Title
Affordable Care Act, Health Care Policy Online Interactive Education Module and "The Hart Project" California State Capitol Legislative Summer Internship

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Government Basics
Federal Level
Learning Objectives

- The student should review and feel comfortable with the fundamental structure of the federal government.

- The student should have a basic understanding of the checks and balances in place between the three branches of the federal government.

- The student can take the opportunity to familiarize him/herself with San Diego County’s congressional representatives, as well as access voter registration materials.
President of the United States
- Elected every 4 years by the electoral college (2 term limit)
- Sign or veto legislation passed by Congress

Supreme Court
- 9 supreme justices nominated by the president
- The Supreme Court can find legislation unconstitutional

Congress
- The House of Representatives
  - 435 representatives
- The Senate
  - 100 representatives
- Pass Legislation
- Can override Presidential veto
The House of Representatives

- The lower chamber of Congress
- The House has been fixed at 435 seats
  - Seats are divided by the 50 states based on the census, with a minimum of one per state
  - Based on the most recent census, California currently has 53 representatives
- Congressmen/women serve 2 year terms with no term limits
- The House has 20 standing committees with different jurisdictions
  - Committees consider and draft bills for issues and recommend measures for consideration by the House
- Visit http://www.house.gov/committees/ for more information about House committees
San Diego’s Congressional Districts and Representatives

https://www.govtrack.us/congress/members/CA
The Senate

- The upper chamber of Congress
- 100 seats divided equally between the 50 states
- By law, a simple majority is needed to pass a bill through the Senate
- In the vast majority of cases, a Supermajority (three-fifths of the Senate) is needed for a bill to pass
  - A supermajority limits debate and prevents filibustering
- Senators serve 6 year terms with no term limits
  - A third of the electorate runs in each biennial election
- Like the House, the Senate has 20 committees
  - There are also 4 Joint Committees that have both House and Senate representatives
  - Senate Caucuses are more informal groups with members that have shared interests
- Visit [http://www.senate.gov/committees/committees_home.htm](http://www.senate.gov/committees/committees_home.htm) for more information
Passing a federal law involves checks and balances from each branch of government

- The legislative branch is responsible for the drafting and passing of new laws
  - Bills go through Congressional committees before being voted on the floor
  - Bills that originate in the House and pass, must then pass the Senate, and vice versa
  - In most cases, a joint congressional committee will reconcile differences between House and Senate versions of a bill
- The president can sign or veto a bill passed by both chambers
  - A presidential veto can be overridden by a 2/3 vote in each chamber
- The Supreme Court can rule laws passed by the other two branches as unconstitutional by a majority vote
Example: The Affordable Care Act

House committee drafts initial healthcare reform bill

The bill goes to the floor of the House of Representatives as H.R. 3926

The bill is signed into law by President Obama on March 23, 2010

Patient Protection and Affordable Care Act

The Senate revises the bill to the America’s Healthy Future Act

The Senate version goes back to the House

Upheld as constitutional by the Supreme Court on June 28, 2012

Passes 220 to 215

Passes 218 to 212

Passes 60 to 39
Importance of the Affordable Care Act

- While the affordable care act was signed over six years ago, controversy surrounding the Affordable Care Act and its implementation is still a main focus in the political arena.

- As a future physician, you will find that friends, family, and patients seek your opinion as healthcare policy continues to evolve.

- It is important to have a basic understanding of this legislation and its impacts, as it will directly affect your future practice and patients.

- We’ll discuss the Affordable Care Act further in Module 5 to help get you started!
Are you registered to vote?

- The next Presidential and Congressional Elections are Tuesday, **November 8, 2016**.
- You can register to vote online at [http://registertovote.ca.gov/](http://registertovote.ca.gov/)
  - The registration deadline is **October 15, 2016**.
- Already registered? You can confirm your registration at [http://www.sos.ca.gov/elections/registration-status/](http://www.sos.ca.gov/elections/registration-status/)
Module 1 Complete...

Proceed to Module 2
Learning Objectives

- The student should review and feel comfortable with the fundamental structure of the California State government.

- The student should have a basic understanding of the roles and responsibilities of State Senators and Assembly members.

- The student can take the opportunity to familiarize him/herself with San Diego County’s senate and assembly representatives. They will be familiar faces if the student gets involved in advocacy efforts!
Governor
- Elected every 4 years by popular vote (2 term limit)
- Sign or veto legislation passed by the legislative branch
- Responsible for the state budget

Supreme Court of California
- Distinct from Federal Court System
- 7 Justices nominated by the governor
- The State Supreme Court can find state legislation unconstitutional

California State Legislature
- Assembly members
  - 80 district representatives
- State Senators
  - 40 district representatives
- Pass Legislation
- Can override governor’s veto

Executive

Judicial

Legislative

California State Government
(parallels federal government structure)
California State Assembly

- The lower house of the Legislature
- 80 seats, districts drawn based on population
  - Currently, assembly members each represent around 465,000 Californians
- Members of the California Legislature elected after 2012 are limited to a total of 12 years in the Assembly and/or the Senate
  - Prior to 2012, assembly members were limited to three 2 year terms
California State Senate

- The upper house of the Legislature
- 40 Senators, with districts drawn based on population
  - Each senator currently represents about 930,000 Californians
- Members of the California Legislature elected after 2012 are limited to a total of 12 years in the Assembly and/or the Senate
  - Prior to 2012, senators were limited to two 4 year terms
San Diego County State Senators

