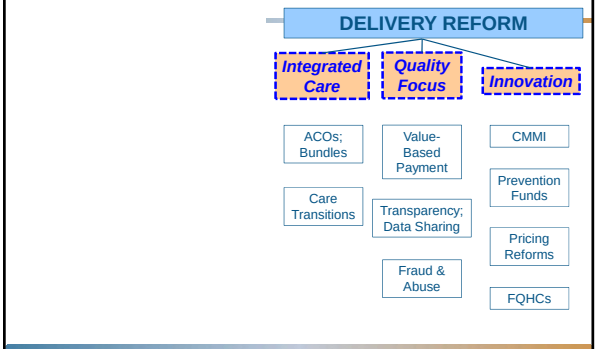


Source: adapted from Donald Berwick, Midyear Meeting of the APHA, June 26, 2012

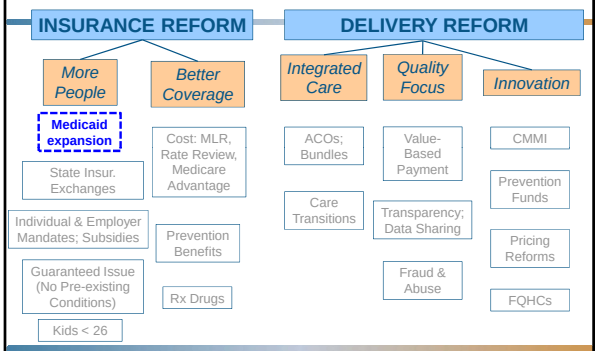
Structure of Changes in ACA



Structure of Changes in ACA



Structure of Changes in ACA



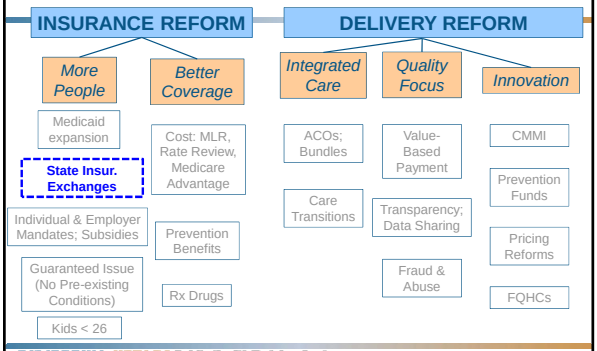
Medicaid Expansion

- Effective January 2014
- Medicaid (Medi-Cal) eligibility expanded to all individuals under age 65 with incomes up to 133% of Federal Poverty Level (FPL)
  - FPL varies by family size.
  - 133% of FPL in 2012:
    - $14,856 for individual
    - $30,657 for family of 4
- All individuals < age 65 with incomes ≤ 133% of FPL will now be eligible for Medicaid
  - In CA: approx. 1 million childless adults newly eligible

Medicaid Expansion

- Most *Healthy Families* eligibles shifted to Medi-Cal Program
- Federal government pays 100% of newly eligible Medicaid beneficiaries
  - This falls to 90% by 2020.
- Impact on States and Providers
  - Reduced uncompensated care
  - States assume up to 10% of financial burden once Feds stop paying 100% of cost.

Structure of Changes in ACA



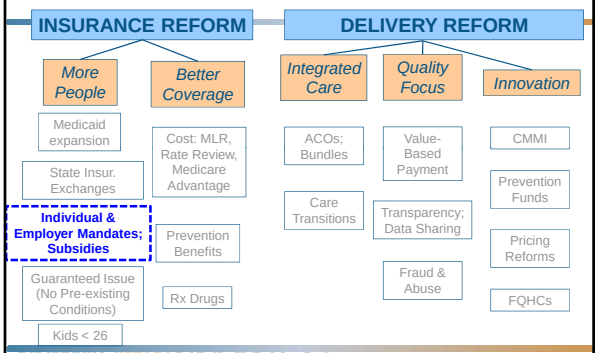
State Insurance Exchanges

- Effective January 2014
- Create new Health Insurance Exchanges at state level
- Choice of health plans available
  - Different levels of coverage & copayments; all provide benefits for given minimum package
- Competitive marketplace with transparent prices where individuals and small businesses can buy insurance policies

