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# The Affordable Care Act

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# Objectives

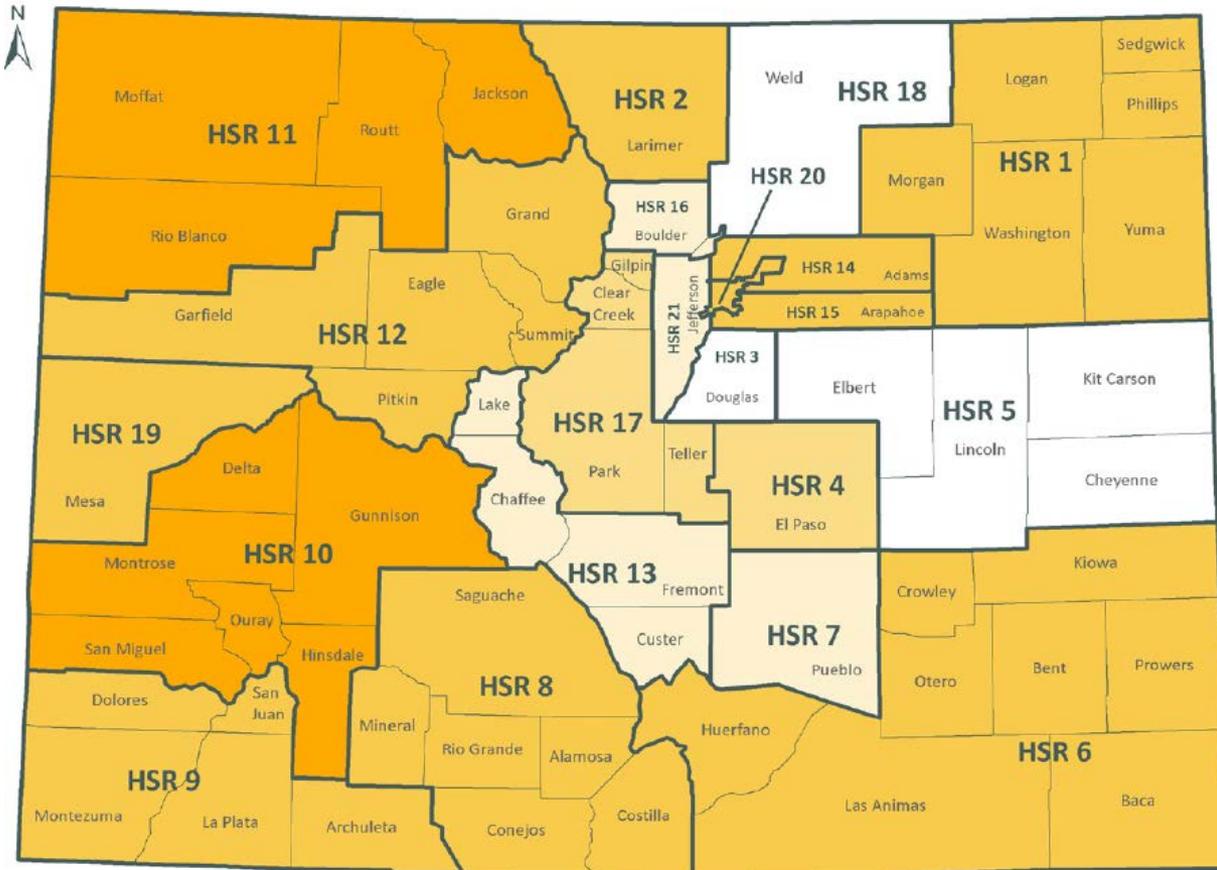
- Discuss the details of the Affordable Care Act
- Discuss public health/chronic disease, health equity and the ACA
- Discuss the shortcomings of the ACA
- Discuss what's next

# What problem is the ACA trying to solve?

- 16% of Americans have no health insurance (nearly 50 million; close to 800,000 Coloradans)
- This number is expected to rise with the increase in the cost of insurance
- This number is expected to rise with the increase in “out-of-pocket” costs for insured individuals

Sources: Gallup-Healthways Well-Being Index, 2010; Colorado Health Institute’s analysis of 2008-2009 American Community Survey and Current Population Survey; Data from 2003-2008 CO Dept. of Insurance and national estimates of the number of uninsured.

