Members of the Brown EMHL Community Comment on the Future of the ACA under a Trump Administration

These posts are part of a series of commentaries on the future of the Affordable Care Act (ACA) by faculty at Brown’s Watson Institute for International and Public Affairs, School of Public Health, and Executive Master in Healthcare Leadership program.

Why the Pressure for Reform?
Jim Austin

Jim Austin is a faculty member in the Brown Executive Master in Healthcare Leadership (EMHL) program. He is also a principal at Decision Strategies International which advises global Fortune 500 companies on navigating change. Austin recently published with two other EMHL faculty members Leading Strategic Change in an Era of Healthcare Transformation.

There are two areas I hope the new administration and Congress tackle in seeking to reform or replace the Affordable Care Act (ACA):

High Deductibles: I was recently at a meeting of the Kentucky Hospital Association and heard from several hospitals that their bad debts “had nearly doubled” in the last 6-12 months. The reason? Patients coming in for services and being unable to afford the deductible of their insurance plans. For example, a patient needs an MRI, but when asked to write a check for the first $350 for the service is unable to, leaving the hospital the choice: either accept a $350 write-off and deliver the service or deny the patient access.

Insurance Availability: In too many areas in our country, especially in the rural areas where 65M+ patients seek services, there are diminishing numbers of individual healthcare insurers. As one person said to me recently, “The individual marketplace for healthcare coverage is dead.” If not covered by an employer, individuals and families are seeing very restricted options, with rapidly rising costs. One person told me in his rural area there was now only one “healthcare marketplace insurance offering” for his family. One impact, apart from the narrowing provider network, is rapidly increasing costs: according to this individual, his family healthcare insurance rate had gone from $600/month to over $1700/month in the past three years.

While we can applaud the expansion of healthcare coverage implicit in the ACA, I can only hope the incoming administration enables that coverage to be affordable and hospitals to expand, not curtail, services.

To learn more about Leading Strategic Change in an Era of Healthcare Transformation, go here.
The Price of Price
Sandra Ferretti, EMHL Program Advisor

Sandra Ferretti is a Program Advisor at Brown University School of Professional Studies and was previously a consultant to the State of RI for the build of the State's Health Insurance Exchange, HealthSource RI. She holds her Masters in Health Services Administration from the University of Michigan.

Health care. It's personal – how we gain access to it, how much we pay for it, and the personal relationship and trust we maintain with our providers. President-elect Trump has nominated Congressman Tom Price (R-GA) to be the Secretary of Health and Human Services. Congressman Price is an orthopedic surgeon by training, and is one of the few Republicans to propose specific alternatives to the Affordable Care Act (ACA), including the introduction in of House Bill 2300 “Empowering Patients First Act” in 2013. The stated goal of this bill: to put, “patients, families and doctors in charge by focusing on the principles of affordability, accessibility, quality, innovation, choices and responsiveness.”

Based on H.R. 2300, what questions should be asked in Congressman Price's Senate Confirmation Hearings about his plans for replacing ACA and advancing consumers’ interest.

Let’s start with affordability – the biggest elephant in the room, and one that the ACA addressed by providing subsidies to individuals and families based on income. Congressman Price proposes to offer tax credits to people buying policies. His 2013 proposal based these credits on age alone and did not account for income. Questions should be raised about the sufficiency of these credits in making policies affordable for low income individuals and families. For a family of four earning $40,000, what percent of their income should go towards health insurance? The tax credits must be structured in a way that provides affordability to all. In addition, the proposal indicates that purchasers could take an “immediate credit” versus waiting for their tax filing. That’s great, but how are insurers “made whole” for the actuarially determined cost of their product? Are they supposed to just accept a reduced premium? Subsidies would need to go to insurers rather than individuals. These policies shift the source and payment of subsidies, but do not ultimately address the underlying cost of insurance and cost of health care.

Next up – access to care. An increasing proportion of available policies in the marketplace are deductible plans. Essentially this means that very little is covered until all of that deductible is paid out by the insured. Consumers need to pay a percent of their income to acquire insurance, and get no benefit from that insurance until they pay out all of that deductible – both individual and family. Mr. Price proposed that “high deductible health plans” be renamed “HSA qualified health plans.” Changing the name obscures the meaning to consumers, given that there is very little consumer understanding of the impact of these plans. For consumers, having these plans means that they don’t get health care services until situations are catastrophic.

Not only do these policies limit access to care but, making matters worse, insurers are trying to curtail costs by limiting their networks of providers that consumers must use to get coverage. Let’s hope that Senators read this bill carefully and leverage the hearings to find out how the new administration's policies will address these consumer concerns.
ACA: A View from the ER Frontline  
Dr. Heather Marshall, EMHL Alum ’15

Dr. Heather Marshall is the Southwest associate regional medical director at Island Medical Management and an Executive Master in Healthcare Leadership 2015 Alum. She runs emergency rooms across the region and is also developing Alternative Payment Models within Emergency Medicine. Dr. Marshall shares her perspective on healthcare reform from her frontline position in the healthcare debate.

As we consider the first few years of implementation of the Affordable Care Act (ACA), as well as its future, several themes emerge. The first theme is that while the ACA expanded health care insurance to millions of patients, access to care has not been expanded at the same rate. More health care insurance has meant more patients seek care, but we have not had a similar expansion in the number of doctors or other advanced practice practitioners.

Despite what many in the public believe, Emergency Departments (EDs) are not overflowing with patients seeking primary care. Rather, ED’s struggle to meet demands because of limitations in getting patients admitted to hospitals or arranging other forms of outpatient disposition. Inpatient healthcare and post-acute care are two of the largest drivers of healthcare expenses in the country. As a result, both commercial payers and public policy are driving attempts to move care away from the inpatient setting. This creates a great deal of pressure for EDs as the threshold for admitting a patient is now much higher than it used to be. Safe discharge of many patients who were previously quickly admitted requires more of ED’s time and resources.

A second clear theme is that both Democrats and Republicans support a movement away from fee-for-service payments to hospitals and doctors and toward value-based payments. The Medicare Access and CHIP Reauthorization Act (MACRA) is a bipartisan agreement signed into law in 2015 that directs Centers for Medicare and Medicaid Services (CMS) to move payments away from fee-for-service. In many ways, the implementation of this law is a bigger challenge for the healthcare industry than the ACA because the infrastructure for this change does not yet exist.

A third theme is that some elements of the ACA will likely remain in place but some will clearly be modified and even expanded into Medicare. The biggest challenge is creating sustainable financing for the expanded insurance coverage to those who cannot afford it. The current premium increases for policies purchased on the exchanges has been one of the drivers for electoral change. Unless healthcare costs decrease, this means that payment must be picked up by one or a combination of the following stakeholders: commercial insurers, hospitals, doctors/providers, the government (state or federal), or the public.

The last theme is that the expansion of Medicaid faces urgent funding challenges. The sustainability of the financing of this expansion is threatened on state levels across the country without even considering the impact of a potential repeal of the ACA. Medicaid is funded through a combination of federal money and state money. Many states fund Medicaid with revenue streams that are dependent upon strong economies and this can create pressure on Medicaid budgets during times of slow economic growth.

When we consider these themes collectively, the importance of addressing health care costs cannot be ignored. A significant part of this includes an honest national dialogue of how to equitably distribute the costs of healthcare delivery and insurance.