Health Reform: Where Are We Headed?

April 1, 2011
Why Pursue Reform?

It is helpful to remember that the status quo was not acceptable to anyone:

• 51 M uninsured and growing
• Over the last 10 years, insurance premiums rose 131%
  • An average family of four pays more than $13,000 annually in premiums
• Healthcare as % of GDP approaching 20%
Making the Case for Reform

“[O]ur health care system is placing an unsustainable burden on taxpayers. When health care costs grow at the rate they have, it puts greater pressure on programs like Medicare and Medicaid. If we do nothing to slow these skyrocketing costs, we will eventually be spending more on Medicare and Medicaid than every other government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close.”

September 9, 2009
Health Reform is Law

The Patient Protection and Affordable Care Act (PPACA) was signed into law March 23, 2010

Amended by the Health Care & Education Affordability Reconciliation Act (signed March 30)

• Provides coverage to 32 M uninsured by 2019
• Costs an estimated $940 B over 10 years
The PPACA: What’s In The Bill

Expanding coverage
Delivery system reform
Taxes/financing changes

Workforce development
Wellness/prevention
Quality and safety
Expanding Coverage to 32 Million

What Would Happen Under Reform

- Exchanges: 26 million
- Medicaid & CHIP: 50 million
- Uninsured: 23 million
- Nongroup & Other: 25 million
- Employer: 158 million

Source: Congressional Budget Office
Coverage: Medicaid

- **ALL** individuals eligible up to 133% of FPL
- Estimates range from 300,000 to 500,000 new enrollees
- HIP program could be plan for newly-eligible; IN awaiting CMS response
- Feds will pay most of cost (phasing down to 90%), plus up to Medicare for PCPs in 2013, 2014
Coverage: Individual Mandate

• In 2014, all individuals required to obtain coverage or face a tax penalty
  ○ Challenged by 20+ AGs, including IN
• Individuals can purchase from exchanges
• Federal subsidies for individuals making up to 400% of FPL ($88,000 for family of 4)
• Those that don’t comply and seek treatment contribute to the hidden tax!
“Small companies and individuals who don’t have insurance through work will be able to purchase insurance through newly created marketplaces, known as insurance exchanges, created and regulated by states.

… Think of it as an Orbitz or Travelocity for health care plans.”

- USA Today
Insurance Exchanges, cont.

States have many options with exchanges:

- Separate/combine for individuals and small biz
- Statewide, subdivide into regions, or multistate
- Opt out and let federal gov. provide exchange
- Inside gov., new agency, or public/private entity

Unsure what IN will do, but IHA has submitted prelim. positions to Daniels Administration
Coverage: Small Employers

Starting in 2014, firms with up to 100 workers will be able to access a small business health insurance exchange (SHOP)

- Intended to increase bargaining power and reduce administrative costs
- Small firms are at a disadvantage vs. big business due to scale, market power

What is an exchange?

- Organizing a chaotic market
- MA, UT only have developed exchanges
Coverage: Small Employers

- Small businesses are eligible for tax subsidies to offer insurance
- Tax credit available immediately in 2010
  - As much as 35% of premiums; max. increases to 50% in 2014 ($40 B in savings by 2019)
- Eligible businesses: Fewer than 25 FTEs, pay average annual wages below $50,000, and cover at least 50% of the cost of workers’ coverage
  - Phases-out gradually for firms with average wages between $25,000-$50,000 and between 10-25 FTEs
Coverage: Large Employers

Large employers (50 or more employees) will be fined if their employees purchase health care coverage through exchanges and receive subsidies to pay premiums.

