Federal and State Health Care Reform: Overview and Reflections

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Topics

• Part I - Federal Reform
  • Goals of Reform
  • Components of the Federal Law

• Part II - Massachusetts Reform - the Next Horizon:
  • Cost Containment and Care Integration
  • Milestones and Challenges

• Discussion
GOALS of the Patient Protection and Affordable Care Act (ACA)

• Significantly reduce the number of uninsured
• Improve value of insurance benefits
• Improve access to insurance coverage
• Improve health care quality and reduce disparities*
• Contain cost growth
Who are the Uninsured?

- In 2009, over 50 million (~16% of) Americans were uninsured:
  - poor (<133% FPL),
  - young (19-25 years) or
  - older with pre-existing medical conditions (ages 50-64)

- Affordability and insurance policy exclusions are main obstacles to coverage

- Uninsured numbers growing steadily

- Medical debt is leading cause of personal bankruptcy

“There’s a fundamental lack of economic security in our country,” Gruber said. “If you don’t get insurance from your employer, you are one bad gene, or one bad car accident away from losing everything.”

Jonathan Gruber, MIT Professor of Economics; architect of MA and Fed health reform model; quoted in “Comic Treatment for Health Plan”, *The Pulse*, Feb 8, 2011.
“Come quickly—I think I had an out-of-pocket experience.”
Components of the Patient Protection and Affordable Care Act

• Mechanisms for coverage of uninsured
• Insurance Reforms
• Financing of the Reform
• Cost containment, quality improvement and innovation*
• Considerations for States

*See Resources slide for Report detailing these
Mechanisms for Coverage

• Medicaid Expansion and expanded CHIP funding

• Employer sponsored insurance –
  • penalties for large employers who do not offer coverage
  • incentives to certain small employers who do offer coverage
  • affordability standards for employees

• Exchanges - to enhance affordable options and transparency for individuals and small businesses

• Tax credits - to subsidize cost of private purchase (133-399% FPL)

• Insurance Reforms and the Individual Mandate
Mechanisms for Coverage: Medicaid Expansions

- Medicaid coverage of Adults up to 133% FPL
  - 100% federally-funded for 3 years; from 2017 on, State share at 10%
  - Requirement has been upheld by federal courts, to date
  - *Option* to add now (without waiver processes) at standard FMAP rate
  - States already covering, pre-ACA, get phased-in FMAP enhancements, if maintain eligibility levels at July 2008 levels (narrow hardship exceptions)

- Medicaid for Former Foster Children up to age 26

- Medicaid Premium Assistance: all enrollees with access to ESI

- *Impact* on hospital and health industry
  - Uncompensated care reduced
  - Medicaid rates become larger portion of payer mix
  - State can leverage new federal revenues for state’s health industry

- *Indirect benefits* to employers and insurers
  - Insurers risk pools – many low income now on Medicaid
  - Medicaid revenues for payment of ESI premiums

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<th>State</th>
<th>Medicaid Enrollment</th>
<th>State Spending</th>
<th>Federal Spending</th>
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Source: Holahan and Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Kaiser Commission on Medicaid and the Uninsured, May 2010.
Mechanisms for Coverage: Employer-Sponsored Insurance (ESI)

- **2010 - Small employer tax credits for insurance offers**
  - < 25 employees; average annual wages <$50K
  - Effective 2010 - 2013; after 2013, credits available for two years

- **2014 - Large employer (> 50 workers) penalties**
  - Up to $2000 per employee per year for not offering benefits
  - ESI affordability –
    - if employee share of premium is more than 8% of income, employee can go to Exchange; if income-eligible, can get tax credits too, and
    - if costs for employees > 8-9.8% of income, employers must provide vouchers for purchase of Exchange products

- **Small employers (< 50) are exempt from penalties**
Health Insurance Exchanges

- For all without access to *affordable* ESI and small employers
  - Open, transparent marketplace for eligible purchasers
  - Standardization of benefits and actuarial value of health plans allows “comparison shopping” and furthers competition
  - Coordination of enrollment and Medicaid eligibility

- Subsidies (Tax Credits) for incomes 133% - 400% FPL; amount to be indexed on sliding scale basis

- More Options:
  - Federal Govt exchange - states can opt to use federal Exchange
  - Multi-state exchanges
  - Option to operate “Basic Health Plan” for those at 133-200% FPL, subject to high value plan criteria and competitive procurement

- Robust use of Exchange can include *competitive procurement* of high value insurance plans for consumers and business
Insurance Reforms

• No pre-existing condition clauses (2010 for children)
• No annual or lifetime caps
• No price increases or rescissions due to sickness
• Access to dependent coverage up to age 26
• Other Consumer protections
  • Uniform explanation of benefits
  • Appeals of coverage denials
  • Limits on out-of-pocket spending; no co-pays for prevention
• Constraining price variation and excess
  • State review of premium increases
  • Price variation subject to community rating (3:1-age; 1.5:1 tobacco)
  • Medical Loss Ratios: 80% - small group; 85% - large group
Individual Mandate