State Insurance Exchanges

- Important to disseminate information about these exchanges
  - Navigator program of education and outreach

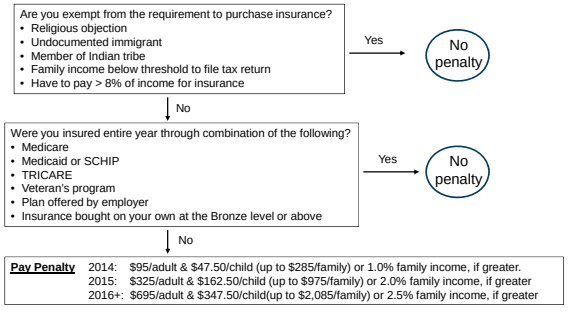
Structure of Changes in ACA



Individual & Employer Mandates

- Individual Mandate
  - Effective January 2014, most individuals required to have health insurance coverage meeting minimum standards
    - Pay penalty if not have insurance unless exempt
- If have existing coverage satisfying minimum benefit package requirement, can keep current policy
- If not have policy, can purchase through Exchange
  - Low-income individuals receive subsidy

Individual & Employer Mandates



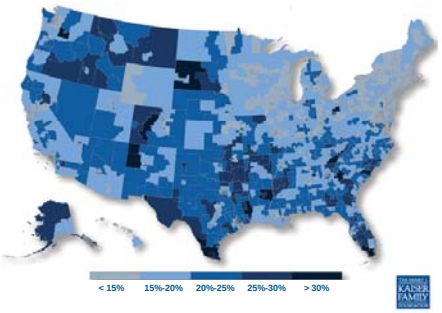
Individual & Employer Mandates

- Is penalty worth it?
  - In 2010, employees paid average of $899 towards cost of individual coverage in an employer plan; paid $3,997 for family of 4.
  - Compare to penalty of $2,085 for family of 4 beginning 2016.
    - While pay less with penalty than if had insurance, medical options much more limited if need to seek care and no insurance policy

Individual & Employer Mandates

- Subsidies for *individuals* to purchase insurance
  - Individuals with low incomes may receive federal subsidy policies purchased through the Exchange
  - Tax credits if income 133% - 400% of FPL
    - Reduces monthly premium; not wait until file tax return.
    - http://healthreform.kff.org/subsidycalculator.aspx
- So: Increased insurance for low-income from
  - Medicaid coverage if income < 133% FPL
  - Subsidies (sliding scale) to purchase insurance from Exchange if income 133-400% FPL

Who Will Benefit from Medicaid Expansion and Tax Subsidies?



Shows % of population (by county) with family income < 400% FPL

Individual & Employer Mandates

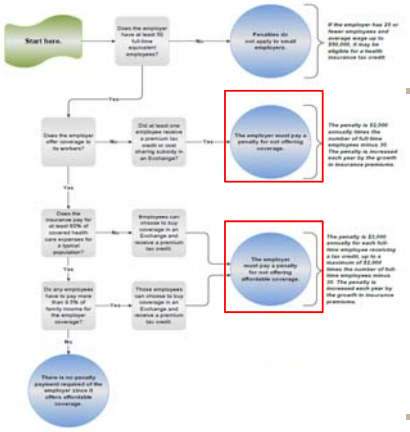
- Why an individual mandate?
  - When insurance companies can no longer ban people with pre-existing conditions, and with more people qualifying for Medicaid (including a number with low SES who have medical needs but did not have insurance before), average premium might increase.
  - Need healthier individuals to buy insurance to offset this.
    - Otherwise, these individuals not buy insurance and wait until sick to seek care (possibly through ER)

Individual & Employer Mandates

- Mandate not new idea
  - Individual mandate was Republican counterproposal to Clinton's health bill
  - Was centerpiece of Gov. Mitt Romney's Massachusetts health reform