# Uninsured in Colorado



14.3% of Coloradans are Uninsured (741,000)

This rate is down from 15.8% in 2011

Percentage Uninsured:

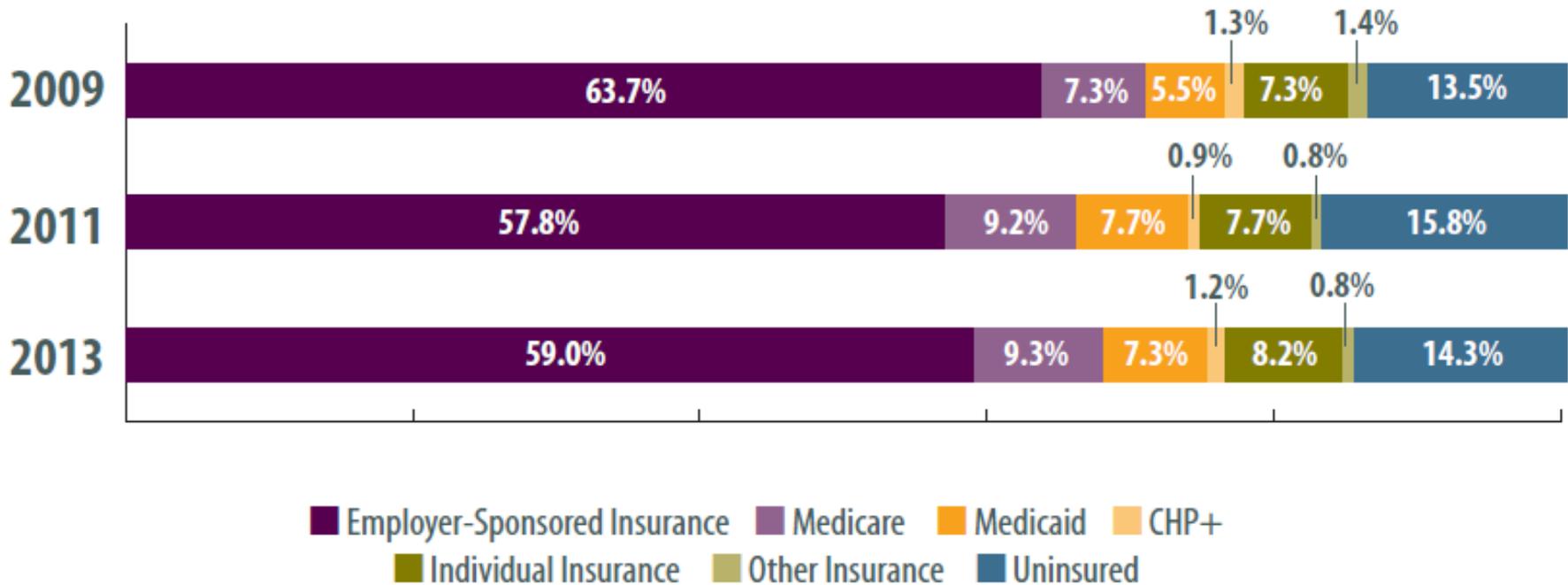


# Budgetary challenges in Colorado

- Health care is over 30% of general fund; still budget issues despite more favorable revenue forecasts
- Fewer employers are providing coverage
- Health insurance premiums growing at twice the rate of the average Coloradan's wages
- Each 1% increase in premium costs is associated with an increase of 1,500 uninsured Coloradans

