The Affordable Care Act: Part I of V

By Tom Szostak

This is the first in a five part series on the changes due to healthcare reform and their impact on imaging. Part I addresses discovering value in a fee for service culture.

October 1, 2013 marked the single most significant change in the history of the United States healthcare sector. Citizens and legal residents could no longer be denied access to purchasing health insurance based upon age, gender, family health histories or prior medical conditions. In addition, health plans sold on the marketplace were required by statute to contain a minimum of 10 essential health benefit requirements.

It was no coincidence that on the same day the health insurance marketplace opened, funding for the federal government ran out. Congress failed to reach a consensus on a continuing resolution to keep the federal government operating. An attempt was made to tie funding to a one-year delay in the requirement to purchase health insurance on the marketplace, which did not happen.

Despite the 17-day closing of the federal government, funding for the health insurance marketplace had been appropriated from the prior year. State- and federal-based marketplaces opened for business on October 1, but not without incident. The online marketplaces experienced higher than anticipated hit rates that led to the website crashing. There were unusually long periods of waiting as citizens and residents attempted to purchase health insurance online or by phone. Along with server issues, there were problems with staffing levels of appropriately educated health navigators, who were tasked with providing clear direction as it related to health plan offerings, requirements to qualify for federal subsidies, and what minimum health plan requirements were needed to avoid tax penalties for a population of first-time purchasers with no understanding as to how the insurance product was supposed to work.

As the days progressed, the confusion proliferated and a lack of ownership of legacy legislation from the White House began to emerge. Doubt replaced confidence as the Obama administration searched for answers and solutions to a less than stellar historical launch, and figures regarding newly covered lives were adjusted downward by one million.

Within two months from the debut of the health marketplace, the website problems that dominated the media began to subside and the number of new health plan enrollees continued to grow. States that had once drawn a line in the sand refusing to expand Medicaid under the provisions of the Patient Protection and Affordable Care Act (ACA) began to reconsider their position (eg, Ohio, Iowa, and Michigan) as changing demographics, the electorate, and economic stimulus weighted the decision.

Even the tone from groups (eg, Chamber of Commerce) that advocated outright repeal of the ACA began to shift and urged amending the law. And, as positions have continued to evolve regarding the health law, positions regarding dates, deadlines, requirements, and allowing legacy health policies a three-year sunset continue to waver in order to meet the short term objectives of politicians at the crossroads of the midterm elections.

Why Health Reform?

We are just beginning to enter the greatest phase of change in the entire history of the healthcare sector in the United States since the launch of Medicare in 1965. For some, this has been anticipated for a long time. For others, this is an unwelcome change that forces a stagnant sector of the economy to adapt. A resistance and reluctance to change lingers amongst many stakeholders within healthcare, but their concerns are not without merit.

Since passage of the ACA in 2010, there have been challenges regarding constitutionality, the election of 2012 and well over 40 votes in the House to repeal the law. All of which have helped to underscore doubt and uncertainty as to why the country should move forward with such sweeping changes in health insurance and delivery reform. The real issue as it relates to the need for meaningful health reform originates from the proponents of the law and a lack of making the general public aware of the consequences of remaining with the status quo.

The issue with healthcare is not political, but economic. According to the recent Congressional Budget Office (CBO) report titled "The Budget and Economic Outlook: 2014 to 2024," there are four key concerns as it relates to federal spending and the national debt:

1. Aging population
2. Rising cost of healthcare
3. Expansion of Medicaid and federal subsidies under provisions of the ACA
4. Interest payments on the debt

Interestingly enough, three of the four concerns are directly related to healthcare and the fourth is indirect. These four concerns are the same concerns expressed by the CBO in their 2013 report.

It's a known fact that the United States spends more on healthcare than any other country. In 2012, healthcare represented 17.8% of GDP, or $2.8 trillion, in spending. This represents more than one-sixth of the entire US economy and is projected to consume 20% GDP by 2018. On a per capita basis, healthcare spending for 2012 was $8915. For the Medicare population, per capita spending was estimated at $11,722. The spending rate for this demographic is anticipated to increase by 44.3% by 2022 (data from National Health Expenditure Projections 2012–2022).

So, why should the rising cost of healthcare be a concern to the federal government? Well, back in 1965 when the Medicare program came into existence, the average life expectancy in the United States was around 70.2 years of age. It's somewhat ironic that the year of the program launch and age eligibility were the same—65. And, to this date, age eligibility has remained static since 1965.

Medicare was a solution to provide healthcare to an aging population who were priced out of the market due to age, health, or limited financial means. Corporations and unions looked for a solution to the growing burden of funding retiree benefits for pensioners. Pension and retiree benefit funding eroded the profitability of corporate America and wage increases became difficult for unions to negotiate for members. Hence, unions and corporate America looked to the federal government for a solution to the escalating cost of healthcare associated with their retiree population. Seniors on fixed incomes could not afford healthcare services when hospitalized and the level of bad debt burdened hospitals. Cost and access became issues.

