

The Affordable Care Act And Its Impact on Future Doctors



West Virginians for Affordable Health Care

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The Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010. The ACA makes fundamental changes in our country's health care system by expanding health coverage to virtually every American; making fundamental changes in the rules that govern insurance companies; and changing the delivery system by placing more emphasis on prevention and primary care.

The Act also contains a number of provisions that will directly affect future doctors. This brochure provides an overview of these changes, including:

- ♦ **Impact of the ACA on patients**, including expansion of health insurance coverage, changes in insurance company rules that reduce discrimination against patients with expensive illnesses, and more emphasis on primary and preventive care.

- ♦ **Impact of the ACA on medical students and residents**, including expansion of the National Health Service Corps, student loans, and graduate medical education.
- ♦ **Changes in the health care delivery system**, including patient-centered medical homes, Accountable Care Organizations, and a Center for Medicare and Medicaid Innovation.
- ♦ **Changes in doctor reimbursement**, including improvements and incentives in Medicare, Medicaid and the Physician Quality Reporting System.

More details on the ACA can be found in the West Virginians for Affordable Health Care's booklet, *The Affordable Care Act: Moving Forward in West Virginia* at www.wvahc.org.



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How Will the ACA Impact My Patients?

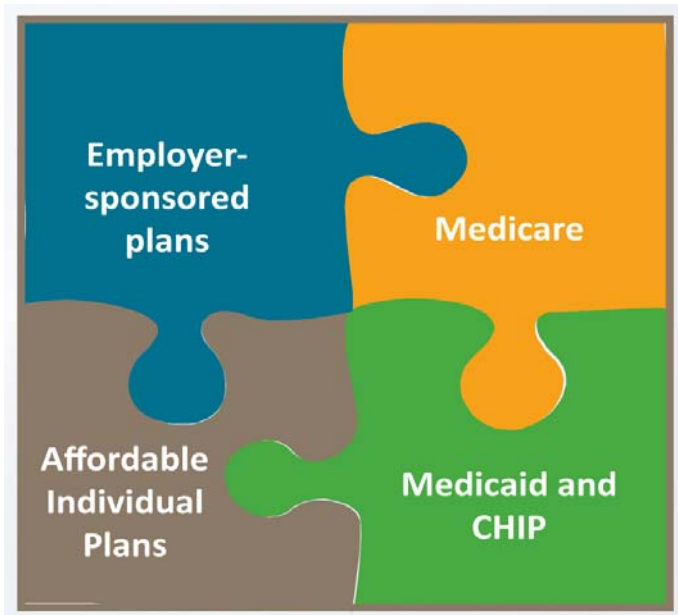
Expanded access to health insurance

Under the ACA, virtually all Americans will have access to affordable health plans by 2014. This will encourage patients to seek appropriate care early on, rather than waiting for their conditions to become more serious and difficult to treat.

The ACA expands health insurance in two primary ways:

1. **Medicaid expansion:** The ACA raises Medicaid eligibility in 2014 to everyone earning less than 138 percent of the federal poverty level (FPL), which is just under \$15,000 for an individual and about \$25,000 for a family of three. This is the greatest expansion of Medicaid in its 45-year history, and will result in an estimated 122,000 new enrollees in West Virginia.
2. **Creation of health insurance exchanges:** The ACA makes private health insurance coverage more affordable through the creation of state health insurance exchanges, beginning in 2014. Exchanges are market places where private insurance companies offer standardized health insurance policies to small businesses and to individuals who do not have access to affordable, comprehensive, employer-sponsored health insurance coverage.

There are significant subsidies for individuals who purchase insurance through the exchange and earn between 100 percent and 400 percent of the FPL (about \$75,000 a year for a family of three). An estimated 178,000 West Virginians will qualify for subsidies as individuals in the exchange. An estimated 42,000 small businesses employing 280,000 people will have the option of purchasing health insurance coverage for their employees in the exchange.



Fundamental changes in insurance company practices

The most important insurance industry change will be the elimination of pre-existing condition limitations beginning on January 1, 2014. Insurance companies will be prohibited from: a) denying people policies due to pre-existing conditions; b) issuing policies with riders that exclude coverage of existing medical conditions; or c) charging higher premiums to people based on their medical conditions.