Joel Anderson (R)  
District 38

Patricia C. Bates (R)  
District 36

Ben Hueso (D)  
District 40

Marty Block (D)  
District 39

http://senate.ca.gov/senators
State Legislative Process

- Article X of the Constitution gives state governments the right to pass laws concerning powers not specified as those of the federal government.
- The legislative branch is responsible for the drafting and passing of new laws.
  - Bills are authored by assembly members or state senators, and then introduced on the floor of the corresponding house.
  - After 30 days, the bill is assigned to the appropriate committee for policy review.
  - If the bill requires allocation of funds, it will also go to the fiscal committee.
- The bill is heard on the floor again after committee review.
- The bill is voted on the third time it is heard on the floor.
- Bills that originate in the Assembly and pass, must then pass the Senate, and vice versa.
- The governor has 12 days to sign or veto bills passed by both houses.
  - A governor’s veto can be overruled by a 2/3 vote in each house.
- The State Supreme Court can rule laws passed by the other two branches as unconstitutional by a majority vote.
Ballot initiatives are proposed laws added to the ballot to be voted on during a general state election.

There are two ways an initiative can appear on the ballot:

1. The Legislature has the ability to place constitutional amendments, bond measures, and proposed changes to current laws on the ballot.

2. Any California voter can put an initiative or referendum on the ballot by getting a required number of signatures:
   - Currently, 365,880 signatures are required for a statute to be added to the ballot (5% of the electorate).
   - 585,407 signatures are required for a Constitutional amendment to be added to the ballot (8% of the electorate).

Other states with ballot initiatives include: Maine, Massachusetts, Michigan, Nevada, Ohio, Utah, Washington, and Wyoming.

A referendum is similar to an initiative, but is a proposed change to a law or part of a law that is already in place.

A simple majority of the electorate is needed to pass a ballot initiative or referendum.
Module 2 Complete…

Proceed to Module 3
Learning Objectives

- The student should be able to understand the various insurance fees a patient must pay in addition to their yearly premiums when healthcare services are received.

- The student should understand the different types of health plans offered and their respective strengths and weaknesses.

- The student should understand where patients get private insurance from and the strengths and weaknesses of each approach.
Private Health Insurance Marketplace

- UnitedHealthcare
- Humana
- BlueCross BlueShield
- Cigna
- Aetna
- Kaiser Permanente
Health Insurance Literacy

- **Co-payments**: a flat fee paid when a healthcare service is received
  - This gives the patient “skin in the game” and attempts to limit overuse

- **Annual deductible**: the amount the patient is responsible to pay before the plan begins covering services in each category (i.e. medical vs. pharmacy benefits)

- **Co-insurance**: once a patient meets the annual deductible, the patient pays a percentage of healthcare costs incurred going forward (i.e. patients pays 20%, plan covers remaining 80%)
  - The patient will pay this percentage until the maximum annual out-of-pocket cost is reached

- **Maximum annual out-of-pocket costs**: this is the set amount that caps what the patient will have to pay in total that year for health related expenses
  - This includes all deductibles, co-payments, and co-insurance paid by the patient
History of U.S. Private Health Insurance

- The first hospital and medical plans offered by insurance companies either paid a fixed amount (scheduled benefits) or a percentage of the provider’s fee
  - Referred to as Indemnity / Fee for Service model
- The patient was responsible for paying the provider for services rendered, and if covered by the insurance policy, the patient would be reimbursed by the insurance company (reimbursement benefits)
- However, by the 1970’s, healthcare costs were rising drastically with indemnity plans
  - This caused a shift towards a more managed, centralized approach to healthcare financing and delivery
The Rise of Managed Private Healthcare

- Managed care: the term stems from techniques instituted to reduce the cost of healthcare delivery while at the same time improving the quality of care.


  - The bill defined a federally qualified HMO as an entity that could collect a premium (subscription fee) and, in exchange, would allow subscribers access to a network of previously contracted providers and facilities.
Managed Care Strategies

- Creation of a network of providers to integrate care delivery
- Standards for selecting providers to include in network
- Continuous quality improvement and utilization review
- Huge emphasis on preventative care
- Financial incentives on both sides (provider & beneficiary) to deliver/utilize care more efficiently
Types of Health Plans Offered

- Health Maintenance Organizations (HMOs)
- Exclusive Provider Organizations (EPOs)
- Point of Service Plans (POS)
- Preferred Provider Organizations (PPOs)
- High Deductible Health Plans with linked Health Savings Accounts (HDHP w/ HSA)
Health Maintenance Organizations (HMOs)

- An HMO delivers all health services within a pre-arranged network of healthcare providers and facilities.
- Patients are assigned a primary care provider (PCP) who must act as a “gatekeeper.”
- Patients will need referrals from PCP to see specialists for care to be covered by the plan.
- If care is delivered out of network, the patient is responsible for the full bill.
  - Out-of-network emergency services are covered at in-network rates.
- Benefits - cheaper than other plans, continuity of care from PCP.
- Disadvantages - the least freedom in choice of providers, requires referrals.
Exclusive Provider Organizations (EPOs)

- Similar to an HMO, enrollees must use in-network providers (same exception for emergency care).
  - If care is delivered out of network, the patient is responsible for the full bill.
- Unlike an HMO, patients do not need to select a PCP and do not need referrals to see specialists within network.
- Benefits - more choice than HMOs, cheaper than PPOs.
- Disadvantages - still must remain in network, pricier than HMOs.
Point of Service Plans (POS)

