Health Care Reform in the U.S.: What are the Issues?

12th International Medical Workforce Collaborative
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May 2, 2010

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A brief history of U.S. health care

- Employer-sponsored coverage: gained traction in response to wage caps during World War II (1942)
- Medicare: federal social insurance program for those age 65 and older (established 1965)
- Medicaid: state-managed program, financed by state & federal funds, for those with low income (established 1965)

The challenge of the status quo

- Employer-based system → gaps in coverage, expensive coverage for people between jobs
- Spotty coverage for prescription drugs, long-term care, other services
- No will to keep costs down

Health reform overview: Patient Protection & Affordable Care Act

- Builds on employer-based system
- Medicaid expansion
- State-based subsidized insurance Exchanges
- Coverage mandate for most individuals
- Systems reform and cost containment
  - Long-term care
  - Primary care
  - Community health centers
  - Workforce

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Who gets left behind?

- Many more people covered
- Many still left out
  - Undocumented immigrants
  - Those exempt from mandate
  - Those who choose to pay a penalty
  - Some percentage of those currently eligible but unenrolled in Medicaid

Current federal minimum income eligibility for Medicaid

- 133% FPL for children 0-5 and pregnant women
- 100% FPL for children 6-19
- 74% for elderly & disabled
- 45% for parents
- Childless adults ineligible

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Medicaid expansion under reform

- Eligibility increases to 133% of federal poverty level
- Includes children, parents, pregnant women, single adults, childless couples
- Provides coverage to an additional 32 million Americans

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Current challenges for Medicaid in New York State

- 1.1 million people eligible but unenrolled in public programs in New York State (41% of uninsured)
  - Nationally, 11 million people uninsured (~25% of uninsured)
- Low reimbursement rates for primary care (comparatively good for specialty and outpatient care)

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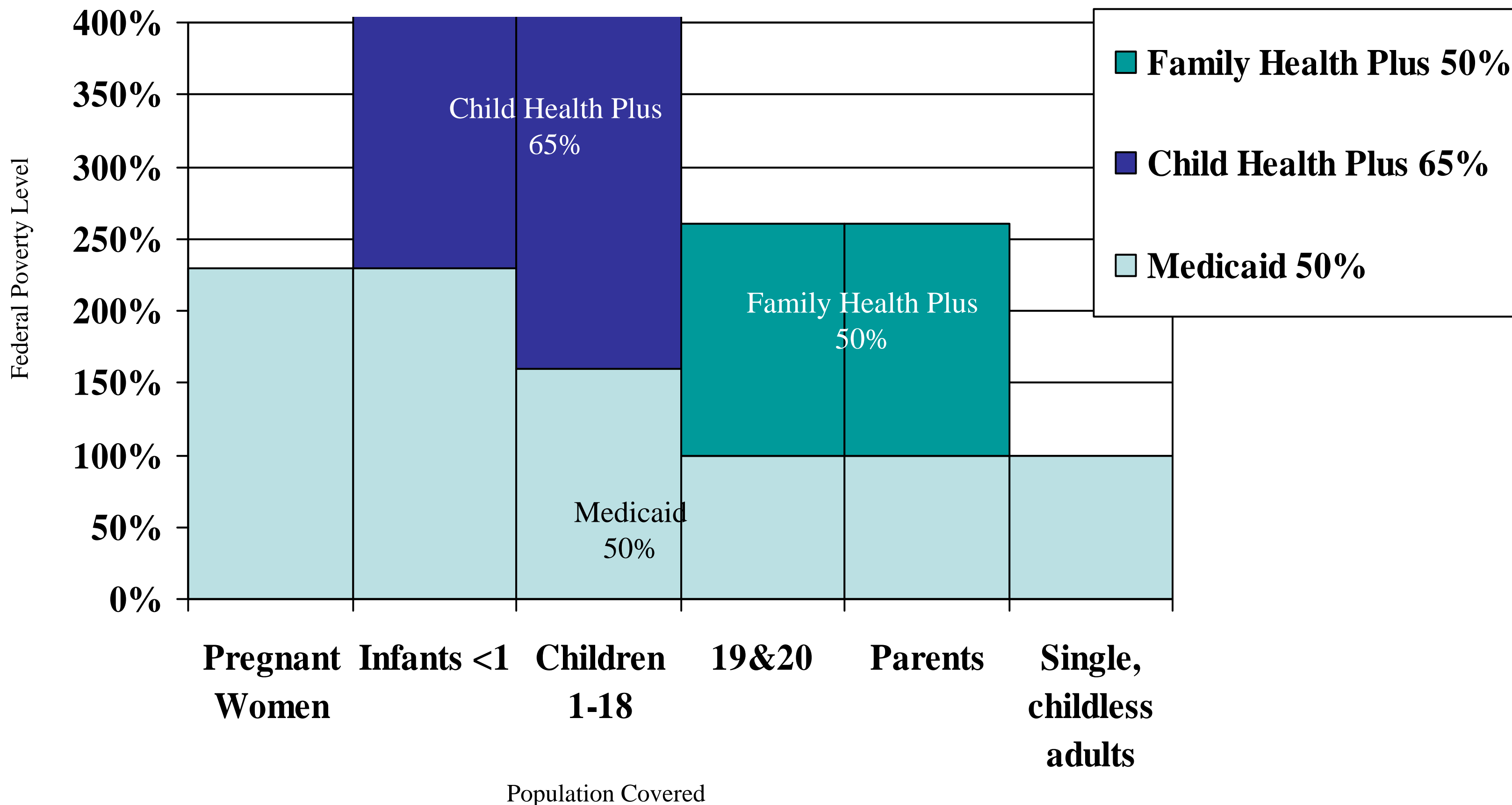
Public coverage in New York State, today