Prohibiting insurance companies from considering the health condition of a person when selling a policy is likely to fundamentally change how insurance companies compete for business. They will have to provide better value, such as more wellness programs and effective chronic disease management programs, in order to attract and retain customers.

Changes in insurance company rules also include allowing young adults to stay on their parents' insurance policy until age 26. A young adult can be a student or out of school; be married or unmarried; be a dependent on their parent's IRS tax return or file their own tax return; live with his or her parents or live separately; and still qualify for coverage.

Emphasis on preventive measures

The ACA removes the financial barriers to preventive services for millions of Americans. It requires clinically effective prevention measures to be covered by government and some private insurance plans with no cost sharing (no deductible, copayment or coinsurance to the patient.)

Medicare: Since the beginning of 2011, Medicare patients have had access to a new annual wellness visit. A wellness visit “includes a personalized health risk assessment; a review of personal and family medical history; and screening for cognitive impairment. In addition, a list will be compiled of all doctors providing care to the patients. Based on the outcome of the health risk assessment, the patient will receive a five-to-ten-year plan for screenings and other preventive services, and advice and referrals for educational services covering weight loss, physical activity, smoking cessation, nutrition and fall prevention.”¹

The wellness visit is provided to the patient with no cost sharing. Additionally, any preventive measure recommended as an A or B service by the U.S. Preventive Services Task Force will be

provided to Medicare patients with no cost sharing by the patient.

Medicaid: Beginning in 2013, the federal government will increase its financial assistance to states that adopt these preventive services as a covered service for adult Medicaid recipients. Nearly 40 million current Medicaid beneficiaries will have access to these preventive measures, and by 2019 an additional 16 million new beneficiaries are projected to have access to free preventive measures.²

Private insurance: Coverage of the recommended A and B preventive measures has been required on all **new** insurance policies since 2010 and will apply to all plans sold inside the exchange after 2014.

Preventive insurance for Women: Finally, when a new plan year begins after August 1, 2012, a series of preventive measures for women must be covered by insurance companies with no cost sharing for the patient. These services include all FDA-approved contraceptives, screening and counseling for domestic violence and sexually transmitted diseases, screening for human papillomavirus, HIV, etc.

How Does the ACA Impact Medical Students and Residents?

National Health Service Corps

Perhaps the most important change in the ACA for future physicians is an increase in funding for the National Health Service Corps. The budget for this scholarship and loan repayment program will be increased by \$1.5 billion over five years, doubling the Corps' current budget.

The scholarship program pays for tuition, some fees, other reasonable costs, and a stipend (\$1,289 a month during the 2011-12 school year) for a student enrolled in an eligible medical degree program. After graduation, scholarship recipients must work as a primary care physician in an area of need. The penalties for non-compliance are severe, however. If physicians fail



to keep this commitment, they are subject to a penalty of three times the amount of the scholarship plus interest.

Under the Corps' loan repayment program, a primary care physician (family medicine, OB/GYN,

general internal medicine, geriatrics and general pediatrics) can receive \$60,000 in loan repayment for two years of service at an approved facility (e.g., federally qualified health centers (FQHCs), rural health centers, etc.) that is located in a Health Professional Shortage Area. In 2011, there are more than 160 sites in West Virginia approved to

accept physicians in the Corps loan repayment program. Physicians can apply for additional years of service in exchange for additional loan repayment, and can receive \$200,000 for 6 years of service, or even additional loan repayment for additional years of service.³

Initial Contract	Full-Time 2 Years \$60,000	Half-Time 4 Years \$60,000	Half-Time 2 Years \$30,000
3 rd year	\$40,000	Initial Contract	\$20,000
4 th year	\$40,000	Initial Contract	\$20,000
5 th year	\$30,000	\$15,000	\$15,000
6 th year	\$30,000	\$15,000	\$15,000
After 6 years	\$200,000	\$90,000	\$100,000

These payments are in addition to the salary paid to the physician by the FQHC or other facility and are not subject to federal or state income taxation or employment taxes (e.g., FICA).