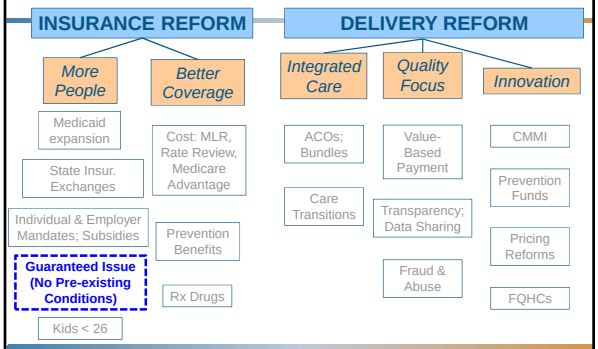
Individual & Employer Mandates

- Business mandate and penalty
  - Businesses with > 50 employees pay penalty if not provide insurance
    - $2,000 per employee (beginning 31st employee)
    - $3,000 each if insur. does not provide sufficient coverage
- Subsidy
  - Currently: **small** businesses may be eligible for credit up to 35% of employer's contribution to employees' health insurance
    - Effective January 2014, credit increases to 50%



Penalties for Employers Not Offering Affordable Coverage (beginning 2014)

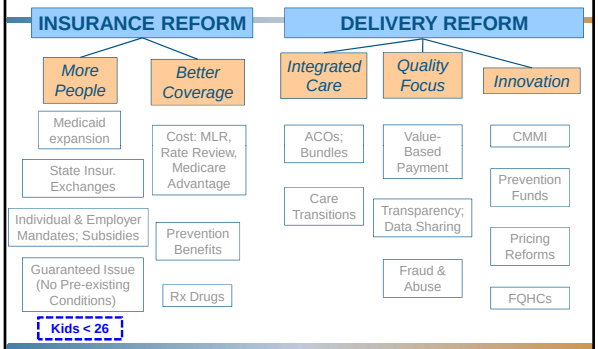
Structure of Changes in ACA



Guaranteed Issue

- Currently implemented:
  - Insurance companies cannot deny coverage to children ≤ 18 years of age due to pre-existing condition
  - Temporary pool to cover adults uninsured for ≥ 6 months due to pre-existing condition
  - Insur. Companies cannot rescind coverage due to error on application or illness that occurs. Also cannot impose lifetime limits on benefits.
- Effective 2014: adults cannot be denied insurance policy due to pre-existing condition

Structure of Changes in ACA



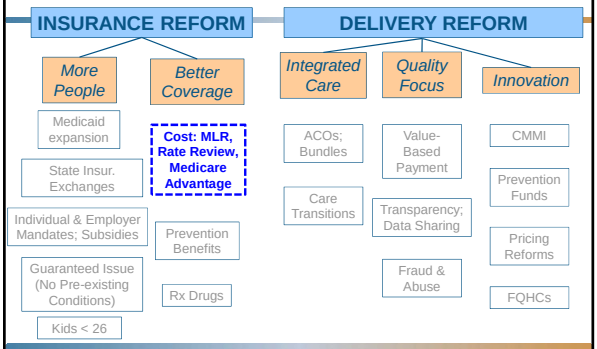
Extending Coverage to Dependent Children

- Currently: adults may stay on parents' insurance plan until they turn 26 years of age.
  - Large % of this age group used to be uninsured
    - Relatively healthy
  - Previous cutoff usually at 21-23 years.

Some Uninsured Remain

- Congressional Budget Office (CBO) estimates 23 million uninsured in 2019
- Who are they?
  - Immigrants who are not legal residents
  - Eligible for Medicaid but not enroll
  - Exempt from mandate
    - Most can't find affordable coverage
  - Choose to pay penalty in lieu of buying insurance

