Healthcare Reform 101

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LEARNING OBJECTIVES

1. List the intended goals of healthcare reform as it relates to improving patient care.
2. Identify three inadequacies in the current healthcare system that the Accountable Care Act is intended to address.
3. Describe three ways in which the ACA will address the goal of payment reform.

ABBREVIATIONS: ACA – Accountable Care Act; CBO – Congressional Budget Office; CHIP – Children's Health Insurance Program; FDA – Food and Drug Administration; PPACA – Patient Protection and Accountable Care Act.

INDEX TERMS: Accountable Care Act, Patient Protection and Accountable Care Act, Obamacare, Health Reform.

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Introduction

Although hotly debated in this country for many years, reform of the healthcare system has been long-anticipated and needed, and many would argue is still a long way from being effectively achieved. On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. This was slightly more than one year after beginning his first term in office. PPACA is also referred to by the terms Affordable Care Act (ACA), Obamacare or, simply, health care reform. This legislation, with its lofty goals, effective reforms and significant flaws, represents the most significant overhaul of this country's healthcare system since the passage of Medicare and Medicaid in 1965 under President Lyndon Johnson. A quality-focused and outcomes-based model is believed to be the only way to achieve real, sustainable savings. It is believed that we need to move from episodic care to coordinated care management and therefore, the ACA's overarching goal was to improve patient access, improve patient experience and quality outcomes and decrease cost.

The need for the reforming of our healthcare system can be represented by the following symptoms. Our current system is evidenced by fragmentation in care delivery, which can result in a poor quality patient experience, inefficient operations, suboptimal clinical outcomes and increased cost. There is significant waste in the system resulting from duplication of efforts, poorly defined processes and loss of information.

While the United States may have the best-trained medical personnel and the highest level of technology, the cold reality is that when compared to all industrialized countries, our cost is the highest and our quality and outcomes are toward the bottom. The escalating costs contribute to the economic woes we experience, primarily because the cost of healthcare places a significant burden on the United State's companies as they try to compete in a global economy. The healthcare cost for employees significantly adds to the cost of goods and services and is out of proportion with the rest of the world.

Affordable Care Act Goals

The main goals of the Affordable Care Act are numerous and far-reaching. While one could easily argue that the ACA is more about payment reform than true, comprehensive healthcare reform, the intended outcomes included the following.[1]

- Universality – All eligible Americans should be in a common risk pool. The ACA, as it is being implemented will cover an additional 32-40

million Americans, but will still leave a large number of Americans without coverage. However, even those without health insurance will still see improved access to some services (such as women's health services) under this legislation.

- Financing - This refers to more equitably spreading the cost of healthcare in this country and assuring that all components of the healthcare system are supporting its cost structure (patients, providers, industry, etc.). This also refers to the assumption that those that are younger and healthier will subsidize some of the care needed by those who are less healthy. This is the concept of a risk pool.
- Cost reduction – The cost of the healthcare system needs to be stabilized and the rate of growth needs to be reduced (this is often referred to as "bending the cost curve").
- Payment reform – The way the healthcare payment and reimbursement systems have developed over time has meant that doing more has always been rewarded – we pay for volume. The ACA introduces the concept of paying for outcomes and value achieved.
- Quality and process improvement – The ACA has significant quality improvement components, including quality indicator measurement and reporting, as well as comparative effectiveness research.
- Prevention & Wellness – There are significant components of the legislation which provide investment and incentives to provide for wellness and preventive medicine.

Coverage Provision

Since the legislation is primarily addressing payment reform, one can summarize the coverage provisions in five categories.[2]

Expansion of public/governmental coverage programs

This is accomplished through expanding Medicaid to 138% of the federal poverty level for individuals under 65 years of age. This applies to both family and individual coverage. This expansion eliminates what was a limitation of the program, prohibiting most adults without dependent children from enrolling in the program. For those with incomes above 138% of the federal poverty level, eligibility for Medicaid and Children's Health Insurance Program (CHIP) will remain unchanged until 2019. Under the law, the federal government will provide 100% of the funding for this expansion in 2014-2016. This will decrease to 90% by 2020 and in subsequent years. If a state had already expanded adult eligibility there will be a phased-in increase in their coverage. However, this cannot be forced on the states, as it was the one provision of the ACA that the Supreme Court ruled was unconstitutional. This has resulted in a wide variability in how and whether states are deciding to implement this Medicaid expansion.

