Finding information about the ACA and its implications is easy. Much has been written, and numerous information sources are available. But all of that pales in comparison with having a look from the inside, as Alan Yordy gives us in this chapter.

According to the Congressional Budget Office, the ACA will add $948 billion to the national budget, and $143 billion of that was meant to be offset by three things: lower hospital payments, increased Medicare taxes on higher wage earners, and additional premiums from young healthy participants.

Lower hospital payments will manifest in many ways, as Yordy points out. Hospitals are facing enormous payment headwinds. At the same time, they will need to increase patient satisfaction as healthcare culture changes from volume-based to value-based.

(continued)
Foresight turns out to be a critical adaptive strategy for times of great stress.

—Jamais Cascio

RUNNING OUT OF RUNWAY

By 2009 healthcare costs consumed 17.6 percent of the total gross domestic product of the United States—$2.5 trillion annually, or $8,160 for every citizen every year. By comparison in 1970 healthcare costs consumed 7.2 percent of the total gross domestic product—$75 billion annually, $360 for every citizen (Kaiser Family Foundation 2009). Projections in 2009 for the Medicare program were dire, suggesting that the program costs would outpace tax-supported funding by 2020. Many economists concluded that the international competitiveness of the United States would be severely compromised if the trend of cost increases continued.

The healthcare-industrial complex was in full bloom. The passage and implementation of the Medicare and Medicaid programs in the mid-1960s fueled much of the growth. More procedures, implantable devices, and pharmaceuticals had been invented in the 40-year period from 1970 to 2010 than during any time in human history. Life expectancy had grown from 70.8 years to almost 78.7 years (CDC 2011). During the same period, the US population grew from approximately 200 million to 325 million. From 1970 to 2010, obesity in the population of the United States grew from 17
percent to 34 percent (CDC 2011). All of these factors explain, in part, the rapid rise in healthcare costs.

In 2009, the Social Security Advisory Board issued a report concluding, “This Board believes it is necessary to offer our own perspectives, not because we are particular experts in health care policy, but because we believe that the rising cost of health care represents perhaps the most significant threat to the long-term economic security of workers and retirees” (Social Security Advisory Board 2009, emphasis added). The debate was on.

THE GRAND BARGAIN

The Patient Protection and Affordable Care Act (ACA) was a grand bargain: almost $1 trillion of payment cuts to providers and increased taxes in exchange for providing 32 million uninsured Americans with affordable health insurance. Physicians, hospitals, and other entitlement spending contributed $455 billion in payment reductions as part of the package (see Exhibit 1.1). Increased Medicare and other taxes contributed $349 billion in new tax revenue. It was the single largest tax increase since the Balanced Budget Act of 1997. On March 23, 2010—the day the bill was signed into law—the wheels were set in motion to fundamentally reorganize one-sixth of the US economy.

Expanding coverage to the uninsured was to be accomplished in two ways: expansion of Medicaid and development of healthcare exchanges. The exchanges would allow the public to purchase health insurance with associated federal subsidies for families with incomes of up to 400 percent of the federal poverty level for 2014—$94,200 for a family of four. Early estimates suggested that 33 to 50 percent of the expansion would come from increasing the eligibility for the Medicaid program to 138 percent of the federal poverty level. The remainder would come from individuals purchasing insurance via the healthcare exchanges, sometime called “marketplaces.” The exchanges and the Medicaid expansion would
provide approximately 71 percent of the US population under the age of 65 with some level of subsidy to be entitled to or purchase health insurance coverage (Families USA 2013). Not since the Great Depression have so many Americans been entitled to a subsidy under a single program.

In exchange for the significant expansion in coverage, hospitals and physicians in the United States agreed to more than $155 billion in payment cuts over a decade. Most of these cuts were focused on Medicare payments and the elimination of disproportionate share hospital (DSH) payments to hospitals that serve a higher percentage of Medicaid and uninsured patients. A multitude of additional requirements, with much of the detail delegated to the secretary of Health and Human Services (HHS), was part of the legislation.

For instance, the secretary was given broad authority to establish rules for the exchanges and to work with states to establish
state-operated exchanges. The rules under which the exchanges operate could either reduce insurance risk or increase the risk. Reducing the risk could be accomplished by spreading it over all the newly insured. One example of risk reduction was the decision to open exchanges for enrollment each year for a period of three months, similar to Medicare Advantage provisions.

Increasing the risk could occur by easing the enrollment criteria and causing the cost of insurance to go up. On the other hand the secretary adopted a rule requiring insurance companies and providers to cover 90 days of care when someone signs up for a plan through an exchange, regardless of whether she has paid her premium. If the premium is not paid, the policy is cancelled within 90 days. During the 90-day grace period, care must be provided at the expense of insurers and providers.

Additionally, the secretary was required to establish rules and provide funding for new exchange start-ups called consumer-operated and oriented plans or “co-ops”—community-based non-profit organizations desiring to provide health insurance products (Hancock 2013). The secretary was also required to draft rules for Medicaid expansion and fraud recovery. All told, the secretary was required to draft and implement regulations in 1,120 specific areas under the ACA.

