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# Impact of Health Care Reform

**By Kristie Danielson, ACA paralegal**

The current U.S. health care system may fall far short of its expected potential. Based on a survey conducted by the University of Cal. Santa Cruz, the U.S. ranked number one in health care spending, but twenty-seventh on the list in terms of life expectancy; far below its European counterparts.

"It is clear our current health care system is not sustainable," said James Watson, Health Care Principal for LarsonAllen LLP, Blue Bell, Pa.

In an attempt to make health care more affordable to Americans, on March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). The law puts in place comprehensive health insurance reforms that will be implemented over several years, with most changes taking place in 2014.

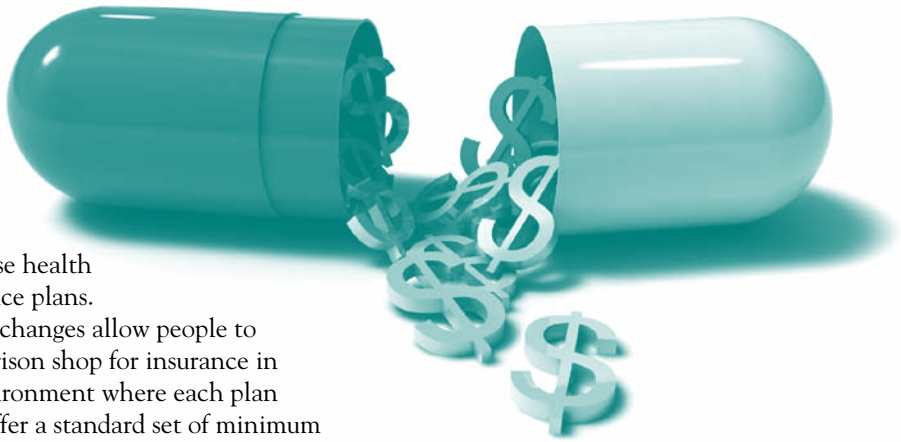
At ACA International's 2011 Fall Forum session, Health Care Reform, Watson discussed some of the ways the PPACA impacts providers.

## Expansion of Coverage

The impact of the PPACA on providers can be seen through the enlargement of insurance coverage.

### Exchanges

One of the ways the Act expands the health care system is by requiring each state to establish an insurance Exchange. An Exchange is an insurance marketplace that allows individuals and small businesses to compare and purchase health insurance plans.



"Exchanges allow people to comparison shop for insurance in an environment where each plan must offer a standard set of minimum essential benefits," Watson said.

The goal of establishing an Exchange is to help individuals and small employers obtain affordable, quality health insurance coverage. Americans with incomes between 100 and 400 percent of the federal poverty line (about $89,000 for a family of four) may be eligible to get subsidies through an Exchange. Small employers may already be eligible for some tax credits if they provide insurance to their employees and pay a portion of the premium cost.

"Under the Act, by 2014, each state is going to be required to have an Exchange," Watson said.

### Medicaid Expansion

The PPACA also expands Medicaid coverage.

"Currently, every state determines their level of Medicaid eligibility," Watson said.

Under the PPACA, states may expand Medicaid eligibility as early as Jan. 1, 2011, and beginning on Jan. 1, 2014, all children, parents, and childless adults, who are not entitled to Medicare and who have family incomes up to 133 percent of the federal poverty level will become eligible for Medicaid.

### Shared Responsibility

Individuals and employers have the responsibility of obtaining insurance coverage under the PPACA.

*Individual Responsibility*

Beginning in 2014, most individuals will be required to maintain minimum essential health care coverage or pay a penalty on their tax returns, which is the greater of $95 or 1 percent of their income per year. This penalty increases annually.