- Similar to an HMO, it covers services rendered within a network of contracted providers
- A PCP selection is required
- To benefit from the lowest out-of-pocket costs, care should be sought within network and specialist should be seen after obtaining a referral from PCP
- If non-emergent care is obtained out-of-network, patient will pay larger percentage of bill than if in-network or if referred out
- Benefits - control over cost with more flexibility over choice of provider
- Disadvantages - can be quite costly if care not obtained in network
Preferred Provider Organizations (PPOs)

- Do not need to select a PCP
- With a PPO, you receive the most comprehensive benefits using a provider who is in-network (i.e. lower out-of-pocket costs)
- You have the choice to use an out-of-network provider, however you will have lower benefits and higher out-of-pocket costs
- Since they usually have broader networks, they tend to have higher premiums
- Benefits - the most flexibility in choice of provider, no need for referrals
- Disadvantages - more expensive than HMOs, EPOs, or POS plans
High Deductible Health Plans with linked Health Savings Accounts (HDHP w/ HSA)

- A Health Savings Plan (HSA) is a tax-advantaged medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan (HDHP).

- In 2016, the IRS set the maximum contribution to an HSA at $3,350 for self-coverage and $6,750 for family coverage.

- The 2016 minimum deductible for a self-coverage HDHP was $1,300 or $2,600 for family plans and maximum out-of-pocket cost at $6,550 for self and $13,100 for family plans.
  - Think of these as catastrophe plans intended to cover catastrophic illnesses.
  - Primary care and specialist visits would mostly be paid out of pocket.

- Funds contributed to this account are not subject to yearly federal income taxes at the time of deposit, thus the tax advantage.

- HSA funds may be used for qualified healthcare expenses at any time without incurring a federal tax liability or penalty.

- HSA funds roll over year to year, therefore accumulating for future needs.

- Withdrawals for non-healthcare related costs incur penalties very similarly to Individual Retirement Accounts (IRAs) if funds are withdrawn before the age of retirement.

Employer Based Coverage

- Employer sponsored health insurance = **55.4% of U.S population**
- ~85% of health insurance premiums are paid by the employer as a part of an employee benefits package
- The employee pays the remaining ~15% using pre-tax/tax exempt earnings

**Benefits**

- **Economies of Scale**
- **Lowered administrative costs with large pooled groups vs. individuals**
- **Reduction in adverse selection**
  - Premiums are lower when all employees are enrolled/pay rather than just the sickest
- **Reduced income taxes (enrollees can use pre-tax dollars to pay their portion of insurance premiums)**

**Disadvantages**

- **Disruption of care when employment changes / termination**
- **Increased healthcare spending (enrollees pay only a portion of costs, thus tend to over-utilize)**
- **Regressive tax in nature**
  - High income earners benefit more when using pre-tax dollars

### Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Conventional</th>
<th>HMO</th>
<th>PPO</th>
<th>POS</th>
<th>HDHP/SO</th>
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<tbody>
<tr>
<td>1988</td>
<td>73%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>27%</td>
<td>46%</td>
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</tr>
<tr>
<td>1996</td>
<td>10%</td>
<td>31%</td>
<td>21%</td>
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<tr>
<td>1999</td>
<td>8%</td>
<td>29%</td>
<td>28%</td>
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<tr>
<td>2000</td>
<td>7%</td>
<td>24%</td>
<td>46%</td>
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<td>2001</td>
<td>4%</td>
<td>27%</td>
<td>52%</td>
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<td>5%</td>
<td>24%</td>
<td>54%</td>
<td></td>
<td></td>
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<tr>
<td>2003</td>
<td>5%</td>
<td>25%</td>
<td>55%</td>
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<td></td>
</tr>
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<td>2004</td>
<td>3%</td>
<td>21%</td>
<td>61%</td>
<td></td>
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</tr>
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<td>2005</td>
<td>3%</td>
<td>20%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>3%</td>
<td>21%</td>
<td>57%</td>
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</tr>
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<td>2007</td>
<td>2%</td>
<td>20%</td>
<td>58%</td>
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<td>2008</td>
<td>1%</td>
<td>19%</td>
<td>58%</td>
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</tr>
<tr>
<td>2009</td>
<td>1%</td>
<td>17%</td>
<td>55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>1%</td>
<td>16%</td>
<td>56%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>1%</td>
<td>14%</td>
<td>57%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>1%</td>
<td>14%</td>
<td>58%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>1%</td>
<td>13%</td>
<td>58%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>&lt;1%</td>
<td>13%</td>
<td>58%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>1%</td>
<td>14%</td>
<td>52%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

Individually Purchased Coverage

- Individually purchased health insurance = **14.6% of U.S population**

- Healthcare exchanges: consumers purchase government regulated/standardized health plans from the government run marketplaces and depending on income level may qualify for premium assistance
  - Annual incomes between 134% - 400% of 2015 FPL ($15,654.10-$47,080 for individuals) qualify for premium assistance through tax credits
  - Tax credits can be used immediately to lower monthly premiums or compiled and deducted at year’s end to lower tax burden

- Direct purchase: the consumer pays the entire premium without employer contribution
  - Average out-of-pocket expenses are higher, with higher deductibles, co-payments, and co-insurance than their employee-insured or exchange-purchased counterparts
  - For self-employed individuals, health insurance premiums paid are 100% tax deductible
Module 3 Complete...

Proceed to Module 4
Health Insurance
Public Marketplace
Learning Objectives

- What is Medicaid, how is it funded, who does it cover, and how many at what cost?

- What is Medicare, how is it funded, who does it cover, and how many at what cost?