In the end, passage of the ACA came down to a single issue—funding of abortion and other women’s healthcare services. During the debate in 2009 and 2010, the bill hung in the balance. For decades the Church Amendments had provided conscience protection for nonprofit hospitals that received federal funds but were morally opposed to abortion (HHS 1973). In 1997 the Hyde Amendment went further and banned federal funding for abortion services. Some argued that the language contained in the ACA would open the door to federally funded abortion. Because contraceptive coverage regulations and conscience clause protection were left to the HHS secretary to determine, there was also concern that the long-standing policy allowing organizations to opt out of providing these services would be revoked.
The Senate acted first, passing a version of the bill that most believed would retain both conscience protection and the Hyde Amendment, which required annual Congressional renewal. In the meantime, the Senate lost its filibuster-proof Democratic majority with the election of Republican Scott Brown from Massachusetts. The smaller majority of Democrats in the House meant that the House would have to adopt the exact version of the bill as passed by the Senate. A holdout group of pro-life Democrats, led by Michigan Congressman Bart Stupak, prolonged debate for months. After President Barack Obama signed an executive order reaffirming the Hyde Amendment, the group relented, and the bill narrowly passed in the House—219 to 212. The grand bargain was complete, but passed without bipartisan support. This single issue overshadowed the more profound changes to healthcare.

THE SUPREME COURT: CASTING THE FUTURE

Pay for Performance. From the beginning the ACA was a partisan debate. Unlike most major social legislation of the past 50 years, there was no central agreement on the tenets of healthcare in America. The ACA had the hallmarks of a debate that would have a long shelf life. A Supreme Court contest was inevitable from the beginning, and not just one. The complexity of the law made it highly likely that many aspects of the law would be tested. The first test went to the heart of the law on two issues: mandating Medicaid expansion and individual insurance purchase.

The major element of the Supreme Court decision in 2012 found that requiring Medicaid expansion in all 50 states was coercive. The court ruled that while the federal government may encourage states to participate in federal programs, it may not require them to do so. “When Congress threatens to terminate other grants as a means of pressuring the States to accept a Spending Clause program (Medicaid), the legislation runs counter to this Nation’s system of federalism” (NFIB v. Sebelius 2012, 5).
The second and more fundamental constitutional issue was the personal mandate requiring individuals to obtain insurance or pay a federal tax. In some adroit constitutional hairsplitting, Justice John Roberts writing for the majority found that the federal government does have the ability to tax citizens to encourage certain behaviors. “The payment is not so high that there is really no choice but to buy health insurance; the payment is not limited to willful violations, as penalties for unlawful acts often are; and the payment is collected solely by the IRS through the normal means of taxation” (NFIB v. Sebelius 2012, 9). A new standard emerged—as long as a tax to encourage the purchase of health insurance is sufficiently reasonable, the tax may stand. For the ACA the tax is $95 or 1 percent of adjusted gross income in year one, rising to $600 or 3 percent of adjusted gross income by year three and thereafter (Healthcare.gov 2014).

The most enduring element of Justice Roberts’ decision will likely be his reinforcement of the Commerce Clause of the Constitution: “…the individual mandate is not a valid exercise of Congress’s power under the Commerce Clause and the Necessary and Proper Clause. The individual mandate thus cannot be sustained under Congress’s power to regulate Commerce” (NFIB v. Sebelius 2012, 58).

In a single opinion, the Supreme Court fundamentally changed the underlying social contract in the ACA and raised doubts for many about the prospects of further expanding healthcare coverage. First, the requirements that the tax must be reasonable, not coercive, and that the Medicaid expansion could not be required made it unlikely that 32 million previously uninsured Americans would gain coverage under the ACA. Second, the ruling made it unlikely that the United States would one day have a single-payer system for healthcare requiring all citizens to have health insurance with some consumer responsibility.

Case law continues to rewrite the ACA. Burwell v. Hobby Lobby (2014) reinstated conscience protection for some private employers who find it objectionable to provide contraceptive coverage to employees. In conflicting opinions, the Court of Appeals for the
Fourth Circuit and the District of Columbia found that providing subsidies for purchasing health insurance through the federal exchange may be a violation of the ACA. The Supreme Court will continue to play a vital role as an interpreter of provisions within the ACA.

**REWRITING THE BASIC RULES OF HEALTHCARE IN AMERICA**

The debate over ethics and morals overshadowed three critical issues that, as a result, received little attention:

- Hastening the move from employer-based insurance to individually purchased insurance
- Moving from defined-benefit health insurance to defined-contribution health insurance, expanding individual responsibility for healthcare costs
- Vesting the Internal Revenue Service (IRS) with significant new regulatory power over healthcare in America.

Since World War II, much of the expansion of health insurance has focused on employer-based health insurance. It was provided as a benefit and could be considered as a pretax expense, making it an attractive way to provide coverage to employees. Employer-based insurance was widely accepted by the early 1960s as an essential employee benefit.

