Healthcare Reform: Impact on Care for Low-Income and Uninsured Patients

Presented by:
Lewis Foxhall, MD
VP for Health Policy
Professor, Clinical Cancer Prevention
UT MD Anderson Cancer Center

Updated June 2014.
Competency 4 Objective

• Explain the influence of healthcare reform as it relates to the current plight of underserved people in the State of Texas.
Association of Insurance with Cancer Care Utilization and Outcomes

Cancer Survival by Insurance Status*. 

*Patients aged 18 to 64 years diagnosed from 1999 to 2000; excluded from the analysis: unknown stage; race/ethnicity other than White, African American, or Hispanic; missing information on stage, age, race/ethnicity, or zip code. Covariates included in the model are age, race, sex, and zip code-based income.
Health System Impact

• How has our health system impacted the care of patients?

• How has it impacted nurses and social workers personally?
International Comparison of Health Care Spending as a Share of GDP, 2011

Note: For countries not reporting 2011 data, data from previous years is substituted.
National Health Expenditures as a Share of GDP, 1980-2040

Source: CEA calculations.
Average Health Care Spending per Capita, 1980–2011
Adjusted for Differences in Cost of Living

Uninsured and Poverty in Texas

• Texas has the highest uninsured rate in the nation, at 22.5% or 5.7 million uninsured people in 2012.

• From 2008 to 2009, the Texas poverty rate increased from 15.8% to 17.1%. From 2009 to 2010, the rate increased to 17.9%. The rate went up to 18.5% in 2011 before falling back to 17.9% in 2012.

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2003-2013

Working-Age Texans Are Most Likely to be Uninsured

- **Under 19**: 17.4% uninsured
- **19 to 64**: 33.9% uninsured
- **65 and over**: 4.5% uninsured

Source: U.S. Census Bureau. (2010). B27010 Types Of Health Insurance Coverage By Age
Texas Medicaid: Who is covered?

August 2012, HHSC data

- Medicaid Children, 2,540,312
- Disabled, 418,368
- Elderly, 320,467
- Poor Parents, 143,406
- TANF Parent, 82,660
- Maternity, 93,531

Total enrolled 8/1/2012: 3.6 million Medicaid; 583,000 CHIP
1 in 7 Texans, but 42% of Texas kids

Source: Center for Public Policy Priorities. (2013). Snapshot: Texas and ACA after the 83rd Regular Session
Income Caps for Texas Medicaid and CHIP, 2012

Annual income limit is for a family of three for child and parent categories. For SSI and Long Term Care, income cap is for one person.

Source: Center for Public Policy Priorities. (2013). *Snapshot: Texas and ACA after the 83rd Regular Session*
With the implementation of changes in the federal health system reform law, an estimated additional 32 million people nationwide will be covered.
Who Benefits from the Affordable Care Act Coverage Expansions?

Percentage of the Nonelderly Population With Income Up to Four Times the Poverty level Who Were Uninsured or Purchasing Individual Coverage, 2010

Eligibility for Coverage as of 2014 Among Currently Uninsured Nonelderly Individuals

- Eligible for Financial Assistance: 56%
  - Eligible for Tax Credits: 27%
  - Eligible for Medicaid/CHIP: 11%
  - Medicaid Eligible Adult: 18%
  - Ineligible for Coverage Due to Immigration Status: 13%
  - Unsubsidized Marketplace or ESI: 21%
  - In the Coverage Gap: 10%

Total = 47.6 Million Nonelderly Uninsured

Notes: Those Ineligible for financial assistance includes people with ESI, individuals eligible to purchase unsubsidized Marketplace coverage, and individuals ineligible for coverage due to immigration status. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.

Remaining Uninsured

- **CBO projects:** 92% of under 65; or 95% of < 65 excluding undocumented will be covered in 2019.

- **U.S. Citizens:**
  - Those with VERY low income, and those who would pay more than 8% of income for most affordable exchange coverage will have no penalty (no mandate).
    - Some of these may remain uninsured, and pay no penalty.
  - Tax penalties are about 1/6 of cost of coverage.
  - Some will be uninsured because they still can’t afford their costs, and will pay a penalty; Others may choose not to be covered and pay the penalty.
Remaining Uninsured

Unknown today: what % of low- & moderate-income Texans may stay uninsured?

Undocumented:
- no Medicaid/CHIP (not before, not now),
- no premium help, and cannot buy at full cost from exchange,
- best estimates say 40% of undocumented in U.S. TODAY have private coverage.