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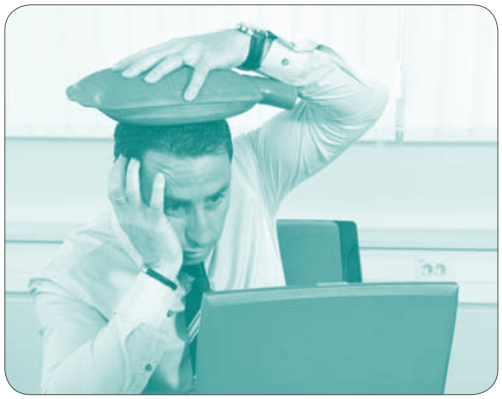
## Employer Health Insurance Premiums Continue to Increase

Premiums for employer-sponsored family health insurance increased by 50 percent from 2003 to 2010, and the annual amount that employees pay toward their insurance increased by 63 percent as businesses required employees to contribute a greater share, according to a new Commonwealth Fund report, *State Trends in Premiums and Deductibles, 2003-2010: The Need for Action to Address Rising Costs*, released on Nov. 17, 2011.



The report examines state trends in health insurance costs and finds that health insurance costs are outpacing income growth in every state in the country. At the same time, premiums are buying less protective coverage: per-person deductibles doubled for employees working for large as well as small firms over the same time period.

According to the report, 62 percent of the U.S. population lived in a state where health insurance premiums equaled 20 percent or more of earnings for a middle-income individual under age 65.

The report is available at *www.commonwealthfund.org/Publications/Issue-Briefs/2011/Nov/State-Trends-in-Premiums.aspx*. An interactive map with premiums in each state is available at *http://www.commonwealthfund.org/usr_doc/site_docs/slideshows/ PremiumTrends2011/PremiumTrends2011.html*.

## Project to Pay Health Centers Based on Quality of Care

The U.S. Department of Health and Human Services announced a project that will provide 500 community health centers in 44 states with approximately $42 million over three years to improve the coordination and quality of care they deliver to people with Medicare and other patients.

Under the Advanced Primary Care Practice project, created by the Affordable Care Act, Medicare will pay community health centers based on the quality of care they deliver. This initiative will reward clinics for improving primary care, such as helping patients manage chronic conditions like diabetes or high blood pressure.

The goal of the initiative is to provide care for patients in a primary care setting rather than an emergency room. To do this, participating health centers will expand their hours, make same day appointments and accommodate patients with urgent care needs.

The project will be conducted from Nov. 1, 2011 through Oct. 31, 2014. Participating health centers will be paid a monthly fee for each eligible person with Medicare that receives primary care services. The CMS Center for Medicare and Medicaid Innovation (Innovation Center) and the Health Resources Services Administration (HRSA) will provide technical assistance to help participating community health centers throughout the study.

More information on the Advanced Primary Care Practice project, including a fact sheet and a list of participating health centers can be found at *http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/fqhc/*.

## Supreme Court to Hear Challenge to Health Care Reform Law

The Supreme Court announced on Nov. 14, 2011, that it would hear oral arguments on the health care reform law by March 2012 and render a decision in late June. One of the primary issues expected to be decided by the Court is the legality of the individual health insurance mandate. The justices will also address whether the Patient Protection and Affordable Care Act is doomed if the individual mandate is ruled unconstitutional.

According to the *New York Times*, the Supreme Court agreed to hear appeals from just one decision, from the U.S. Court of Appeals for the Eleventh Circuit—the only court so far to strike down the mandate.

The Court scheduled five and a half hours of oral arguments instead of the usual one hour, indicating the significance of the case.

## Impact of Health Care Reform

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*Employer Responsibility*
Employers who have more than 200 employees and offer health insurance will be required to automatically enroll new full-time employees into that health care coverage and continue enrollment for existing full time employees.

"Employers have to pay penalties if they have employees enter and receive subsidies through the Exchange," Watson said.

If an employer plan is affordable for its employees, no penalties are incurred because their employees will not be eligible for subsidies regardless of their income.

"If an employee pays a premium that is more than 9.5 percent of their household income or the employer's plan does not have a 60 percent actuarial value then the plan is deemed not affordable," Watson said.

Understanding the economic situation of employees may help businesses deal with insurance reform.

"Each provider or company needs to understand the demographics of their employee base," Watson said.