Insurance (Health Benefits) Exchanges

Although the web rollout of the federal and many of the state exchanges did not go well, structurally this aspect of the ACA has to do with creating Amazon.com-like web sites where individuals can shop for and purchase insurance. It is also where small employers (up to 100 employees) can purchase insurance for their employees. The goal is to provide the necessary information for individuals to make an informed buying decision. One aspect of the exchange concept is that based on your income, and other factors, you may be eligible for cost sharing or premium subsidies. These subsidies are based on whether the individual has access to insurance elsewhere (i.e. through their employer) and income level. The subsidy is determined on a sliding scale based on income and will assist in paying premiums and limiting out-of-pocket expenses. The exchanges are not available to illegal immigrants. One of the factors that received attention as the October 1, 2013 exchange rollouts occurred was that there is a minimum benefit set that the insurance plan must meet in order to be sold on the exchange. This resulted in some people losing their current coverage. Participating insurers are required to provide four levels of coverage that will vary in terms of benefits, premiums and out-of-pocket expenses. In addition, a catastrophic health plan must be made available.

Changes required of private insurance plans

One aspect of healthcare reform that comes the closest to being uniformly embraced is that the new regulations prohibit an insurer from denying coverage based on health status (pre-existing conditions) or from charging more based on health status or gender. This is in addition to the previously mentioned requirement for plans to meet a minimum standard benefit set,

including caps on out-of-pocket spending. Insurers must also cover dependent children until they turn 26, reduce the variation in premiums based on geography, tobacco use and family size. Insurers can no longer impose lifetime limits on coverage and can only cancel coverage in cases of fraud. As mentioned earlier, there is a defined set of preventive services which must be covered, increases in annual premiums are subject to review (already the case in many states) and limits on how much of the premium can be used to cover administrative expenses (not more than 20%).

Individual mandate

Surprisingly, the Supreme Court ruled that the individual mandate was constitutional because it was viewed as being a tax. Beginning in 2014, all individuals will be required to carry health insurance or incur a penalty of at least $695 per individual or $2085 per family, or 2.5% of the household income. The only exceptions will be based on hardship, religious objections, American Indians, or individuals whose income falls below the tax filing threshold or if the lowest cost premium exceeds 8% of income.

Employer requirements

The business community had lobbied hard against a "mandate" and succeeded, but businesses with at least 50 employees will be assessed a fee per full-time employee in excess of 30 if they do not provide coverage. Employers, with a large number of employees, must enroll employees in the lowest cost premium plan if the employee does not select a plan or officially opts out (i.e. because their spouse has coverage).

Additional goals for healthcare reform

Additional changes, which are included in the regulations, go beyond the payment reforms described previously. These changes fall into the areas of cost containment, improving quality and healthcare system performance, prevention and wellness, long-term care and investments in the healthcare system. These will be rolled out in phases between 2011-2019.[3]

Cost containment

This will be achieved first through administrative simplification, although the role out of the website and the exchanges may ultimately incur significantly increased implementation costs. It is felt that having a single set of eligibility verification and claims status rules, electronic fund transfer requirements and requirements for enrollment, information-gathering, certification and authorizations will simplify the entire process and result in savings. Additionally, Medicare payments are restructured under the ACA and include:

- Restructuring payments to the Medicare Advantage plans and reducing geographical disparity while also recognizing differences in quality. A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits.
- Reducing annual market-basket adjustments (i.e. cost of living) to inpatient hospital rates, home health, skilled nursing and other Medicare providers (i.e. clinical laboratory fee schedule) and adjust for productivity. It is here where the clinical laboratory was hit twice. The fee schedule updates are eliminated for five years and the fee schedule will be reduced, annually through the productivity adjustment, a number which will come from the Bureau of Labor Statistics.
- Freezing the threshold for income-related Part B Medicare premiums through 2019 and reducing subsidies for Medicare Part D premiums for people with incomes higher than $85000 (individuals) or $170,000 (couples).
- Establishing an Independent Payment Advisory Board to develop recommendations to reduce the annual growth in Medicare spending. During the political debate, it is this board that was often referred to, by opponents, as the "death panels".
- Development of Accountable Care Organizations (ACO)that allow for cost sharing based on improvements in cost and quality (ACOs are covered in a separate article in this issue).
- Create an Innovation center within CMS (Centers for Medicare and Medicaid Services) to test, evaluate and expand Medicare, Medicaid, and CHIP payment structures and methodologies.
- Reduce expenditures related to preventable hospital readmissions and for certain hospital-acquired conditions (i.e. infections).
- Authorize the Food and Drug Administration (FDA) to expand the approval of generic drugs.
- Enhance oversight to reduce waste and fraud and abuse in the system.

