The Reinvention And Renewal Of US Health Care

By Susan Dentzer
Editor-in-Chief, *Health Affairs*
Presentation to University of Iowa Health Care
November 13, 2012
This presentation at a glance

- Major changes afoot in health care ecosystem – the reinvention and renewal
- Galvanized by – but will extend far beyond – Affordable Care Act, which now moves forward
- Triple Aim focus; rapid cycle transformation schedule
- Payment and delivery system reforms; innovations
- Issues in Affordable Care Act Implementation
- Some conclusions
Obama Signs Affordable Care Act into Law, White House, March 23, 2010

The bill “enshrines the core principle that everybody should have some basic security when it comes to their health care.”

Two and one half years later, having survived legal challenges that went to the Supreme Court and the 2012 elections, implementation now moves forward.
Simplified Structure of Health Reform

- Move away from classic fee-for-service payment
- Pay health care providers in new ways to spur delivery system reform, enhance patient care, get rid of waste and slow the growth of health spending
- Accountable Care Organizations
- Patient Centered Medical Homes
- Various pilot and demonstration projects, some new, some building on experiments tried in previous administrations
Simplified Structure of Health Reform

- Financing (taxes, slower Medicare spending and fees) to pay for above

- Health Promotion and Prevention initiatives, including $15 billion Prevention and Public Health Fund (Iowa has received $10.9 million in grants, according to HHS)

- Other, including workforce and capacity development

- Iowa has received $39.9 million to support community health centers; $1.5 million for personal and home care aide training program; $8.6 million for program to bring health professional to meet with high-risk families of young children
The Triple Aim

- Better health
- Better health care
- Lower cost

Core principle now at heart of major U.S. payment and delivery system reform efforts

Donald Berwick, MD
Former Administrator
Centers for Medicare and Medicaid Services
Better Health
# The State Of US Population Health

## Key Drivers of Health Status

<table>
<thead>
<tr>
<th>Health Factor</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Obesity</td>
<td>66% adults obese or overweight</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>28% inactive</td>
</tr>
<tr>
<td>Smoking</td>
<td>23% smokers</td>
</tr>
<tr>
<td>Stress</td>
<td>36% high stress</td>
</tr>
<tr>
<td>Aging</td>
<td>22% &gt; 55 years old</td>
</tr>
</tbody>
</table>

## Contribution to Premature Death

- Genetic Predisposition: 30%
- Environmental Exposure: 15%
- Social Circumstances: 10%
- Behavioral Patterns: 5%
- Health Care: 40%

**29 percent of Iowans obese**

Social determinants of health

- Income and Income Distribution
- Education
- Employment or unemployment; job security; working Conditions
- Early Childhood Development
- Food Insecurity
- Housing
- Social Exclusion; Social Safety Network
- Access to Health Services; Disability
- Gender, Race, Aboriginal (Native American/Indian) Status
The Social Determinants
“Ten Tips For Better Health”

1. Don’t be poor. If you can, stop. If you can’t, try not to be poor for long.

2. Don’t have poor parents.

3. Own a car.


5. Don’t live in damp, low-quality housing.

6. Be able to afford to go on a vacation and sunbathe.

7. Practice not losing your job and don’t become unemployed.

8. Make sure you have access to benefits, particularly if you are unemployed, retired, or sick or disabled.

9. Don’t live next to a busy major road or near a polluting factory.

10. Learn how to fill in the complex housing benefit/shelter application forms before you become homeless and destitute.

Source: Centre for Social Justice, Canada; Social Determinants Across the Lifespan, <http://www.socialjustice.org/subsites/conference/resources>.
The 8 Different Americas

- Harvard School of Public Health researchers identified 8 different “Americas” with as much as a 33-year difference in life expectancy
- Based on race, ethnicity, geographical location
- At high end, Asian American women in Bergen County, NJ had life expectancy of 91 years in 2001
- Black males: average life expectancy 68.7 years
- At low end, Native American men in South Dakota had life expectancy of 58 years

Main reason for differences: sharply disparate rates of chronic disease

Widening disparities in life expectancy


In 2008, US adult men and women with fewer than 12 years of education had life expectancy roughly equal to all American adults in the 1950s – 60 years ago

