Transcript

Patient Protection and Accountable Care Act of 2010


1. This lecture covers healthcare reform and the Patient Protection and Affordable Care Act. I’ll use the acronym ACA when referring to the law, as it will be revisited many times throughout the course.

2. The presentation objectives include:
   - Summarize historical context of the Patient Protection and Affordable Care Act of 2010 (ACA)
   - Explain the rationale for the policy
   - Evaluate the major components of the ACA
   - Distinguish the Supreme Court decisions regarding ACA

3. The healthcare debate has been an issue for both parties for over one hundred years. Healthcare reform has always been a contentious issue. Although the debate started one hundred years ago, the 3 major overhauls to our healthcare system were in 1965, 2003 and 2010. There has been support from either parties at different times, and sometimes division within a party. Health reform is certainly a complicated and political matter.

   This is a brief history of healthcare reform since Teddy Roosevelt brought it up in his 1912 Bull Moose Party presidential campaign platform. One sentence in Teddy’s platform read: “...the protection of home life against the hazards of sickness, irregular employment and old age through the adoption of a system of social insurance adapted to American use.” He lost this election, and the debate on healthcare reform didn’t come around for another twenty years.

   Franklin Roosevelt (FDR) considered providing health insurance to all Americans in 1935 as part of the Social Security Act (SSA). It wasn’t included as part of the agenda, as he was afraid that the bill wouldn’t pass if health insurance provisions were included.

   Truman pledged a plan for reform four months after FDR’S death. The American Medical Association criticized his plan and some Republicans referred to it as communism, a similar as the ACA being labeled as socialized medicine.

   President Eisenhower was influential in expanding access to insurance with the Federal Employees Health Benefits program. The program became the model of insurance options for all Americans. He also created the tax break for employer-sponsored health insurance. This tax break costs the government more than $150 billion annually.
4. President Kennedy championed Medicare, but the bill was defeated.

President Johnson attempted reform twice and was able to create the Medicare and Medicaid programs by amending the Social Security Act.

President Nixon proposed comprehensive healthcare reform but he was impeached when his campaign committee bugged the Democratic Party’s campaign headquarters. The health reform issue got lost to the scandal headlines.

President Carter was not a proponent of national health insurance - that was Ted Kennedy’s cause. The issue split the Democratic party during Carter’s administration.

5. President Reagan expanded Medicare with catastrophic coverage for senior citizens, but President George Herbert Walker Bush repealed Reagan’s expansion.

President Clinton was hit with widespread opposition to his healthcare reform bill. It was written in secrecy and under the direction of the first lady, Hillary. The Clinton administration was unable to communicate the benefits of the bill in an uncomplicated manner. The bill was strongly opposed by the insurance industry with a strong advertising campaign against reform.

President George W. Bush, a Republican, added prescription drug coverage to Medicare with Part D.

Obama's legislation came from an idea, begun under the Eisenhower administration and developed under Nixon, of a market for healthcare based on private insurers and employers. Eisenhower locked in the tax break for employee health benefits; Nixon pushed prepaid, competing health plans, and urged a requirement that employers cover their employees. Obama applies Nixon's idea and takes it a step further by requiring all Americans to carry health insurance, and giving subsidies (government payments) to those who need it.

6. Why was healthcare reform needed? The main problem is the uninsured. This is why president Obama referred to his legislative effort in late 2009 as “health insurance reform.” In 2009, there were 50 million people without health insurance in the United States.

7. Who are the uninsured? Generally speaking, they are the working poor. Look at the chart on the left. More than half of the families have someone in the family working full time. In the middle, FPL stands for Federal Poverty Level, and 100% of the FPL in 2009 was about $22,000 for a family of four. So, over three-quarters of the uninsured made less than 250% of the FPL.