That benefit was often fully covered by employers. The norm was indemnity coverage, meaning that after the employee paid an often modest deductible, all additional medical expenses were paid by insurance via the employer’s health plan. While the costs of health insurance remained low in the early days, employees often made few contributions to the premium payment; employers covered the costs.

8  Capital Projects and Healthcare Reform
The services were limited as well. In the mid-1950s a primary care physician would typically manage up to 20 common drugs, and hospitals had limited technology to apply to serious diseases such as cancer, heart disease, and stroke. Forty percent of the drugs prescribed in 1960 would not have been available in 1954 (Stevens 1996). With the inception of the Medicare and Medicaid programs in 1965, which paid doctors and hospitals for the entire cost of care, the rapid expansion of medical technology and treatments began in earnest.

The structure of the health exchanges places considerable emphasis on the individual. Tax credits are individually based. Purchasing is focused on the individual. And while small businesses (those with fewer than 50 employees) are also given tax credits, little attention is given to creating exchanges for small employers. With no penalties for small employers to drop coverage for their employees and significant tax credits for individuals to purchase healthcare insurance, the ACA has the potential to hasten the move from employer-based coverage to individual coverage. In fact, the Congressional Budget Office (CBO 2014) estimates that both employer-based coverage and non-group coverage will decline, shifting coverage to the exchanges.

The ACA also gives employers openings for creativity. Some large employers concluded that the $2,000 to $3,000 federal tax per employee is significantly less than the cost of providing health insurance. Some are seeking to establish their own private health insurance exchanges. Much like the public exchange, large private employers prompted by human resource consulting firms have established programs in which the employer provides a specific financial contribution to an employee. The employee can then select from a variety of options and pay the difference between what the employer contributes and the actual cost of insurance. The result of this second trend is that employees will now cover more of their own healthcare expenses and employers will limit their financial exposure for healthcare cost increases (Howard 2014).
These two trends that received virtually no debate in 2010 will ultimately reshape healthcare in the US. For hospitals and physicians it means that patients will have much higher out-of-pocket expenses and that collection prior to elective services will be essential. High-deductible plans will also encourage individuals to purchase basic healthcare services from low-cost retail vendors, leaving high-complexity services for hospitals and physicians. Employers will limit their increase in expenses to the rate of general inflation.

Yet to be fully understood by the public is the role of the IRS in ACA implementation. The IRS was granted broad powers to collect information regarding Americans’ health purchasing decisions and assess taxes based upon that information. The executive branch has urged initial leniency in enforcement of these powers. Information related to health insurance and calculation of subsidies is now required as part of individual annual income tax filings. But unlike ordinary tax obligations, the ACA eliminates the ability of the IRS to collect fines and impose penalties for those refusing to pay the tax for failing to obtain insurance. Only the US attorney general may file a civil action to collect overdue ACA tax obligations.

MIND THE GAPS

There is a growing gap between incentives provided by exchanges and the private sector and those included in public programs. Medicare and Medicaid, now comprising approximately 45 percent of total health coverage expenditures, have very different rules (Healthcare.gov 2014). Medicare is a federally administered program; Medicaid varies from state to state. While the federal government pays more than two-thirds of the Medicaid bill, many of the rules, payment rates, and coverage guidelines are set by each state.

The 2012 Supreme Court decision resulted in greater disparities in state Medicaid programs. Not only do states set the rates for
provider payments under the Medicaid program, but each state establishes rules of participation. Over the past two decades, various states have been granted waivers to compliance with federal Medicaid regulations. Waivers range from an Ohio program to provide special services to seniors to an Oregon program to limit the provision of certain services when medical efficacy has not been demonstrated. Because of the waivers far more variations in state Medicaid programs exist than there are states.

Yet the programs all have one thing in common. Compared to employer-provided insurance and insurance exchange products, there is little patient participation in payment for the program. This lack of patient participation results from the fact that most Medicaid clients have annual incomes of less than 138 percent of the federal poverty level—$32,500 for a family of four (CMS 2014). Hence, there is less engagement by the Medicaid patient in the financial aspects of healthcare delivery.

Compounding this dynamic is the fact that the payment rates to physicians and hospitals established by states for their respective Medicaid programs are usually 60 to 75 percent of the cost of providing care to this population. Depending on the state’s economic health, the federal government typically pays anywhere from half to two-thirds of the cost of Medicaid in each state—about 57 percent on average. The ACA established the incentive to cover the entire cost of the Medicaid expansion for those states that chose to expand the program. By 2019 the federal government will reduce its portion of the cost to 90 percent for the expansion population.