- Falling life expectancy particularly pronounced for less-educated women

- Mix of factors seems to be at play, including obesity, smoking, stress, prescription drug abuse

- When race and education are combined, disparities are even more striking
How education differences drive life expectancy

Life Expectancy At Birth, By Years Of Education At Age 25, By Race And Sex, 2008

SOURCE Authors’ analysis of data from the National Vital Statistics System and the Census Bureau (Notes 24–26 in text).
Olshansky et al study, Health Affairs, forthcoming, August 2012
Study captures national attention
Variation by level of education and racial/ethnic group

Those who have not graduated from high school are 2.6 times as likely to be in less than very good health than college graduates.
Iowa counties ranked by underlying health factors; lightest are healthiest, dark blue the least healthy.
Source: County Health Rankings and Indicators, the Robert Wood Johnson Foundation
Iowa counties ranked by health outcomes; lightest color counties have best outcomes, darkest have worst. Source: County Health Rankings and Indicators, The Robert Wood Johnson Foundation
Hospitals’ New Roles in Population Health

- New requirements under Affordable Care Act on tax-exempt hospitals and health systems

- To retain 501(c)(3) [tax exempt] status, organization must conduct a “community health needs assessment” at least every three years

- Must adopt implementation strategy to meet the community health needs identified through the assessment

- Penalty: $50,000 excise tax for each year that a tax-exempt hospital subject to these provisions fails to satisfy requirement
Better health care
“Crossing the Quality Chasm: A New Health System for the 21st Century”*

- US health care not sufficiently
  - Safe
  - Effective
  - Patient Centered
  - Timely
  - Efficient
  - Equitable

*Source: Institute of Medicine, 2001
“Still Crossing the Quality Chasm”

- April 2011 issue of Health Affairs
- Much progress; much remains to be done
Patients’ Safety: Still At Risk

- Adverse events in hospitals may be 10 times greater than previously measured.
- Showed adverse events occurred in 1 in 3 admissions.
- Medication-related errors and events related to surgeries and procedures were those with greatest severity level.

Source: *Health Affairs* 30, No. 4 (2011): 581-589
“Amenable mortality:”
US falling further behind Europe

- Amenable mortality = deaths that should not occur in the presence of timely and effective health care

- Comparison of amenable mortality in the United States compared to those in France, Germany, and the United Kingdom between 1999 and 2007.

- Overall, amenable mortality rates among men from 1999-2007 fell by only 18.5 percent in the United States compared to 36.9 percent in the United Kingdom.

- Among women, the rates fell by 17.5 percent and 31.9 percent, respectively.

- US deaths from circulatory conditions—mainly, cerebrovascular disease and hypertension – were the main reason.

Care Coordination/Avoidable hospital use

- Advanced Illness/End of Life
- Half of older Americans (51%) visited emergency department in last month of life; 77% of those seen in ED admitted to hospital
- 68% of admitted died in hospital
- Americans’ broad preference is to die at home
- Emergency department use in last month of life rare when enrolled in hospice one month before death

Source: Alexander K. Smith et al, “Half of Older Americans Seen In Emergency Department In Last Month of Life; Most Admitted To Hospital, And Many Die There,” Health Affairs, June 2012
Tackling Unnecessary Variation and Overuse: The Case of End-of-Life Cancer Care

- Morden et al, “End-Of-Life Cancer Care For Medicare Beneficiaries Is Highly Intensive Overall, But Varies By Two-Fold In All Types Of Hospitals”

- Study of end-of-life care for Medicare beneficiaries with advanced cancer and poor-prognosis -- i.e., likely to die in less than a year

- Found large variations among all types of hospitals in share of patients dying in hospital; hospice use; share of patients seeing 10 or more physicians in last six months of life

- Source: Nancy E. Morden et al, “End-Of-Life Care For Medicare Beneficiaries With Cancer Is Highly Intensive Overall And Varies Widely,” Health Affairs, April 2012 31:786-796
Lower Costs
“Health care costs are the pounding headache to which all of us in medicine will awaken each day for the rest of our lives.”

