The Affordable Care Act: Part II of V

By Tom Szostak

This is the second in a five part series on the changes due to healthcare reform and their impact on imaging. Part II addresses legislation and simplification of the ACA.

In Part I of this series, the macroeconomic issues that stakeholders in healthcare face was discussed. The US spends the most globally on healthcare on a per capita basis. Despite this high rate of consumption, there is not much to show for it in terms of outcomes, mortality, and life expectancy when compared to other developed nations. The fragmented and fractured health system that has been developed is both expensive and inefficient. Payment schedules that reimburse providers for healthcare services reward volume over value and serve as the foundation that discourages care coordination or patient centered services.

The healthcare sector has seen explosive growth as a segment of the economy since Medicare and Medicaid made their debut on the national stage in 1965. Prior to 1965, national health expenditures as a percentage of GDP remained relatively static. The healthcare sector has seen dramatic growth and has required the federal government, by statute, to continue to fund programs as mandated. Once viewed as a threat to the medical profession, healthcare as a sector of the US economy outpaced all other sectors since Medicare and Medicaid were introduced. See Figure 1.

Continued funding of public and private sector healthcare programs has a cascading effect on other segments of the economy. As more dollars are allocated and consumed within healthcare, other sectors of the economy are deprived of funds or spending. For example, states must balance budgets and if Medicaid costs increase, then funding must be shifted to ensure the states meet statutory requirements to receive federal matching funds. Possibly, state funding for education or tax incentives for businesses are reduced in order to meet state Medicaid program participation. Or, states might have to increase taxes in order to ensure that funding is available for all programs.

In March 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. It was the biggest expansion of the social safety net since the inception of Medicare and Medicaid as Titles 18 and 19 of the Social Security Act. Despite the controversy surrounding the enormity and reach of the law, the ACA has served as a catalyst driving rapid transformation throughout the healthcare sector.

In one form or another, the ACA will have an impact on everyone. Be it as health plan members, medical device manufacturers, patients, providers, insurance carriers, caregivers, or employers—all stakeholders within healthcare will be affected by the various statutes that this law has created. With well over 2000 pages of legislation, the ACA has resulted in more than 18,000 pages of regulation through the federal rule making process in which stakeholders have provided input.

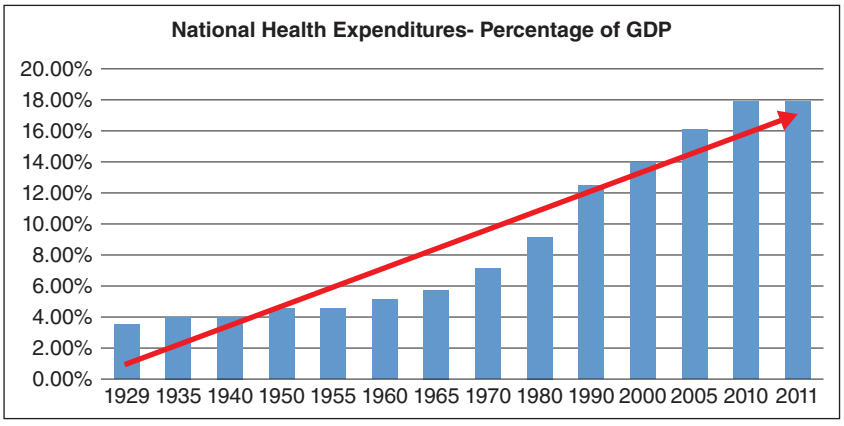

Figure 1 • National Health Expenditures—Percentage of GDP. (Data compiled from various sources by the Centers for Medicare & Medicaid Services.)

The ACA was built around three key tenets: access, quality, and cost. When the law is viewed from this perspective, it seems simple. Following is a closer a look at the objective of these three tenets and their intended purpose.

Access

The main goal of the health law was to remove all barriers from purchasing health insurance. As of October 1, 2013, people once considered uninsurable could no longer be denied the right to purchase insurance based on gender, pre-existing conditions, family health history, or age. The intent of the law was to reduce the number of uninsured Americans by 32 million and to achieve a 93% population coverage threshold by 2019.

