

“ACA” Where Are We Now?

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Agenda

- Review of last week
 - Additional questions to answer
- State Exchanges
- Constitutionality Questions
- Impact on Medicare
- Impact on Doctors, Quality
- How Did We Get Here?!
- Conclusions
- Discussion
- Next year?

Additional Questions

- Website for Pre-existing conditions insurance: www.healthcare.gov
- Income levels for Part B premiums
- What's the current Federal Poverty Level
- Medicare questions
- Likely impact on doctors' role, quality of care
- Where did ACA come from?

Income levels for Part B (and D)

- Standard Part B premium now is \$99.90, which covers about $\frac{1}{4}$ the cost for a beneficiary.
- For married couples, filing jointly,

<u>if MAGI is</u>	<u>IRMAA</u>	
	<u>for Part B</u>	<u>for Part D</u>
– \$170K +	add \$40.00	\$11.60
– \$214K +	add \$99.90	\$29.90
– \$320K +	add \$159.80	\$48.10
– > \$428K	add \$219.80	\$66.40
- So couple with \$225K (MAGI) pays about \$400/month for Part B alone, about $\frac{1}{2}$ the cost.

Federal Poverty Level, 2011

- For the Lower 48 + D.C.
 - One person \$10,890
 - Two person family \$14,710
 - Three \$18,530
 - Four \$22,350
- So, 400% of FPL for family of four = \$89,400. Estimate for 2014 = \$93,699.

Part IV: State Exchanges

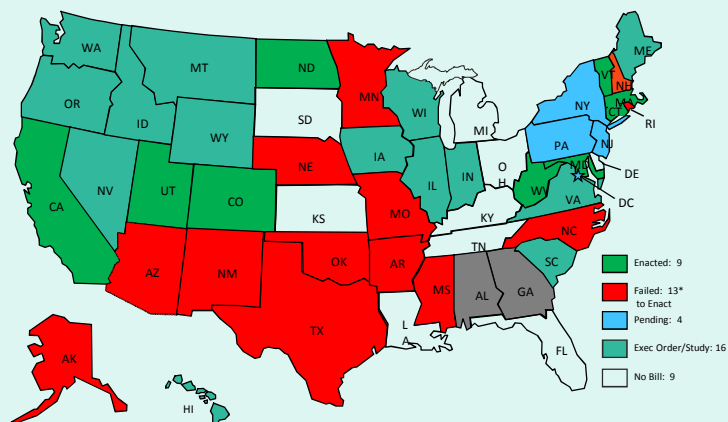
- Each State – one or two Exchanges, probably two.
- Small Biz Exchange for employers with <101 employees, at least until 2017
- Individual Exchange: a blend of Expedia and FEHBP
 - “Summary of Benefits and Coverage” (SBC) rule issued in August, 2011
 - Individual market expected to quadruple
 - How much subsidy do you get?
- Open season every fall; standardized information on prices, quality, networks, etc.

Exchanges (cont'd)

- Can be gov't agency or non-profit organization
- Exchange will not be only source of insurance, but
 - Only source of subsidy.
- If State does not set up the Exchanges,
 - Federal Gov't will do it. (The “Federally facilitated” option)
 - One glitch.
- Planning Grants
 - \$326 million so far
 - And \$250 million in “rate review” grants
- What's governing philosophy?
 - “Active Purchaser” or “Clearinghouse”?
 - Or Massachusetts v. Utah

Current Status of State Exchanges/State Legislation

For States that do not develop an Exchange approved by HHS by January 1, 2013, a Federal Exchange will be implemented.



* Governors support planning for market Exchange to preserve state control.