--Thomas Lee, CEO, Partners Healthcare
The toll of health care costs on American families

- In 1999-2009, an average American family of four saw its annual income increase from $76,000 to $99,000

- Nearly all those income gains were erased by higher health spending

- The greatest burden of national health spending has fallen on families in the lowest one-fifth of the income distribution

- Average annual income in 2004 of $13,450.

Sources: David Auerbach and Arthur Kellermann; Patricia Ketsche et al; Health Affairs, September 2011.
Both visible and “invisible” health expenditures have grown.

*Figures are monthly spending for an average US family of four.
Healthcare Costs Are Concentrated Among Small Group Of Sickest Patients: Medicare

- **23 Million Beneficiaries**
  - Spending $1,130 each
  - Total Spending = 5%
  - ($26 B)

- **16.1 Million Beneficiaries**
  - Spending $6,150 each
  - Total Spending = 20%
  - ($104 B)

- **7 Million Beneficiaries**
  - Spending $55,000 each
  - Total Spending = 75%
  - ($391 B)

2010 Medicare
- Spending Projection = $522 B
- 46 Million Beneficiaries
- Spending Per Beneficiary = $11,347
Waste in Health Care: The Savings Opportunity

- Six categories of waste estimated to equal 21% to 34% of all US health spending (estimated $558 billion to $910 billion annually)

- Overtreatment – subjecting patients to care that can’t possibly help them, and may be harmful

- Failures of care coordination – what happens when patients fall through the cracks, e.g., unnecessary hospital readmissions

- Failures in execution of care processes – e.g., not doing things known to be effective, such as infection control

- Administrative failures – when payers have inefficient or misguided rules

- Pricing failures: when prices are far above what would be seen in well-functioning markets – e.g., CT and MRI costs in US

- Fraud and abuse

Institute of Medicine Study Released September 2012

BEST CARE AT LOWER COST

The Path to Continuously Learning Health Care in America

Targets of Opportunity For Savings

- Missed Prevention Opportunities $55 billion
- Unnecessary Services $210 billion
- Inefficiently Delivered Services $130 billion
- Excess Administrative Costs $190 billion
- Fraud $75 billion
- Prices That Are Too High $105 billion
Wide Variations in Prices And Quality

- **Heath Affairs Issue**, September 2012

- **Articles Include**
  - “Payers Test Reference Pricing And Centers of Excellence” – Robinson & MacPherson
  - “Wide Variation in Episode Costs Within a Commercially Insured Population Highlights Potential To Improve Efficiency Of Care” – Ellis et al
Safeway Reference Pricing For Colonoscopy (Limit = $1,250)

Range of Prices Paid by Safeway for Colonoscopy in Three Markets, plus Reference Price Limit Established in 2010

Source: Safeway Health
# International Price Variation

<table>
<thead>
<tr>
<th>Service (US$)</th>
<th>Cost* (US$; 25 and 95%tile)</th>
<th>Medical Tourism** (US$)</th>
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<tbody>
<tr>
<td>Cost/Hosp. Stay</td>
<td>7,707 14,427 Canada US (4,001; 45,902)</td>
<td>India CA Bypass 4,525</td>
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<tr>
<td>Angioplasty</td>
<td>12,581 29,055 New Zealand US (18,266 – 60,448)</td>
<td>US CA Bypass 67,583</td>
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<tr>
<td>Normal Delivery</td>
<td>1,336 2,997 France US (2,380 – 4,848)</td>
<td>India Hip R. 4,308</td>
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<tr>
<td>MRI Imaging</td>
<td>874 1,009 Switzerland US (509-2590)</td>
<td>US Hip R. 38,017</td>
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*International Federation Health Plans 2010 Report*
Variation Across Markets in Episode Costs and Care Quality for Cardiac Catheterization (Diagnostic)

More than 3-fold variation in price; nearly 20 percentage point difference in quality

Note: Data includes only physicians designated as providing higher-quality care.
Variability, even among “the best”