8. Why is not having health insurance a big deal? Don’t most people get the care they need eventually, such as through the emergency departments? Well, yes, this is partly true because of our safety-net system discussed in our previous lecture. But, as this chart shows, lack of health insurance the biggest reason for people not having a regular doctor or getting needed care. This is evidence that people without insurance don’t get primary or secondary care, so that when they finally go the emergency department, they may have been sicker, less happy, and less productive all along.
9. So, how can reforming the insurance market fix things? Well, there are real practical problems with the health insurance that leads to the dysfunction. We’ll just present one very serious market problem, among many. The concept most important insurance market concept to understand is adverse selection. Adverse selection begins with the idea that only the sick get health insurance when it is expensive. Without the healthy to subsidize the insurance pool, the cost of insurance goes up. Then the relatively less sick people with insurance can no longer afford to remain insured. Then the cost goes up because only the really sick keep their insurance. And so on and so forth.

Practically speaking, spiraling insurance premiums has an impact on regular people. For example, teachers may have difficulty paying for their share of rising insurance premium rates, so they go without insurance and insure their children through government programs, such as SCHIP. Corporations are spending more on insurance coverage, which effects their profits and on their ability to increase employee wages. Employer-based insurance is a problem for small businesses due to the expense. Smaller businesses lack the bargaining power that large businesses have resulting in higher premiums. Finally, I imagine many people didn’t leave their jobs to start a new business because the cost of paying health insurance premiums through the individual market was too much.

10. After almost a hundred years of debate, the political circumstances finally came together in 2010. There was a Democrat in the White House and a Democratic majority in the House and the Senate. The support from liberal organizations, like MoveOn.org, AARP, FamiliesUSA, and SEIU, in terms of political fundraising, advertising, and the lobbying of corporate interests, was substantial. It was sold in two phases - benefits in the short-term (phase 1); sacrifices in the long-term (phase 2). ACA was passed without a single Republican vote.

11. The President signed the bill into law on March 23, 2010. Yes, Mr. Biden, this is a big deal. If you are not aware of this reference and are not offended by coarse language, search “big deal Biden” on YouTube.

12. The provisions of the Affordable Care Act are designed to address problems with rising costs and problems with access to health care for many individuals, insured and uninsured. The legislation addressed holes in the system that created barriers to affordable care and access by protecting consumers of health insurance, improving quality of care, lowering costs, and expanding access. We’ll discuss each of these concepts in turn in the remaining slides.

13. First, consumer protections. These provision are directed at insurance companies so that consumers are protected from unfair practices that insurance companies use to maximize profits.

The first provision includes new rules to prevent insurance companies from denying coverage to individuals with pre-existing conditions. The law also limits the ability of insurance companies to charge higher rates due to gender, health status, or other factors.
The law also prohibits insurance companies from dropping coverage. In the past, insurance companies could search for an error on a customer's application or other technical mistake and use this error to stop covering the person when he or she got sick. The new law makes this illegal.

Under the new law, insurance companies will be prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays. Lifetime dollar limits are the maximum amounts an insurer will pay to an individual.

Funding became available to the states for their use to regulate insurance company rate increases. States that do not already do so may begin a process formal review of unjustified health insurance hikes.

Finally, to ensure premium dollars are spent on health care, the new law requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement – called medical loss ratio. Plans that spend too much on overhead must provide rebates to consumers.

14. There are other provisions are intended to lower health care costs, which will enable us to use our limited resources more wisely so that more people can benefit from our healthcare system. First, and probably the biggest change felt in our society, is the Health Insurance Exchange. Health insurance exchanges serve as portals through which individuals and small businesses can compare and purchase health insurance. States could have established and run the exchange in their state, or they could have let federal government run it. As most of you probably heard in the news, the health exchanges began in 2014.

The goal of the healthcare law is to extend insurance coverage to virtually every American citizen. The individual mandate requires individuals to purchase a qualified health plan or face a penalty. If premiums are more than an individual can afford, the federal government will subsidize, or finance a portion, of the individual’s health insurance cost. Remember, without the mandate, many healthy individuals would not enroll in insurance plans, and the plans would suffer from “adverse selection.” If the majority of the new enrollees are unhealthy the money insurers collect in premiums would not be enough to cover claims and premium rates would skyrocket.