Source: Blue Cross and Blue Shield Association, August 18, 2011

Exchange Functions

- Define the Service Areas
- Determine eligibility of consumers
 - Citizens? Lawful residents? Medicaid eligible? Household income? Employed? Employers' benefit plan?
 - Need data from SSA, IRS, DOL, DHS
 - Redetermine annually and after any status change
- Establish appeals process for challenging eligibility determinations
- Set standards for “Qualified Health Plan”
 - Then an application process
 - Then select QHPs for next Open Season;
 - another appeals process
 - Then institute rate review program,
 - plus appeals process

Exchange Functions (cont'd)

- Set up website for consumers
- Set up public education program
 - Fund Navigator Program
- Premium aggregation system or no?
- Devise, implement risk adjustment system
- Assure self-sufficiency by 1/1/2015

Governors Worried

States need much new legislation, both re Medicaid and re ACA reforms, but ...

- Legislatures don't meet that often
- All the Federal Rules are not out yet
- Not enough experienced IT companies
- States under big financial stress in general
 - Not lots of extra staff

Benefits of Exchanges

- Market strength for individuals, small groups.
- Administrative cost savings
- Many choices, none bad.
- Comparative information easily available, transparent.
- Adverse selection mitigated via risk adjustment .
- Should attract new, innovative options
- Could achieve the goals of “managed competition;” could save private insurance.

The Challenges for Exchanges

- Information overload quite possible
 - KISS or else
- Gov't preferences can lead to “command and control” rather than market competition.

Part V: The Constitutionality Questions

- 5 District Courts
 - 3 to 2 in favor
- 4 Appeals Courts
 - 3 to 1 in favor
- 6 Petitions went before the Supreme Ct; seeking review of 5 issues:
 - 1. individual mandate
 - 2. is that mandate severable from the rest of ACA?
 - 3. is this case premature (the “AIA issue”)?
 - 4. the Medicaid expansion
 - 5. the employer mandate

Constitutionality (cont'd)

- 5 ½ hrs for oral arguments (probably March)
 - 2 hrs for individual mandate
 - 1 ½ for severability
 - 1 for AIA issue
 - 1 for Medicaid

Constitutionality (cont'd)

- Tenth amendment
 - Any power not given to the U.S. gov't is reserved for the States or the people
- Article I, section 8
 - Power to tax
 - Power to regulate interstate commerce
 - All laws “necessary and proper”
- If “penalty” is a “tax”, there’s no problem

Constitutionality (cont'd)

- Justice Dept: The penalty is a tax
 - It's part of the IRS code
 - To be enforced by the IRS
- Opponents: The penalty is not a tax
 - Congress said so
 - No revenue estimates were ever made
 - IRS cannot use its normal enforcement powers.
- Judge: I'm taking the Congress and the President at their word!

Constitutionality (cont'd)

- The crucial question (?): two views --
 - Is failure to buy a commercial activity?
 - Is mandate designed to regulate economic conduct?
- Both sides agree:
 - If mandate falls, the rest won't work.
 - But Court may not agree.
 - What did Congress intend?
- If mandate is upheld:
 - ACA goes forward, but ...
 - Can you be forced to buy broccoli?

Constitutionality (cont'd)

- Severability?
 - Guaranteed issue requires mandate, but ...
 - What about State Exchanges?
 - Essential benefits? Required preventive services?
 - Cover kids to age 26?
 - Medical Loss Ratio Rules?
 - ACOs?, PCORI?, IPAB? Closing Part D doughnut hole? Better pay for Medicare primary care docs? Many others

Constitutionality (cont'd)

- The AIA issue
 - Is the penalty a tax?
 - If so, then no review before 2015
 - Is the Court politically sensitive?
 - Could be explosive decision in a Presidential year
 - The AIA issue is an escape route

Constitutionality (cont'd)

- Medicaid
 - Congress cannot tell State Legislatures what to do, but
 - It can put conditions on Federal \$
 - But if conditions amount to compulsion, then
 - Congress is dictating to States
 - Which is unconstitutional
- So, do ACA Medicaid expansion rules amount to compulsion?