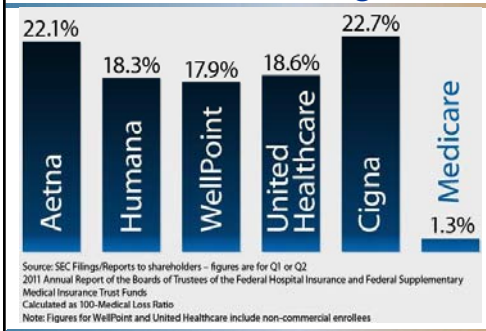
Structure of Changes in ACA



Cost: MLR and Medicare Advantage

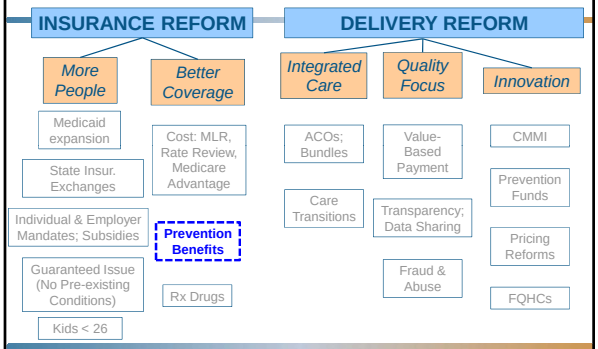
- Medical Loss Ratio (MLR): % of premium received by insurance company that is paid out in benefits.
  - Ex: if premium = $1000, and insurance company pays $800 in benefits, MLR = 80%
- ACA requires ≥ 85% of premium dollars collected for large employer plans spent on services
  - MLR ≥ 80% on plans to individuals and small employers.
    - Why the difference?

Cost: MLR and Medicare Advantage



Source: SEC Filings/Reports to shareholders – figures are for Q1 or Q2
2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds
Calculated as 100-Medical Loss Ratio
Note: Figures for WellPoint and United Healthcare include non-commercial enrollees

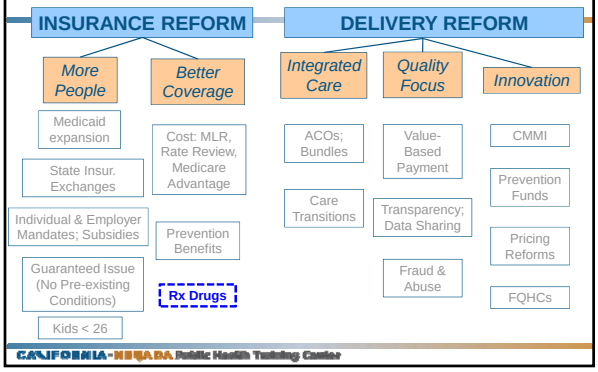
Structure of Changes in ACA



Prevention Benefits

- ACA encourages preventive care:
  - New funding to state Medicaid programs if provide preventive services at little or no cost
  - Free preventive services (e.g., annual wellness visit; personalized prevention plan) for Medicare beneficiaries
  - Effective 9/23/10, newly issued insurance plans must cover certain preventive services (e.g., mammograms, colonoscopies) without charging deductible or copay by individual

Structure of Changes in ACA



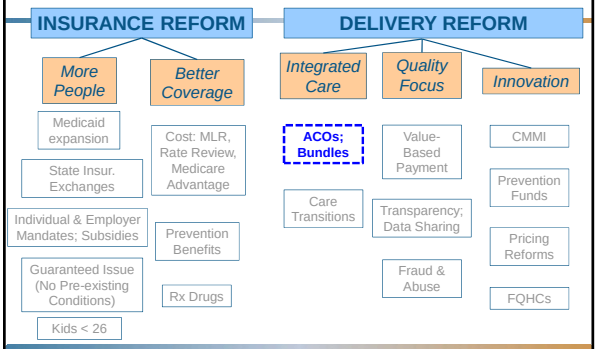
Prescription Drugs and Medicare

- Medicare Donut Hole defined
  - Individual spends $2,930-$6,657 in 2012 on Rx drugs . . . pays 100% out of pocket
    - Pay only portion of cost if expenditure < $2930 or > $6657.
- Medicare beneficiaries who reach "donut hole" in Rx coverage
  - receive 1-time tax free $250 rebate check (June 2010).
  - 50% discount if buy covered brand name Rx drugs
    - This discount increases in future until "donut hole" eliminated (2020)