# Employer-based Insurance

Health Insurance Coverage, All Ages, 2009-2013



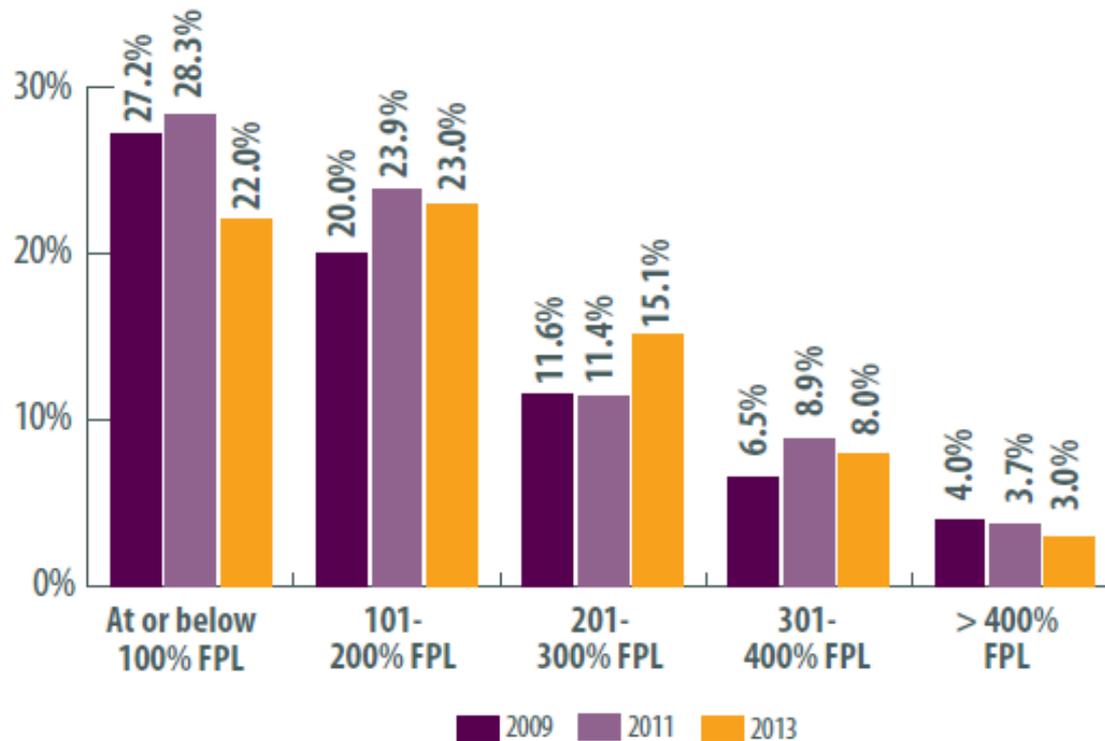
# The Working Uninsured

- Nearly 58% of uninsured Coloradans have jobs
- 45% of these working uninsured work for others, and 13% are self-employed
- Of the employed uninsured, 59% said they were offered insurance by their employer but turned it down due to cost

Note: 2011 CHAS data

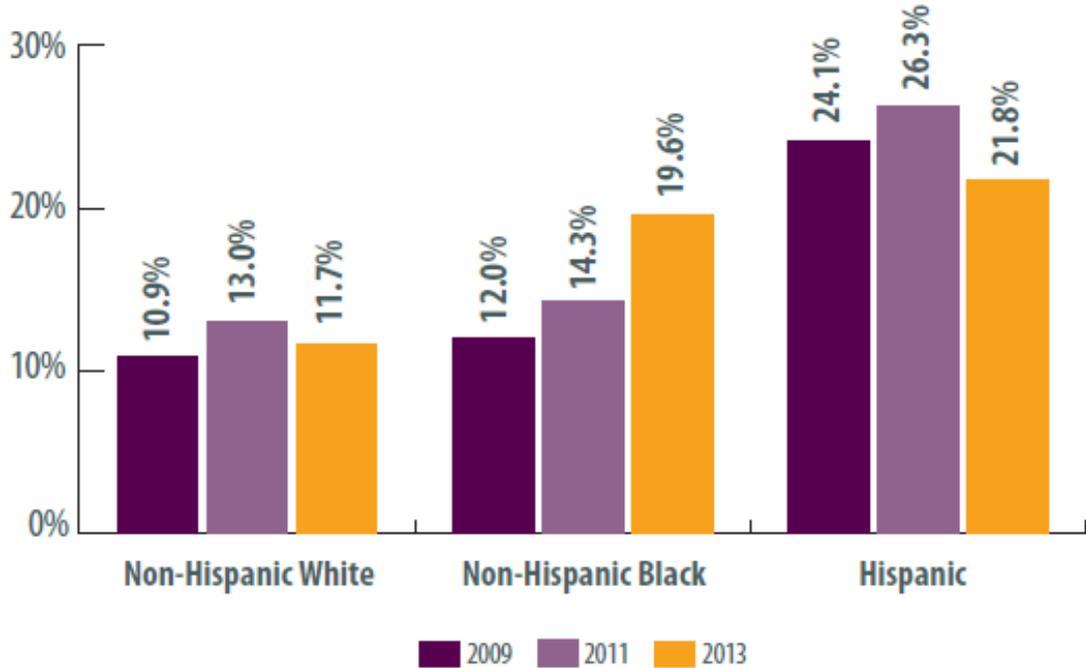
# Lack of Coverage Associated with Poverty

Uninsured Rates by Federal Poverty Level, 2009-2013



# Lack of coverage associated with race/ethnicity

**Uninsured Rates by Race/Ethnicity,  
Colorado, 2009-2013**



# Doesn't everyone have access to care?

- EMTALA (Emergency Medical Treatment and Active Labor Act) requires hospitals to provide emergency care regardless of ability to pay
- Emergency care does not equate to access to health care
- Lack of coverage impacts patient choices
- Human capital costs of lack of access to care is substantial

# Delaying Needed Medical Care

- 47% did not see a dentist
- 38% did not see a doctor
- 32% did not see a specialist
- 22% did not fill a prescription
- 17% did not see a mental health provider

Note: 2011 CHAS data

# Mortality and medical coverage

- July NEMJ article on Medicaid expansion:
  - States that expanded Medicaid ahead of the ACA had lower mortality rates
  - Deaths averted, associated with expansion, were 19.6/100,000 per year
  - For Colorado, this translates to 629 deaths averted per year, more than the number of women who die from breast cancer and the number of men and women who die from colon cancer