- “A Collaborative Of Leading Health Systems Finds Wide Variations In Total Knee Replacement Delivery And Takes Steps To Improve Value”
- “High Value Healthcare Collaborative”, including Cleveland Clinic, DHMC, Denver Health, Intermountain, Mayo (more since added, including University of Iowa)
- Pooled data to examine differences in primary total knee replacements (total US costs 2008 = $9 billion)
- Found substantial variations in such metrics as hospital lengths-of-stay; found longer operating times associated with higher complication rates
- Used findings to alter care, including more coordinated management for complex patients
- Cost data forthcoming

Source: Ivan M. Tomek et al, *Health Affairs*, June 2012 vol. 31 no. 6 1329 ff
## Comparison among institutions

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<thead>
<tr>
<th>Metric</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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<tr>
<td>Mean LOS</td>
<td>3.6</td>
<td>4.2</td>
<td>3.9</td>
<td>3.3</td>
<td>3.2</td>
<td>3.2</td>
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<tr>
<td>Median LOS</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>By MD # of procedures</td>
<td>3.6</td>
<td>3.8</td>
<td>4.4</td>
<td>3.5</td>
<td>3.3</td>
<td>3.5</td>
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<tr>
<td>(annual) 0-99</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>200+</td>
<td>--</td>
<td>--</td>
<td>3.4</td>
<td>3.0</td>
<td>2.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Surgery on Mon.</td>
<td>3.6</td>
<td>4.2</td>
<td>3.7</td>
<td>3.2</td>
<td>2.9</td>
<td>3.1</td>
</tr>
<tr>
<td>On Fri.</td>
<td>3.6</td>
<td>--</td>
<td>4.3</td>
<td>3.4</td>
<td>3.0</td>
<td>3.3</td>
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31.2% difference, low to high

16% difference
Reinvention and Realignment

Payment and Delivery System Transformation
The core problem of fee-for-service medicine...

...volume ahead of value.
Payment Innovation: Improving Value And Affordability

Old Model

- Reward unit cost
- Inadequate focus on care efficiency and patient centeredness
- Payment for unproven services; limited alignment with quality

New Model

- Reward health outcomes and population health
- Lower cost while improving patient experience
- Improve quality, safety and evidence
Innovations under CMS

- Payment reform: fundamental shift away from fee-for-service medicine
- Delivery system reform: encourage reorganization of system to take out waste and deliver high-value care
- Different opportunities for providers based on readiness
- Strategic partnerships with data
- Robust quality monitoring
- Emphasis on multi-payer strategies and approaches

Jonathan Blum, Centers for Medicare, CMS
Center for Medicare And Medicaid Innovation

- $10 billion over five years to experiment ("mandatory" spending)
- Seeking cost-saving innovation platforms in 3 areas:
  - Improving care of particular types of patients
  - Improving care coordination
  - Improving care for patient populations overall

Dr. Richard Gilfillan, Acting Director, CMMI
Innovations under CMS

- Program to reduce unnecessary readmissions; hospitals above certain ratios for readmissions in 3 conditions begin to be penalized under Medicare in October 2012

- Medical homes: All-payer national pilot; Medicaid “health homes”

- 25 states have now implemented patient-centered medical homes in Medicaid

- Medicare bundled payment initiative

- Medicare Advantage plans – differential payments based on quality scores began in 2012

- Value-based purchasing for hospitals begins in October 2012
Innovations under CMS

- Physician quality and outcomes incentives to begin in 2015
- Comprehensive Primary Care Initiative – 500 primary care practices in 8 geographic areas
- Community-based care transitions program
- Federally qualified health centers patient centered medical home demonstration
- Federal coordinated care office and evolving experiments to better coordinate care of “dual eligibles” (Medicare + Medicaid)
Innovations under CMS

- Accountable Care Organizations, including

- Medicare Shared Savings Program (now 131 organizations participating, including Genesis ACO, Iowa Health Accountable Care, One Care and University of Iowa Affiliated Health Providers)

- Pioneer program (32 participants, including Iowa Health System)

- “Advance Payment” ACOs (15 participants)

- Total of more than 2.5 million Medicare beneficiaries participating in all Medicare ACO’s = 7-8 percent of entire fee-for-service portion of Program

- Medicaid ACO’s in Minnesota, Colorado, Oregon and Washington
Accountable Care Organizations