Prescription Drugs and Medicare

- Example: Ms. Smith reaches donut hole
- She buys a drug that costs $400
  - Also dispensing fee of $2
- With Discount Program of 50%, she pays $200 (50% of $400) + $2 dispensing fee
- Ms. Smith pays $202 for Rx, but entire $402 counted as out-of-pocket spending
  - She will reach donut hole cap sooner and enjoy 95% copayment for additional Rx from Medicare

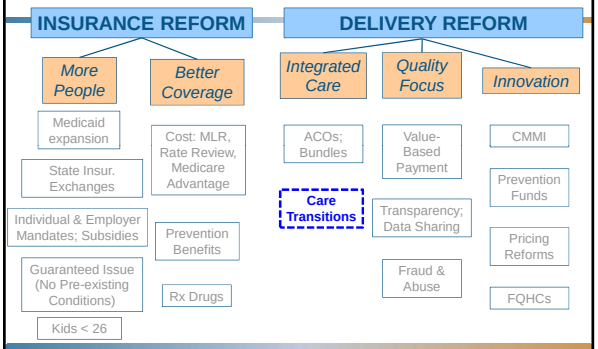
Structure of Changes in ACA



ACOs; Bundles

- ACA provides incentives to form "Accountable Care Organizations" (ACOs)
  - Physicians, hospitals, other providers
  - Coordinate patient care; improve quality; reduce unnecessary hospital admissions
  - If reduce cost, can keep some of savings
- Bundled payment
  - Hospitals, physicians, other providers paid flat rate for episode of care (instead of each service)
    - Incentive to deliver services more efficiently

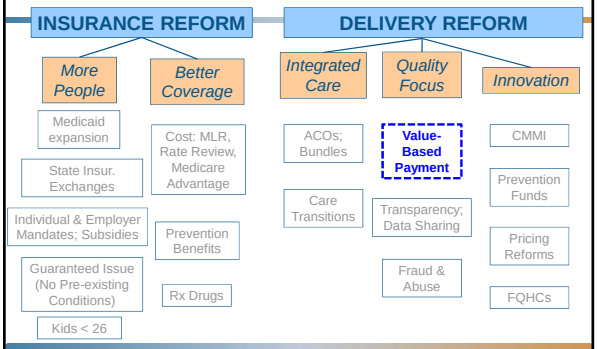
Structure of Changes in ACA



Care Transitions

- Community Care Transitions Program:
  - Coordinate care for hospitalized Medicare beneficiaries
    - link to services in communities
  - Expected result: avoid unnecessary hospital readmissions
    - Decrease costs; improve outcomes

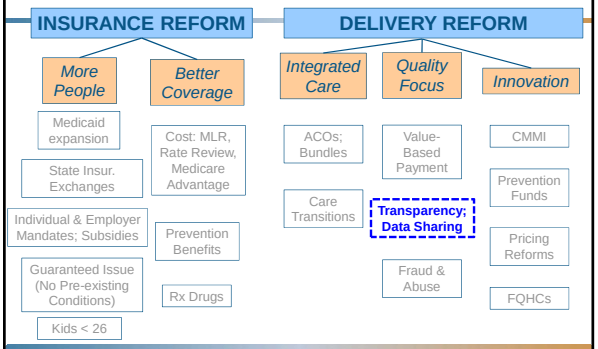
Structure of Changes in ACA



Value-Based Payments

- ACA establishes a hospital Value-Based Purchasing program for "traditional" Medicare
  - Offers financial incentives to hospitals to improve quality of care
  - Hospital performance publicly reported
    - Initially: heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care
- ACA ties MD payments to quality of care provided

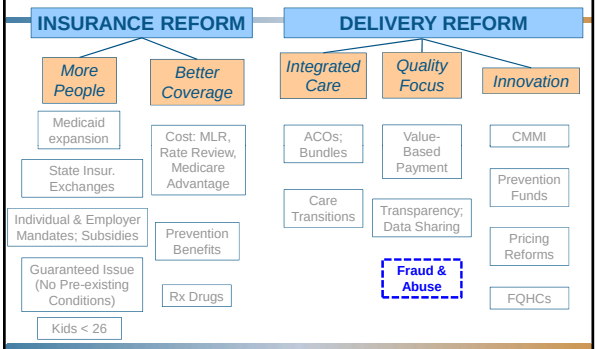
Structure of Changes in ACA



Data Sharing

- New measures to standardize billing & require health plans to implement confidential electronic exchange of health information
  - Computerized health records
    - Reduce costs, reduce medical errors, improve quality
- "Meaningful Use"