- The student should have a general understanding of the four parts of Medicare and be able to name 3 key differences between Medicaid and Medicare.
Current State of U.S Health Insurance

- The Current Population Survey discovered that the percentage of people with health insurance for all or part of 2014 was **89.6%**
  - Employment based insurance = **55.4%**
  - Medicaid = **19.5%**
  - Medicare = **16.0%**
  - Direct purchase = **14.6%**
  - Military health care = **4.5%**

* >100% because some purchase private in addition to their entitled public insurance

U.S. Public Health Insurance

- ~35.5% of U.S population receives socially funded healthcare (i.e. single-payer public health insurance)

- The two largest single-payers are programs called Medicare and Medicaid
  - Medicaid / CHIP - over 71.6 million beneficiaries as of May 2015 (19.5% of U.S population)
  - Medicare - over 55.5 million beneficiaries as of year end 2015 (16% of U.S population)

http://kff.org/state-category/medicare/
What is Medicaid?

- Medicaid is a means tested social welfare healthcare program that covers numerous services set aside for families and individuals with low incomes and limited resources or those with certain disabilities who are U.S. citizens or legal residents.

- It is jointly funded 50/50 by the federal and state governments, but administered solely by the respective states.

- The federal government sets minimum guidelines for eligibility, however, states can choose to expand coverage beyond that minimum threshold.

- Total U.S. Medicaid spending was $492.3 billion and $63.9 billion of that was spent solely in California in 2014 (i.e. Medi-Cal).

http://kff.org/medicaid/state-indicator/total-medicaid-spending/
Children’s Health Insurance Program (CHIP)

- CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.
- Every state offers CHIP coverage, but terms of coverage vary.
  - Some states have co-pays for certain services and/or monthly premiums.
- In some states, CHIP covers parents and pregnant women.
- Routine "well child" doctor and dental visits are free under CHIP.
Before the ACA, federal funding for Medicaid was only for specified categories of low-income individuals:

- Children (through CHIP)
- Pregnant women
- Parents of dependent children
- Individuals with certain disabilities
- People aged 65+

Lower income adults not meeting above criteria and not eligible for Supplemental Security Income (SSI) were largely ineligible prior to ACA.

We will discuss the Affordable Care Act and its effect on Medicaid in detail in Module 5.
Medicare: What is it?

- Medicare is an example of a **social insurance program paid for solely by the federal government**.
- It serves U.S. citizens or legal residents **65+ who have paid taxes into the Medicare system**.
- It also serves **younger individuals with certain disabilities and chronic disease** (e.g. end-stage renal failure, hospice care, and ALS).
- It is broken into **4 parts** (Medicare Part A, B, C and D).
**Original Medicare - Parts A & B**

- **Medicare Part A (Hospital Insurance):** Covers inpatient hospital stays or brief skilled nursing facility stays following hospital admission.
  - If you are eligible for social security (i.e. paid taxes into the system), you do not pay a monthly premium for Part A, but there is a deductible for inpatient stays.

- **Medicare Part B (Medical Insurance):** Covers outpatient expenses, labs, imaging, screenings, and long term supplies.
  - A monthly premium is charged and it varies based on income level.
  - There is also a deductible that needs to be met, typically with 20% coinsurance afterward.
Medicare Part C

- **Medicare Part C: Medicare Advantage**

  - Purchased through a private provider who is contracted through Medicare and typically covers all aspects of Original Medicare.

  - Since these private plans are a form of *managed care*, they are often *cheaper* (i.e. smaller deductibles, cheaper coinsurance) or can provide *more additional benefits* (e.g. eye exams, hearing aids, dental, coverage while abroad) than those covered by Original Medicare.

- **It is optional**

  - Patients have the choice between non-HMO Fee For Service with Original Medicare or HMO managed care with Medicare Advantage.

- **Purchasers must still pay their Part B premiums** to enroll in these Part C health plans.
Medicare Part D

- Medicare Part D: Prescription Drug Benefits
  - Anyone with Medicare Part A&B is eligible for Part D
  - The plan is regulated by Medicare but administered by a private health plan or pharmacy
  - Created in 2006 to help seniors pay for the rising cost of prescription drugs not covered under Original Medicare
  - The benefits are not standardized and different plans can cover different drugs and various prices
Medicare Enrollment Continues to Rise

The total number of US Medicare beneficiaries has increased by 13.4% in 4 years. The table below shows the number of beneficiaries from 2011 to 2015:

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>48,944,303</td>
<td>50,828,094</td>
<td>52,506,598</td>
<td>54,095,565</td>
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</tr>
</tbody>
</table>

Source: [Kaiser Family Foundation](http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/#graph)
Medicaid vs. Medicare

- Medicaid is mostly for **low income adults and children**
- Medicare is mostly for **senior citizens (65 years +)**
- Medicare is 100% federally funded and run vs. Medicaid which is funded equally between the two and run exclusively by the states
- Medicaid reimburses providers a fraction of what Medicare pays them for the same services (we’ll discuss reimbursement more in module 7)

[Medicaid to Medicare Fee Index](http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/)
Module 4 Complete…

Proceed to Module 5
Learning Objectives

- The student should be familiar with the main components of the Affordable Care Act.

- The student should have a basic understanding of Medicaid and the populations it provides for.

- The student should understand the limits to the implementation of the Affordable Care Act and how some Americans have fall into a “coverage gap.”
The Affordable Care Act: Background

- The Affordable Care Act (ACA) was signed into legislation by President Obama in 2010 with implementation scheduled through 2018.

- This legislation has been hotly contested and issues with its implementation have been a focus of media attention.