# Determinants of access to health care

Three interrelated areas:

- Coverage (Accessibility)
- Cost (Affordability)
- Capacity (Availability)

# The Affordable Care Act

- Increase access to health care through addressing the three interrelated areas:
  - Increase coverage
  - Build primary care workforce (capacity)
  - Insurance reform (coverage/cost)
  - Improve effectiveness and efficiency (cost)



**THE  
COLORADO  
TRUST**

# The Patient Protection and Affordable Care Act

## One Hundred Eleventh Congress of the United States of America

AT THE SECOND SESSION

*Began and held at the City of Washington on Tuesday,  
the fifth day of January, two thousand and ten*

### An Act

Entitled The Patient Protection and Affordable Care Act.

*Be it enacted by the Senate and House of Representatives of  
the United States of America in Congress assembled,*

#### SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Patient Protection and Affordable Care Act”.

**[Note: This print is of the Patient Protection and Affordable Care Act (“PPACA”; Public Law 111-148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (“HCERA”; Public Law 111-152). The text of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790), as enacted (in amended form) by section 10221 of PPACA, is shown in a separate, accompanying document. This document has been prepared by the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and its clients; it is not an official document of the House of Representatives or its committees and may not be cited as “the law”. HOLC welcomes any corrections or suggestions to this document; these should be emailed to [edward.grossman@mail.house.gov](mailto:edward.grossman@mail.house.gov).]**

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

#### TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

##### Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

- Sec. 1001. Amendments to the Public Health Service Act.
- Sec. 1002. Health insurance consumer information.
- Sec. 1003. Ensuring that consumers get value for their dollars.
- Sec. 1004. Effective dates.

##### Subtitle B—Immediate Actions to Preserve and Expand Coverage

- Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.
- Sec. 1102. Reinsurance for early retirees.
- Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
- Sec. 1104. Administrative simplification.
- Sec. 1105. Effective date.

##### Subtitle C—Quality Health Insurance Coverage for All Americans

#### PART 1—HEALTH INSURANCE MARKET REFORMS

- Sec. 1201. Amendment to the Public Health Service Act.

#### PART 2—OTHER PROVISIONS

- Sec. 1251. Preservation of right to maintain existing coverage.



**ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS**

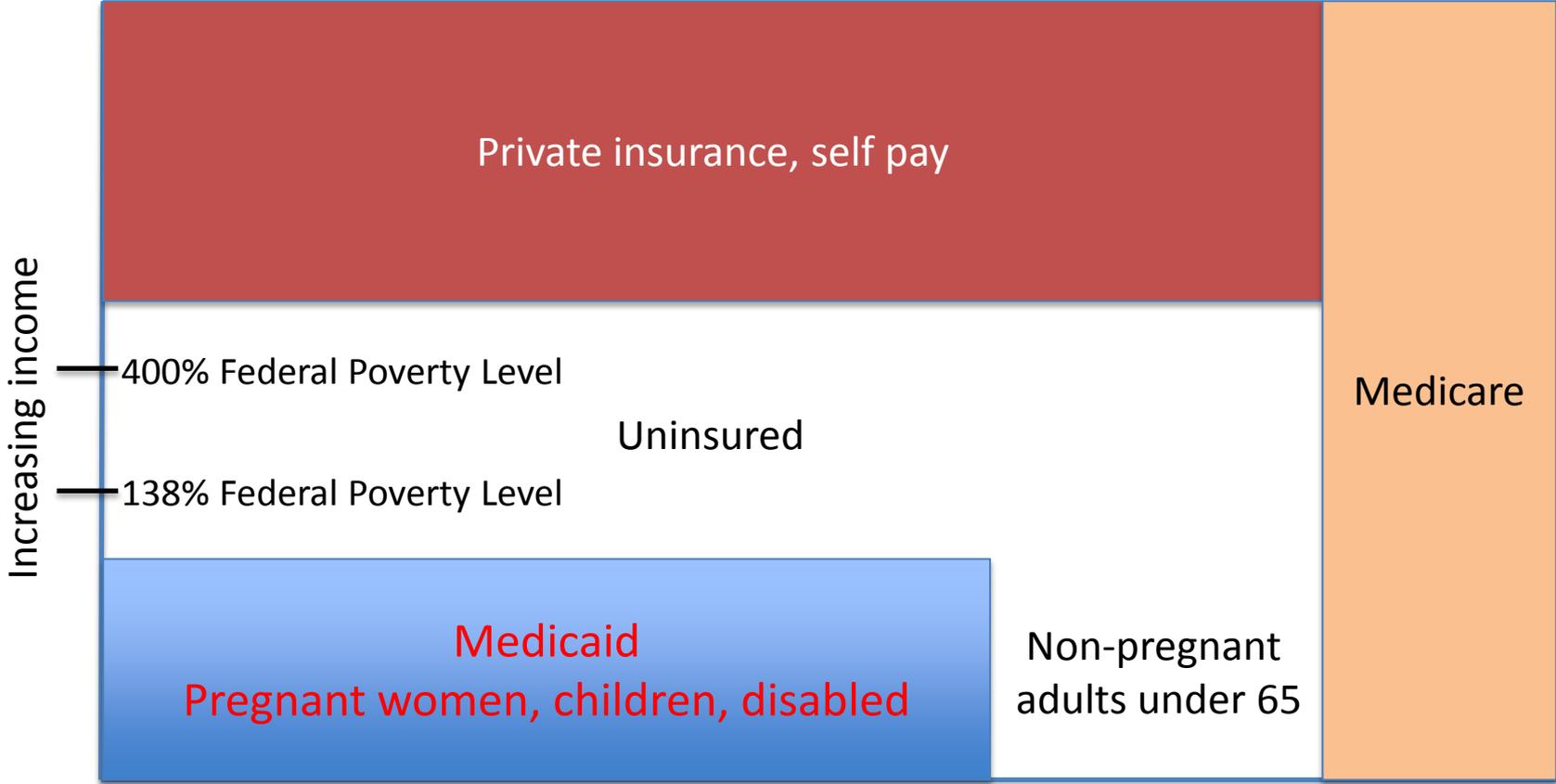
# Increase coverage

- Eliminate coverage barriers
  - No denial of pre-existing conditions
  - No coverage rescissions for new conditions
  - No annual or life-time coverage caps
  - Dependent coverage up to age 26
  - No co-pays for proven preventive services
  - Close the Medicare donut hole