The employer mandate does not require employers to offer insurance, but if their employees qualify for a subsidy in the health insurance exchange due to high premiums or limited coverage, the employer will then pay a penalty. Some employers are eligible for tax credits to help them provide insurance benefits to their workers.

There are standardized benefit levels designed to cover a certain amount of an individual’s statistically predicted health expenses. The levels are termed “gold,” “silver,” and “bronze.” The intention is to improve the coverage for those that may be considered “underinsured” and exposed to high medical bills. However, as the health exchanges were rolled out, thousands of people complained that their previous plan no longer met the standards. As a result, they were dropped from their health plan, and President Obama’s promise that “you can keep your plan” was decried a
lie. This development could have been predicted as a study 2012 in *Health Affairs* found that “More Than Half Of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014.” (Gabel, et al., 2012).

15. ACA attempts to reduce the rising cost of care in multiple ways. The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients that improve the quality of care, and reduce the rate of growth in healthcare costs for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).

Also, the law establishes a hospital Value-Based Purchasing program (VBP) in traditional Medicare through organizations called Accountable Care Organizations. This program offers financial incentives to hospitals to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program.

Independent Payment Advisory Board is an aggressive attempt to slow the increases in health care spending in Medicare. The ACA specifies that the board be made up of 15 “individuals with national recognition for their expertise in health finance and economics, actuarial science,” and other related medical fields. The current process requires Congress to act, and political pressure makes cuts to physician payments extremely difficult. In this process, the IPAB recommends any cuts to Congress, but is not allowed to cut Medicare members’ benefits - only providers’ payments. However, the process is structured so that its cuts are highly likely to take effect, because Congress has to proactively block the IPAB’s recommendations and come up with savings of the same amount somewhere else in the budget. The IPAB is very controversial, as many view the board as unaccountable to voters.

16. Obama’s Death Panels. As you can see from Sarah Palin, the former Vice Presidential candidate, the idea of an Independent Payment Advisory Board represents health care rationing. Ms. Palin posted on Facebook, “The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society,’ whether they are worthy of health care. Such a system is downright evil.” What do you think? Is this what the IPAB is designed to do? Is the rising costs of healthcare in the U.S. a big enough problem to warrant an independent panel that recommends cuts to doctors pay?

17. The donut hole was created to hold down costs when the prescription drug coverage was added in the Medicare Modernization Act of 2003. It refers to a gap in coverage once a Medicare enrollee hits a certain benefit limit. By 2020, the coverage gap will be closed, meaning there will be no more donut hole, and seniors will pay 25% of the costs of their drugs until they reach the yearly out-of-pocket spending limit.
18. Improving quality is another goal of the Affordable Care Act, starting with preventive care. Insurers must cover certain preventive services, such as mammograms and colonoscopies, without charging a deductible, co-pay or coinsurance.

Also, a new $15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy -- from smoking cessation to combating obesity. (We’ll review this fund in a future lecture.)

Also, to strengthen the primary care workforce, new incentives in the law were designed to expand the number of primary care doctors, nurses and physician assistants by way of scholarships, loan repayments, or tax relief, if they practice primary care or in communities with a shortage of health care providers.

The STARS pay-for-performance program bonuses Medicare Advantage health plans for meeting certain quality performance measures, such as blood pressure control.

Comparative Effectiveness Research funding is provided for research into what can be called pragmatic trials. The idea is to research whether a certain treatment intervention is significantly better than another treatment for a particular sub-population. This is different that studying whether a treatment works like they do in clinical trials for new drugs, for example. Comparative Effectiveness Research wants to know whether the intervention is better COMPARED to another treatment. But wait! Will this be used for health care rationing? What about Sarah Palin’s parents? Actually, no. The law expressly forbids the government from using a “measure that discounts the value of a life because of an individual’s disability as a threshold to establish what type of health care is cost effective or recommended.”

