

## LEGISLATING HEALTH CARE REFORM

### Overview of the Legislative Process

The need for changes to the health care system in the United States was over a decade in the making. In 1993, President Clinton set up a Task Force on Health Care reform. Long before the current Administration made it the focus of its agenda in 2009, prominent health care institutions, such as the Institute of Medicine, proposed changes to health policy due to health and wellness crises, access to care, and increasing health care costs. University thought leaders, such as Michael Porter, PhD of Harvard School of Business, challenged the health care business model; calling for consumer value for money spent on health care. Porter published Redefining Health Care in 2006, a seminal work on why fundamental changes were needed. Dr. Porter is still analyzing better ways to manage health care costs today. His work on value-based purchasing and bundling episodes of care continues to influence health care delivery today. During the Bush Administration the House and Senate held 17 hearings on health care reform. Health care reform in the United State is a continuous process.

Although the topic is the legislative process for health care reform, the Patient Protection and Affordable Care Act of 2010 (hereafter referred to as the ACA) should not be considered typical or representative of the legislative process in the United States. In fact, the ACA was not a comprehensive plan. It was a digest of individual pieces of legislation and policy positions.

Five Congressional Committees had overlapping responsibilities for drafting important sections of the proposed legislation. Rather than having the Administration draft legislation as had been attempted by President Clinton, President Obama submitted his principles and goals to Congress for them to draft legislation. In the House, 3 committees have jurisdiction over health care:

Energy & Commerce Committee jurisdiction includes Public health; mental health; biomedical research and development; health information technology, privacy; Medicare, Medicaid and private health insurance; medical malpractice and medical malpractice insurance; drug abuse; the Department of Health and Human Services; the National Institutes of Health; and the Indian Health Service.

Ways & Means Committee jurisdiction includes the health care programs of the Social Security Act such as the supplementary medical for the disabled and Children's Health Insurance Program (CHIP), tax credits and deductions for health insurance premiums and health care costs, health care delivery systems and health care research.

Appropriations' jurisdiction is over spending bills by setting specific expenditures and, thereby, spending limits. This includes setting the budget for Health & Human Services (HHS), which includes the Centers for Medicare & Medicaid Services (CMS).

On June 19, 2009 the Chairmen of the 3 House Committees released a draft bill which included provisions for a health insurance exchange, public health insurance option, Medicaid expansion, the individual mandate for insurance purchase, and employer covered insurance or contribution fees.

Historically, bills are marked up and debate occurs. This shapes interim and final versions of legislation. However, as public media and public scrutiny increased, public deliberation decreased. The more discussion moved behind closed doors, the greater the public and political criticism. Although many

provisions had bipartisan support at one time or another, each party began using sections of bills for political attacks. A prime example is the Independent Payment Advisory Board. Initially intended to review treatment efficiency, best practices, and value-based purchasing decisions, it became labeled a “death panel”.

On October 14, 2009 three versions of the House bill 3200 were introduced but stalled. On October 29<sup>th</sup>, House bill 396, the Affordable Health Care for America Act, was introduced in an attempt to resolve different tax provisions in earlier bill versions. It had not gone to any committees for review but went to the House floor on November 7<sup>th</sup> where it passed. Three days later it went to the Senate.

While the House was passing its bill, two Senate committees were drafting their legislation. In the Senate, the Finance Committee undertook health care finance reform, the uninsured, and insurance coverage reforms. The Senate Health, Education, Labor and Pension Committee (HELP), chaired by Senator Edward Kennedy, focused on access to care, health care delivery and reducing the number of uninsured.

The House and Senate bills began to diverge as the two Senate committees drafted their separate versions. The Senate HELP Committee completed its bill first and submitted it to the Congressional Budget Office (CBO) for an estimate of the legislation’s cost. The initial estimate was that the legislation would cost \$1 trillion and decrease the uninsured by 16 million people. Changes were made that brought the cost down.