The Corps' loan repayment program is a competitive program and not an entitlement. However, more than 100 clinicians in West



Virginia are participating in the NHSC loan repayment program in 2011. The loan repayment program will open for new applications in December 2011. Details of any changes, including different amounts of loan repayment and different approved sites, will be available at <http://nhsc.hrsa.gov/loanrepayment/>.

Student loans

The ACA also modifies the Primary Care Loan Program. No longer will a parent's income be considered when determining the financial need of a medical student in this program. Formerly, a physician had to practice in primary care until the loan was repaid. Now, a physician has to practice for 10 years or until the loan is repaid, whichever comes first. Finally, the interest penalty for noncompliance is reduced from 18 percent to the current interest rate plus two percent.

Graduate medical education (GME)

The ACA will redistribute as many as 900 unused GME slots to hospitals in states with the lowest ratio of resident physicians to patients. Three-fourths of the redistributed GME slots will go to primary care or general surgery residency programs.

The ACA also directs the Secretary of the U.S. Department of Health and Human Services (HHS) to grant \$230 million over a five-year period to establish "teaching health centers," allowing residency programs to be developed at FQHCs, rural health clinics, and other community-based settings.

How Will the ACA Change the Delivery System?

One of the most far-reaching aspects of the ACA is reform of the health care delivery system by placing greater emphasis on preventive care, primary care, and coordinated care.

“The current (payment) system, based on volume and intensity, does not disincentivize, but rather *pays more for overuse and fragmentation* (emphasis added),” said Mark McClellan, Director of the Centers for Medicare and Medicaid Services (CMS) under President George W. Bush.⁵ The ACA addresses the problems of overuse and fragmentation of the health care delivery system with several major provisions, which include:

Patient-centered medical homes

The ACA defines a “health home” as a team led by a primary care provider, which could be a physician, nurse practitioner or physician assistant leading a team of other professionals. The team would provide “comprehensive care management, care coordination, health promotion, transitional care, referral to community and social services, patient and family engagement, and the use of information technology to link services.”⁵

The ACA provides state Medicaid programs with a 90 percent match for two years to establish health homes for Medicaid beneficiaries. West Virginia is in the process of applying to CMS for additional funding to establish health homes for certain chronic diseases, such as diabetes and asthma.

The ACA includes three concepts to support health homes: community health teams, community-based collaborative care networks, and primary care extension centers.

1. **Community health teams** bring together a broad spectrum of health professionals from medical specialists to dietitians to social workers. The team contracts with local primary care practices to focus on care coordination and integration of care for *patients with chronic illnesses*. Vermont passed comprehensive health care reform that includes community health teams. Funded by both private and public insurance payers, participating physicians

receive an extra \$1.20 to \$2.39 per member per month (PMPM) to coordinate with community health teams and to develop a care management plan for each participating patient.



2. **Community-based collaborative care networks** are similar to community health teams, but provide the integrated health care *services to low-income patients*. These networks would provide, for example, not just care and case management and after-hours care, but also transportation services. An existing example of these networks is the highly successful Community Care of North Carolina (CCNC). The CCNC is a public-private partnership between Medicaid, CHIP and 14 regional, non-profit networks. Each network receives \$3.00 PMPM for care coordination and each participating physician receives \$2.50 PMPM. The care coordination has reduced emergency department expenses by 23 percent and saved North Carolina more than \$500 million since 2006.⁶
3. **Primary care extension centers** are designed to provide practicing primary care providers with education and technical assistance on evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The funding for this initiative after 2012 is uncertain, however.

Accountable Care Organizations (ACOs)

ACOs are voluntary associations of primary care providers, specialists, hospitals and other health care providers. The ACOs agree to be responsible for the quality outcomes of their

Medicare practice panel of at least 5,000 patients. If the ACO meets quality outcomes and reduces projected costs, then Medicare will share the savings with the ACO. Although patient-centered medical homes are not directly referenced in the ACO provisions of the law, it is expected that they will play a central role in coordinating the care of the Medicare patients.

Innovation Center

The ACA establishes the Center for Medicare and Medicaid Innovation within CMS. The center is

charged with researching, developing, testing, and expanding innovative payment and delivery system models to improve quality and reduce costs, with the capability of rapidly introducing into the Medicare and Medicaid systems those payment and delivery models found effective. The ACA recommends that the center initially review the results of patient-centered medical homes for high-need individuals, women’s health care, and comprehensive or salary-based payments to clinicians.