At the end of 2013 the federal government assessed the actual expenditures per Medicaid enrollee in each expansion state and set the payment rates accordingly. This policy tends to “bake in” the disparities in provider payment rates that vary widely from state to state. For instance, the Kaiser Commission on Medicaid and the Uninsured (2010) found that for the states expanding Medicaid, the payment per Medicaid enrollee per year varied from a low of $3,441 in California to a high of $8,029 in Washington, DC.
Support for the ACA has been variable in the early years (See Exhibit 1.2). At no point did the law enjoy broad support from the electorate. Aside from those whose views of the ACA were shaped by political considerations, the two early beneficiaries of the legislation were young people under the age of 26 and those with preexisting medical conditions. As of January 2011, children, step-children and foster children up to age 26 could be added to their parent’s health insurance coverage. The children need not reside with their parents and could be married so long as they met the age requirement. Approximately 3 million young adults are projected to obtain coverage under this provision (Kennedy 2014).

Also in 2011, all employer-based health plans were required to provide coverage for all conditions, including plans offered in the insurance exchanges and Medicaid. The major exception to the requirement was health plans purchased in the individual market. The US Government Accountability Office estimates that 20 to 66 percent of all adults in the United States have preexisting conditions that previously prevented them from obtaining health insurance coverage (Knox 2014).

There are other winners as well, according to one early analysis of firms whose stock value has increased. Advertising agencies retained by federal and state exchanges to promote sign-ups had strong performance in 2013 (Knox 2014).

Information technology (IT) firms were another group of early winners in the run up to implementation of insurance exchanges. Estimates range from $350 million to as high as $634 million spent on IT projects to build the Healthcare.gov site (Kessler 2013, Vlahos 2013). Because of tight timelines, much of this work was contracted outside of normal government procurement processes. The federal exchange was plagued by early IT issues, resulting in contract revisions and terminations.
Exhibit 1.2 Tracking Poll Chart Since 2010

ACA Opinion Still Tilts Negative, But Narrowing Since January

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

Source: Kaiser Family Foundation (2014).
One of the most glaring expenditures occurred in Oregon, which spent more than $160 million with Oracle, one of the nation’s leading technology companies. An additional $100 million was spent on other preparations, including advertising. The website did not function by the time enrollment was closed in early 2014. Oregon then announced that it would give up on a state exchange and join the federal exchange—www.Healthcare.gov.

As of March 31, 2014, the first round of enrollment in the federal exchanges ended. A few losers were emerging as well. The first were employers whose insurance premiums increased to cover the cost of the ACA mandates. United Health Care estimated that premiums would increase 116 percent in the individual market, 25 to 50 percent in the small group market, and 20 to 25 percent in the large group market (Jugan 2012). An independent study commissioned by the State of Oregon concluded that rates for the individual and employer market would climb by at least 35 percent and could increase more than 50 percent by 2015 (Wakely Consulting Group 2012). The American Health Policy Institute, a group representing human resource professionals for larger employers, estimates that the ACA will add from $4,800 to $5,900 per employee to the cost of health insurance for large employers. The total cost of the ACA to all large US employers over the next ten years is estimated to be from $151 billion to $186 billion, or 5.9 percent more than what they would otherwise spend (Troy and Wilson 2014). Regardless of the source, estimates of cost increases to employers that provide insurance for their employees are the norm.

Some employees not qualifying for individual subsidies may also be net losers. Anecdotes abound regarding small employers that have decided to provide a stipend to employees rather than continuing to provide health insurance. In the early roll-out it has been assumed that those who need health insurance coverage due to medical conditions will purchase through the insurance exchanges.

Some employees are also facing changes in the number of hours worked. The ACA defines a full-time worker who must be offered
coverage as anyone working for an employer 30 or more hours per week. Anecdotes suggest that some employers are creating positions limited to 25 to 29 hours per week to avoid this requirement. This mirrors pre-ACA enactment when some employers limited employee hours to 35 hours per week to fall below the threshold for providing benefits, including healthcare coverage.

The last group of employees affected by the ACA is unionized workers in the retail sector. Their employers face competition from companies without an organized work force. Unions often maintain healthcare trusts that are employer-funded while nonunion employees may receive insurance through the exchanges. As the union employers encounter stiff price competition from nonunion groups, they will likely be pressured to reduce healthcare costs. This pressure is likely to come in the form of offering higher-deductible plans similar to public-sector healthcare exchanges. Over time, union health trusts will be pressured to reduce the cost of healthcare, even to the point of offering private health exchanges themselves.

THE EARLY NUMBERS

Much has been made of the fact that the administration reached its goal of enrolling more than 7 million people during the opening enrollment period ending March 31, 2014. In some cases the enrollment period was extended, leading to claims that the final number may be closer to 8 million (Kennedy 2014).

This number masks the reality of the enrollment. Remember the original contract—32 million additional insured Americans with approximately one-third enrolled under the Medicaid program and two-thirds enrolled in commercial insurance plans via the exchanges? Most medical provider associations, including the American Hospital Association and the American Medical Association, supported the ACA under these assumptions, despite significant payment cuts also part of the act. The premise was that
charity care and bad debt would be substantially reduced to offset payment reductions.

Final numbers from the federal government are not yet available. The early numbers from three states that were aggressive in enrolling individuals under the ACA stand in stark contrast to the original agreement. Current enrollment estimates suggest that 80 to 90 percent of the Medicaid enrollees are Americans who previously had no healthcare insurance. The exchanges are a different story. Current estimates are that only 30 to 40 percent of the exchange enrollees are new. Most are transitioning from other insurance onto the exchange.