The Senate Finance Committee’s bill was drafted through the efforts of 3 Democratic Senators [Senators Baucus, Bingaman, and Conrad] and 3 Republican Senators [Senators Enzi, Grassley, and Snowe]. While the bill was drafted, certain negotiations were taking place. Senator Baucus was negotiating with the pharmaceutical industry for more affordable drugs. The White House negotiated with hospital associations for \$155 billion in hospital savings. The Senate Finance version was the last bill drafted and incurred the greatest criticism. It covered the fewest people and did not have a public health coverage option. Amendments were made to cover more individuals and reduce the cost of the legislation.

After both bills were reported finally to the Senate floor, Senate Majority Leader Harry Reid led efforts to merge both bills into one on November 18, 2009.

The House and Senate bills still had to be reconciled in order to become law. This was also a complex process. The House Democrats were unwilling to accept the Senate version and the Senate could not get 60 votes to pass changes in the House version. After much discussion, the House passed the Senate version which went to the President for signature. Immediately a reconciliation bill was passed amending it. The reconciliation bill was sent to the Senate where it was passed with a simple majority vote. March 23, 2010 is the official date of what is now known as the Affordable Care Act or ACA.

### **Legal Challenges**

Members of several state legislatures have attempted to counteract and prevent implementation of elements of the bill within their states. Legislators in 29 states have introduced measures to amend their constitutions to nullify portions of the health care reform law. Thirteen state statutes have been introduced to prohibit portions of the law. Two states have already enacted statutory bans. Six other legislatures attempted to enact bans, but the measures were unsuccessful.

Twenty-eight states have filed joint or individual lawsuits to strike down the Individual Mandate, a provision in the ACA which requires individuals to purchase insurance coverage or pay a penalty. All of these have failed.

**Individual Mandate:** In *National Federation of Independent Business v. Sebelius* and *Florida v. United States Department of Health and Human Services*, the Supreme Court declared that the legislatively-declared "penalty" was constitutional as a valid exercise of the Congressional power to tax, thus upholding the individual mandate. The Court also limited the expansion of Medicaid initially proposed under the ACA.

**Tax Credits:** *King v. Burwell*, a high-profile case, dealt with premium subsidies to eligible taxpayers who reside in a state that declined to establish a health insurance exchange. Many states had decided that, rather than creating their own exchanges, individuals who chose to access coverage under the ACA could do so through the federal Health Insurance Exchange. Because of specific language in the ACA, approximately 5 million people would have lost their insurance subsidies and coverage since their states had not created insurance exchanges. The Supreme Court ultimately concluded that the IRS can allow premium tax credits for individuals residing in states in which the federal government established the exchange.

**Contraception:** Access to contraception and the conflict with religious beliefs poses one of the major, ongoing legal challenges to the ACA. In 1993, based on the concerns of religious groups that religious freedom was being destroyed, the Religious Freedom Restoration Act was passed by Congress and signed into law. Contraception has become the battleground between these two federal laws.

*Burwell v. Hobby Lobby* was decided on June 20, 2014. As applied to closely held corporations, the regulations promulgated by the Department of Health and Human Services requiring employers to provide their female employees with no-cost access to contraception was determined to be a violation of the Religious Freedom Restoration Act.

For the fourth time in three years, the Supreme Court agreed to rule on challenges to the new federal health care law — this time, religious non-profit institutions' objection to the Affordable Care Act's birth control mandate, which requires employers to provide their female employees with health insurance that includes no-cost access to certain forms of birth control. The Court accepted parts of all seven cases on that issue filed with it under the ACA. It has not yet spelled out how those will be consolidated for a hearing — planned for late March.

### **Major Provisions Operational Today**

The ACA contains provisions that directly target insurance coverage reforms, how health care is organized, delivered, and paid for in the US. These focus on testing new models of delivery such as Accountable Care Organizations (ACOs), changing reimbursement away from volume of services to value for care given, and system improvement investment.