Legal Permanent Residents:
- Adults are excluded from Texas Medicaid under state law, but
- Can purchase from Exchange and qualify for help with premiums.
The Patient Protection and Affordable Care Act: Immediate Benefits for Texas
Specific provisions phased in to 2018
The Affordable Care Act: Provisions Enacted by Year
Access to Insurance for Uninsured with Pre-Existing Conditions

• Provides new coverage options to individuals who have been uninsured because of a pre-existing condition. This is in addition to existing state high risk pool coverage option.

• $493 million federal dollars are available to Texas from 2011 through 2013.

To qualify for coverage:

• Must be a citizen or national of the United States or lawfully present in the United States.

• Uninsured for at least the last six months before you apply.

• Must have a pre-existing condition or have been denied coverage because of your health condition.
• **Extending Coverage for Young Adults.** Under the law, young adults will be allowed to stay on their parents’ plan until they turn 26 years old (in the case of existing group health plans, this right does not apply if the young adult is offered insurance at work).

• **Rebuilding the Primary Care Workforce.** These include funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas. (National Health Service Corps)

• **Insurance Companies Accountability.** The law allows states that have, or plan to implement, measures that require insurance companies to justify their premium increases will be eligible for $250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014.

Source: Healthcare.gov
• **Allowing States to Cover More People on Medicaid.** States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available.

• **Increasing Payments for Rural Health Care Providers.** 68% of medically underserved communities across the nation are in rural areas. These communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities.

• **Strengthening Community Health Centers.** The law includes new funding to support the construction of and expand the services at community health centers, allowing these centers to serve some 20 million new patients across the country. Supports the 318 Community Health Centers in Texas but also supports the construction of new centers.

Source: Healthcare.gov
### Texas Federally-Supported Health Centers, 2010

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Center Population</th>
<th>State Population³</th>
<th>US Population³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent at or Below 100% of Poverty</td>
<td>74%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>Percent Under 200% of Poverty</td>
<td>93%</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>Percent Uninsured</td>
<td>54%</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>Percent Medicaid</td>
<td>27%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Percent Medicare</td>
<td>6%</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Percent Hispanic/Latino</td>
<td>66%</td>
<td>40%</td>
<td>16%</td>
</tr>
<tr>
<td>Percent African American</td>
<td>14%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Percent Asian/Pacific Islander</td>
<td>1%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Percent American Indian/Alaska Native</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Percent White</td>
<td>83%</td>
<td>42%</td>
<td>64%</td>
</tr>
<tr>
<td>Percent Rural⁴</td>
<td>42%</td>
<td>11%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Race/Ethnicity may not sum to 100% due to rounding and non-inclusion of two or more races. Race data is inclusive of Hispanic/Latino population. 0% may indicate <0.5%. Rural data from 2010.
Funding the National Health Services Corps

The Act provides funding for the National Health Service Corps ($1.5 billion over five years) for scholarships and loan repayments for doctors, nurses and other health care providers who work in areas with a shortage of health professionals. This will help the 12% of Texans who live in an underserved area. Provision enacted 2010.

- [http://nhscjobs.hrsa.gov](http://nhscjobs.hrsa.gov) is a searchable database for open positions within the within High-Need Areas for Primary Care Medical, Dental and Mental Health Providers.

- For a full list of benefits of the NHSC program, please go to [http://nhsc.hrsa.gov/](http://nhsc.hrsa.gov/).
## Texas Healthcare Shortages

### Texas Public Health Indicators 2010

<table>
<thead>
<tr>
<th>Health Professions Shortage Areas (HPSAs)</th>
<th>U.S. Rank</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>2</td>
<td>440</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td>344</td>
</tr>
<tr>
<td>Dental Care</td>
<td>2</td>
<td>244</td>
</tr>
</tbody>
</table>

**Nursing Shortage Estimates** 41,900

*Sources: Health Professions Shortage Areas: Primary Care, Mental Health, Dental Care FY 2010 data come from HRSA’s Geospatial Data Warehouse, State Profile Report (accessed November 2, 2010).*
Provisions Enacted - 2011

- **Offering Prescription Drug Discounts**
  Seniors who reach the coverage gap will receive a 50% discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020.

- **Providing Preventive Care for Seniors**
  The law provides certain preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare with no out of pocket costs.

Source: Healthcare.gov
• **Yearly Wellness Exam**
  If new to Medicare, “Welcome to Medicare” physical exam is now covered without cost sharing during your first 12 months of Part B coverage. This exam is a one-time review of health as well as education and counseling about preventive services and other care. If enrolled in Part B for longer than 12 months, can get a yearly wellness visit to develop or update a personalized prevention plan based on your current health and risk factors.