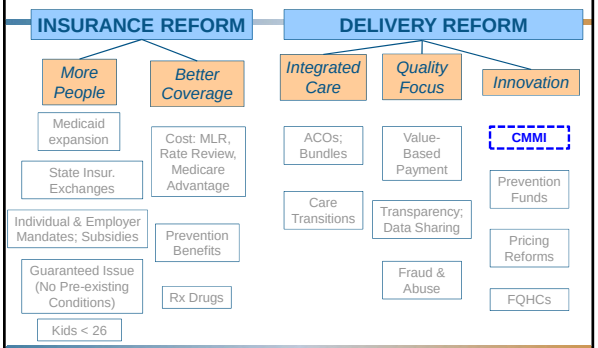
Structure of Changes in ACA



Fraud & Abuse

- New resources and procedures to identify and reduce fraud and waste

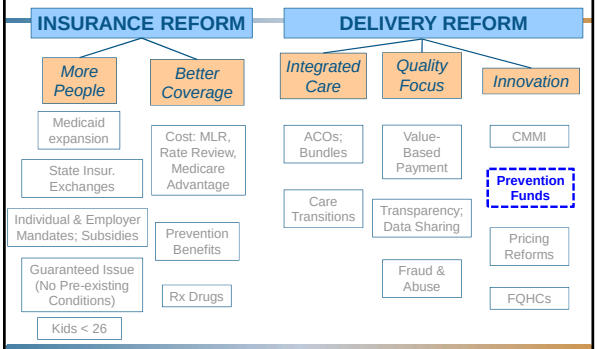
Structure of Changes in ACA



CMMI

- New CMMI: Center for Medicare & Medicaid Innovation
  - Testing new ways to deliver and pay for care to patients in order to
    - Improve quality of care
    - Decrease growth in costs
- $ millions in grants to organizations to test different models

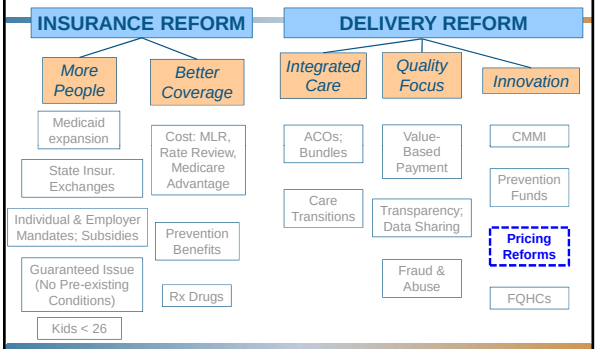
Structure of Changes in ACA



Prevention Funds

- New $15 billion Prevention & Public Health Fund
  - Invest in proven prevention & public health programs; identify new prevention methods
- Some of this $15 billion already reduced by Congress to fund other projects
  - Republicans view this as a health "slush fund"
- Currently supports this PHTC; also Community Transformation Grants

Structure of Changes in ACA



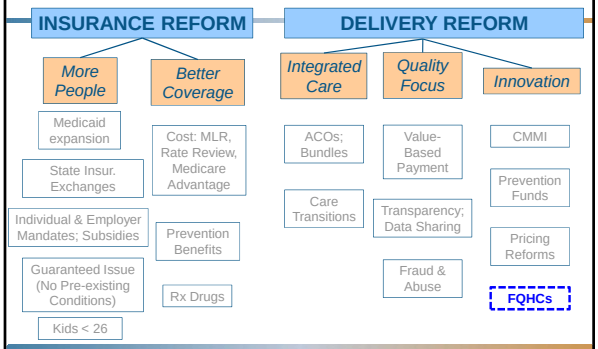
Pricing Reforms

- Medicare HMOs (Medicare Advantage plans) were paid > $1,000 more per person on average than spent on "traditional" Medicare beneficiaries.
  - ACA gradually eliminates this difference
    - Beneficiaries still receive all Medicare guaranteed benefits; possibly not some "additional" HMO benefits
    - HMOs also may receive bonus payment for high quality care