Rather than enrolling one new Medicaid recipient for every two commercial/exchange enrollees, current estimates suggest that there are four to five new Medicaid enrollees for each commercially insured exchange enrollee. In the state of Washington with one of the more successful enrollment efforts, as of March 31, 403,852 citizens had been enrolled in Medicaid. The exchange enrolled 146,497 (Healthcare Authority of Washington 2014).

Assuming that nationwide approximately 7 million enrolled in the exchanges and an additional 4.8 million enrolled in the 26 states with Medicaid expansion, it could be estimated based on the Western states’ experience that the number of new enrollees would be 7 million—out of the total of 56 million uninsured Americans.

IMPLICATIONS FOR PHYSICIANS AND HEALTHCARE SYSTEMS

Pay for Performance. Pay for performance (P4P) has gotten a lot of attention. Under P4P, hospitals get paid more or less based on performance measures, mostly relating to clinical and patient service quality. Considerable attention has focused on the Institute for Healthcare Improvement’s Triple Aim: improving the patient experience of care (including quality and satisfaction), improving...
population health, and reducing the per-capita cost of care. While
the Triple Aim will continue to be the focus of many healthcare
systems, a much larger impact on physician and hospital financial
health will come from other changes:

- Cuts in Medicare reimbursement beyond what the ACA
  had envisioned
- New CMS regulations such as the “two-midnight rule”
  that reduces payments for hospital utilization
- The inability of the ACA to meet the original goals of the
  program for a robust commercially insured population.

Depending on location reductions in payment from these and
other factors could reduce net revenue by 5 percent or more.
Reduced utilization resulting from higher copayments and
deductibles will also further reduce net hospital revenue. Com-
bined with other steps to reduce hospital use, admissions will be
weak for the foreseeable future. The political calculus in 2010 was
that hospital utilization would decline as a result of the industry
improving patient quality and safety performance. Whether that
calculus was correct is an open and disconcerting question.

**Higher Deductibles.** High deductibles and more patient
participation in the cost of care have had an early and profound
impact. While the nation’s best hospitals have improved outcomes
(Premier, Inc. 2014) there is growing evidence that when faced
with a high out-of-pocket payment for care, patients postpone or
cancel elective procedures. Physicians and hospitals must now con-
sider themselves in the retail business. When an emergent condi-
tion under the terms of Emergency Medical Treatment and Labor
Act (EMTALA) does not exist, providers find themselves need-
ing to address the matter of high deductibles. The most progres-
sive organizations are prequalifying patients and making payment
arrangements for elective (nonemergent) procedures prior to their
scheduling. This single change in practice is causing some patients
to reevaluate the urgency of an elective procedure. The risk is that delays could result in conditions becoming more expensive to treat.

**Strained Safety Net.** States that aggressively expanded the Medicaid enrollment are now finding early access issues, especially to primary care providers. As the Medicaid rolls grow to more than 20 percent of many organizations’ revenue, it is now considered likely that some limits on Medicaid service are necessary. As part of the 2013 federal budget agreement, cuts in disproportionate share hospital (DSH) payments to hospitals were postponed until 2016 (CBO 2013). However, as a result of the delay, the cuts will be deeper in future years.

**Consolidation.** Pressures on utilization and payment make the consolidation of providers inevitable. These pressures include a predicted decline in acute care utilization from 10 percent to 50 percent, increased regulatory requirements, and the push for provider organizations to assume greater risk. Risk-taking by ACOs, Medicare Advantage programs, and Medicaid risk organizations requires sufficient capital reserves to cover financial losses associated with patient care. These factors result in a reduction of net revenue on the same or smaller book of business.

Some futurists predict that the nation will have five to seven large health systems by 2030 with a number of regional niche players. The 2013 merger of Community Health Systems and Health Management Associates created the nation’s largest for-profit health system (Brimmer 2013). Similarly the Trinity/Catholic Health East merger created the largest faith-based system in the United States (Selvam 2013). The result of this consolidation is likely to be fewer US hospital beds by 2020 and increased focus on ambulatory settings for care delivery.

This should be no surprise. For most of the post–World War II period, healthcare has operated as a community-based cottage industry focused around the hospital, protected from market forces by cost-based reimbursement. Now market forces have been enhanced by greater consumer participation in covering the cost of medical care. Yet the greatest change, ushered in by the advent
of Medicare and Medicaid and enhanced by the ACA, is the role of government as “price fixer” for physician and hospital services. The good old days of cost-based reimbursement are fading, giving way to an era of fixed payments that often do not cover today’s cost of delivering care to those who have been given an entitlement to receive that care. In this environment, mergers, acquisitions, and failures are inevitable.