#### **Health Insurance Coverage and Exchanges**

The ACA instructed each state to establish its own state-based exchange (SBE). If a state elected not to create an exchange or if the Secretary of Health and Human Services (HHS) determined a state was not prepared to operate an exchange, the law directed HHS to establish a federally facilitated exchange

(FFE) in the state. Fourteen states and DC established SBEs in 2014, while the remaining 36 states have FFEs. In some states that have FFEs, the states carry out certain functions of the exchange. In other states, the exchange is wholly operated and administered by HHS.

The Centers for Medicare & Medicaid Services (CMS) is incurring significant administrative costs to support FFE operations. According to CMS, a total of \$456 million was used to support exchange operations over the period FY2010-FY2012. CMS spent \$1.545 billion on exchange operations in FY2013 and an estimated \$1.390 billion in FY2014. The agency has relied on a mix of annual discretionary appropriations and funding from other sources for these expenditures. Those sources include expired discretionary funds from the Nonrecurring Expenses Fund, mandatory funding from the Health Insurance Reform Implementation Fund and the Prevention and Public Health Fund, and FFE user fees. CMS budgeted \$1.8 billion for exchange operations in FY2015.

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid. However, when existing policies were cancelled because they did not contain these provisions there was public anger by people who lost their coverage. This anger continues to further the demand for repeal of the ACA.

2015 was a difficult year for the changing insurance markets. Twelve of the 23 ACA funded CO-Ops (Consumer Operated and Oriented Plans) failed. United Health Group expressed concern about the individual market and is limiting its offerings for 2016. Whether United Health Group's actions will be followed by other insurers and how it will affect the insurance market remains to be seen.

#### Medicaid Expansion

Provisions of the ACA would have expanded Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines (\$14,484 for an individual and \$29,726 for a family of four in 2011) by Jan. 1, 2014. As passed by Congress, states failing to participate in this expansion would risk losing their entire federal Medicaid funding.

The Medicaid expansion provision of the law led to challenges that rose to the U.S. Supreme Court where, on June 28, 2012, the court ruled that Congress may not make a state's entire existing Medicaid funds contingent upon the state's compliance with the PPACA Medicaid expansion. In practice, this ruling makes the Medicaid expansion a voluntary action by states.

Given this new choice, most states have been weighing the costs and savings associated with expanding Medicaid to cover most people under the age of 65 with incomes at or below 138% of the federal poverty level (or \$16,242 per year per beneficiary in 2015). Even with the federal government paying

for a significant portion of the cost of coverage for the newly eligible—100 percent in 2014 through 2016, decreasing to 97 percent in 2017 and eventually 90 percent in 2020 and thereafter—fiscal uncertainties remain. As of December 2015, 31 states have expanded Medicaid (including Washington DC), 4 states are still discussing expansion, and 16 states are not adopting expansion.

Texas declined to expand Medicaid and continues to cover only women, children and the disabled. Instead, Texas requested approval of a Medicaid 1115 Waiver from CMS. The 1115 Waiver provided federal funding to design and implement health care delivery system changes that would improve access to care and cost savings. Houston Methodist chose to develop a mental health transition of care project as part of the Texas 1115 Waiver program. Renewal of the Medicaid 1115 Waiver is currently in negotiations between the state and CMS.

#### Health Care Delivery Reform Delivery Model(s):

##### Accountable Care Organizations (ACOs)

An ACO is an entity formed by providers that agree to collectively take responsibility for the quality and total costs of care for a population of patients. In 2012, the ACA established the Medicare Shared Savings Program. If the ACO meets quality benchmarks and keeps spending for their patient below budget, they receive half the resulting savings, with the rest going to CMS. In 2015, there were more than 400 shared savings ACOs serving 7.2 million beneficiaries or 14% of the Medicare population. This is in contrast to the 52 out of 220 ACOs that succeeded in 2013. Most ACOs opted to share in the savings but not the losses.

##### Medical Homes

There has been considerable evidence that comprehensive, coordinated, and well-targeted primary care can improve outcome and reduce per-patient costs. Medical homes include programs that involve private physician practices, community health centers, and home-based care providers.