Pricing Reforms

- ACA increases payment to ***rural*** health providers
- ACA requires states pay primary care MDs ≥ 100% of Medicare rates beginning 2014 for primary care services.
  - Federal government provides funds for this
  - Intended to increase number of primary care MDs

Structure of Changes in ACA



FQHCs

- ACA provides new funding to support construction and expansion of services at community health centers
  - Large % of newly insured individuals expected to seek care at community health centers
- Also new incentives to increase # primary care MDs, RNs, and PAs.
  - Scholarships; loan repayments if work in underserved areas

Other Noteworthy Parts of ACA

- Insurance companies must justify large rate increases
- Voluntary long-term care insurance (CLASS)
  - Original legislation included it. Secretary of DHHS has "pulled it off" the table; not viable to implement
- Nonprofit 501(c)(3) hospitals must conduct community health needs assessment

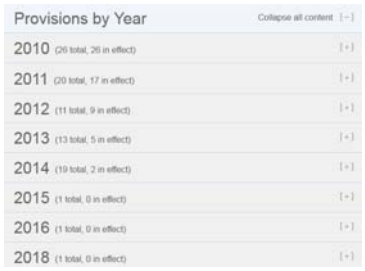
Other Noteworthy Parts of ACA

- Support coordinated care through "patient centered medical homes"
- Funding comparative effectiveness research to identify most effective treatments
- Stimulate # primary care MDs through grants and loans
  - loan forgiveness program if work in rural/ underserved areas

Access vs. Cost

- Would you say that the ACA will be successful:
  - Increasing access to care?
  - Increasing quality of care?
  - Decreasing the growth in health expenditures?

Health Reform Implementation



http://healthreform.kff.org/timeline.aspx

Summary: Health Reform Implementation Timeline

2010

- Some insurance market changes—no cost-sharing for preventive services, dependent coverage to age 26, no lifetime caps
- Pre-existing condition insurance plan
- Small business tax credits
- Premium review

2011-2013

- No cost-sharing for preventive services in Medicare and Medicaid
- Increased payments for primary care
- Reduced payments for Medicare providers and health plans
- New delivery system models in Medicare and Medicaid
- Tax changes and new health industry fees

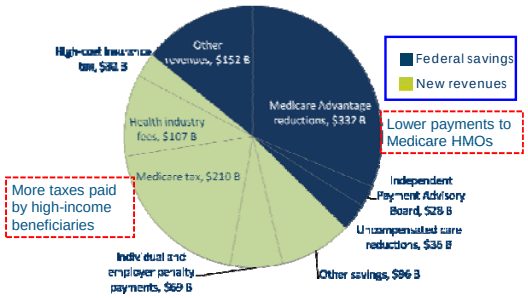
2014

- Medicaid expansion
- Health Insurance Exchanges
- Premium subsidies
- Insurance market rules—prohibition on denying coverage or charging more to those who are sick, standardized benefits
- Individual mandate
- Employer insurance coverage requirements

Financing the ACA

- ACA funded from combination of additional revenues and presumed cost savings
  - Additional costs:
    - insurance coverage provided to many currently without insurance
    - Additional benefits (services covered)
  - Presumed cost savings from changes in delivery system to increase efficiency

Financing ACA: 2010-2019



Total Cost = $938 Billion

(Savings to Federal Deficit = $124 Billion)

 Source: Congressional Budget Office, 2010

Legal Challenges to ACA

- Suits brought in many states challenging constitutionality of ACA
  - All but 1 lower court decision favored constitutional view of ACA
- Supreme Court agreed to hear case.
  - Justice Sotomayor urged to recuse herself since she worked on development of ACA
    - She refused based on insufficient grounds for recusal

Legal Challenges to ACA

1. Is this the time to decide on constitutionality, or wait until major provisions implemented in 2014?
2. Does individual mandate exceed federal power under constitution
   a) Argument: Commerce Clause provides right to regulate economic activity; but forcing some to purchase insurance when otherwise would not amounts to regulating ***inactivity***
3. If individual mandate unconstitutional, is it separable from ACA or does that mean entire ACA should be ruled as unconstitutional
4. Is ACA clause requiring states to participate in Medicaid expansion or risk federal dollars for current program constitutional?

