Implementation Challenges

2:20 p.m. to 3:50 p.m.

Mr. Gildemeister will review several key statistical measures compiled and published by his office at the DOH. He will establish that access to healthcare insurance coverage does not necessarily mean that the individual has access to needed healthcare services.

Dr. Springer will present an overview of the state's primary care physician workforce shortage. Dr. Springer will identify current and anticipated health care workforce shortages; evaluate current and potential incentives currently available to develop, attract, and retain a highly skilled and diverse health care workforce; and identify current causes and potential solutions to barriers related to the primary care workforce. These barriers include training and residency shortages; disparities in income between primary care and other providers; and negative perceptions of primary care among students.

Professor Hyman will discuss other ongoing challenges with health care reform implementation.

Stefan Gildemeister

Mr. Gildemeister is the Minnesota State Health Economist. He is also Director of the Health Economics Program at the Minnesota Department of Health. Before serving in this and other positions at the health department beginning in 1998, Gildemeister conducted comparative research for a number of research institutions in the United States and Germany. He is a graduate of the New School for Social Research and the University of Bremen with a master's degree in both economics and business administration.

Jeremy Springer, MD

Jeremy Springer, M.D., is chair of the Minnesota Medical Association's Primary Care Physician Workforce Expansion Advisory Task Force. Dr. Springer practices in the areas of adolescent health, sports medicine, and obstetrics at Park Nicollet in St. Louis Park, MN. Dr. Springer is a graduate of the University of Minnesota Medical School.

David Hyman, JD, MD

David A. Hyman, MD, JD, is the Ross and Helen Workman Chair in Law and Professor of Medicine at the University of Illinois, where he directs the Epstein Program in Health Law and Policy. He focuses his research and writing on the regulation and financing of health care. He teaches or has taught Health Care Regulation, Civil Procedure, Insurance, Medical Malpractice, Law & Economics, Professional Responsibility, and Tax Policy.

While serving as Special Counsel to the Federal Trade Commission, Professor Hyman was principal author and project leader for the first joint report ever issued by the Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition" (2004). He is also the author of "Medicare Meets Mephistopheles," which was selected by the U.S. Chamber of Commerce/National Chamber Foundation as one of the top ten books of 2007. He has published widely in student edited law reviews and peer reviewed medical, health policy, and law journals.

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MANHATTAN INSTITUTE FOR POLICY RESEARCH

WHY OBAMACARE WILL END HEALTH INSURANCE AS WE KNOW IT

Richard A. Epstein &
David A. Hyman

INTRODUCTION

President Barack Obama's signature health-care legislation, the Patient Protection and Affordable Care Act (PPACA), was sold to the public with the explicit promise that "if you like your health plan, you can keep your health plan." On June 15, 2009, President Obama assured the annual meeting of the American Medical Association: "No matter how we reform health care, we will keep this promise:…. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what."[1] Similarly, at a press briefing on June 23, 2009, President Obama stated: "If you like your plan and you like your doctor, you won't have to do a thing. You keep your plan; you keep your doctor. If your employer's providing you good health insurance, terrific. We're not going to mess with it."[2] To this day, the White House website has a "Reality Check" page devoted to "debunk[ing] the myth that reform will force you out of your current insurance plan," which flatly states that "you can keep your own insurance."[3]

These promises were not made lightly. Their chief function was to defuse the public opposition that had sunk the previous attempt at comprehensive health reform during the Clinton administration. Instead of a wholesale restructuring, President Obama promised that the PPACA would not work major changes into the fabric of American health care for the large majority of the American people who feared disruption in their own

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coverage, even as those same Americans were willing to entertain targeted reforms to deal with the uninsured. But at no point was the proposed remedy on the same modest scale as this framing of the problem would suggest. Indeed, although President Obama's promise suggested otherwise, private plans were necessarily threatened by the massive expansion of federal coverage.

Despite the president's promise that "you can keep your own insurance," key PPACA provisions are calculated to undermine the long-term viability of the private insurance market, by making existing coverage unaffordable or unavailable at any price. Indeed, while individuals may technically be allowed to keep their plans, that protection exists in name only. Plan serial numbers may temporarily remain the same, but the PPACA's combination of high taxes, large subsidies, and extensive mandatory contractual terms seems likely to eventually drive most private insurance plans out of business.

The methodical hollowing out of the president's promise is proceeding in three sequential stages. The first stage was completed with the enactment of the PPACA, which claimed to grandfather existing coverage but did not really do so. The second stage is currently taking place, during the long transition between the passage of the PPACA and the time that its major regulation of the private marketplace—most notably, the individual mandate and the exchanges—takes effect in 2014. Assuming that the Supreme Court upholds the constitutionality of the PPACA and that President Obama is reelected, the PPACA will be implemented more or less as written. Then, the third stage, necessarily more speculative than the first two, involves the likely effects once the PPACA is fully phased in, beginning in 2014.