Q: Will employers pay $2,000 penalty and dump workers into the exchange, and if so... …what would the impact be on payment?
Immediate Insurance Reforms

Effective September 23, 2010:

- No cancellation of coverage when someone becomes sick
- No lifetime benefit limits or unreasonable annual limits
- No pre-existing condition exclusions for children under age 19 (*others impacted in 2014*)
- Free preventive care (including immunizations for children)
- Adult children up to age 26 can stay on their parents’ health plan
Reforming the Delivery System

Creates new ways to tie payments to quality improvement

- Accountable Care Organizations
- Bundling Pilots
- CMS Center for Innovation
- Value-Based Purchasing
- Geographic Variation
- Medical Homes
- Gain-sharing
- Medical Liability Demonstrations

“Value Over Volume” or “Quality vs. Quantity”
Changing the Payment Model

Provider Cost Accountability

- Prospective Payment System
- Pay-for-Performance
- Hospital-Physician Bundling
- Episodic Bundling
- Shared-Savings Model/ACO
- Capitation

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Indiana Hospital Association
Wellness and Prevention

- Health status impacts costs
- IN making improvements in areas such as childhood immunization, but more work to do

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Indiana</th>
<th>US</th>
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<tbody>
<tr>
<td>% of Adults with Diabetes</td>
<td>2008</td>
<td>9.5%</td>
<td>8.2%</td>
</tr>
<tr>
<td>% of Smoking Adults</td>
<td>2008</td>
<td>26.0%</td>
<td>18.3%</td>
</tr>
<tr>
<td># Deaths due to Heart Disease per 100,000</td>
<td>2006</td>
<td>217.2</td>
<td>200.2</td>
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Source: Kaiser Family Foundation
IHA Remains Concerned

IHA recently submitted concerns, priorities to Indiana Interagency Task Force on PPACA

- Medicaid expansion and shortfall
- Provider shortage, particularly in primary care
- State insurance exchange
- Future of HIP under reform
- Impact of DSH reductions

Indiana Hospital Association
Cost Shift From Medicaid

Payments as Percentage of Cost

Source: IHA Databank
Implementation

What will be expected of health care organizations?

1. More integrated care
   - Innovation
2. More at-risk payments
   - Cost, Efficiency
3. More accountability
   - Quality, Transparency
Net Impact Not Certain

Cumulative Impact of Reform Assumptions

- 2010-2012: Payment cuts, limited newly insured
- 2013-2014: Continued, but decreased payment cuts, productivity offset, significant newly insured
- 2015-2019: Continued payment cuts, productivity offset, DSH reductions, significant newly insured
$155 B over 10 years mainly is achieved through:

- Market basket cuts
  ($500 M for IN hospitals from 2010-2014)
- Medicare/Medicaid DSH payment reductions
  *Exact impact unknown*
- Hospital-acquired conditions penalties

**BUT hospitals will experience reduced uncompensated care and additional revenue/payment for the newly insured**
“There must be a tighter incorporation of doctors into the business of hospital management. Physicians are the primary users of the hospital, yet they often remain completely isolated from the economic realities of hospital functioning.”

Kenneth Williamson, Associate Director of the AHA
(New York Times, April 28, 1968)
More Access = More Demand

- Uninsured use 60% of services of the insured
- MA reform experience: longer wait times for doc visits, EDs
- Need for more providers, particularly in primary care
- Some hospitals looking to partner with FQHCs, analyze ED capacity
Which Way Are We Headed?

- IN prime example of the implementation dilemma
  - Also WI, KS, IA, and others
- Judge Vinson decision – mandate is unconstitutional, but no broad injunction
- One of 28 states suing and Gov. opposes, but…
  - ✓ Exec. order authorizing exchange
  - ✓ Accepted some grants
  - ✓ Preparing for Medicaid expansion
  - ✓ Legislation to support ACOs*

* (IHA and Hall Render, not Administration)
“Moment of Truth”

- Federal deficits not sustainable

Source: CBO
House GOP Pledge

Specific agenda items include:

• Put repeal up for a vote ✓
• Enact medical liability reform (Bill moving)
• Expand health savings accounts
• Purchase health insurance across state lines
• Ensure access for patients with pre-existing conditions
Repeal and Replace?