Supreme Court Ruling on 6/28/12

- ACA upheld in its entirety (significant caveats)
- Conservative Chief Justice Roberts emerges as savior of ACA
  - Sided with liberals on individual mandate
- Court rejected federal authority under Commerce Clause
  - **But** upheld individual mandate by framing the penalty for refusing to buy insurance as a **tax** that Congress does have power to regulate using its taxing authority.

Supreme Court Ruling on 6/28/12

- Court decided that threatening to withhold all Medicaid funds from states that reject Medicaid expansion is unduly coercive and unconstitutional
  - Medicaid expansion exerts such a profound change on nature of the law that should be treated as a **new** and ***optional*** program for states
  - States now appear to have an option whether they expand Medicaid up to 133% FPL
    - Note: this was major way to increase coverage

Impact of Ruling on Medicaid Expansion

- If state decides **not** to expand Medicaid to 133% FPL:
  - Eliminate coverage for poorest residents (family incomes 100%-133% FPL)
  - ACA presumed these covered by Medicaid expansion
  - Tax subsidies to purchase insurance through Exchange not available to uninsured persons with family incomes 100%-133% FPL

The Future of ACA

- Continued attacks on PH and Prevention Fund
- Legislative battles over other key provisions
- Congressional attempts to
  - Repeal entire ACA
  - Starve ACA of funds needed to implement it
- More lawsuits
  - 20+ lawsuits already filed over contraceptive coverage
- Large % of American public still oppose ACA

Impact of PPACA on Individuals and the Community

Direct Impact on Individuals

- Already implemented
  - Insurance reform
    - children < 26 on policy
    - MLR ≥ 85%
    - prohibit rescission of policy if ill
    - no lifetime limits of coverage
    - new preventive services without copays
    - rebates and discounts on Rx for Medicare beneficiaries
    - 0% tax on tanning parlors

Direct Impact on Individuals

- Future implementation
  - Medicaid expansion
  - Subsidy to low-income individuals who purchase insur.
  - Pay fine if choose not to purchase insurance
  - Possibly better coordination of medical services
  - Higher tax if high-income Medicare beneficiary or have "Cadillac" insurance
  - Possibly less access to primary care provider (due to increase in # insured
  - No pre-existing conditions used if purchase insurance
  - Possibly decrease "optional" services provided by Medicare HMO

Impact on Providers and Provider Organizations

- Adoption of technology
  - Computerized patient records
  - Better care coordination
- Increased demand for services
  - Large increase in % of population with insurance
- Changes in practice
  - Reduce hospital readmissions
  - Greater demand for selected preventive services
  - Demonstrate high quality care and outcomes
  - Partnerships with other providers (through ACOs)
  - Probably pressure to reduce costs

Impact on Public Health and Local Health Departments

- More people insured; possibly less demand for clinical services provided by LHDs
- Form partnerships with providers for services through ACOs
  - Partnerships with FQHCs; potential new revenue
- Collaborate with non-profit hospitals to conduct required community health needs assessments
- Develop new business models to bill or contract for services
  - Needed due to reduced public funding
- Leverage $ from Prevention & PH Fund and other prevention initiatives in ACA

The Future of ACA

- More legal challenges; attempts to repeal ACA or strip out funding
  - Outcome of November elections crucial to future of ACA
- Many changes in some components
  - E.g., increasing penalty if not purchase insurance? Increased taxes or reduced payment rates?
- Is this the first step toward National Health Insurance?

CaNvPHTC
CALIFORNIA-NEVADA Public Health Training Center
www.CaNvPHTC.org

Thank you!

Please Complete Evaluations