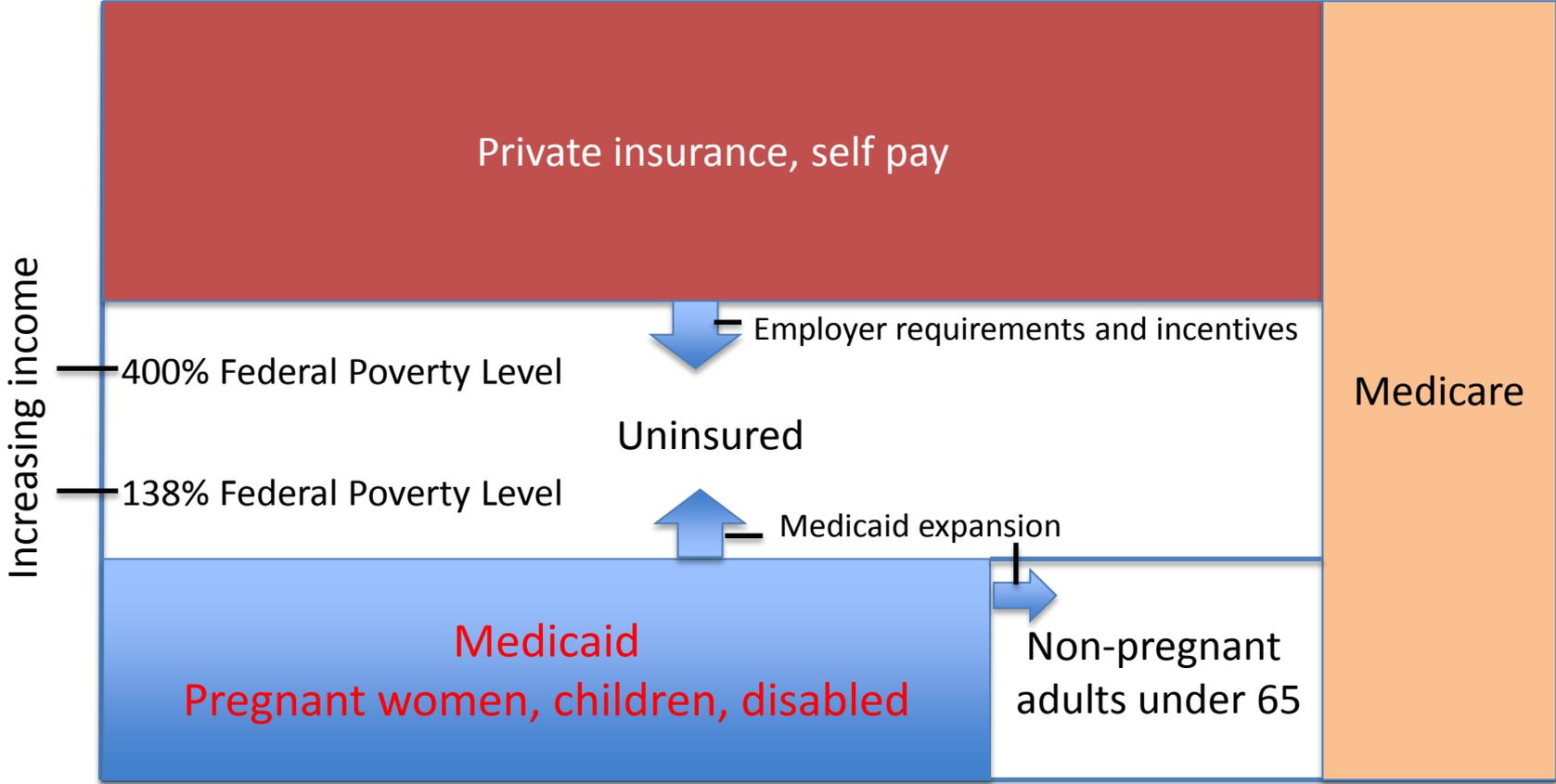
# Increase coverage

- Expand Medicaid eligibility to 138% poverty level for children and adults (non-Medicare)
- Expand employer-provided coverage via incentives, requirements and penalties
- For those in-between: subsidize coverage purchase through insurance exchange
- Require coverage purchase for all (with exemptions and exclusions)