- The purpose of this module is to take a look at some of the key elements of the ACA and how its implementation is taking shape.
ACA Prevention and Quality

- Establishment of the Prevention and Public Health Fund
  - $5 billion for 2010 through 2014 and $2 billion for each subsequent year to support prevention and public health programs
  - Included funding for increasing the supply of Primary Care Providers

- Creation of the National Prevention, Health Promotion, and Public Health Council
  - The council’s purpose is to develop a national prevention, health promotion and public health strategy

- Grants for employer-based wellness programs
- Preventative care covered in premiums
- Requires nutrition labeling on menu at chain restaurants
- Focuses on quality measures
  - Allows the formation of Accountable Care Organizations (ACOs)
    - Merging of hospital groups and providers with the goal of improved quality
  - Changes in hospital payments based on quality measures rather than productivity
Health Insurance under ACA

- Adult dependent coverage increased to age 26
- Pre-existing Condition Insurance Plan
- Requires insurance plans to include preventative services (no cost-sharing) that are rated as an A or B by the US Preventative Services Task Force
  - ex: immunizations and contraception
- Requires insurance companies to spend 80-85% of premium dollars on clinical services and quality, with rebates to consumers if less than this measure is spent in a fiscal year
- Prohibits lifetime coverage limits
- Federal funding for the establishment of state Health Insurance Exchanges
- Online consumer platform at healthcare.gov
Health Insurance under ACA as of 2014

- Created state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP)
  - Platform for individuals and businesses less than 100 people to purchase health insurance
  - Government subsidies via tax credits for individuals/families making between 100% and 400% of the Federal Poverty Line
- Prohibits lifetime and annual coverage limits
- Guaranteed availability of insurance
  - Can buy regardless of health condition and renew annually
  - Rating to be based only on age, geographic region, family composition, and tobacco use
    - Limits a 3:1 ratio in premiums based on age
    - Limits 1.5 to 1 ratio for smoking
- Individual requirement to have health insurance
  - Phased-in tax penalties for the uninsured
- Employer requirements
  - Tax penalties for not providing employee insurance
ACA Changes to Medicare

- Reduction in Medicare payments (productivity adjustments)
- Established a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures
- Reduced payments for preventable hospital readmissions (bounce-backs)
- Pilot program for bundle payments
  - We will discuss more about reimbursement types/strategies in Module 7
- Reduced payments to hospitals with above-average rates of hospital-acquired infections
ACA Changes to Medicaid and CHIP

- Provided funding to expand eligibility of both Medicaid and CHIP
  - Expanded Medicaid to anyone not eligible for Medicare and under 138% of the federal poverty line
  - Increased PCP payment rates to 100% of Medicare rates (100% federally funded for 2 years)
  - Increased CHIP’s federal match rate
  - Expanded states ability to fund home and community-based health services
  - Expanded federal funding for non-institutional long-term health services
- 3-year grant funding for state development of chronic disease prevention models for Medicaid enrollees
  - Centers for Medicare and Medicaid Innovation
- Prohibits federal payments to states for Medicaid services related to hospital-acquired infections
- Established the Federal Coordinated Health Care Office to improve coordination of patient eligible for both Medicaid and Medicare
Medicaid Expansion

- Before the ACA, federal funding for Medicaid was only for specified categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with certain disabilities, and people aged 65+.

- With the implementation of ACA, Medicaid was expanded to include childless, non-disabled, non-elderly, non-pregnant adults making less than 138% of the FPL ($16,245 in 2015).

- Nationwide, almost 8 million Americans who were not eligible before ACA are now actively enrolled in Medicaid, with 1.5 million more with pending enrollments.

- The expansion was made optional by Supreme Court ruling in 2012. States have the right to maintain pre-ACA eligibility levels and currently 20 states have declined to expand Medicaid.

- This has left over 3 million Americans in a “coverage gap.”

Medicaid “Coverage Gap”

In states without the Medicaid expansion, people making less than 100% the federal poverty line are not eligible for health insurance subsidies because they are supposed to be covered by Medicaid. This leaves them with no affordable insurance option.
Medi-Cal Coverage after ACA

- California’s Medicaid program (Medi-Cal) now provides healthcare across 5 different low income populations:
  - **Children (Birth-18)** - coverage through Children’s Health Insurance Program (CHIP)
  - **Non-disabled non-elderly adults** (19-64) with income below 138% of the federal poverty line
  - **Pregnant women** - finances 40% of all childbirths in the country. Covers prenatal care through the pregnancy, labor, and delivery, and for 60 days postpartum as well as other pregnancy-related care
  - **Non-elderly individuals with disabilities** (19-64) - includes coverage for people who are working or who want to work
  - **Low income seniors** (65+) or those w/ disabilities dual-eligible for Medicare

ACA Implementation

- The ACA has a 9 year implementation schedule (2010-2018)
  - The majority of its implementation is now completed
- The Supreme Court ruling in 2012 has blunted the ACA’s impact, as 20 states have not expanded their Medicaid programs
- In late 2015, a Republican majority in Congress passed a “repeal and replace” law that was vetoed by President Obama
  - The direction of national healthcare will be greatly impacted by which party occupies the White House next term

http://kff.org/interactive/implementation-timeline/
Module 5 Complete...

Proceed to Module 6
The Healthcare Triangle
Cost, Quality, and Access
Learning Objectives

- The student should understand the components of the healthcare triangle and the relationship between them.

- The student should have a basic understanding of U.S. healthcare costs compared to other 1st world nations.

- The student should reflect on the importance of reducing healthcare costs as a future practitioner of medicine.
The Three Corners of the Healthcare Triangle

When looking at healthcare as a system, it is helpful to consider the trade-offs of decision making.