In areas where household income is low, the employee portion of the insurance premium costs will also have to be low to avoid employer penalties for subsidy-eligible employees.

### Redefining the Payment System

The PPACA attempts to redefine the health care payment system by shifting from fee-for-service to a value-based payment system.

"Payment reform involves rewarding and increasing value," Watson said.

A value-based payment system focuses on wellness programs and chronic care prevention to promote collaboration among providers in an attempt to contain health care costs.

"The overall goal of reform is to increase health care value by improving quality and reducing costs," Watson said. "Providers need to understand what it costs to treat each patient."

A value-based payment system focuses on the value of the treatment provided by linking payments to quality performance. Watson contended the goals of a value-based payment system are:

- To encourage the use of evidence-based medicine;
- To reduce fragmentation and duplication of health care services (e.g., paying for the same lab test for one patient because the second provider did not have a record showing the test had already been done);
- To encourage management of chronic diseases;
- To establish a health information exchange; and
- To engage consumers.

**Focus on Quality Care**

Under the PPACA, the government pays providers for giving better care and holds them accountable for the patient's health outcome.

"Quality is related to measuring outcomes from treatment, instead of strictly compliance based," Watson said. "The focus is shifting from short term to long term care."

Evaluating re-admissions and hospital acquired conditions are two ways the Act will measure quality of care.

"Under the Act, there will be penalties for excessive re-admissions," Watson said.

Even if a patient is discharged from a hospital only to return with the same or similar condition, providers are held accountable. Providers need to learn to work together, because evaluations and costs will be based on the entire continuum of care.

"Collaboration of providers needs to happen to be successful under health care reform," Watson said.

**Measuring Quality Care**

As a means to evaluate the quality of care patients receive, the Centers for Medicare and Medicaid Services has established clinical benchmarks and surveys to evaluate the quality of care in hospitals and will be establishing similar quality benchmarks for other health care providers in the coming years.

"Seventy percent of the metrics are based on clinical benchmarks and thirty percent are based on patient experience of care surveys," Watson commented.

Electronic health records will play a central role in ensuring quality benchmarks are met, monitored and reported. Sharing of these records among providers will be essential to ensure fragmentation and duplication are reduced, care transitions are improved, and best practice protocols are consistently applied.

### Impact for Providers

Providers should establish a strategy for how they want to meet certain goals in order to improve quality and efficiency while reducing cost.

"Providers need to have a plan in place for how they are going to meet benchmarks," Watson said.

In a reformed health care environment, providers will need to understand not only the costs attributable to the services they provide by disease, condition or treatment but also the total cost of care for a particular patient. Establishing strong relationships with other health care organizations is important to ensure continuity of care throughout the patient's treatment.

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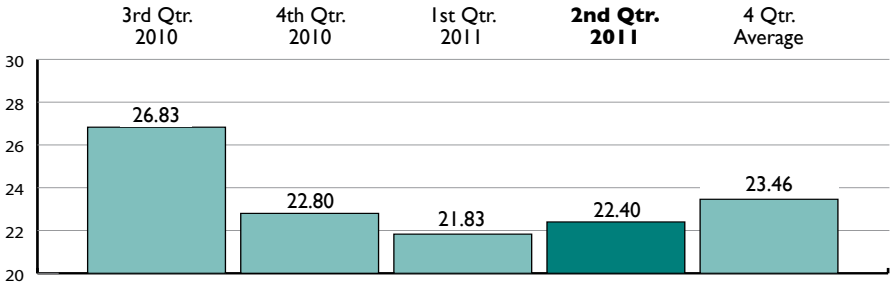
# DATA WATCH

## A/R Aging on the Rise

In the second quarter of 2011, U.S. hospitals reported 22.40 percent of accounts receivable (A/R) aged greater than 90 days, up from 21.83 in the first quarter. Despite the decline in A/R aging performance, U.S. hospitals still hit the benchmark for this financial indicator, which is to hold A/R aged more than 90 days to 25 percent or less of total A/R.

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