**Innovation.** Much of the healthcare system was built by and for the post–World War II generation. As social media have become ubiquitous, younger generations seeking healthcare services will hasten innovation in healthcare delivery. High deductibles and the need for convenience make it more advantageous to seek care in easily accessible settings with minimal waiting and easy payment. Retail centers, such as the startup ZoomCare.com, will replace more cumbersome traditional systems of care delivery. Providers in this category focus on the cash-paying patient, typically do not accept Medicaid, and often have advanced technology used to connect to the patient for everything from scheduling to billing.

Many innovations will be technology-based. Eric Topol (2013) describes the “creative destruction of medicine” by detailing the potential of technology to connect patients to providers in real time. While the old notion of house calls by physicians is returning in some communities, a more profound change is likely to take place. Using electronic home monitoring and “telehealth” consults, conditions from congestive heart failure to diabetes can be managed with minimal involvement of traditional clinics. In an extreme example of innovation, the IBM computer Watson is being programmed to assume simple diagnostic tasks that could ultimately replace a number of physicians’ diagnostic tasks (Yuan 2011). As physicians and hospitals take more financial risk under ACA, those that survive will be early investors in new technology and innovation.

**Information Technology.** The American Recovery and Reinvestment Act of 2009 (also known as the stimulus bill) contained a provision that will reverberate for many years—to spend $19.2 billion on healthcare information technology and establish requirements
that all physicians and hospitals must meet by 2015 or face fines for noncompliance (HHS 2009). Underlying the act were assumptions that 70 percent of hospitals and 90 percent of physicians would have electronic medical records (EMR) by 2020. Hospital-based providers, those employed in provider-based entities, were not eligible for incentive payments. The penalties for failure to comply, unless granted an exemption due to hardship, were significant—approximately 1 to 2 percent of total Medicare payments to hospitals and 3 percent of the total Medicare fee schedule for physician practices.

Unprecedented expenditures on EMRs began in earnest. While the incentives provided until the penalty period begins in 2015 are usually 10 to 20 percent of the actual cost of an EMR, the penalties persuaded most hospitals and physicians to plan for large investments in IT. Three years prior to the adoption of the stimulus bill, Rand Health estimated that cumulative healthcare IT expenditures would be more than $120 billion by 2020 (Hillestad 2005). Savings resulting from these investments resulting in better care would be five to six times the investment. Today, expenditures in 2020 for mobile healthcare IT alone are expected to be $50 billion (Grand View Research 2014).

Despite these massive investments under way in healthcare, neither the stimulus bill nor the ACA included provisions for interoperability. There is no requirement that systems provided by different vendors and used by various health systems will be able to share common patient information. This requirement will be essential for seamless patient care, one of the goals of the ACA.

SHOW ME THE MONEY

Capital will be critical to transform the American system of healthcare. While capital investment in acute care hospitals’ bricks and mortar generally will fade, massive investments in innovation, IT, and ambulatory care will predominate. If the 1990s was the decade
of “bricks and mortar” capital, the current decade will be characterized by “clicks and order” capital. Technology investments will predominate, allowing providers to obtain real-time clinical information to manage care and place all orders electronically.

The mainstay of healthcare financing is likely to be tax-exempt bonds for nonprofit community-oriented delivery systems. Organizations that are able to maintain A+ to AA ratings will continue to have access to markets at prevailing market rates. Most access to this form of capital will be secured by a claim on the revenue streams of these organizations.

At the same time, sources of capital are likely to become more diverse. In 2000, approximately 10 percent of all US hospitals were owned by for-profit organizations. By 2010 that number increased significantly and will continue to grow. Investors will play a great role in funding the development of the healthcare delivery system. The 2012 acquisition of HealthCare Partners in California by the dialysis company DaVita for $4.4 billion suggests that public companies see value in healthcare delivery (Tirrell and Kitamura 2012).

Recently, taxable debt has also proven to be a stable source of financing, as an alternative to bond financing. With low interest rates and in a break from traditional tax exempt financing, Catholic Health Initiatives assumed $1.2 billion of new debt in 2012 through a consortium of banking partners (Williamson 2013).

Regardless of the source of financing, the resulting pressures from the ACA and the maturing of the healthcare industry will place greater emphasis on growth, consolidation, and operating success. Successful organizations are likely to have the following characteristics:

- Large organizations with $5 billion or more in revenue with a significant level of integration across the care-delivery spectrum
- Ability to demonstrate annual net revenue growth or compound annual growth rate (CAGR) of 6 to 8 percent
• Strong balance sheet with at least 175 days of cash
• Effective balance of care for public sector patients (Medicare and Medicaid) and commercially insured patients
• Geographic diversity, not dependent upon the policies of any single political jurisdiction for funding and regulation
• Quality, patient safety, and patient engagement scores that are in the top quartile nationally
• Reasonably strong operating performance of at least 9 to 12 percent operating earnings before interest, taxes, depreciation and amortization (EBITDA)
• Substantial market share, often first or second in geographies served
• Ability to manage financial risk in the delivery of care, often having some insurance capabilities

Organizations with at least five to six of these characteristics will have significant advantage under the ACA. In the past rating agencies looked primarily at financial measures. Today, issues related to integration of pre-acute, acute care, and post-acute delivery are given consideration as are measures of quality and patient engagement. While a strong balance sheet and solid annual operating performance are still highly valued by rating agencies, the ACA focus on bundled payment and P4P has placed greater value on attributes beyond simply financial measures.