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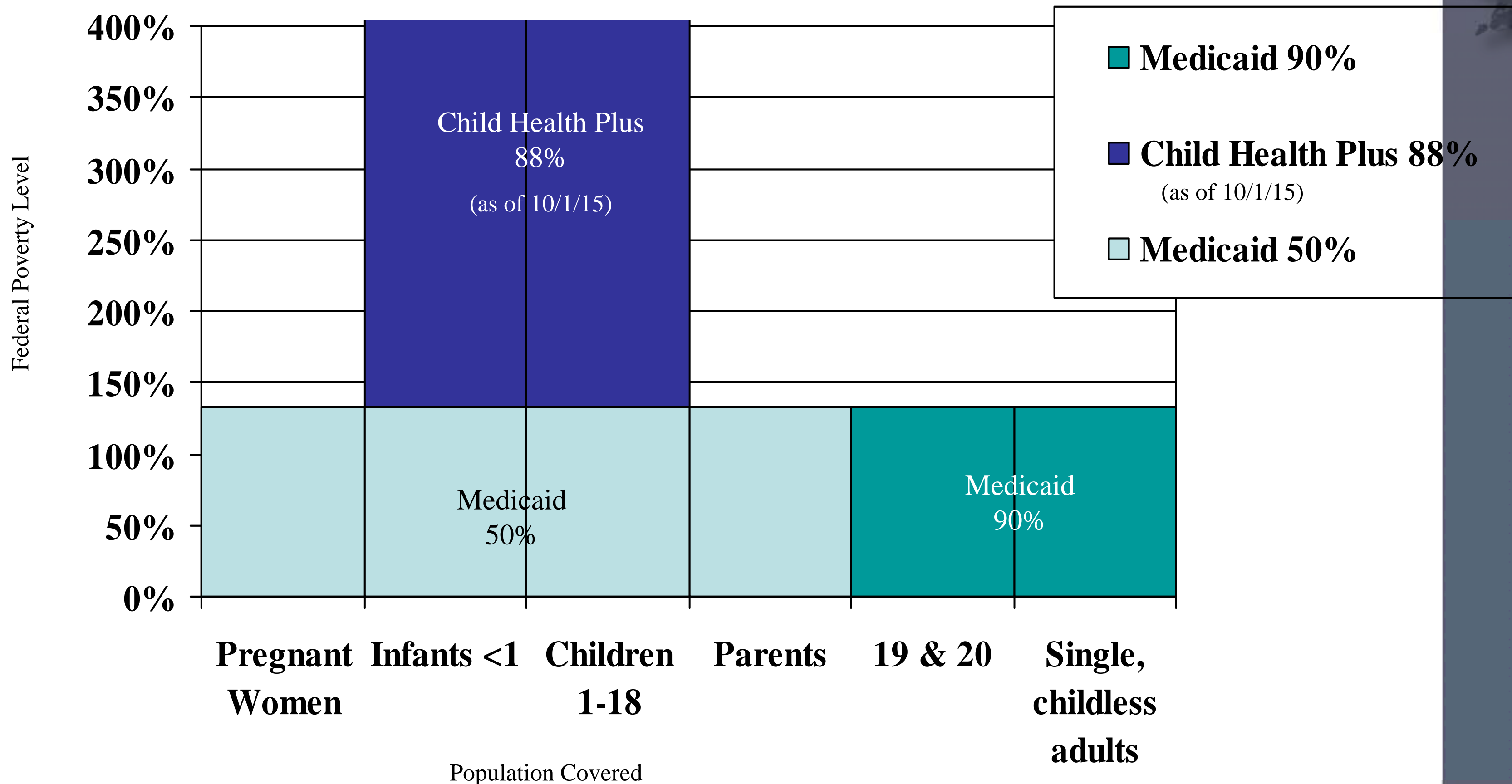
Public coverage in New York State, 2019



