THE UCLA CENTER FOR HEALTH POLICY RESEARCH

The Potential Impact of Health Care Reform in Los Angeles County

Beyond Health Care Reform: A Vision of the Future
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Goals of Health Care Reform

Improve Access to Health Care via Insurance Expansion

- 50.7 million uninsured estimated in 2010 (Census)
  - Improve access to primary and specialty care
  - Improve affordability of health care premiums and out-of-pocket spending
  - Pre-existing conditions and rescission practices

Reduce Spending in the Health Care System (i.e. "Bend the Cost Curve")

- $2.5 trillion dollars in overall spending (17.4% of GDP)
  - One-third of health care spending is attributed to fraud and waste
  - Overuse of services, geography and fee-for-service incentives are often blamed

Goals of Health Care Reform

Improve Quality and Patient Safety

- Reduce medical errors, improve outcomes, coordinate care
  - Reward providers and insurers for providing high quality care
  - Reduce Readmissions and Hospital-Acquired Infections

Improve Wellness and Health Behaviors

- Incentivize healthy behaviors and preventive services
- Reduce out-of-pocket costs for preventive services
- Address burden of chronic illness, obesity and other long-term cost drivers in the health care system

Expansion of Access :

- An individual mandate to have insurance coverage
  - $695 per person ($2,085 per family max) tax penalties levied by 2016 or 2.5% of income
- Creation of a state-based Health Insurance Exchange (HIE) for individuals and small businesses
  - Online marketplace of private for-profit and non-profit insurers for people in the individual market or small businesses, as well as all federal legislators
- Increase Employer Offer of Health Insurance
  - Employers with more than 50 employees subject to penalties
- Guaranteed Issue, Minimum Benefits, Community Rated premiums and Affordability Protections in the H.I.E.
  - Individuals would have premium subsidies (up to 400% of FPL)
- Increases in Medicaid eligibility levels (133% of FPL)
- Reinsurance program for employers providing early retiree benefits to those age 55+ (80% of claims from $15k to $90k)

Reductions in Cost:

- Reduced cost shifting through insurance mandate
  - Uncompensated care will be reduced, DSH Subsidies reduced
  - Mandated Medical Loss Ratio (80-85% of premiums spent on medical care)
- "Cadillac" Tax on employee plans with rich benefits
  - 40% excise tax on premium amounts over $10,200 for individuals or $27,500 for families
- Pilot and Demonstration Programs in Medicare and Medicaid
  - Innovation Center within CMS created to explore and test new payment methods
  - Accountable Care Organizations – incentives for integrated delivery (2012)
  - Encourage state programs for bundled payments (3 days prior and 30 days after hospitalization) and global capitation to safety net hospitals.
- Reduce waste, fraud and abuse via federal and state data sharing
- State insurance compacts to permit purchasing coverage across state lines

Quality Improvement :

- Value-based purchasing in Medicare
  - Will allow Medicare to compensate hospitals for meeting quality performance benchmarks (National Quality Improvement Strategy)
  - Independence at home demonstration projects that allow Primary Care teams to be paid based on Medicare savings
- Medicaid payment reform
  - Increased Federal Matching rate (90%) for programs to establish “health home” for high-risk enrollees
  - Increase in PCP Medicaid rates to Medicare rates in 2013 and 2014
- No federal funding can cover Medicaid claims for readmissions or healthcare acquired infections (HAI), similar to new Medicare policy
- New penalty for “excess” readmissions in Medicare
- Comparative Effectiveness Research
- Community Based Collaborative Care Network
  - Support coordination and integration between providers

Other Solutions in the PPACA:

- Prevention and Wellness Programs
  - Elimination of cost sharing for preventive services
  - Comprehensive health assessment and personalized prevention plans available to Medicare beneficiaries
  - Evidence-based prevention and wellness program guidelines
  - Chain restaurants and vending machines required to post nutrition info
  - Small business wellness grants
- Workforce Issues
  - 10% Bonus Medicare payments to PCPs from 2011 to 2015
  - Redistribution of unused specialty slots for primary care residency training
  - Train physicians to work in medical home or chronic care teams
  - Enhanced funding for increasing capacity and preparing NPs and PAs
- Encouraging Long-Term Care insurance purchasing
  - CLASS Act