ACO Principles

- Put the patient and family at the center
- Have a memory about patients over time and place
- Attend carefully to handoffs, especially as patients journey from one part of the care system to another.
- Manage resources carefully and respectfully
- Be proactive
- Be data-rich.
- Innovate in the service of the Triple Aim: better and better patient care, better population health, and lower cost through improvement.
- Continually invest in the development and pride of its own workforce, including affiliated clinicians.
ACO Contracts, Private Sector

- Roughly 300 ACO-like contracts now on market
- Advisory Board Estimate: more than 38% growth in ACO contracts in last 9 months
- Vast majority are on private side, not Medicare or Medicaid
- Proliferation of models: e.g., Wellmark Blue Cross Blue Shield and Iowa Health System; Wellmark and Genesis Health System; Wellmark and Mercy Medical Center
- Elsewhere: Advocate Health System and Blue Cross Blue Shield of Illinois; Inova/Aetna in Northern Virginia, announced June 2012; 8 ACO’s formed by Blue Shield of California
Implications for Hospitals And Health Systems

- Lower hospital utilization: fewer admissions and readmissions
- When there is hospitalization, far more focus on care transitions and minimizing excess expense and disruption
- Tighter linkages with other community providers, including primary care physicians and nursing homes
- More employment of physicians, particularly specialists
- Engagement in far more on population health and disease prevention
Blue Shield of California

- Launched pilot ACO with Dignity Health (formerly Catholic Health Care West) and Hill Physicians in January 2010 for 41,000 CalPERS employees and dependents

- Global budget; shared upside and downside risk

- Tactics included eliminating unnecessary care, such as excessive bariatric surgery; coordinating processes such as discharge planning; reducing variation in practices and resources; reducing pharmacy costs

- 2010-11 combined results: $37 million in savings to CalPERS; compounded annual growth rate for per member per month costs was ~3% vs. ~7% for everyone else
Brookings-Dartmouth Pilot ACO Sites

- Article by Larson et al in November 2012 *Health Affairs*

- Four pilots with between 7,000 and 50,000 patients and 90 to 2,700 participating physicians (HealthCare Partners, Torrance, CA; Monarch HealthCare, Irvine, CA; Tucson Medical Center, AZ; Norton Healthcare, Louisville, KY)

- Sites had varying degrees of experience with performance-based payments; however, all formed collaborative new relationships with payers and created shared savings agreements linked to performance on quality measures.
Brookings-Dartmouth Pilot ACO Sites

- Each organization devoted major efforts to physician engagement.

- Site leaders recognized that “the transition to accountable care was fundamentally about culture change.”

- Recommendations: Policy makers now need to consider how to support and provide incentives for the successful formation of multipayer ACOs, and how to align CMS and private-sector performance measures.

- “This process [of transitioning to an ACO] will require continued adaptation not only in terms of the structure of the contracts, but also in terms of the organizational attributes that may be necessary in different contexts.”
An Academic Health Center Goes ACO

- Robert Wood Johnson Medical School, part of University of Medicine and Dentistry of New Jersey
- Made major changes in governance model, finance structure, compensation and incentive systems, information technology infrastructure, decision-making processes
- Forecast three years from beginning clinical operations to break-even status
- Challenges: start-up funding; achieving true collaboration among providers; “understandable if unfortunate skepticism about health system transformation.”
- Clinical costs higher than those of other providers in region; uncertainty about whether payers will support
- Importance of disentangling and defining the cost of academic, research and charitable missions to engender support

Source: Alfred F. Tallia and Jenna Howard, “An Academic Health Center Sees Both Challenges and Enabling Forces As It Creates An Accountable Care Organization,” Health Affairs 31, no. 11, 2388-2394.
Other Innovations
“Hospital At Home”

- Presbyterian Health Services, New Mexico, in partnership with Johns Hopkins

- Identified patients who could be “hospitalized” at home and deployed physicians and nurses to care for them

- All results equal or better than in hospital

- Receipt of antibiotics in pneumonia patients and medications for heart failure patients superior

- Variable costs per stay are $1000-$2000 lower = 19%

- Patient satisfaction mean score = 90.7%

- Source: Lesley Cryer et al, “Cost For Hospital At Home Patients Were 19 Percent Lower, With Equal or Better Outcomes Compared To Similar Patients,” Health Affairs, June 2012