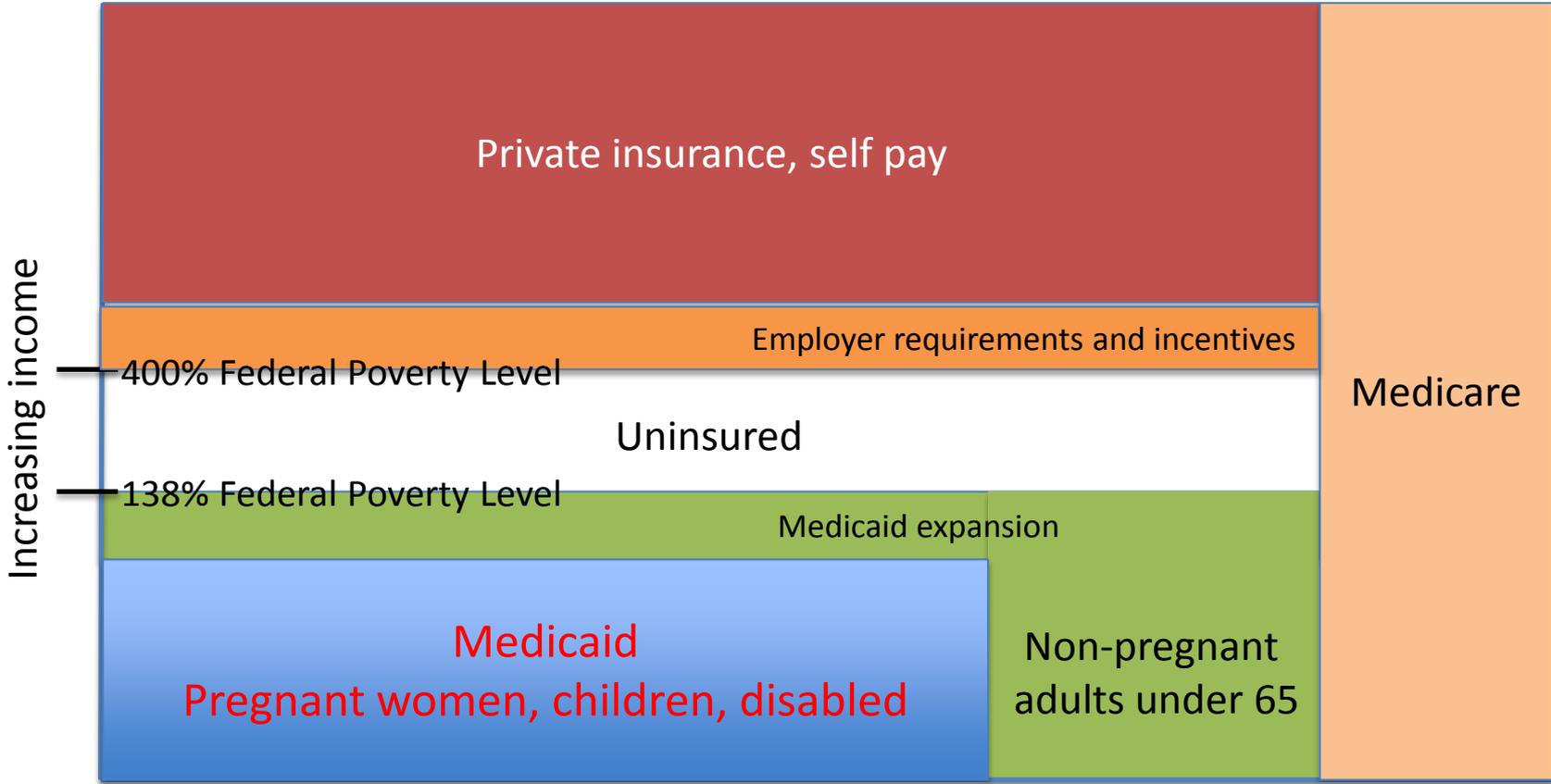
# Increase Coverage



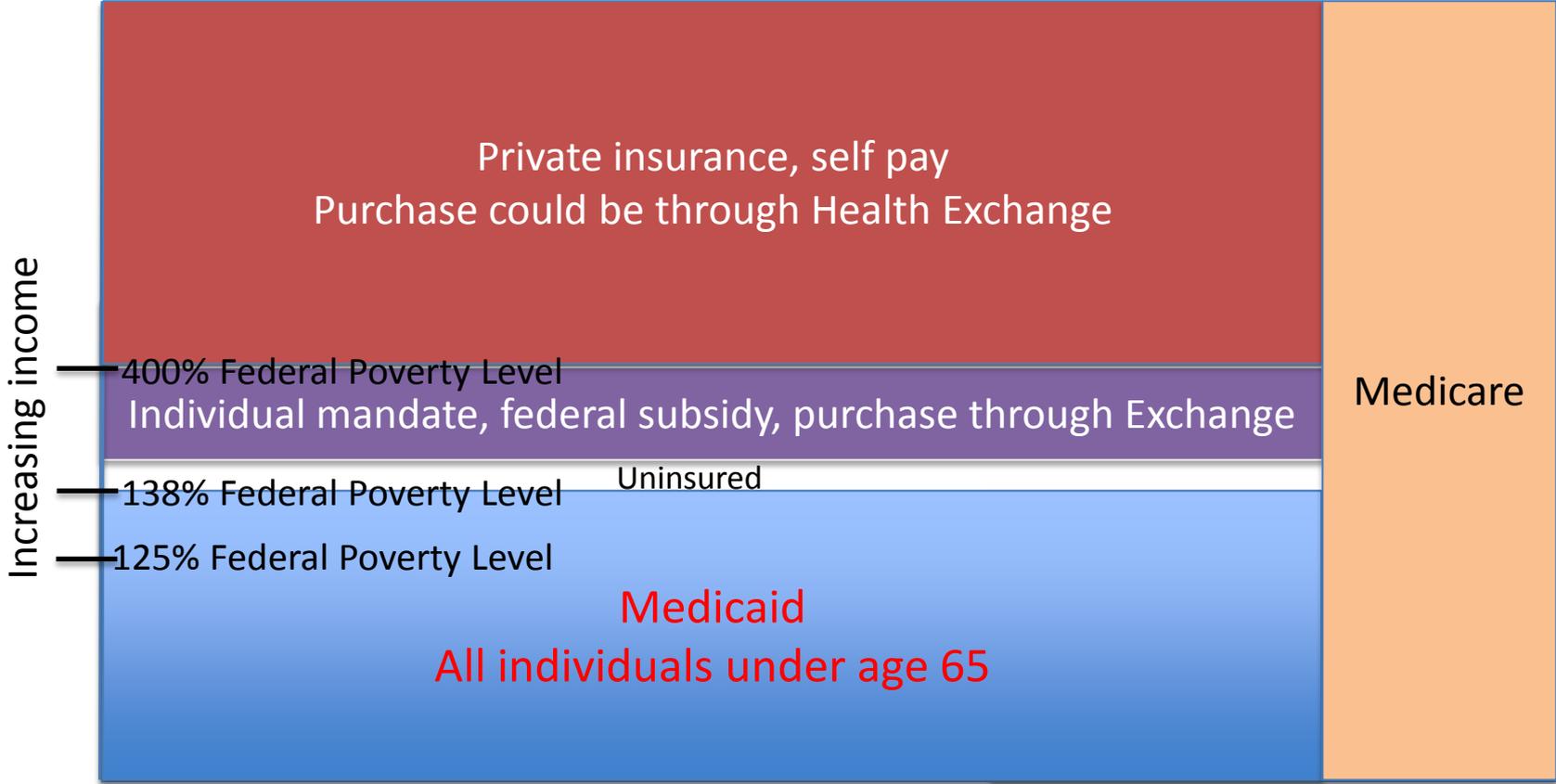
# Increase Coverage



# Increase Coverage



# Increase Coverage



# Increase capacity

- Increased primary care clinician training
- Enhanced safety net funding
- Loan repayment supporting primary care for underserved populations
- Optimized scopes of practice regulation
- Team-based care support (patient-centered medical homes)