##### Comprehensive Primary Care Initiative

The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer initiative designed to strengthen primary care. Since CPC's launch in October 2012, CMS has collaborated with commercial and State health insurance plans in seven U.S. regions to offer population-based care management fees and shared savings opportunities to participating primary care practices to support five core "Comprehensive" primary care functions. These five functions are: (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood. CMS pays a management fee of \$20 per member per month. This has had a small impact on reducing ED visits and hospitalization.

##### Multi-Payer Advanced Primary Care Practice Demonstration

Medicare and 8 state pilots are testing how to support physician practices to function as medical homes. This initiative focuses on infrastructure needs such as information technology, data sharing, care management and quality improvement. Timely data sharing remains the biggest challenge in this model.

## Provider Payment Reform

The Affordable Care Act included many payment reform provisions aimed at promoting the development and spread of innovative payment methods to facilitate the adoption of effective care delivery. The earliest of the ACA's provisions related to provider reimbursement slowed growth in fee-for-service payment levels. After 5 years of slowed growth, health care spending picked up with growth topping 5% in 2014 and early 2015 estimates forecast to be the same. The downside of increased Americans with health insurance is increased health care spending. The second factor driving increased spending is the increase in spending on pharmaceuticals. These increases are still below the historical highs of 7% to 10% seen before the ACA.

Other ACA provisions targeted quality problems that led to inefficiencies and jeopardize patient health. The law imposed financial penalties on hospitals with high rates of hospital-acquired conditions and readmissions. From 2010 to 2013 hospital acquired conditions fell by 17% and held at that low in 2014.

Penalties for higher than expected rates of readmissions for Medicare patients within 30 days from discharge were imposed beginning in 2012. Since then, 30 day readmission rates nationally have declined from over 19% to less than 18%. There are challenges from hospitals about unfair penalties for medically complex patients but those metrics will most likely be refined rather than eliminated.

The value-based purchasing program for hospitals is intended to create greater accountability for performance by dispensing bonuses and penalties tied to publicly reported quality measures. Similar programs for physicians are being implemented in phases, starting in 2015, with a full rollout to all fee-for-service providers in 2017.

The ACOs are also testing a payment approach known as bundled payment, a single reimbursement for all the services required for a given medical condition or procedure. This means that physician, hospital, or post-acute services can all be covered under a single payment, which should incentivize the various providers involved in a given patient's care to work together more efficiently. Nearly 7,000 post-acute care providers, hospitals, and physician organizations have signed up to participate in bundled-payment demonstrations, which represent a further step away from payment for individual services and toward shared accountability for quality and costs. This payment methodology appears to be most effective for bundling of certain specialty services such as hip or knee replacement but more challenging for the long term care of medical problems such as diabetes or chronic obstructive pulmonary disease.

In 2015, Secretary Burwell announced a goal to have at least 90% of traditional Medicare payments linked to some form of ACO, medical home, bundled payment, or other value-based payment method by 2018.

<http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years>

### **Summary**

"I think that probably no one fully anticipated when you have a law that phases in overtime how much confusion that creates for a lot of people." — HHS Secretary Kathleen Sebelius, April 2013

- U.S. House has voted 56 times to repeal or undermine the ACA (as of August 18, 2015)
- Numerous legal challenges to the ACA of which 4 are Supreme Court cases

- Enrollment status: 16.4M individuals insured with the uninsured rate dropping by 5% since 2013.
- Individual mandate remains a problem with people choosing to pay a penalty rather than pay a monthly premium they believe to be unaffordable.

From policy organizations to medical journals, everyone in health care and politics is pausing at this 5 year mark to assess the impact of the ACA. The only consensus appears to be that it is too soon to draw definite conclusions. Major reform of a complex problem has had, and will continue to have, successes and failures. Insurance coverage of the uninsured is better but did not achieve the coverage goals that were expected. Spending has slowed. Hospital acquired infections and readmission rates are down. One academic at a Health Affairs conference in Washington made the comment that “we were already starting the quality initiatives but the ACA forced us to speed up the process.” Maybe that is the real success story of the legislative process that created the ACA.