How Will the ACA Impact Doctor Reimbursement?

Medicare payments

Beginning in 2011, primary care physicians and general surgeons treating Medicare patients will receive a 10 percent bonus for office visits, nursing home and home visits. In order to qualify, providers must bill at least 60 percent of their services in primary care. This bonus will be in effect from 2011 through 2015, and is projected to increase reimbursement to a physician’s practice in the range of \$2,000 to \$16,000 per year.⁷

Medicaid payments

In 2013 and 2014, primary care physicians treating Medicaid patients will be paid Medicare rates for equivalent primary care services. In West Virginia, it is estimated that Medicaid rates are only 77 percent of Medicare rates. During 2013 and 2014, these reimbursement rates will rise to 100 percent, almost a 30 percent increase. The federal government will pay 100 percent for this increase in physicians payments.

Physician Quality Reporting System

What was known as the Physician Quality Reporting Initiative (PQRI) is extended under the ACA. Physicians who volunteer to report quality outcomes for their patients (e.g., the percentage of their diabetic patients that have an A1c below 7) receive a one percent increase in the Medicare reimbursement in 2011, and a 0.5 percent increase in 2012 through 2014. Physicians who

choose not to report the quality data will receive a 1.5 percent decrease in Medicare payments in 2015 and a two percent reduction in 2016.

Sustainable Growth Rate

The ACA does not correct the Sustainable Growth Rate — commonly referred to as the “doctor (payment) fix.” The Sustainable Growth Rate was passed in 1997 by a Republican Congress and signed into law by President Clinton. The law, based on a



complex formula, prescribes an annual adjustment to Medicare Physician Fee Service rates based on the degree that expenditures for these services grow faster than the economy. Congress has passed numerous short-term fixes to keep these cuts in physician payments from going into effect. Now, the Sustainable Growth Rate would require an almost 30 percent reduction in Medicare payments to physicians. Fixing it permanently would cost \$300 billion over the next 10 years, a challenge that has stymied both Democrats and Republicans. The ACA did not address the problem, but “kicked the can down the road” for future Presidents and Congresses to solve. The Sustainable Growth Rate is a serious problem with no easy answers.

Conclusion

The ACA will make dramatic changes in health care over the coming decades. Almost all Americans will have access to health insurance coverage, and the rules governing insurance companies will be changed fundamentally to eliminate their ability to cherry-pick customers and avoid insuring people with pre-existing conditions.

The ACA also promotes clinically effective preventive measures to Medicare patients and for all new private insurance policies, including those sold inside the new health insurance exchanges.

The ACA expands the National Health Services

Corps and redirects unused residency slots to primary care. The ACA increases reimbursements to primary care physicians, but fails to address the Sustainable Growth Rate problem.

Finally, the ACA attempts to reform the nation's delivery system by promoting health homes. Health homes promote quality primary care by reimbursing practices for coordinating the care to their patients across specialists, hospitals, and nursing homes. This fundamental shift in the way we deliver health care may be one of the most profound impacts of the ACA.

Footnotes

1 Melinda Abrams, Rachel Nuzum, Stephanie Mika, and Georgette Lawlor, *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers and Payers*, The Commonwealth Fund, (January 2011). Accessed on December 22, 2011 at www.commonwealthfund.org/.

2 Ibid.

3 *National Health Service Corps Loan Repayment Program*, U.S. Department of Health and Human Services (November 2010). Accessed on December 22, 2011 at <http://nhsc.hrsa.gov/loanrepayment/servelonger.htm>.

4 Mark McClellan, Aaron N. McKethan, Julie L.

Lewis, Joachim Roski, and Elliott S. Fisher, *A National Strategy To Put Accountable Care Into Practice*, Health Affairs. (May 2010): 982–990.

5 Melinda Abrams, et. al., *Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers and Payers*, (2011).

6 Ibid.

7 Ibid. The American Academy of Family Physicians projected that a physician's practice would receive an additional \$2,000 per year, while the American College of Physicians estimated that a general internist would receive \$12,000 to \$16,000 in annual additional payment from the ten percent increase in Medicare payment.



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