Changes already starting…

- Children will not be excluded from the individual market due to pre-existing conditions
  - However, several insurance plans have said they will stop selling child-only policies on individual market
- No cost sharing for preventive services
- Adult children up to age 26 can be added to parent's plan
- Ban on rescissions
- State high-risk pools

Influencing Implementation

- Many provisions of the PPACA rely on the Secretary of the Department of Health and Human Services to propose rules
  - Official rulemaking process
    - Publication of Proposed Rule
    - Public Comment Process
    - Review and Inclusion of Comments (Secretary's Discretion)
    - Final Rule publication in the Code of Federal Regulations
  - Stakeholders should contact HHS prior to publication of proposed rule
    - To identify specific elements that need to be discussed or addressed
- States are responsible for enacting legislation to implement state programs
  - High Risk Pool, HIE, Medicaid State Plan Amendments, Waivers

Opportunities for State Innovation

- PPACA includes grants for states to develop new initiatives:
  - Creating the Health Insurance Exchange
  - Establishing Mechanisms for Rate Review
  - Establishing "Health Homes" for certain high-need Medi-Cal beneficiaries with 90% FMAP (2011-2012)
  - Grants for Insurance Rate Review
  - High-Risk Pool (separate from MRMIP)
  - University-based clearinghouse of payment data (UCR)
  - Risk Adjustment and Reinsurance
  - Increasing Medicaid rates for primary care (2013-2014) to Medicare – 100% FMAP

State Challenges prior to 2014

- State budget and complying with Maintenance of Effort in Medi-Cal and Healthy Families
- Implementing the state 1115 waiver in time of economic uncertainty
- Setting up the small group and individual Health Benefit Gateway (“the Exchange”)
  - California Health Insurance Exchange (AB 1602 / SB 900)
  - Setting the stage for insurance choices and competition
- High-Risk Pool: limited enrollment possible (PCIP)
- Physician shortage and maldistribution

State Challenges after 2014

- Compliance with the individual mandate
  - Adverse Selection, Pent-Up Demand
- Medi-Cal payment levels and physician participation (100% FMAP for 2013/14)
  - Can state maintain this level of reimbursement and is it worth it to expand the Medi-Cal provider network?
- Enforcing and calculating the Medical Loss Ratio
  - What counts and what will it do to plan design?
- How will regulation work
  - Exchanges (Individual/Small Group), Non-Exchange
  - DMHC and DOI