Johnny Baker, 49, COPD patient in “Hospital At Home” program
Changing Technology Makes More Care Delivery Innovations Possible

- Technology company Qualcomm – making new inroads into wireless health

- Sponsoring a $10 million X Prize competition to “develop a mobile solution that can diagnose patients better than or equal to a panel of board certified physicians” – and keep track of vital signs”

- Remote monitoring makes possible a future where ICU patients will be hospitalized at home
“Shared Decision Making:” Patients and Physicians

- Largest observational study done to date on shared decision making for patients contemplating joint replacement surgery for hips and knee osteoarthritis

- Group Health, system serving more than 600,000 patients in Washington State and Northern Idaho

- Intervention: use of decision aids prepared by Informed Medical Decisions Foundation and an affiliated company, Health Dialog

- Source: D Arterburn et al, *Health Affairs*, September 2012
“Shared Decision Making”

- Introduction of decision aids in use across Group Health system resulted in short-term reductions in surgeries
  - 26 percent fewer hip replacements, 38 percent fewer knee replacements
  - Lower costs in range of 12 percent to 2 percent

- Findings support concept that patient decision aids for some conditions highly sensitive to patients’ and physicians’ preferences for care reduce the rates of elective surgery and lower costs.

- Unknown as yet: Will more patients elect surgery over time as condition worsens, or will their preferences remain the same?

- Source: D Arterburn et al, “TK,” Health Affairs, September 2012
The Election Results
The Affordable Care Act takes effect

People Without Health Insurance Coverage: 1987 to 2011

- Private coverage rate stable for first time in 10 years; percentage with government health insurance rises from 31.2% to 32.2%
- 3 million young adults on parents’ policies; 20,000 in Iowa

Note: The data for 1999 reflect the results of follow-up verification questions, creating a break in the historical series.
Health reform moves forward…but what are the implications for …

- Health insurance regulations?
- Exchanges? 17 states and DC on target to run own; deadline extended
- Fate of subsidies?
- Medicaid expansion? Many states still opposed
- Medicare reform?
- Deals on budget, debt ceiling, sequestration, deficit reduction, tax reform?
Insurance Market Regulations

- Regulations of considerable consequence forthcoming in a number of areas, including
- Standards for qualified health plans
- Minimum standards for essential health benefits
- Age-rating (3:1)
Moving Ahead with Exchanges

- Marketplaces (web sites) for buyers of health insurance in both individual and small group markets

- Theory of exchanges: “managed competition” – insurers compete to provide benefits packages that are standardized so people can easily comparison shop

- Will offer a variety of certified health plans that offer the state’s version of “essential health benefits” and provide information and educational services to enrollees

- Exchanges to serve as enrollment “portals,” including for Medicaid and the Children’s Health Insurance Program

- Open enrollment to begin October 1, 2013
States still have to inform the Obama administration whether they plan to set up an exchange by November 16, the original deadline; but

States also now have an extra month to send the federal government “blueprints” for how they will have the health exchange up and running by 2014
Health Insurance Exchanges: Marketplaces for Individual and Small Group Insurance

- The States have options in setting these up: can make them
- Fully State-run
  - Statewide, Regional, or Sub-state
  - Individual, small business (together or separate)
- Fed-State Partnership (proposed options)
  - State takes on plan management only
  - State takes on consumer assistance only
  - State takes on plan management & consumer assistance
- Federally “facilitated” or fully Federally-run
Likely State Exchange Arrangements
As Of Nov. 2012
Small Business Health Options (SHOP) Exchanges

- In addition to an individual exchange, states must operate a SHOP exchange where small businesses can purchase health insurance.

- States can operate the SHOP exchange separately from individual exchanges, or merge the two.

- States can restrict eligibility to employers with 50 or fewer workers until 2016.

- In 2016, must open to employers with 100 or fewer workers.