The corners of the triangle, cost, quality, and access, all affect each other, directly or indirectly.
If a healthcare system were to have a fixed budget, an increase in the quality of medical care delivered could result in decreased access to care. Ex: An increase in specialized doctors could improve the quality of management of specific diseases, but would decrease the number of primary care physicians for the population as a whole. An increase in specialty providers would also cause an increase in healthcare costs.
One strategy for increasing access to care is increasing the scope of practice for non-physician providers. While this strategy does make healthcare more accessible, studies have questioned the quality of this care and have shown an increase in medical costs associated with over-ordering of diagnostics.
Cost decreases can be associated with quality increases through thoughtful systems and physician efforts.
And conversely, increasing cost is often not associated with an improvement in quality.

The U.S. has the most expensive healthcare system in the developed world, but is among the lowest for health outcomes.
While some of the ACA focused on addressing issues of cost, quality, and access, the majority of the law’s impact was focused on insurance.

It is important to note that health insurance does not directly equal access. Low reimbursement rates for Medicaid often severely limit patient access to many providers, so increasing the number of people insured does not directly increase access to care.
The US spends more than twice as much on healthcare.
The U.S. National Budget for 2016

Nearly 1.1 trillion dollars
Healthcare Cost Continue to Rise

![Healthcare Cost Graph]

Health Care
US from FY 2004 to FY 2021

$ trillion nominal


act. est.

[usgovernmentspending.com]
Healthcare costs are a national problem that will not self-resolve.

- Restructuring of the healthcare system is inevitable.
- Quality measures are going to play an important part in determining the viability for healthcare delivery systems.
- Physician awareness and involvement in these changes is ideal for patient care, but changes will be made with or without us.

- We will discuss the role of organized medicine and physician advocacy in Modules 8 and 9
Module 6 Complete…

Proceed to Module 7
Healthcare Costs
Reimbursement
Learning Objectives

- The student should understand the shortcomings of the current Fee For Service reimbursement system and why incentives need to be realigned.

- The student should have a basic understanding of the pros and cons of the 4 different most commonly used reimbursement strategies.

- The student should understand the concept of Value Based reimbursement and its key tenets.
Money in Medicine

- The healthcare spending crisis has brought much attention to the reimbursement models currently used in U.S. healthcare systems.
- Debate remains over how to align economic and health incentives to accomplish these ends.
Reimbursement models lie on a spectrum from paying the provider (physician +/- hospital) for every individual service performed to paying the provider a predetermined sum of money each year to treat a population of patients.

The patient care is negatively effected at both extremes of the spectrum.
Reimbursement Models

- A blend must be strived for to limit risks to both over and under treatment.
- A system that rewards providers for rendering quality care in an efficient manner creates the potential to limit skyrocketing healthcare costs and improve overall health outcomes.
Fee for Service (FFS) Model

- In the **most commonly used model**, a physician is paid by the health plan a pre-negotiated dollar amount for every service offered to a patient as a part of the treatment plan.

- While straightforward in principle, in practice, various trends have been found.
  - This model places more **financial incentives on volume over value or quality**.
  - A purely FFS model does not create strong enough incentives for preventative care and care coordination amongst providers or for beneficial outcomes.
  - It also has the moral hazard of over-treating patients to recoup more reimbursement dollars than might have been necessary to achieve an effective treatment.

- Without alteration, there is real concern that this structure will continue to add to national healthcare expenditures without necessarily improving healthcare outcomes.

- The United States leads in healthcare spending, but has poorer results in several key health outcome measures such as life expectancy and the prevalence of chronic conditions.

Per Diem Model

- The provider is paid a pre-negotiated amount per patient for each day that the patient receives care from that provider.
  - All services rendered, regardless of how many or few, are covered by that same fixed amount.

- This model, in its purest form, does not take into account how intensive the services rendered are.
  - Providers will be overly compensated for some patients and undercompensated for others.

- If this system does not have pre-negotiated rates based on patient demographics or related to a diagnosis, it creates a greater financial risk for the provider.
  - Providers can be financially “punished” for having sicker patient populations.

- Many times the flat fee paid is related to the admitting diagnosis and its severity.
In this model, a single provider or multiple providers are paid a predetermined amount for all services s/he provides during that defined “episode” of care. Payments are tied to severity of illness to limit provider financial liability. This model encourages providers to be more efficient and not over utilize services, leading to healthcare dollar savings.

A large payer that uses this model is Medicare. Medicare pays providers for treatment of diagnosis-related groups (DRGs).

This allows Medicare to make prospective payments tied to the admitting diagnosis with tiered payments based on severity of the illness.

This ensures providers are compensated properly for the disease or illness they are treating based on averaged historical costs of similar presentations in that geographic region.

DRG-based systems have been criticized for taking too long to update payments based on changes in medical technology and expenses.

Multi-provider bundled episode of care payments have come into favor to reduce administrative cost incurred from paying multiple providers for their care of the patient during a care episode.
Episode of Care Model Example

Patient presents with appendicitis

Medicare would pay a lump sum for this admission $$$

Diagnosis:
- labs
- imaging

Treatment:
- antibiotics
- surgery (OR, surgeon, anesthesia)

Hospital bed and administrative costs
Capitation Models

- Pure capitation is where one or multiple providers are paid a regular, fixed amount to cover all treatment required by their patients during that year/coverage period.
  - This reimbursement is supposed to cover all healthcare needs, regardless of severity.