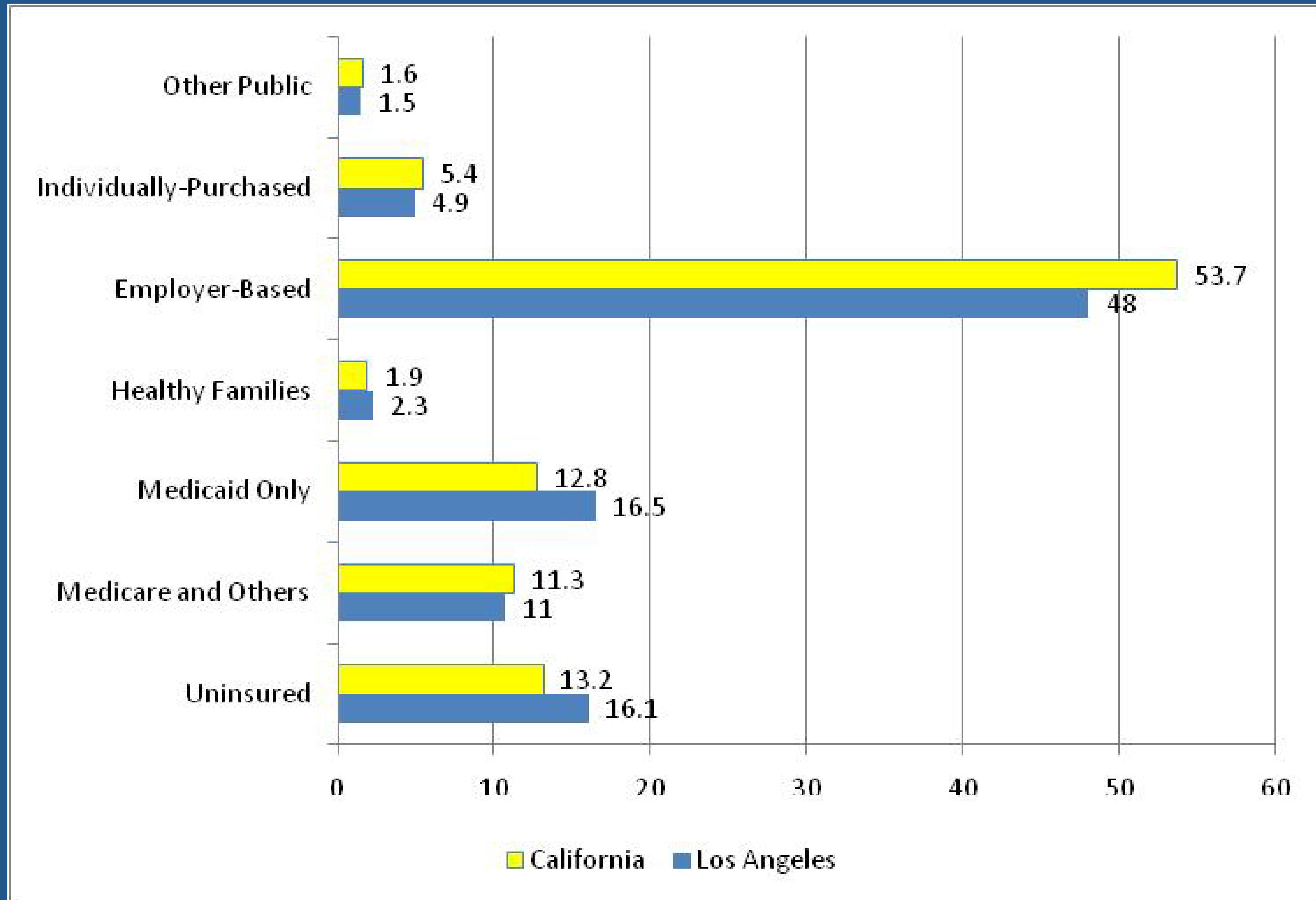
Federal Challenges

- The Individual Mandate
  - Sufficient penalties to encourage take-up
- Rate Review by federal government is limited
- Medicare Advantage Impact
  - How will bidding changes and quality incentives change offerings, cost sharing, and added benefits
- Disproportionate Share Hospital funding
  - Reductions in DSH payments vs. continued need for uninsured or underserved
  - Cost-Shifting may be limited by Medi-Cal changes, but fee increases are not permanent

Personal & Individual Challenges

- Shifting sources of coverage
  - Exchange, CHIP, Medi-Cal, and Employer-Based
  - Decision making for care and coverage
- Affordability
  - Close to 15% of Californians who do not receive subsidies (>400% of FPL) could be above the financial hardship threshold (100,000 or more individuals)
- Patient Navigation
  - Previously uninsured or underinsured individuals could have difficulty seeking or understanding primary care and medical home →pent-up demand