19. To increase access to care, under the new law, young adults will be allowed to stay on their parents' plan until they turn 26 years old, unless they are offered insurance at work.

Also, the Medicaid expansion provision is one of the most important of the Affordable Care Act. Medicaid eligibility expanded to all adults with income below 133% FPL (or about $31,000) - even those without children - which is a big change.

In the original law, if a state decided not to expand Medicaid, they would lose the federal funding they had been receiving since 1965. We’ll look at the Supreme Court ruling in the next slide.

20. To date, the Supreme Court has reviewed three provisions of ACA. First, the individual mandate. This is a very important component of the ACA. The States’ argument against the individual mandate was that the government did not have the power to penalize citizens for not doing something, in this case, not purchasing insurance. The Obama administration argued that the federal government was granted the power to penalize through the Commerce Clause of the 10th Amendment of the Constitution, which gives the federal government the power to regulate commerce among the states. Surprisingly, what they said was that the individual mandate was not a penalty, but a tax. The
individual mandate was upheld; the ACA may not have been financially sustainable without it due to adverse selection.

However, the Supreme Court required the Medicaid expansion provision to be modified. The expansion would have been the single most important way low-income adults could be eligible for affordable health insurance coverage. The court told the federal government that they couldn't remove the existing funds if a state did not expand their Medicaid program. The Medicaid expansion provision became optional for the states. Many states are already in the process, others have no plans to expand. Some that would have been eligible for the Medicaid expansion will be able to get subsidies for coverage through the health insurance exchange.

Another challenge to the ACA had to do with the money that the government provides to people who can’t afford to pay the full price of health insurance in the online exchange. These monies paid by the government are called subsidies. The Supreme Court decided in the summer of 2015 that it was permissible for the federal government to subsidies the purchase of health insurance plans in all states.

21. Unlike the Medicare Part D law passed in 2006, the Affordable Care Act paid for new spending through cuts in other areas or new taxes. To pay for the ACA, individuals earning over $200,000 a year or families earning over $250,000 will pay a higher Medicare tax beginning in 2013. These high earners make up only 2% of the population.

Several new fees are designed to reinforce that goal or to extract contributions from industries that will profit from it. Drug companies will pay annual fees totaling $27 billion, medical device companies will pay a 2.3% tax on certain products, and insurance companies will pay annual fees totaling $60 billion. Medicare Advantage (MA) plans are administered by private insurance companies. The MA plans cost taxpayers 12-17 percent more on average than traditional Medicare plans. The Medicare cuts you may have heard about are directed at these overpayments to the private MA plans.

The largest percentage of funding for the ACA comes from cuts to Medicare, followed by increases in the Medicare tax. Also, hospitals agreed to accept smaller increases in their Medicare payment rates over the next ten years in anticipation of more insured patients. The reimbursements that hospitals receive will rise more slowly than they have in the past.

Employer based health insurance is deducted from taxable wages and is therefore tax-free. To discourage the use of high-end plans, called Cadillac plans, which lead to overuse of health services, these plans will be taxed if the policies cost more than $10,200 for individual coverage and $27,500 for family coverage. This is far more than the national average and won’t affect that many people.

Certain components of Health Savings Accounts (HSAs) will no longer be tax free. HSAs will be covered in a future lecture.
Employers will not be required to provide health benefits, but those that provide no coverage or skimpy coverage could incur a penalty. As discussed above, individuals without qualified health coverage will also incur a penalty.

22. This is a very complex topic and it’s important to understand the concepts to succeed in the course. It will be helpful to review this lecture before each exam. It is remarkable that the ACA passed considering the failed attempts to reform healthcare in the past and the comprehensiveness of the bill. It will be years before we understand whether the law accomplished its goals of:

- Expanding access to health insurance
- Making coverage more affordable
- Improving comprehensiveness of coverage
- Improving coordination of care
- Controlling the growth in costs