Times have changed significantly since the launch of Medicare in 1965. Innovation in medicine, increased awareness of disease, and reduced infant mortality helped to advance life expectancy to 78.8 years. Clearly, these advancements in medicine could not be foreseen by the Medicare actuaries when they were factoring in the future financial viability of the program. Remember, the federal government was assuming financial responsibility for this demographic for a little over five years. Today, that responsibility has increased by 260% to almost 14 years of paying for healthcare services. And, forecasting the cost of the program was significantly underestimated.

In 1965, the actuaries had forecasted the cost of the Medicare program at $12 billion for 1990. The real cost was $90 billion; or underestimated by 750%.

As of 2011, the baby boomer generation started to become eligible for Medicare benefits. Over the course of the next 19 years, the Medicare program will experience a seismic shift in its beneficiary population, as it is estimated that enrollment will reach 79 million. This translates to 20% of the US population by 2030.

This rapidly expanding Medicare population has grown up in a world of employer-based health insurance that had its origin during World War II. Health insurance was masked as a benefit in order to retain and attract talent. A culture evolved within the US that created this "benefit" culture with no sensitivity to cost.

It will come as no surprise, then, that on a per capita basis, we outspend other developed countries on average by 250%. Ironically, Western European countries developed their healthcare systems after World War II as a means to end disparities within their populations. Culturally and philosophically, the design and approach to healthcare was focused on ensuring that the population had access to services for prevention and wellness so that citizens were healthy and present at work which helped to drive a country's GDP.

Consumption of healthcare services increases exponentially as people age and become eligible for Medicare. Eighty percent of lifetime consumption of healthcare services will occur in the last two years of life. As the average age of

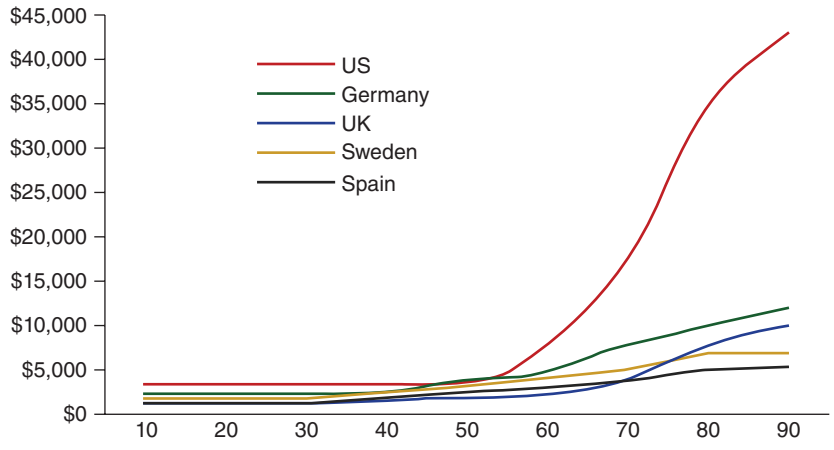

Figure 1 • Annual Per Capita Healthcare Costs by Age

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the population shifts, Figure 1 demonstrates the added burden the federal government will inherit on a demographic that has paid taxes into a program that is required by statute. In comparison to Western European countries, the rate of consumption in per capita spending is relatively flat beyond 65.

In the United States, the approach to healthcare is different in design and has evolved over the years as a cottage industry. Healthcare has developed in a silo environment with little connectivity between providers and facilities as it relates to the needs of the patient. Healthcare became transactional in nature and there was no accountability for the service provided. If patients were readmitted to a hospital or went to specialists for primary care services, there were no penalties and payment was usually assured.

This fragmented and fractured healthcare system that is supported by fee-for-service payment schedules rewards providers by the volume of services versus the value of care that is offered. Providers of healthcare services that are focused on high quality care for the population that they treat are penalized. More than likely, they will see fewer patients because they work to ensure their population is well and active within their communities. In turn, no reward is provided for the services they deliver and they receive less compensation. This misaligned payment system supports the "treatment" aspect of healthcare and does not address "wellness."

So, as the facts regarding the US healthcare system are reviewed, the reality is that based on current payment models, rate of consumption, burden to the federal deficit, employers and consumers, this approach to care is financially unsustainable. As healthcare continues to consume a greater portion of the GDP and costs shift more to consumers, spending is reduced in other sectors of the economy. The economy begins to fire on five cylinders instead of six. Savings rates decline, people might forego purchasing a new car, or funding for education might take a backseat. As the debt level increases with the federal government, borrowing rates increase and that trickles down into all sectors of the economy.

The viability of the Medicare program will be in question as insolvency looms on the horizon. Continued funding for an insolvent program will come under the guise of bonds and borrowing against the Treasury. One thing that most experts would agree upon is that the US has developed the most expensive and inefficient healthcare system in the world.

Tom Szostak, healthcare economics manager for Toshiba America Medical Systems, Inc., serves as the company's expert on healthcare policy and reimbursement, responsible for researching, analyzing, and effectively communicating all changes in legislation or payer guidelines that affect reimbursement of Medicare or commercial insurance payments. Szostak supports and educates purchasing organizations, health systems, as well as Toshiba's sales, marketing and executive staff in matters regarding healthcare policy, reform, reimbursement and economics.