• **Tobacco Use Cessation Counseling**
  This benefit is now considered a covered preventive service, whether or not you have been diagnosed with an illness caused or complicated by tobacco use. While the counseling is a covered service, the co-insurance and deductible will apply if you have already been diagnosed with a tobacco related illness.

Source: Healthcare.gov
Screening
No Medicare Part B deductible or copayment for approved screenings:

- Bone mass measurement
- Cervical cancer screening, including Pap smear tests and pelvic exams
- Cholesterol and other cardiovascular screenings
- Colorectal cancer screening (except for barium enemas)
- Diabetes screening
- Flu shot, pneumonia shot, and the hepatitis B shot
- HIV screening for people at increased risk or who ask for the test
- Mammograms
- Medical nutrition therapy to help people manage diabetes or kidney disease
- Prostate cancer screening (except digital rectal examinations)
• **Improving Health Care Quality and Efficiency**
  The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients.

  Additionally, by January 1, 2011, HHS will submit a national strategy for quality improvement in health care, including by these programs.

• **Improving Care for Seniors After They Leave the Hospital**
  The Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities.

• **The Independent Payment Advisory Board** may begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund.

Source: Healthcare.gov
• **Increasing Access to Services at Home and in the Community**
The Community First Choice Option allows states to offer home and community-based services to disabled individuals through Medicaid rather than institutional care in nursing homes.

• **Bringing Down Health Care Premiums**
To ensure premium dollars are spent primarily on health care, the law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement.

If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers.

Source: Healthcare.gov
• **Addressing Overpayments to Insurance Companies**

Today, Medicare pays Medicare Advantage insurance companies over $1,000 more per person on average than is spent per person in Traditional Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The law levels the playing field by gradually eliminating this discrepancy.
• **Linking Payment to Quality Outcomes**
  The law establishes a hospital Value-Based Purchasing program (VBP) in Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients’ perception of care.

• **Encouraging Integrated Health Systems**
  The new law provides incentives for physicians to join together to form “Accountable Care Organizations.” These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save.

Source: Healthcare.gov
• **Reducing Paperwork and Administrative Costs**
The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care.

• **Understanding and Fighting Health Disparities**
To help understand and reduce persistent health disparities, the law requires any ongoing or new Federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce disparities.
• **Improving Preventive Health Coverage**
  To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost.

• **Expanding Authority to Bundle Payments**
  The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment “bundling,” hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare.

Source: Healthcare.gov
• **Increasing Medicaid Payments for Primary Care Doctors**
  As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government.

• **Providing Additional Funding for the Children’s Health Insurance Program**
  Under the law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid.

Source: Healthcare.gov
Prohibiting Discrimination Due to Pre-Existing Conditions or Gender
The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual’s pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status.

Eliminating Annual Limits on Insurance Coverage
The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive.

Ensuring Coverage for Individuals Participating in Clinical Trials
Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

Source: Healthcare.gov
• **Making Care More Affordable**
  Tax credits to make it easier for the middle class to afford insurance will become available for people with income between 100% and 400% of the poverty line who are not eligible for other affordable coverage. (In 2010, 400% of the poverty line comes out to about $43,000 for an individual or $88,000 for a family of four.)

• **Establishing Affordable Insurance Exchanges**
  Starting in 2014, if an employer doesn’t offer insurance, the employee will be able to buy it directly in an Affordable Insurance Exchange. An Exchange is a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer you a choice of health plans that meet certain benefits and cost standards.

Source: Healthcare.gov
• **Increasing the Small Business Tax Credit**
  The law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50% of the employer’s contribution to provide health insurance for employees. There is also up to a 35% credit for small non-profit organizations.

• **Increasing Access to Medicaid**
  Americans who earn less than 133% of the poverty level (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100% federal funding for the first three years to support this expanded coverage, phasing to 90% federal funding in subsequent years.

• **Promoting Individual Responsibility**
  Under the law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption.

Source: Healthcare.gov
Ensuring Free Choice
Workers meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance Exchanges.
• **Paying Physicians Based on Value Not Volume**
  A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care.
A shared responsibility requirement, commonly called an individual mandate, requires that all persons not covered by an employer sponsored health plan, Medicaid, Medicare, or other public insurance programs purchase and comply with an approved private insurance policy or pay a penalty, unless the applicable individual is a member of a recognized religious sect exempted by the Internal Revenue Service, or waived in cases of financial hardship.