IT’S STILL EARLY, BUT . . .

Although the most significant elements of the ACA are still early in their development, a number of ideas deserve more scrutiny during implementation. Twenty-six states and the District of Columbia are participating in the Medicaid expansion. Thirteen states will not participate. The remainder are still making determinations
regarding participation or are seeking alternate means of participation (see Exhibit 1.3). This factor leads to the first hypothesis that needs further investigation: States that delayed implementation of Medicaid expansion will have more time to determine how to fund expansion (if at all); providers in those states will be in a stronger financial position.

In these states virtually all of the new enrollees will be through the exchanges and will have some form of commercial insurance. Since commercial insurance payments to providers are generally higher

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**Exhibit 1.3 Where the States Stand on Medicaid Expansion**

26 states, DC, Expanding Medicaid—May 22, 2014

![Map of the United States showing Medicaid expansion status](image)

**EXPANDING COVERAGE FOR LOW-INCOME RESIDENTS**

- Expanding Coverage: 27
- Considering Expansion: 4
- Not Expanding Coverage at This Time: 20

Notes: Based on literature review as of May 22, 2014. All policies subject to change without notice.

HHS has announced that states can obtain a waiver to use federal funds to shift Medicaid-eligible residents into private health plans.

The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

than Medicaid payments, providers will see a significant benefit with the infusion of new enrollees with payment for health services at higher rates. This will improve the payer mix for these health systems.

Prior to the implementation of the ACA, there were many predictions of an impending shortage of primary care physicians. The ACA attempted to address this matter with higher short-term payments (at Medicare rates) for seeing Medicaid patients. Innovation grants from CMS also provided incentives to create patient-centered medical homes (PCMHs). However, other changes counteract these incentives. Some providers do not serve or have closed their practices to Medicaid recipients. This practice, known as cherry-picking, leaves those practices with patients mostly with commercial insurance or some form of Medicare, including Medicare Advantage.

This leads to the second hypothesis: For states that expanded Medicaid, the early years will be marked by expanded insurance with limited access to some physician specialties, especially primary care. Under this scenario, the ACA will have provided insurance to millions of new Medicaid enrollees, some of whom will have limited access to primary care physicians. Where safety net hospitals close due to lack of funding, hospital access also could become an issue.

With the potential for limited access to primary care, one solution that is being explored in many communities is development of federally qualified health centers (FQHCs). Most FQHCs provide primary care services and receive additional federal funding beyond what Medicare or Medicaid generally pays. They also provide services that are similar to those in PCMHs. The additional funding results in FQHCs receiving three to four times the amount of payment that would be provided to non-FQHC health providers. Most private physicians groups and clinics do not qualify for FQHC funding, leading to the third hypotheses: Specialty mechanisms such as FQHCs will be critical to serving the Medicaid population. These entities have the effect of transferring additional costs of care under the Medicare and Medicaid programs to the federal government.

Part of the grand bargain of the ACA was 32 million new enrollees and a ratio of two new exchange enrollees for every new...
Medicaid enrollee. Early reports suggest that a minority of enrollees through the exchanges are new enrollees, and may be moving from employer-based coverage to individual coverage. While some Medicaid enrollees are moving from other insurance, a far greater percentage of the Medicaid enrollment is from those who are newly insured.

In March 2012 the CBO concluded, “Fewer people are now expected to obtain health insurance coverage from their employer or in insurance exchanges; more are now expected to obtain coverage from Medicaid or CHIP or from non-group or other sources. More are expected to be uninsured” (CBO 2012). By April 2014 the CBO anticipated “that coverage through the exchanges will increase substantially over time as more people respond to subsidies and to penalties for failure to obtain coverage . . . and that coverage through the exchanges is projected to increase to 24 million in 2016” (CBO 2014). Exchange enrollment is then projected to remain approximately the same through 2024.

Accepting at face value the CBO report of 6 million exchange enrollees in 2014, this projection requires a four-fold increase in enrollment by 2016. This large projected gain in exchange enrollment in such a short period of time leads to the fourth hypothesis: Enrollment in the exchanges will fall short of the estimates envisioned at the time the ACA was passed.

Other CBO projections in the April 2014 report seem contradictory. For instance, the average annual federal subsidy per exchange enrollee is projected to be $4,830 by 2016. The average annual cost of a silver-level exchange insurance plan is projected to be $4,400 (CBO 2014). During the first year of enrollment more than 80 percent of the enrollees purchased either the silver plan or the less expensive bronze plan. Yet the tax for failing to purchase insurance in 2016 is $695 annually, or 2.5 percent of annual income. This suggests the fifth hypothesis: Current taxes imposed in lieu of purchasing insurance will prove to be an inadequate incentive to purchase insurance unless the cost of insurance less the federal government subsidy is approximately equal to the $600 annual tax. If the
tax is significantly less than the cost of the insurance to enrollees, most people will make the rational choice of the tax unless they have a medical condition requiring treatment. Since there are no accurate projections for actual market dynamics, only time will yield the answer.