# Decrease costs

- Insurance reform
  - Health Exchange/Marketplace for consumer-driven insurance purchasing
    - Uniform basic benefit packages
    - Plans compete on price (and additional benefits)
    - Enhanced consumerism
  - Annual rate review
  - Uniform billing/payment systems
  - Standardization of other administrative processes

# Decrease costs

- Reduce/eliminate cost-shifting for un- and under-compensated care (individual mandate)
- Payment and delivery system reform
  - Accountable care organizations
- Purchasing co-ops
- Age rating limits
- Fraud and waste reduction

# Decrease costs

- Wellness support
- Enhanced health data reporting
- Patient-Centered Outcomes Research Institute (PCORI)
  - Comparative effectiveness research to inform treatment and, with caveats, coverage decisions
- Medicare Advisory Board

# Capture cost reductions

- Cap on medical loss ratio
  - Limits administrative costs (including shareholder profits) to 15-20% of premiums costs (medical loss ratios of 80-85%)
  - Savings above the limit must translate to lower premiums

# Title IV—Prevention of Chronic Disease and Improving Public Health

- National Prevention, Health Promotion and Public Health Council
  - Advisory Group on Prevention, Health Promotion and Integrative and Public Health
  - National Prevention and Health Promotion Strategy
- Prevention and Public Health Fund
- Community Transformation Grants (2010-2014)
- Healthy Aging, Living Well pilot grants (55-64 y.o., 2010-2014)
- Immunizations for adults, demonstration programs for improved rates (2010-2014)
- Public Health Services and Systems Research
- Epidemiology and Laboratory Capacity Grant Program (2010-2013)
- Public Health Workforce Loan Repayment Program
- Community Health Workers grants (health behaviors/outcomes)
- Fellowship training in public health
- U.S. Public Health Sciences Track

# The ACA and chronic disease

- Pilots and support:
  - Medical homes
  - Accountable Care Organization
  - Independence at home medical practice
  - Other delivery/payment system reform pilots
  - Community health teams
  - School-based health centers
  - Nurse-home visitor programs

# The ACA and Health Equity

- 39% of the newly insured under Medicaid expansion are racial/ethnic minorities
- Nearly half the adults uninsured adults eligible for subsidies through the marketplace are racial/ethnic minorities
- Funding will support public health programs to reduce disparities in reproductive health among racial/ethnic minorities

# The ACA and Health Equity

- Requires all federally funded health programs and population surveys to collect data on race, ethnicity and language
- Includes support for research and demonstration on cultural competency education for health care providers
- Gives preference for loan repayment to providers with cultural competency training

# The ACA and Health Equity

- Funds training for low-income individuals as health care paraprofessionals through historically minority colleges
- Includes strategies to recruit racial/ethnic minorities into health care provider and leadership roles
- Elevates the National Center on Minority Health and Health Disparities at NIH to Institute status, with planning and coordinating power to conduct health disparities research

# Supreme Court Ruling

- Kennedy wrote the opinion himself
- 5/4 ruling upholding almost all the ACA
- Neither “side” liked the opinion
  - “Against” disagreed about the individual mandate
  - “For” disagreed that the individual mandate was a tax and therefore constitutional
- What was lost: states don’t have to accept the Medicaid expansion or lose all Medicaid funding

# ACA shortcomings

- The federal health care reform law is not perfect

“We passed the bill we could, not the one we wanted”

# ACA shortcomings

- No requirements to change care delivery and payment systems to decrease costs/increase value
- High cost services are not directly addressed (pharmaceuticals, hospitals)
- Penalties on business too low
- Adverse incentives for businesses
- Penalties on individuals too low

# ACA shortcomings

- Capacity improvements will lag demand
- Does not cover everyone (leaves out 34 million nationwide, 250,000 in Colorado)
- Does not address undocumented immigrants
- Complicated interaction with decreasing DSH payments
- Employer mandates delayed
- Cost savings depend on all parts of the law, including insurance purchase by healthy young people

# In spite of these issues...

- Federal health care reform represents a major opportunity to remarkably expand coverage
- May be the only opportunity many of us see
- There is no alternative plan
- Without reform, the situation will degrade quickly, and reform will need to occur emergently

# What next?

- Many policy makers still balking at implementation—both sides have dug in
- Colorado has expanded Medicaid and
- Colorado has implemented the exchange with some success
- National enrollment has been a disaster
- Success depends on enrollment
- Costs will go up at least initially (already seen)
- Capacity issue could be equally disastrous