Insurance Status in Los Angeles and the rest of California



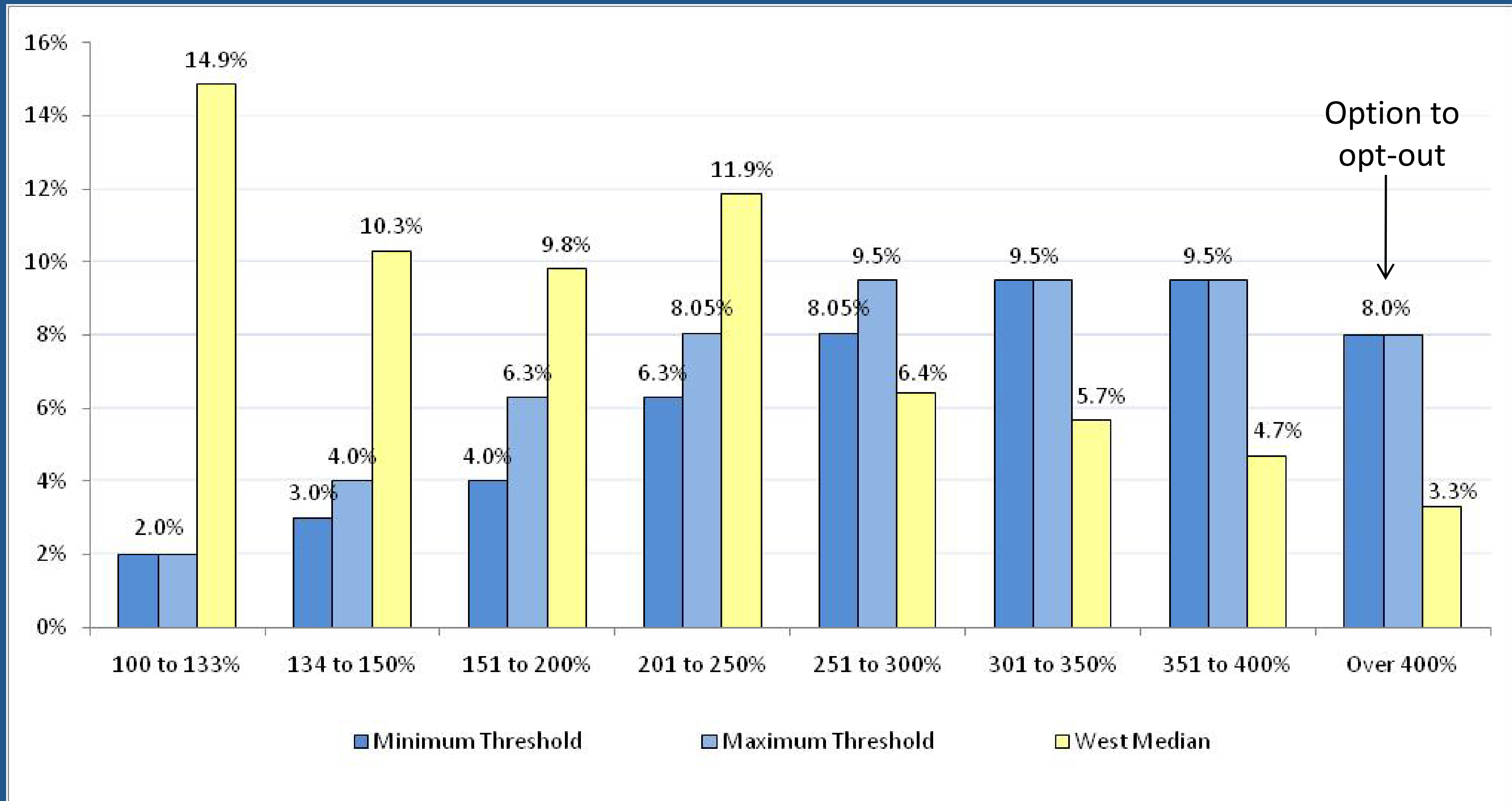
Source: 2007 California Health Interview Survey, www.askchis.com

Income and Potential Subsidy Eligibility for Currently Uninsured in Los Angeles County

Med-Cal Eligible	Basic Health Plan or Significant Subsidies	Eligible for Subsidies	Not Eligible for Subsidies
Less than 133% of FPL	134 to 200% FPL	201 to 400% FPL	Over 400% FPL
47.6%	19.9%	20.1%	12.5%

Source: 2007 California Health Interview Survey, www.askchis.com

Median Premium Spending by Individual Market Policyholders in comparison to PPACA Affordability Levels, Western U.S., 2010



Source: Analysis of the Medical Expenditure Panel Survey (MEPS) adjusted to 2010 Dollars by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center

Closing Thoughts

- Los Angeles, due to high rate of low-income uninsured stands to benefit
  - Medi-Cal expansion will be vital
    - workforce demands will need to be met
    - 100% FMAP only applies to new population of eligibles
- Reduction in DSH - 75% from 2014-2023
- New insurance choices in the Exchange
- Protecting immigrants
  - 5 year legal residents can join Exchange, but not Medicaid; undocumented excluded from both
- Remember, these are Authorized Programs, not Appropriations!

Questions?

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For information on the details of PPACA:

http://healthreform.kff.org/

www.healthreformgps.com

www.healthreform.gov

UCLA Extension Health Reform Short Course, Nov 13th from 9a-5p

- Sign up at www.uclaextension.edu/healthreform
- Discounts available for groups of 4 or more