Quality

The federal government migrates from being a passive payer of healthcare claims and becomes an active purchaser of healthcare services. Initially, a small percentage of provider payments are tied to quality metrics, patient satisfaction, and outcomes. There is a dedicated focus on redesigning the delivery of healthcare that forces collaboration between providers/caregivers in the form of a value driven health service.

Cost

It is the intended goal of the ACA through insurance and delivery reform to bend the cost curve and corral healthcare inflation so that it is in alignment within one percent of annual GDP growth. Prior to ACA passage, the Medicare Hospital Insurance Trust Fund (MHITF) was set to become insolvent by 2017. The ACA helped to extend the life of the Medicare Trust Fund through 2030. According to the 2013 Trustees Report, the MHITF will be 87% funded in 2027. Consequently, that results in a 13% funding deficit that will need to be resolved from either increased tax revenues, spending reductions to the Medicare program, or increased borrowing through the issue of treasury notes to continue to fund a federally mandated program. Possibly, there could be a combination of all three avenues to continue to ensure funding for the program.

Two Distinct Categories of Reform

The ACA incorporates the three tenets of access, quality, and cost to improve the delivery of care, reduce waste, increase quality/patient satisfaction, and to preserve the Medicare program for years to come. It is no simple task to redesign the US delivery system from a fragmented and fractured system that was built under the guise of employer based benefits that evolved during the World War II era. A lack of sensitivity to "true" pricing and a notion that health benefits are free and limitless has helped to support this volume driven health system that has burdened corporations and federal and state governments as the cost of healthcare has outpaced inflation for several decades.

To simplify this complex, multigenerational problem, the ACA can be looked at as two types of reform: insurance reform and delivery reform.

Insurance Reform

Insurance reform removes pre-existing barriers to allowing consumers to purchase health insurance in the private sector. No longer can insurance carriers make the cost of health insurance premiums out of reach because of age. For example, premiums cannot exceed three times the lowest rate that is sold to the lowest age rating band on the state based health insurance exchanges. As well, pre-existing conditions, gender, or family health histories can no longer be cause for denying coverage or raising premiums to a point where paying for coverage would be deemed excessive.

Health insurance plans must work within the confines of ensuring that health plans sold to individuals, small employers, and large employers have 80–85% of the premiums spent on healthcare services. If insurance companies fail to meet this medical/loss ratio requirement of the ACA, then the remaining balance under the benchmark requirement must be returned in the form of a rebate to the individual or employer. This segment of the private sector represents around 75 million covered lives. This aspect of the law works to ensure that funds are spent on healthcare services and not on administrative costs. The end result is to keep health plans affordable to consumers who are required to purchase coverage by law.

Delivery Reform

As providers of healthcare services, delivery reform will have a greater and more meaningful impact as care is redesigned/reengineered in a manner that drives care coordination and connectivity between healthcare providers; eliminating services that are not medically necessary for diagnostic or therapeutic services. Alternative payment models, such as Accountable Care Organizations (ACOs), Hospital Inpatient Value-Based Purchasing (HIVBP), Penalties for Excessive Readmissions, and Bundled Payments for Care Improvement (BPCI) place increased emphasis on spending benchmarks that incorporate quality and outcome metrics. These new alternative payment models will drive provider organizations to build governance boards that ensure compliance of cost, quality, and outcomes metrics. Risk is shared between provider organizations and payers as healthcare delivery is no longer one sided. Services that are provided are viewed with greater scrutiny as risk is shared and economic utility is factored in.

Insurance reform has an interdependent connection to delivery reform as employers move employees to high deductible health plans that create price sensitivity in a sector of the economy that has been serviced by a wholesale insurance product. Employers are looking into alternative insurance benefit design by redefining the offering in the form of a defined contribution product.

Employees would be provided a set amount of money to purchase health insurance and determine the level of risk that they are willing to take with multiple plan offerings from a host of insurance providers. The risk begins to shift to the consumer, which drives increased awareness of price and level of risk that they are willing to assume based on personal health histories or anticipated needs. This shift toward an employer based private health insurance exchange is anticipated to increase in 2018 when the Cadillac tax for high cost, employer based health plans takes effect.

The ACA can be best simplified as health insurance and delivery reform. Alternative payment models (APMs) and how these risk sharing arrangements will help to improve quality, decrease cost, and improve outcomes and patient satisfaction will be explored further in Part III.

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.