Constitutionality (cont'd)

- Legal opinions vary as to what the Supreme CT will rule, but tend (slightly) to support upholding the law. Why?
 - Historical Guiding principle: support Congress whenever possible
 - Who's on the Current Court

Constitutionality (cont'd)

- Prognostications
 - 1. Let's make it fast. By end of June
 - 2. Ginsburg, Breyer, Sotomayor, Kagan
 - Likely on the same side
 - 3. Roberts, Scalia, Alito, Thomas
 - Likely on another side
 - 4. Whither Justice Kennedy?
- Last Case re Interstate Commerce powers: 2005.
 - Four of today's Justices were not on the Court

Constitutionality (cont'd)

- Suppose mandate is struck down –
 - If Democrats have enough power
 - Just tweak the law
 - If Republicans have the power
 - No tweaks, just burial
 - Then what?
- Wyden waiver?

Medicare Questions

- Direct Impact of ACA on Medicare
 - Pay for reform
 - Medicare Advantage Plans (Part C)
 - Payment update formula
 - “Doc Fix” (Sustainable Growth Rate, or SGR)
 - Tax hikes on high income (to 2.35% on wages + 3.8% on unearned income)
 - Closing the Doughnut hole (Part D) by 2020; 50% discount on brand name drugs.
 - Pay primary care docs more, through 2015.
 - Penalties for Hospital readmissions and nosocomial infections
 - Lots of R & D re new payment methods
 - New push on fraud and abuse (a Medicare perennial)
 - Independent Payment Advisory Bd. (IPAB)

Some history behind IPAB

- Medicare costs: consistent annual increases higher than CPI – heading for disaster.
- The Medicare Payment Advisory Committee (MEDPAC) annually recommends cuts or changes to slow the rise
- Congress annually says no, such changes might upset their constituents, especially doctors, or hospitals, or elderly, etc.
- So, cuts are not made, the beat goes on.

ACA's answer: The Independent Payment Advisory Board

- 15 Member Board of Experts
 - Plus three from HHS, ex-officio
 - Full time job, six year term; Senate confirmation.
 - Can hire staff outside civil service rules
 - Unusual powers vis-à-vis Congress
- When Medicare Actuary projects \$ growth (for 2015 ++) above a specified target rate ...
 - IPAB must submit proposed cuts to meet target
 - Congress must approve, or find equal cuts, or get out of the way (tight specified timelines)
 - HHS must implement (unless Congress finds better alternative, quickly)

ACA Constraints on IPAB

- Don't touch rates for hospitals or hospices for the next ten years
- Recommendations must not result in rationing of care
- Must not raise revenues, premiums or cost-sharing
- Must not restrict benefits
- Must not modify eligibility requirements, or make any structural changes to Medicare
- What's left?!

Advantages

- “Puts the knife in someone else’s hand.”
- Allows Congressmen to rant against the cuts, but not stop them
- Could greatly influence the private sector
 - Both in controlling prices for private payers
 - And in increasing cost shifting to private payers

Disadvantages

- Cannot attack the heart of the problem, the structure.
- Effectiveness implausible
 - Congressional Committee Chairs don’t like it.
 - Reduces their power (and fundraising potential)
 - Lobbyists/providers don’t like it.
 - Reduces their access to policy making
 - Could lead to “rationing,” “death panels”, etc.
- May have short life. See Sen. Cornyn’s bill: “The Healthcare Bureaucrats Elimination Act.”
 - Co-sponsored by four Republican Senators
 - Target: The IPAB
 - “The IPAB is the definition of a gov’t takeover”
 - Gov’t takeover of Medicare?!?!
 - Translation: IPAB takes over Congressional responsibility

If the IPAB survives, can it work?

- Questions
 - Board members?
 - Heavily academic (the experience, philosophy that entails)
 - Will they trade research, practice, teaching for 6 yrs (for \$165K/yr)?
 - Forced to focus on short-term?
 - Congressional barons' responses?
 - SGR history?
 - Is their explicit task possible, to cut payments while maintaining access and quality?
 - Major cost shift?
 - Leads to All-payer system?