• Applies to **adults and children**

• **Tax Penalty** – *Greater of* 2.5% of income above tax filer’s threshold, or $695 ($2085 for family)

• **Exemption** from Mandate if insurance is not “Affordable” ; i.e., premium costs > 8% of income

• **Which insurance products** meet mandate? All ESI, Individual market products, grandfathered plans satisfy federal mandate

• **Tax credits** (subsidies) for those with income less than 400% FPL who purchase health insurance
Insurance Mandate - Challenges

• Why the mandate?
  • Primarily to allow costs of insurance reforms to be spread (“pooled”)
  • Once it begins (2014), risk pool is improved - costs are spread
  • Moderates adverse selection and premium price pressure, but…

• Interim Effects - Insurance reform comes years before mandate
  • Adverse selection and premium increases
  • Unaffordability: medical debt burden may worsen
  • Loss of support for law ? or
  • Increased understanding of why a mandate is needed?

• Constitutionality: Commerce Clause and Tax Policy
  • Unprecedented amount of time devoted to oral argument of the case
  • Possible outcomes – uphold or strike down in whole; or strike down only certain provision, preserving others
  • Surprising attention to Medicaid expansion constitutional challenge
Financing mechanisms: 2010-2019

• Funding Sources:
  • Excise tax on high-cost health plans (not until 2018)
  • Taxes on high-income earners (>$200K ; $250K for couple)
  • Health care sector industry fees
  • Reductions to Medicaid DSH payments
  • Slower growth of increase for Medicare rates (“market basket update”)
  • Independent Payment Advisory Board and related savings
  • Revenues from Individual and Employer Penalties

• Total Cost = $938 Billion
• Savings to Federal Deficit = $124 Billion

Source: Congressional Budget Office, 2010
Timeline for Implementation

2010
Immediate insurance reforms
   Tax credits for small employers
   Begin to close doughnut hole
Medicaid expansion option
   Funding opportunities
   Early planning

2011
System improvement initiatives
   Promotion of ACOs, Pay Reform
   Comparative Effectiveness Studies
   Insurance reforms
   Medicare reforms
   CLASS

2013
Medicaid expansion
   Exchanges launched
   Employer requirements/assessments
   Premium & cost sharing subsidies
   Insurance reforms
   Medicare reforms
   Individual Mandate

2014

2016
Excise tax on high-cost health plans

2018
Option for multi-state compacts
Some Considerations for States

- Leveraging federal funds to economic advantage
- Using Exchanges to improve competitive market
- Consider *indirect* economic benefits of
  - Medicaid expansion for adults ≤ 133% FPL
  - Other options under Medicaid for FMAP enhancement and Federal Grants
- Challenge - state share funds for Medicaid expansions
- New State Roles in Cost Containment: What works?
  - Robust or Minimal approach to Exchange development
  - Balance: Regulating costs/premiums vs. facilitating market competition
  - Global Rates and ACOs – how much to leave to “market forces”? 
  - Insurance rate regulation – likely to be an area of increased state action
- Leading by example: State roles in leading reform
II. Mass. Health Reform “Part II”: Costs Unresolved Issues

• Escalating Health Care Costs
  • not correlated with improved quality or health outcomes
  • not responsive to interventions to date

• Care coordination is spotty, not integrated

• Market power, not value, drives most prices / costs
  AG Report: January 2010—biggest providers command largest market share and highest prices; market consolidation continues

• Capacity limits are undermining access to care and ER utilization is not diminishing

• DSH hospitals still reporting higher-than-expected uncompensated or under-compensated care
Health Care System and Payment Reform: Three Areas

- Clinical Practice Reform - PCMH, ACOs
- Alternative Rate Methods – Bundled, Global
- Legal and economic system-level reform
  - Health System Cost and Quality Oversight
  - Provider, health plan, consumer protection regulation
  - Down-streaming risk – regulation of conflicts
    - At ACO level vs.
    - At physician-patient level
    - Relation to patient protections and provider choice issues
Mass. Health Reform “Part II” - Recent Milestones

- Special Commission Report – July 2009
- Administration takes lead in policy development dialogue with stakeholders – Fall 2009 and winter 2010
- PPACA – Enacted March 2010
- Health Care Quality and Cost Council—Committee on the Status of Payment Reform Legislation – Fall 2010
  - ACOs
  - Alternative Payment Methods
  - Market Consolidation Issues
  - Rate Regulation
  - Governmental Role in Oversight of Transition
  - Recommendations adopted
Milestones (continued)