- After 2017, states can open their exchanges to more than 100 workers.
Exchange Work to Be Done

- Governance
- Legal Authority
- Stakeholder Input
- Plan Benefit Design and selection of benchmark plan
- Plan Selection Strategy: active purchaser or open model
- Plan Rating Systems
- Provider Network Standards
- Role of brokers
- Role of navigators

- IT Infrastructure
- Billing Procedures
- Website and Call Center
- Outreach and Education
- Financing
- Fiscal Integrity

Certification Deadline is January 1, 2013.
Iowa’s Exchange?

- Gov. Branstad now says he’s in favor of state-run exchange

- Iowa Departments of Public Health, Human Services, Insurance Division and Governor’s office now leading exchange planning process

- State has received federal exchange planning and establishment grants of $35.4 million
The Supreme Court Ruling on ACA: Medicaid Expansion

- Medicaid expansion violates the Constitution by threatening States with the loss of their existing Medicaid funding if they decline to comply with the expansion.

- Constitutional violation is remedied by precluding Secretary of Health and Human Services to withdraw funds

- With this proviso, Medicaid expansion is constitutional

- But...states in effect have an option not to pursue expansion if they choose

- States weighing costs versus benefits – e.g., federal government picks up 100% of coverage costs for 3 years, dropping to 95% in 2017; 94 percent in 2018; 93 percent in 2019; 90 percent in 2020 and beyond
How Medicaid Enrollment Will Change by Median Income with Medicaid’s Expansion

Median Medicaid/CHIP Eligibility Thresholds, January 2012

- 250% for Children
- 185% for Pregnant Women
- 63% for Working Parents
- 37% for Jobless Parents
- 0% for Childless Adults
- 79% for Elderly and Individuals with Disabilities

Minimum Medicaid Eligibility under Health Reform - 138% FPL ($26,344 for a family of 3 in 2012)
Gov. Branstad has said he’s opposed to Medicaid expansion

Influx of federal funds to Iowa projected at $800 million annually

Additional 150,000 Iowans eligible – on top of 400,000 currently in program

Potential replacement for IowaCare waiver program scheduled to end in 2014
Medicaid Expansion and Iowa

- Iowa Hospital Association board voted August 2012 that Medicaid expansion was “appropriate public health policy for Iowa”

- Vital offset to estimated Medicare payment reductions of more than $2.3 billion over next 10 years under ACA
Who Will Be Helped?

Kaiser Commission On Medicaid And The Uninsured

FACES OF MEDICAID

NOVEMBER 2011

THE KAISER FOUNDATION
Congressional Elections

- House of Representatives:
  - Democrats 196 seats; Republicans 234; 2 Independents; 5 still undecided
  - Republicans lost at least 10 seats
  - 218 needed for majority

- Senate:
  - Democrats 53 seats, Republicans 47
  - Democrats picked up 2 seats, in Massachusetts and Indiana; Maine independent Angus King likely to caucus with them
The Fiscal Cliff and Prospects for A Major Deficit Reduction Deal

- If sequester goes into effect, 2% cut in Medicare; Medicaid held harmless; other across-the-board cuts

- Some possible scenarios being discussed: cuts postponed into next year; negotiations begin on larger package of deficit reduction/tax reform

- Republicans agree to revenue increases in exchange for..

- Deferral of implementation of Affordable Care Act by one year to save money on Medicaid expansion and subsidies in exchanges
The Fiscal Cliff and Prospects for A Major Deficit Reduction Deal

- Medicaid reform? Per capita cap; block grants?
- Medicare reform? Fix to Medicare physician payment issue?
- Tax reform: Further restriction on tax exclusion for employer-provided health insurance
“Prediction is very difficult, especially about the future.”

-- Danish physicist and Nobel Prize Winner Niels Bohr
Health Reform
Summary Views
“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”

--Bill Gates Jr.
“I don’t believe there’s any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can’t completely ignore.”

The Late Comedian
George Carlin
“The Americans always do the right thing...after they’ve exhausted all the other alternatives.”

Sir Winston Churchill
“There has never been a better time to be an Innovator in health care.”

--Don Berwick, former administrator, CMS 
Military Health System conference 
January 2011
“We always need to remember that behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time.”

The Final Verdict on National Health Reform?

“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”

--the late Jerry Garcia of the Grateful Dead
The End