Impact on Doctors' Role, Quality

- National Strategy for Quality Improvement in Healthcare.
- Massachusetts experience
- Accountable Care Organizations (ACOs)
- Patient-Centered Outcomes Research Institute (PCORI)

Why PCORI?

- Less than 50% of U.S. delivered healthcare is “evidence-based”
 - It’s based on “professional opinion,” not peer-reviewed science
 - At least 1/3 of U.S. healthcare is unnecessary. [Which 1/3?!]
- “Evidence-based” procedures usually are known to work for white males.
 - Minorities and women are not usually the subjects of the research
 - Even among white males, the evidence varies widely
- Need major new investment in “comparative effectiveness research” (CER)
 - Mostly sophisticated, expensive research
 - All parties should contribute to it.
 - Without it, cost reductions will be across the board

So Who’s Afraid of CER?

- Doctors’ organizations
 - Threat to doctor autonomy, professional opinion
- Drug and device manufacturers
 - Comparative data can be bad for business
- Disease Advocacy Groups
 - CER could lead to restrictions on costly treatments for our diseases.
 - Could slow innovation; make docs “risk adverse”
 - If “evidence-based” medicine not done, malpractice risk rises
- Conservatives
 - Could lead to Gov’t takeover
 - Gov’t could “pull the plug on Granny”
 - It’s NICE! (Nat’l Institute for Clinical Excellence) And could lead to QALYs!

What's the ACA Answer?

- Create new Institute independent of gov't
 - Non-governmental, non-profit entity: The Patient-Centered Outcomes Research Institute.
- Make its board represent all special interests
 - Seats at the table for all who worry
- Make its operations fully “transparent”
 - Publicize all potential conflicts of interest
- Make its funding assured, independent of special interests
- Prohibit its findings from becoming policy
 - Informational only

The Board of PCORI (sounds like Italian goat cheese)

Board named in September, 2010.

3 consumers/patients;
 7 providers [4 docs (at least one surgeon), 1 nurse, 1 hospital rep, 1 “integrative health practitioner”],
 3 private payers,
 3 reps of pharma, device and diagnostic manufacturers,
 1 “independent health services researcher”
 2 gov't reps (at least one Fed),
 + heads of NIH and AHRQ

Constraints on PCORI

- Focus all on clinical effectiveness, without attention to costs.
- Must make research findings promptly available to all, in understandable language
 - But must not include any practice guidelines, coverage recommendations, payment or policy recommendations
- Concerning Medicare, Secretary is prohibited from using findings in any way to put lower value on life remaining to elderly, disabled, or terminally ill
 - Compared to younger, non-disabled, healthier person
 - Though that limitation “shall not be construed to ...”
- Shall not develop or use measures that relate to “dollars per quality adjusted life years”

How Did We Get Here?

- Long history of reform efforts
 - Many ideas from Clinton (1993) carried forward.
- 2008: Reform in both party’s platforms
 - Much agreement on mostly secondary issues
 - But both included subsidies for low income
 - Dems: mandated access; employers play-or-pay; health care system as is; gov’t imposed cost control; Medicare is the model
 - Repubs: change incentives to control costs; empower consumers; get employers out; more competition; FEHBP + HSAs is the model
- Democrats won the election.

He we got here (cont'd)

- Obama: My top domestic priority
- Congress, take over!
 - House and Senate bills, hearings, wrangling
 - November: House passes bill, 220-215
 - December: Senate passes bill with 0 Repubs
 - January, Mass: Kennedy seat goes to Republican; Dems no longer have 60 votes in the Senate.
 - March, Pelosi-Reid find way around Senate
- March 23, 2010. PPACA becomes law, with no Republican support.
- November, 2010. Dems lose the House.

Conclusion

- From legislation on this scale
 - Expect the unexpected.
- Let's hope ACA succeeds
 - It can be made to work, and
 - Alternatives will probably be worse
- ACA can be implemented to go either way
 - Toward Exchange-based market competition under strict rules, or
 - Toward a one-size fits all public utility