Inside Healthcare Reform 101

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Putting aside the polarizing politics of the health reform law, the Affordable Care Act, a.k.a. Obamacare, is making people ask one fundamental question. “What’s in it?”

It’s hard to summarize 2700 pages of a bill, which is now the law in a 24 page booklet, but it is possible. Doctors often synthesize huge textbooks in a simple 15 minute bedside conversation.

So, here we go. First and foremost - think of the problem with American healthcare system as a stool with three broken legs.

First leg is Access – the ability to go to a doctor or have insurance. Today 47 million Americans are uninsured and experts suggest that this leads to 45,000 deaths each year.

Second is Cost - the ability to pay for health services, whether as an individual, a state or a nation. Today, our healthcare expenditure per person is nearly twice that of many developed countries.

Third is Quality- getting the right care every time. Today, Americans do not receive 45 percent of the recommended care, and many receive more testing than needed.

The reform law addresses each of these problems by increasing access, trying to contain costs and focusing attention on quality. The law fundamentally changes the way insurance companies operate, and how individuals will obtain and maintain health insurance.
Choosing a health insurance plan

In order to get healthcare, we must have health insurance through our employers (private insurance), Medicare (for those 65 or older or disabled), Medicaid (for the poor), or self purchased.

The healthcare reform law requires all individuals to have health insurance. Those without insurance coverage will have to pay a tax penalty ranging from $700 to $2000 a year or 2.5% of household income.

The law expands the number of insured in three major ways:
- Requires employers with more than 25 employees to provide health coverage.
- Expands Medicaid benefits to individuals and families earning less than 133% of the federal poverty level, which is $24,350 for a family.
- Continues funding of the Children’s Health Insurance Program (CHIP), which provides insurance to children and teens whose families make incomes that are modest but too high for Medicaid.

The law also creates state based Insurance Exchanges through which individuals/families earning 133% to 400% (about $80,000 for a family) of the poverty level can purchase health insurance with subsidies. Small businesses can also purchase insurance through separate exchanges.

The law creates four benefit categories of health plans plus a separate catastrophic plan to be offered through the Exchange. No provisions exist for a public option. States can create a basic health plan to cover those with income less than 200 percent of the poverty level.

The law creates Consumer Operated and Oriented Plan (CO-OP) programs to foster the creation of non-profit, member-run health insurance companies.

With these changes the Congressional Budget Office (CBO), the nonpartisan official score keeper, estimates that 32 million more Americans will have health insurance.
The Congressional Budget Office (CBO) estimates that the bill will cost $938 billion over ten years.

These costs will be financed through four strategies:
Cuts will be made in Medicare and Medicaid saving billions of dollars. Medicare Advantage which is a managed care program for the elderly will also have some cuts.

**New taxes:**
- A 0.9% Medicare tax on those individuals earning more than $200,000 or couples earning more than $250,000. Also 3.8% tax on investment income on this group.
- A 2.3% tax on sales of medical devices.
- A 10% tax on indoor tanning services.

**New Fees:**
- Insurance companies will pay fee of $8 to 14.3 billion each year
- Pharmaceuticals will pay fees of $2.8 to $4.0 billion each year
- Additional revenues from other cuts and taxes.

Tallying up all the cost and the new revenues, over one trillion dollars, the CBO estimates that the bill will reduce the deficit by $124 billion over ten years.
The reform law makes healthcare quality a legislative priority. In order to know if we are getting the right care, we need to measure, publicly report, and pay for the right care. The reform law creates a national quality improvement strategy.

**Specifically the law requires:**
- Establishing a Patient-Centered Outcomes Research Institute to research on “what works” with medical treatments. The findings will not mandate guidelines or recommendations for payment for health coverage.
- Paying hospitals based on performance of quality measures under a hospital value-based purchasing program in Medicare.
- Extending the program to skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Developing a Medicaid state plan for patients with chronic medical conditions such as diabetes or mental illness.
- Establishing Community-based Collaborative Care Network Program to support providers to integrate services.
- Increased data reporting on disparities such as race and ethnicity.

“How do I get the best care?”

**Quality**

**Better Care**

**Affordable Care**

**Better Health for Populations**
When a piece of legislation affects 350 million people who have a collective healthcare expenditure budget of $2.1 trillion, it is not clear what changes will have the most impact. So under the law a number of pilot projects will be developed:

- An Innovative Center within Centers for Medicare and Medicaid will test new strategies to improve quality and reduce cost.

- A state pilot project, which enhances patient safety by reducing medical errors to seek an alternative to malpractice legislation, will be developed.

- A Medicaid pilot project to pay for medical services to providers such as doctors and hospitals through bundle payments, where doctors, hospitals and others are paid for an episode of care not fee for service. If successful the pilot will be expanded.

- An independence at Home Medicare pilot program to provide primary care health services to patients at home through a team of health professionals.

- A voluntary insurance program to improve the quality of long term care will be established for purchasing community living assistance services. If you have functional limitations the program will provide $50 or more in non-medical services to maintain community residence. Also, non-institutionally-based long term care services will be increased by providing enhance federal matching payments to eligible states.

- An accountable care organizations (ACO) which will allow providers such as hospitals, physicians and others to organize and provide care which meets quality thresholds and results in cost savings among Medicare patients.
It’s unclear if premiums will go up or stay the same for those with private insurance. However insurance companies offering health plans will be under greater regulations.

- Health plans will be required to report where the premium dollars are allocated such as clinical services, quality and administrative services.
- Rebates will be provided to consumers if health plans spend more than 80% (in individual and small group markets) or 85% (in large group markets) of the premiums for non clinical or quality services.
- All increases in premiums by health plans will be reviewed and will require justification.
- Health plans may be excluded from the exchange based on unjustified premium increases.
- Health plans cannot place a lifetime limit on a dollar value of coverage.
- Health plans cannot drop patients for any reason except for fraud.
- After 2014 health plans cannot deny individuals based on preexisting conditions.

