Public Health Implications of Health Reform

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...The most frustrating thing about health care reform is asking for a second opinion!
Public Cognitive Dissonance

• Health care system is broken and costs too much money
• We should fix it by getting all the “waste” out of the system and through “prevention”
• But we shouldn’t have anyone (government or insurers) interfere with physician-patient decisions
• And we should cover the uninsured - but we shouldn’t be taxed to do that
Health Reform Goals

• Major coverage expansion
• Lower costs
  – Individuals and families
  – Society
  – Government
• Eliminate unpopular insurance practices (e.g. pre-existing conditions)
• Improve health?
  – Uninsured vs Insured
The Coverage Approach

• Insurance market reforms
  – Eliminate medical underwriting - premiums vary based on age, geography, tobacco use
  – Eliminate lifetime and annual limits
  – Regulated marketplace (“exchanges”)

• Require Americans to carry insurance (enforced through tax code)

• Subsidize or cover ($$$)
  – <133% FPL: Medicaid expansion
  – 133%-400% FPL: subsidized private coverage
Health Insurance Coverage of the Nonelderly by Poverty Level, 2008

- Employer/Other Private
- Medicaid/Other Public
- Uninsured

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Employer/Other Private</th>
<th>Medicaid/Other Public</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100% FPL</td>
<td>20%</td>
<td>45%</td>
<td>35%</td>
</tr>
<tr>
<td>100-199% FPL</td>
<td>42%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>200-299% FPL</td>
<td>71%</td>
<td>12%</td>
<td>18%</td>
</tr>
<tr>
<td>300-399% FPL</td>
<td>83%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>400%+ FPL</td>
<td>92%</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The federal poverty level (FPL) was $22,025 for a family of four in 2008. Data may not total 100% due to rounding.

SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS.
Characteristics of the Uninsured, 2008

Family Work Status
- Part-Time Workers 14%
- No Workers 19%
- 1 or More Full-Time Workers 66%

Family Income
- 400% FPL and Above 10%
- 200-399% FPL 23%
- <100% FPL 38%
- 100-199% FPL 29%

Age
- 55-64 9%
- 30-54 43%
- 30-29 30%
- 0-18 18%

Total = 45.7 million uninsured

The federal poverty level was $22,025 for a family of four in 2008. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS.
Uninsured in 2019

- 55 Million Uninsured without Health Reform

32 Million Newly Insured

- 23 Million Uninsured
  - 1/3rd Undocumented Immigrants

Source: Congressional Budget Office
The Coverage Timeline

• 2010
  – Adult children dependent coverage up to age 26
  – Children with pre-existing conditions
  – High risk pool (state-based)
  – Small business tax credits

• 2014
  – Medicaid expansion
  – Establish state-based insurance exchanges
  – Private coverage subsidies
## High Risk Pool

<table>
<thead>
<tr>
<th></th>
<th>Health Reform Law</th>
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</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>Pre-existing condition Uninsured x 6 months</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>HHS establishes min. benefits Actuarial value: 65% of costs</td>
</tr>
<tr>
<td><strong>Premiums and Cost-Sharing</strong></td>
<td>Premiums based on avg. risk population Vary by: age (4:1), geography, tobacco, family size Out of pocket max: $5,950/$11,900 (after premiums)</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>$5B nationally (fixed pool)</td>
</tr>
<tr>
<td><strong>Timeline</strong></td>
<td>June 2010</td>
</tr>
</tbody>
</table>
Community Health Centers

- Community Health Centers Trust Fund
  - Operational: $9.5 billion over 5 years
    - Increase capacity to serve 20 million new patients
  - Capital: $1.5 billion over 5 years

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>Trust Fund +</th>
<th>Discretionary Funding (est.)</th>
<th>Total Annual Funding (est.)</th>
<th>Total Annual Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2011</td>
<td>$1 Billion</td>
<td>$2.19 Billion</td>
<td>$3.19 Billion</td>
<td>$1 billion</td>
</tr>
<tr>
<td>FY 2012</td>
<td>$1.2 Billion</td>
<td>$2.19 Billion</td>
<td>$3.39 Billion</td>
<td>$200 million</td>
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<tr>
<td>FY 2013</td>
<td>$1.5 Billion</td>
<td>$2.19 Billion</td>
<td>$3.69 Billion</td>
<td>$300 million</td>
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<tr>
<td>FY 2014</td>
<td>$2.2 Billion</td>
<td>$2.19 Billion</td>
<td>$4.39 Billion</td>
<td>$700 million</td>
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<tr>
<td>FY 2015</td>
<td>$3.6 Billion</td>
<td>$2.19 Billion</td>
<td>$5.79 Billion</td>
<td>$1.4 billion</td>
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</tbody>
</table>

Source: National Association of Community Health Centers
Beyond Coverage – Reforms to Clinical Services
Primary Care Incentives

• Payment increases for primary care
  – Medicaid rates increased to Medicare rates in 2013 & 2014
  – Medicare primary care 10% bonus (2011-2015)

• Education initiatives to grow primary care workforce and train for future practice models
  – Increase primary care residency positions and funding
  – Support for Teaching Health Centers
Clinical Preventive Services

• First dollar coverage (public and private insurance)
• Mandated benefits
  – Empowers US Preventive Services Taskforce to provide a minimum benefit standard (A and B)
  – ACIP recommended vaccines
  – Smoking cessation for pregnant women (Medicaid)
• Wellness visits and personalized prevention
Cost Effectiveness

Source: Cohen et al., NEJM 2008
Workplace Wellness

• Promising approaches to improve health through incentive programs in the workplace
• Legislation allows financial incentives or discounts for achieving wellness objectives and provides tax credits to small businesses
• Challenge: does it then permit medical underwriting?
Quality Incentives and Penalties

• Hospital pay for performance (P4P) program
  – Future expansion to other institutional care
• Implement financial penalties for hospital acquired infections
  – 1% reduction in Medicare payments for outliers
Care Coordination

• Goals:
  – Integrate clinical services to improve quality
  – Population focus
  – Align provider incentives
  – Lower costs

• Strategies:
  – Readmission penalties (30d)
  – Bundled payments
  – Accountable care organizations (ACOs)
  – Independence at home (home care)
Readmission Penalties & Bundled Payments

• Hospital readmission occurring within 30 days of discharge
  – Target conditions with risk adjusted readmission measures (heart failure, MI, pneumonia)
  – Encourages provider coordination
  – Challenges: low SES populations, optimal rate

• Bundled payment for episodes of care (3 days prior to admission, admission, 30 days post-discharge)
  – Inclusive of physician and hospital fees
  – Similar concept to prospective hospital payment (DRGs) but expanded set of services to align incentives
  – Challenges: allocating payments
Accountable Care Organizations

- Voluntary Medicare pilot program
- Concept: create quasi-integrated provider networks - based on the idea that most patients and physicians use single hospitals
- Financial Incentive: allows providers to share in cost savings
  - Providers report on quality and costs
  - Need robust primary care participation
Summary

• Coverage: decrease number of uninsured by 32 million (94% covered)
  – Benefits directed at lower end of income distribution
  – Residual uninsured population and demand for primary care will sustain safety net demand

• Delivery reforms: first dollar coverage of preventive services, wellness, integration
  – Major expansion of clinical preventive services – need to address underuse
  – Integrating and coordinating care - bundling and gain sharing opportunities as primary strategy