- The capitation model can be applied to specific conditions.
  - This model is very similar to episode of care repayment.
  - The provider is incentivized to limit the amount of episodes related to that condition by effectively treating the patient at the cheapest possible cost.
  - Condition-specific capitation is mainly used in the outpatient setting.

- Capitation favors preventative care and cheaper, faster, better outcomes, however the provider does take greater risk if patients’ treatments become more complex and costly, especially given demographic/geographic differences.
Reimbursement Model Shortcomings

- Currently, in the most commonly used strategies, providers are not adequately reimbursed for spending the time to explore a patient’s history, symptoms of illness, or disease prevention.
- In the fee for service model, providers are overcompensated for ordering additional diagnostic tests, treatments, and medications.
- The Per Diem model does not incentivize efficiency or improved outcomes.
  - The provider will be paid for each day service is rendered, with no reward for curing or discharging the patient quickly.
- Financial risk carried by providers can create a moral hazard called “up-coding” when DRGs are used in the Episode of Care Model.
  - Up-coding is the fraudulent practice of making a more severe diagnosis so as to cover for potential unexpected costs incurred later down the line.
- Cost avoidance in the capitation model can lead to under-treatment or delayed diagnosis.
Optimizing Reimbursement

- Re-aligning the priorities in our healthcare system with provider incentives to include quality and efficiency of process would result in more disease prevention, clearer and more accurate diagnoses of illnesses, and more tailored care.

- It would also limit the amount of adverse outcomes, while leading to improved care and better coordinated follow-up.

- A reimbursement model with these aims would maximize quality while decreasing cost.

  - This would lower national healthcare costs and improve patient outcomes.
Pay for Performance (Value Based Model)

- For a reimbursement system to be successful it must accomplish these key measures:
  - Reward providers based on health outcomes, improvement in quality of care rendered, and efficient resource utilization (i.e. outcome and process measures)
  - Compensate physicians fairly for care coordination and management of patients
  - Be extremely transparent to providers and payers
  - Be sustainable and have a review process that allows for payment growth with changes in medical technology
  - Adjust payments accordingly based on illness severity and varying demographics amongst patients seen in that community (i.e. age, incidence of disease within population, etc.)
  - The system must not allow providers to select for healthier/wealthier patients ("cream skimming")

Examples of Potentially Beneficial Financial Incentives

Table 3 shows financial incentives for primary care providers (PCPs) that are aligned with positive patient health outcomes and have the potential to lower national healthcare costs.

- These rewards could easily be constructed into our Value-Based Model.
Module 7 Complete…

Proceed to Module 8
Learning Objectives

- What is organized medicine? Name three organizations that medical students can join nationally and locally.
- The student should be able to discuss a few recent initiatives sponsored by the CMA and SDCMS.
- The student should be able to understand the shortcomings of organized medicine.
Organized Medicine

- Organized medicine is when medical students, residents, and physicians join professional organizations to better advocate for themselves and their patients.

- Some examples of these networks include the American Medical Association (AMA), the California Medical Association (CMA), and our very own San Diego County Medical Society (SDCMS).

- Joining an organization gives students and doctors a voice in the ever-evolving landscape of politics and medicine.
The American Medical Association

- Founded in 1847
- Represents the largest association of physicians and medical students in the USA, with greater than 200,000 physician members
- They are also responsible for the publication of the JAMA: Journal of the American Medical Association
Criticism Against the AMA

- The AMA has often been criticized for pursuing the interests of practicing physicians solely at the detriment of public health needs.

- Opponents claim that the AMA purposely keeps the supply of physicians low to ensure higher pay for practicing doctors.

- Counter arguments have been made as the AMA is now in favor of expanding medical education to help solve the current doctor shortage.
The CMA was founded in 1856.
Currently, the group represents over 40,000 California physicians.
CMA headquarters is located in Sacramento, and its leaders often work directly with the Legislature.
Each year, CMA has a comprehensive program of legislative, legal, regulatory, economic and social advocacy.
This agenda can be directly influenced by medical student advocates.
UCSD sends two medical student delegates to CMA’s annual conference.
Recent CMA Initiatives

- Partnered with the Save Lives California coalition to make a ballot initiative increasing the Tobacco tax by $2/pack
- Sponsored AB 2121, a Responsible Beverage Service Training bill aimed to reduce unsafe serving practices after the tragic car crash involving 5 UCSD medical students and a drunk driver
- Fought trial attorneys on a ballot initiative in order to maintain the current version of the Medical Injury Compensation Reform Act (MICRA)
- Co-sponsored SB 277, which removed numerous personal belief/religious belief exemptions for vaccination requirements before entry into public or private elementary and secondary schools
- Organized a rally at the Capitol building to eliminate the 10% Medi-cal reimbursement cuts made in 2011
Recent SDCMS Initiatives

- Fought scope of practice bills with various allied health professionals to ensure they have adequate training for their scope of practice.

- Bar to corporate attempts at the potential commercial exploitation of medicine.

- Protected MICRA to ensure patients have access to affordable and accessible healthcare.

- Increase Medi-Cal reimbursements to ensure those patient with Medi-Cal can access quality healthcare in an efficient manner.
Module 8 Complete…

Proceed to Module 9
Advocacy
How to Get Involved
Learning Objectives

- The student should be aware of the different types of opportunities for advocacy.

- The student should be able to discuss two recent examples of UCSD medical students advocating for change.

- The student can take this time to evaluate his or her drive to be an advocate and get involved.
Why should physicians be advocates?