The Commonwealth Health Insurance Connector in Massachusetts provides an instructive lesson for the nation regarding the last issue—the number of health plans offered through the exchanges. When the plan was first implemented in 2007, six major insurance carriers offered health plans in the state. Until implementation of the ACA, two major insurers offered plans and captured a significant share of the market—Harvard Pilgrim and a Blue Cross affiliate. Later Centene Corporation under the name CeltiCare was added, the first new insurance product in the state in 20 years (Corlette et al. 2011). Under the ACA offerings in 2014 a few more, mostly small plans entered the state exchange. Nevertheless the first six years of the Massachusetts Connector suggest the last hypothesis: The number of insurers and exchanges will consolidate significantly over the next five years, leaving fewer insurance exchange options. This early Massachusetts experiment did not result in a significant reduction of healthcare costs, which led to implementation of rate controls on insurers in 2013.

BUDGET RECONCILIATION AND GRAND BARGAIN

What we know today as the ACA is actually two pieces of legislation. The first is the Patient Protection and Affordable Care Act, HR 3590. This bill was adopted first by the US Senate, then the House. The second is the Health Care and Education Reconciliation Act of 2010, HR 4872. HR 4872 was adopted by a process known as budget reconciliation, originally designed to make small revisions to federal budget legislation. Over the years creative legislators expanded the use leading to the Byrd Rule, which placed some limits on the process. Most importantly, the legislation
cannot increase the federal budget deficit. If a provision increases the deficit, the life of the provision is ten years.

To date the ACA is not subject to the ten-year limitation of the budget reconciliation process because all current projections indicate that its implementation will reduce the budget deficit. The impact of the ACA is being watched carefully with annual projections from the CBO. The most recent calculation is that the ACA will reduce the deficit by less than the original projections: “$152 billion, rather than $206 billion, for that decade” (CBO 2014).

If the budget impact of the ACA threatens to increase the budget deficit, the ten-year limitation on any bill adopted by budget reconciliation will be the subject of significant debate and could automatically trigger review. The Health Care and Education Reconciliation Act of 2010, which contains a number of crucial budgetary matters that support the ACA, could be subject to review in 2020.

While most in Congress now quietly admit that some form of the ACA is here to stay, a potential threat is repeal by the same budget reconciliation process that passed a portion of the ACA. Under this scenario the Republicans would need to hold a majority in the House and Senate and win the presidency. The Supreme Court ruling that the heart of the ACA is the ability of the federal government to assess a tax seems to strengthen the case for repeal by the budget reconciliation process.

All of these scenarios are conjecture. The partisan nature of the ACA’s passage, the shift to an individual insurance market with high deductibles, and the unintended consequences inevitable in such a massive overhaul of a large segment of the economy ensure an ongoing debate. Yet the ACA’s chance of survival is significantly enhanced by the large-scale entitlement it created, one that will ultimately benefit more than 70 percent of all Americans.

You have to be fast on your feet and adaptive or else a strategy is useless.

—Charles de Gaulle
Key Takeaways

• The healthcare bill was unfinished when it was passed.

• Reform is not likely to live up to the promise to deliver 32 million newly insured Americans in exchange for the healthcare industry giving up $1 trillion in payments over ten years. The impact it will have remains to be seen.

• The bill is heavily weighted to reducing costs concurrently with increasing coverage—a high-wire act at best to coordinate the timing.

• In order to get the bill passed, Congress used the budget reconciliation process, eliminating improvements that are often made in Conference Committee. The ACA is also at risk for ongoing Supreme Court challenges.

• The bill was imperfectly planned and executed and made more difficult with the Supreme Court decision to eliminate the requirement for Medicaid expansion.

• The focus on IT solutions in the stimulus bill of 2009 and related expenses have created a major impediment to other capital spending.

NOTES

1. The exact number of new pages and details of 2014 IRS 1040 and forms related to ACA are still under development as of June 1, 2014.

2. These estimates are gathered from conversations with various officials who are sampling enrollee’s insurance status. McKinsey and Company have completed a sample from across the nation (McKinsey Center for US Health System Reform 2014).
3. The calculation assumes that 80 percent of Medicaid enrollment is new enrollees and that 40 percent of exchange enrollment is new enrollees. As more data become available, this calculation may change.

4. The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions: 1) improving the patient experience of care (including quality and satisfaction); 2) improving the health of populations; and 3) reducing the per capita cost of healthcare.

5. The medical home is a concept first introduced by the American Academy of Pediatrics (AAP) in 1967. In its initial version, the AAP defined the medical home as the center of a child’s medical records. At the time, the care of children with special healthcare needs was the primary focus of the medical home concept. The definition has evolved to reflect changing needs and perspectives in healthcare. Today’s medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. Another key factor is that the focus of the medical home has shifted to include all children and adults, not just children with special healthcare needs.

6. Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
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