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Health insurance exchanges

- State- or regional-based marketplaces for the sale and purchase of insurance, in 2014
- Subsidies available for individuals and businesses purchasing coverage through the exchange
- Until 2014, interim high-risk pools for those with pre-existing conditions

Individual mandate

- Most Americans will be required to have health insurance by 2014
- Some exceptions: financial hardship, religious objections
- Increasing annual penalties for uninsured beginning in 2014
- Businesses >50 employees required to offer insurance coverage

Additional coverage provisions

- Bars insurance companies from discriminating based on pre-existing conditions for new policy holders
- Bars insurance companies from rescinding existing coverage because of illness
- Allows young adults up to age 26 to remain on parents’ plan
- Covers mental health and substance use services on par with other covered care

Additional coverage provisions

- Covers preventive services, with no out-of-pocket costs to patients
- Will define minimum "essential benefits" that all plans must cover
- Caps individual out-of-pocket expenses for health care
- Establishes a voluntary long-term care insurance program

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Massachusetts model

- More than 97% of residents covered
- 92% have a usual source of care
- Significant gains in access to dental care and preventive services
- Improved access for newly-enrolled as well as those with existing coverage

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Source: S. K. Long and P. B. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* Web Exclusive, May 28, 2009, w578–w587.

Massachusetts model

- More than 20% of adults, and nearly 1/3 of lower-income adults, reported not getting needed care
- Emergency department use for nonemergency conditions did not change post-reform
- Early gains in affordability of care not sustained over time

Source: S. K. Long and P. B. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* Web Exclusive, May 28, 2009, w578–w587.

National lessons from Massachusetts

- Local health care delivery systems must be prepared to support an influx of new patients requiring primary care and follow-on services
- Cost pressures can undermine access to care, even with expanded coverage

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Source: S. K. Long and P. B. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* Web Exclusive, May 28, 2009, w578–w587.

Key health reform provisions: Primary Care

- Increases Medicaid payments for primary care to Medicare rates
- Provides 10% bonus payment to primary care physicians in Medicare
- Provides $11 billion for community health centers and National Health Service Corps
- Improves support for school-based health centers and nurse-managed clinics

Key health reform provisions: Primary Care

- Primary care extension program
- Grants to develop primary care residency programs
- Teaching health centers
- Grants for family nurse practitioner programs
- Rural physician training

Key health reform provisions: Primary Care

- Geriatric workforce development
- Revised HRSA health professions student loan guidelines
- Eliminate regulatory barriers to training in ambulatory sites
- Reauthorize AHEC program

Key health reform provisions: Workforce

- Support health workforce planning and policymaking
- Improve access, esp. in underserved areas
- Increase support for health careers
- Address workforce shortages
- Encourage delivery system reforms to improve quality of care and reduce costs

Key health reform provisions: Workforce

- Establishes Workforce Advisory Committee to establish national strategy
- Distributes unused Medicare GME positions
- Provides scholarships, loans, and grants to increase workforce in underserved areas
- Supports training programs on new care models (e.g., medical homes, team management)

Key health reform provisions: Public and Community Health

- Public health workforce loan repayment
- Mid-career public and allied health scholarships
- Public health sciences track and the commissioned corps
- Public health fellowships
- Preventive medicine & public health training grants

Key health reform provisions: Nursing

- Family nurse practitioner training
- Nurse faculty loans and loan repayment
- Nurse student loans
- Workforce diversity grants for training
- Graduate nurse education demonstrations
- Nurse career ladder and retention grants
- Nurse-managed health clinics

Opportunities to control costs and spending

- Reimburse providers based on value, not on volume
- Strengthen preventive and primary care services, including through community health centers
- Improve the quality of care for people with chronic conditions (e.g., diabetes)
- Reduce unnecessary hospital readmissions

Key health reform provisions: Demonstration Projects

- Comparative effectiveness
- Wellness programs
- Community-based prevention programs
- Medical-malpractice models
- Provider payment innovations

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