- We have a responsibility as physicians (and future physicians) to advocate for the needs and rights of our patients.
- We can speak clearly and confidently on behalf of the patients we care for on a daily basis.
- We are in the best position to understand the complex healthcare needs of our patients.
- If physicians don’t advocate for patients and standards of care, decisions will be made that impact our ability to practice medicine without our buy-in.
How can medical students get involved?

- Support organized medicine
  - Become a part of CMA
    - UCSD sends two medical student delegates to the annual meetings.
  - Join the San Diego County Medical Society:
    - [https://www.sdcms.org/MembershipFAQs/JoinSDCMSCMANow/StudentApplication.aspx](https://www.sdcms.org/MembershipFAQs/JoinSDCMSCMANow/StudentApplication.aspx)
  - Help with lobbying efforts and grassroots movements!
    - UCSD medical students have lobbied for numerous causes locally, in Sacramento, and at state conventions.
    - Medical students can play a crucial role!
      - You are doing something VERY difficult, and people appreciate and respect your time. They know if you are taking time away from studying, the issue you are representing is VERY important!

- Stay informed!
  - UCSD is unique in that it is the only medical school in the country with an elective course dedicated to the politics in medicine- Take advantage!
  - California Healthline is a great resource to stay up to date.
Advocacy in Practice

- Advocating through organized medicine can aid in both strength of numbers and strength of message
  - An important part of advocacy efforts is having a clear and consistent message
  - Practice your talking points and stay on topic
  - Be concise and consistent
Advocacy in Action

- On May 15, 2015, two UCSD medical students were tragically killed by a drunk driver that was on the wrong side of the freeway.
- Grief-stricken by the senseless loss of life in this preventable tragedy, two UCSD medical students, Nicole Herrick and Daniel Spinosa, went to Sacramento with the goal of legislative action to reduce fatalities like this in the future.
- Their efforts were met with huge support from CMA and their initiative was authored by San Diego Assemblywoman Lorena Gonzalez.

**PURPOSE**

To help reduce alcohol service to already intoxicated individuals and to reduce drunk driving, this bill would require establishments that serve alcohol to customers to employ servers and managers who have received responsible beverage service training.

**SUMMARY**

This bill would require, starting July 1, 2020, people who serve alcohol or managers of servers at facilities that serve alcoholic beverages on the premises to have completed a course on responsible beverage service. Servers and managers would be required to undergo training every three years.

On-sale retail license holders would be required to document that employees are current on required training when applying or renewing their alcohol license.

The bill would require applicable training programs to include at least four hours of instruction and cover:

- the social impact of alcohol
- the impact of alcohol on the body
- state laws and regulations relating to alcoholic beverage control
- intervention techniques to prevent the sale of alcohol to underage or intoxicated people
- the development of management policies that support prevention of sale of alcohol to underage or intoxicated people.

The bill requires the Department of Alcohol and Beverage Control to, by January 1, 2020, establish a list of training courses that meet the criteria established in the bill.

**BACKGROUND**

Excessive alcohol consumption has many health impacts, including many long and short-term health impacts. A study in the American Journal of Preventive Medicine found that excessive alcohol consumption cost the nation almost $250 billion in 2010.

One of the short-term health risks associated with excessive alcohol consumption is injury or death from alcohol-impaired driving. Alcohol-related deaths from car accidents still make up a third of all car accident fatalities. According to the California Highway Patrol, in 2013 there were 1,197 people killed in collisions involving alcohol.

Another 23,179 people were injured in such collisions. But statistics obscure the impact to each of the individuals involved. In 2015, two second-year medical students studying at the University of California San Diego medical school were killed by a severely intoxicated driver driving the wrong way on a San Diego freeway. This loss has reverberated across California’s physician community.

Binge drinking, defined as consuming five or more drinks for men and four or more drinks for women during a drinking occasion, is strongly associated with alcohol-impaired driving. An analysis of the Behavioral Risk Factor Surveillance System survey found that over 10 percent of binge drinkers drove during or within two hours of their binge drinking episode. Of those, over 50 percent had been drinking in licensed establishments.

Responsible beverage training has been found to increase appropriate server practices, increase refusal to serve obviously intoxicated patrons, and decrease the percentage of intoxicated patrons leaving an establishment. Three years after Oregon mandated responsible beverage service training, fatal single vehicle nighttime crashes decreased by an estimated 23%.

Fifteen other states and the District of Columbia currently have mandatory responsible beverage service laws.
**Advocacy in Action**

- On June 2\textsuperscript{nd}, 2015, five UCSD medical students lead a coalition of UC medical students in CMA’s Medi-Cal Rally.
  - 4,000 people from all over California came to the Capitol to make lawmakers and the Governor aware of the detriments to patients that were created when reimbursement rates for Medi-Cal were cut by 10% in 2011.
- The primary focus was the decrease in access for pediatric patients created by the cuts, especially for those being raised in lower income communities.
  - Medi-Cal, the nation’s largest Medicaid program, has a significantly high proportion of children enrolled, approximately one third of California’s kids.
  - By sharing patient care experiences with lawmakers, the group gave their best effort to persuade legislators that reversing budget cuts would increase all children’s access to high quality, affordable healthcare.
- Two weeks later, the legislature placed a budget initiative on the Governor’s desk that included a $37 million earmark to compensate Medi-Cal providers retroactively, money to assist providers of low-income patients and ensure they could continue providing access to care.
Module 9 Complete...
Congratulations!

You’ve finished the Introductory Modules!
Want to learn more about the ACA, becoming an advocate, and the politics of medicine?
Sign up for Dr. Hertzka’s fall quarter elective- ANES 223!