High income individuals will pay greater taxes.

Flexible spending accounts such as HSA (health saving account) which allow employees to shelter money for medical expenses will be reduced from $4,000 or $5,000 to $2,500, and the accounts will not cover over-the-counter drugs.
Medicare patients can continue with their coverage and receive the same services. Overall there are some upsides and downsides.

**Upside:**
- The “doughnut hole” (the gap in coverage exists when enrollees are in between $2700 and $6154 for their prescription cost) in the Medicare Prescription Part D Plan will be closed. When beneficiaries hit the gap in coverage beneficiaries they receive the following:
  - In 2010 beneficiaries will receive $250 rebate
  - In 2011 beneficiaries will receive a 50% discount on brand-name drugs.
  - In 2020 doughnut hole is eliminated
- No copayment on preventive services approved by the US Preventive Services task force. There are over 30 such services such as mammography, immunizations, colon cancer screening.
- Medicare beneficiaries will receive a comprehensive health risk assessment and will have a personalized prevention plan, and Medicare will pay for an annual checkup.
- Incentive will be given for behavior modification programs such as smoking cessation and weight reduction.

**Downside:**
- Higher Medicare Part B (doctor’s services) premiums until 2019 for those earning over $85,000.
- Beneficiaries on Medicare Advantage may see some reduction in their services and/or higher premiums.
Young Adults:
At present 30% of Americans ages 19-29 are uninsured.

- All young adults will be required to buy coverage, however a number of benefits and subsidies will apply.
- Individuals can stay on their parent’s coverage up to the age of 26. At present the age range varies depending on the state.
- Individuals can purchase a cheaper catastrophic coverage through the exchange
- The premiums for a traditional benefits package will be lower than that of older individuals

Medicaid Patients:
An estimated 16 million low-income Americans will be added to Medicaid

- Those who earn less than 400% of the poverty level (about $88,000 for a family) can receive subsidies to help buy coverage.
- Hardship waivers for not purchasing insurance are available if the cheapest available plan is more than 8% of the total income.
Fewer than 25 employees:
- Not required to buy insurance for employees, however tax credits are available to help with coverage.
- By 2017 Small Business Exchanges will be available to buy insurance.

Over 50 employees:
- Required to provide health coverage or face a fine.

Over 200 employees:
- Automatically enroll employees in health insurance plan. Employee may opt out of coverage.

In order to focus emphasis on prevention, grants will be provided to establish wellness programs at the workplace. Employers will also receive technical assistance and additional resources to evaluate employer-based wellness programs.

Employers will be permitted to offer employees rewards in the form of health insurance premium discounts to those who participate in a wellness program and meet certain health related standards.

Large corporations which own chain restaurants or sell food sold from vending machines will be required to disclose nutrition content on each item.
Health reform will not require patients to change their doctor, nor will it change the doctor-patient relationship. However doctors and hospitals will be affected as millions of people are added to the insurance pool. The health reform law offers bonuses and incentives to address this greater load while focusing on improving quality.

**For Doctors the Reform Law will:**

- Provide a 10% bonus payment to primary care physician and general surgeons practicing in underserved areas, like inner cities and rural communities from 2011 through 2015
- Increase training programs for primary care and general surgery doctors, and provide scholarships and loans to support training of health professionals
- Develop primary care models such as medical homes, team management of chronic diseases to improve office care.
For Hospitals the Reform Bill will:

- Reduce payments to hospitals for preventable hospital readmissions, and reduce payments to hospitals by 1% for hospital-acquired conditions such as hospitals infections

- Reward hospitals in counties with lowest quartile Medicare spending with total of $400 million in 2011 and 2012

- Require non-profit hospitals to determine the needs of their community and develop a strategy to meet those needs. Also, to widely publicize a financial assistance policy and make every effort before undertaking extraordinary collection actions.

- Reduce the market basket payment updates (the annual payment increase hospitals and other providers receive) and link them to productivity.

- Reduce Medicare Disproportionate Share Hospital payments by 75% and then increase based on the population of uninsured population and the uncompensated care provided

Other Changes which will affect Providers:

- Improve access to care by increasing funding to community health center and the Nation Health Service Corps by $11 billion

- Establish an independent payment advisory Board to submit legislative proposals on how to reduce the growth in Medicare spending. The Board is prohibited from submitting proposals that would ration care, increase revenues, or change benefits.
Different parts of the law take effect at different times. For example, health insurance becomes mandatory in 2014 while tax on high insurance plans “Cadillac-plans” occurs in 2018.

**Within 6 months**
- Health plans cannot deny children with pre-existing conditions
- Young adults can stay on parents’ coverage until age 26
- A temporary high-risk pool will provide health coverage to individuals with pre-existing conditions. The pool will cover individuals until 2014 when insurance plans will no longer be able to deny patients due to pre-existing conditions.
- Tax credits will be available for small businesses for providing insurance to employees

**In 2011**
Insurers need to spend at least 80% of premiums on health services or provide a refund to individuals.

**In 2013**
Medicare Payroll Tax for couples making over $250,000

**In 2014**
All are required to have insurance or penalties for individuals or employers.

**In 2018**
High-cost employer provide policies – about $27,500 for a family are subject to 40% tax.
For the most comprehensive summary of the law go to www.kff.org

For the White House explanation of the health law: http://www.whitehouse.gov/healthreform

For the Republican Party explanation of the health law: http://www.gop.gov/indepth/pledge/healthcare#body

For the Congressional Budge Office's report on the Affordable Care Act: http://www.cbo.gov/topics/health-care/affordable-care-act