• State Legislation – filed February 17, 2011

• Medicare Shared Savings Program” (section 3022 of PPACA)
  • Federal ACO Regulations (CMS) and Waivers (OIG, DOJ, FTC, IRS) for participants – proposed April 7, 2011, for program start in Jan. 2012
  • Regulated entities seek delay and “interim rule” designation
  • October 2011 release of final rules - massive and detailed (700+ pages)
  • CMS selected 27 health systems nationally to start this “experiment”

• EOHHS’ ACO RFI – released June 3, 2011; responses analyzed

• CMMI – Center for Medicare and Medicaid Innovation – awards federal funds to EOHHS for Integrated Care Demonstration for “dually-eligible” persons (elderly and disabled persons)

• State Legislature signaled intent to pass a bill last year; got “bogged down”…but release of new bill now imminent…
# Many Areas of Law Affect Health Care

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<td>Safety Net Funding: DSH/FQHC</td>
<td>ERISA</td>
<td>Government Innovation/ Reform</td>
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# Health Care is Heavily Regulated

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**State**
- Medicaid
- DPH
- EOHHS
- Inspector General
- Attorney General
- DOI
- DHCFP

**Federal**
- CMS
- OIG
- FTC
- HHS
- DOJ
- IRS
Health Care Laws: Challenging to understand

**Medicaid Statute** — Judges have referred to it as:

- A *"Serbonian bog,"* quoting John Milton's epic poem *Paradise Lost* ("A gulf profound, as that Serbonian bog Betwixt Damiata and Mount Casius old, Where armies whole have been sunk.").
- "Almost **unintelligible** to the uninitiated,"
- "**Aggravated assault on the English language,**"
- "**Resistant** to attempts to understand it," and
- "**Labyrinthian."
John Milton’s Serbonian Bog
Why is Phase II Reform “Bogged Down”? ACOs: Governance and Oversight

• What Should an ACO look like?
  • “Formal Legal Structure”-PPACA/CMS/Bill
  • Conflicts of Interest-
    Separate practice of medicine from the obligation to be cost-efficient through new organizational structures.

• How Should an ACO be Governed?
  • Shared Governance Requirements/CMS
  • Hospital or Physician Practice at the top?
  • Which of the network providers receives payments?

• How Should an ACO be Regulated?
Why is Reform - Phase II Bogged Down?  
ACO Formation: Legal Hurdles

- Federal and State Anti-Trust laws
- Anti-Kickback Laws—Federal statute with criminal penalties
- Civil Monetary Penalties law
  Federal law that prohibits hospitals from paying physicians to limit services to hospital patients under the physician’s care.
- Tax
  PPACA is silent regarding tax status of ACOs.
- Corporate Practice of Medicine (state).
Why is Reform-Phase II Bogged Down?

Market Consolidation: yes or no?

• Price constraint: via market forces vs. regulation?

• Cost-efficiencies, risk pooling and high quality may be best achieved by allowing the best to rise to top; resulting in a small number of ACOs, but...
  • Anti-trust and pricing concerns raised
  • Could promote lots of ACOs (in the name of competition), but may not achieve high quality of care or price efficiencies; also, risk pools shrink

• Regulation of price is another option-
  • Allow market to sort out quality competition and allow government to monitor and regulate price?
  • Which prices? provider prices or health plan prices?
Why is Reform-Phase II Bogged Down? 
Risk Issues

- In transition to integrated health systems, ACOs will take on more risk as part of bundled or global payments for total patient care management and delivery.
  - Increased risk may affect costs and access - need for consumer protections and rules against ‘creaming’

- Competition among many ACOs ≠ price reduction.
  - Even with lots of ACOs, cost may not come down because of risk issues.
  - When separate, smaller pools of patients are established, the risk is increased for each ACO and pricing rises to cover that risk.

- New approaches to pooling risks, rather than separating risks, are needed to make ACOs and global payments work
Mass Health Reform - What’s next?

- **Debate** will continue re: balance between market – driven reform vs. government-driven reform; e.g.,
  - Stuart Altman’s Coalition of Health Care Leaders
    - promoting virtues and feasibility of private sector action over regulation and government design
  - Attorney General and Inspector General argue for regulation

- **Roadmap** for transition to ACO and Global Payments aligned with federal reform timelines - 2014 is pivotal year

- **State action** - reform and align health purchasing activity in conformity with system integration, cost and quality goals

- **Federal action** - policy and purchasing will drive health care markets – PPACA rollout; Medicare policies, and CMS Innovation

- **The Economy** – voter demand for affordable care will increase
Resources

• Kaiser Family Foundation: www.healthreform.kff.org
• Federal HHS - Consumer info: www.healthcare.gov
• National Governors Association: www.nga.org
• National Association of Insurance Commissioners www.naic.org

• See “PPACA – Pilot Programs, Demonstration Projects and Grants”, posted at www.umassmed.edu/chle
  • Summary of federal support and funding in the ACA for innovations and improvements in health care delivery, quality and pay reform
• Other Health Reform Reports – www.umassmed.edu/chle
Contact information

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