- House voted 245-189 on Jan. 19th for full repeal
- Senate passage of repeal unlikely
- President has veto power, and even House lacks 2/3 majority needed to override
- House more likely to defund certain elements
The Deficit Commission

• Seeks to control health care costs by “aggressively implementing and expanding payment reform pilots”

…but delivery reform is not just about costs– it’s the right thing for patients
What provisions most directly affect nurses?
Health Reform

Reauthorization of Title VIII Nursing Workforce Development Programs

These programs, under the Public Health Service Act, are the primary source of federal funding for nursing education and help insure that there will be enough nurses in the future to care for the masses who will need healthcare.
Health Reform

The major grant programs are:

Advanced Education Nursing: Provides grants to nursing schools and academic health centers to enhance education and practice for nurses in master’s and post-master’s programs. These programs prepare nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse educators, nurse administrators, and public health nurses. The legislation also removes the 10% cap on grants for doctoral education.
Health Reform

The major grant programs are:

Workforce Diversity Grants: Provide grants to help people from disadvantaged backgrounds, including students from economically disadvantaged families as well as racial and ethnic minorities.

Nurse Education, Practice and Retention Grants: Support schools and nurses at the associate and baccalaureate level. Grants go to schools of nursing, academic health centers, nursing centers, state and local governments and other entities.
Health Reform

The major grant programs are:

**National Nurse Service Corps:**
The Nurse Education Loan Repayment Program repays 60 percent of nursing student loans in return for at least two years of practice in a facility that has a critical shortage of nurses.

The Nursing Scholarship Program supports students enrolled in nursing school. Upon graduation, scholarship recipients are required to work full time for at least two years in a facility designated to have a critical shortage of nurses.
Health Reform

The major grant programs are:
Nursing student and nurse faculty loan programs:
Establish loan programs within schools of nursing to support students pursuing master’s and doctoral degrees. Upon graduation, loan recipients are required to teach at a school of nursing in exchange for cancellation of up to 85 percent of their educational loans, plus interest, over four years.
Health Reform

Nurse-Managed Clinics
This provision will capitalize on the ability of nurse practitioners to provide high-quality primary and preventive care by defining “nurse-managed health clinic” in the Public Health Service Act and creating a new $50 million grant program to support innovative safety net providers. Nurse-managed health clinics serve as crucial health care access points in areas where primary care physicians are in short supply.
Health Reform

Demonstration Provision for Graduate Nurse Education
This provision will allow Graduate Medical Education monies to be directed to Advanced Practiced Registered Nursing programs to support clinical education. In a letter to congressional leaders, the American Association of Colleges of Nursing said that the measure was “uniquely structured to address the need for expanded clinical education, which has been a barrier to APRN enrollments.”
Health Reform

Funding for National Health Service Corps
Raising the level from $75 million to $300 million will enable the National Health Service Corps to double its field strength by Sept. 30, 2010, HRSA says. Through scholarship and loan repayment programs, the Corps helps Health Professional Shortage Areas in the U.S. get the medical, dental and mental health providers they need to meet their tremendous need for healthcare.
Health Reform

National Healthcare Workforce Commission
An independent group of 15 members will be chosen to assess needs of the healthcare workforce, evaluate programs and make recommendations to Congress and the Administration. Nurses will be among those considered for the positions.
Health Reform

Nurse-Family Home Visit Partnerships
The maternal, infant and early childhood home visitation provision adds $1.5 billion over five years that can help programs such as Nurse-Family Partnership, in which specially trained registered nurses deliver home visits to first-time, low-income mothers for a period of 2 1/2 years, coaching them on healthy pregnancies and helping them cope with the realities of caring for small children.

Studies have found that the program yields lasting improvements in a variety of maternal, child health, and social indicators.
Health Reform

School-Based Health Centers
The legislation authorizes a federal SBHC grant program and an emergency appropriation that would provide $200 million for SBHCs over four years. These centers provide comprehensive preventive and primary healthcare services to students on a school campus, particularly the uninsured and underserved. They are staffed by a team that includes nurse practitioners.
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Health Reform

Stay Tuned!