Improving Quality and Health System Performance

It is this area where much promise for actual improvement in care delivery lies. The list of proposed initiatives include the following.[4]

- Support comparative effectiveness research by establishing a new outcomes research institute that will conduct research comparing effectiveness of clinical treatments. Comparative effectiveness research is designed to inform health care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care. This can be accomplished in two ways. Researchers look at all of the available evidence (a "research review") about the benefits and harms of each choice for different groups of people from existing clinical trials, clinical studies, and other research. Alternatively, researchers conduct studies that generate new evidence of effectiveness or comparative effectiveness of a test, treatment, procedure, or healthcare service.
- In order to begin to address much-needed tort reform, demonstration grants will be available to states to evaluate alternatives to current tort litigations.
- Establish a pilot program to develop and evaluate paying in a bundled payment for acute/inpatient, physician, outpatient hospital and post-acute care services to cover the period 3 days prior to hospitalization and 30 days post-discharge. This, much like the concepts of the Accountable Care Organization, begins to look at providing incentives to improve the hand-offs and transitions that patients experience in our healthcare system. This is being proposed for both Medicare and Medicaid.
- Establish a value-based purchasing program based on quality measures. This will be piloted in hospitals and later expanded to skilled nursing facilities, home care agencies and ambulatory surgery centers.
- Improve coordination of care for those dually eligible for Medicare and Medicaid.
- Develop a state medical home model to better coordinate care and improve care management for those with two or more chronic conditions or those with one chronic condition and a mental health diagnosis.
- Improve reimbursement for primary care services.
- Understand and reduce disparities based on race, ethnicity, sex, disability, language and for under-served rural areas.

Prevention and Wellness

- Develop a council to coordinate federal prevention, wellness and public health activities.
- Eliminate Medicare and Medicaid cost-sharing (co-payments) for preventive services recommended by the U.S. Preventive Health Task Force and waive deductibles for colorectal cancer screenings.
- Authorize Medicare coverage of personalized prevention plan services including a comprehensive health risk assessment annually.
- Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs (i.e. tobacco cessation).
- Provide grants to employers for the establishment of employee wellness programs.
- Permit employers to offer employee rewards (i.e. premium discounts) for participating and making improvements as the result of a wellness program.
- Require chain restaurants and vending machine companies to disclose nutritional content of each item sold.

Long-term care

- Develop a national, voluntary insurance program for assisted living.
- Provide new options for home and community-based services to be covered by Medicaid.
- Provide community-based attendant services to individuals with disabilities requiring an institutional level of care.
- Develop incentive program for increasing non-institutional based long-term care.
- Require standardized reporting for all skilled nursing facilities.

Other investments

- Improve workforce training and development
  - Develop national workforce strategy for healthcare workers
  - Redistribute, to underserved areas, unused Graduate Medical Education training

positions
    - Scholarships and loans for workforce training with an emphasis on increasing diversity and interdisciplinary programs.
    - Increase capacity for nursing education through expansion of programs, financial support, loan repayment and retention grants. Create a career ladder for nursing.
    - Focus training models on primary care team development. This is an important component of the ACO and Medical Home models.
- Increase funding for community-based health centers.
- Strengthen emergency department and trauma care capacity.
- Improve emergency preparedness training.
- Non-profit hospitals will be required to perform community needs assessments every three years.

Summary

The intent of the Affordable Care Act is to ensure that all Americans have access to quality, affordable healthcare while significantly reducing the cost burden for this country. It is estimated that an additional 32 million individuals will be covered. The Congressional Budget Office (CBO) estimates this legislation will reduce the deficit by $143 billion in the first 10 years (2011-2020) with an additional $1.2 trillion in savings during the subsequent decade.

Healthcare reform is a challenging problem to comprehend and change. That is why it has taken so long to pass any legislation related to this issue. We are almost 50 years post-introduction of Medicare and Medicaid and while there has been much dialogue and a number of infamous attempts to tackle the issue, the ACA is the first successful attempt to pass legislation. History will tell if Congress and the President "got it right" but the alternative of doing nothing was also unacceptable. One might predict that some of what has been legislated and already implemented will stand and result in positive change (i.e. the focus on preventive health and wellness) while other aspects will require change – some minor and some major. We are already seeing changes and timelines that are being modified and delayed. This is a topic that will require an ongoing assessment and look-back to see what was done correctly and what needs to be changed.

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