RESTRICTIONS ON GRANDFATHERED PLANS

If President Obama had wanted to limit the impact of the PPACA on existing coverage arrangements, the starting point should have been a comprehensive and durable grandfathering of all existing plans. That way, the PPACA would not directly dictate changes in existing coverage, even if it had indirect spillover effects on the overall supply and demand of health-care services. Although the PPACA did include a weak grandfathering provision, it also imposed multiple regulatory obligations on private plans. More specifically, the PPACA required private plans to take steps to:

- Allow adult children to remain on a parent's policy until age 26;
- Restrict the percentage of premiums that could be spent on profit and overhead (also known as regulating medical loss ratios, or MLRs);
- Prohibit the use of exclusions on preexisting conditions for coverage provided to children (aged 18 and under);
- Gradually eliminate annual and lifetime limits on coverage; and
- Cover certain preventive services at no cost to the patient.

Each of these provisions doubtless sounds like a good thing—but none is consistent with the promise made by President Obama. Ordinary people don't think that they keep their existing coverage just because they keep the same plan number, while the underlying benefits and administrative structure of that plan are changed by government order. More important, as detailed below, several of these provisions have had a very significant impact on private coverage during the two years since the enactment of the PPACA.

Finally, the PPACA left the door open for private plans to lose their grandfathered status, depending on regulations that the secretary of Health and Human Services (HHS) was directed to issue at some later date. Early estimates suggested that a majority of plans would lose their grandfathered status in short order.[4] Thus, the explicit statutory language of the PPACA is largely inconsistent with the promise made by President Obama, even before one considers how the legislation has been implemented to date.

DIFFICULTIES WITH IMPLEMENTATION

To date, efforts to implement the PPACA have been dogged by economic and political difficulties, which are likely to prove even more intractable as time goes forward. The provisions that have taken effect are largely off-budget, in an obvious attempt to make the PPACA's cost look lower during the ten-year budgetary window used to "score" the cost of legislation. We focus on three of the provisions mentioned above.

Preexisting Conditions

Effective September 2010, the PPACA banned the use of exclusions based on preexisting conditions for children. A similar (but broader) prohibition takes effect for adults in January 2014. The 2014 ban is accompanied by an individual mandate to obtain coverage, but the 2010 ban was not.

Decreeing a ban on excluding preexisting conditions without adding an individual mandate is inherently destabilizing. Indeed, the federal government is now defending the constitutionality of the individual mandate before the Supreme Court as a necessary and proper means for preventing the PPACA's regulation of private insurance, including the prohibition on exclusions based on preexisting conditions, from destabilizing the coverage market. During the 2008 campaign, then–Senator Obama supported a ban on preexisting conditions for children, accompanied by a mandate to obtain coverage. In so doing, he implicitly acknowledged how difficult it would be to impose one without the other.

Predictably, some insurers responded to the market disruptions created by this provision by substantially raising prices, while others announced that they would no longer offer child-only policies, and some announced that they would withdraw from the market entirely.[5] The federal government scrambled to find a way to minimize the fallout, with mixed results.[6] It is difficult to see how this sequence of events is consistent with a promise that "you can keep your own insurance," when the PPACA changes key contractual provisions in ways that make existing coverage unaffordable, or unavailable at any price.

Minimum Essential Coverage

The PPACA contains detailed provisions that outline what it terms "minimum essential coverage."[7] The detailed and expansive provisions require employers to offer "Cadillac" coverage to workers who often cannot pay for it out of their modest incomes. Some employers have for years offered "mini-Med" plans to their low-wage employees, but those mini-Med plans do not satisfy the standards for minimum essential coverage. The drafters of the PPACA apparently assumed that such employers would simply sweeten the offered benefit package—but many employers instead informed HHS that unless these conditions were waived, they would drop coverage entirely. Rather than face this gap in coverage, HHS gave short-term waivers to more than 1,000 employers, covering more than 3 million workers, while denying waivers to other employers. Some states received waivers from the MLR requirements, while others did not. But for these discretionary waivers, the PPACA would have caused the complete meltdown of this part of the coverage market, again indicating the mismatch between the promises made by President Obama and the economic reality of the PPACA. Further, the reliance on discretionary waivers papers over serious difficulties in plan design and presages that the balance between employer plans and the government exchanges will prove highly unstable once the exchanges open for business in January 2014.

Religious Exemptions for Abortion, Contraception, and Sterilization

The PPACA has also created another huge unresolved controversy over whether the government can require religious institutions to cover health-care services for abortion, contraception, and sterilization for their employees. The Catholic Church, in particular, has announced that it cannot accept those obligations, and will order its affiliated entities to drop all coverage unless the rules are changed. The administration has scrambled to respond, suggesting that insurers should provide

these services at no extra charge, or that some other compromise can be worked out after the 2012 election.

Whatever one thinks of the moral questions involved, this controversy highlights the extent to which the PPACA will result in changes in existing coverage. The controversy is also sure to impose additional pressures on the PPACA. Many religious organizations self-insure for basic coverage—so for them, the "compromise" offered by the Obama administration is a sham. Further, religious organizations that do not self-fund will still face increased costs so long as insurance carriers can insist on price increases for general coverage when special services are left unpriced. The impasse foreshadows major disruptions of existing health-care plans.

FUTURE DIFFICULTIES

After January 2014, the PPACA will provide subsidies for individuals who do not obtain coverage through an employer to obtain coverage through state-run or federal exchanges. But the implementation of this plan is fraught with difficulty because the PPACA did not eliminate the existing tax subsidies for obtaining coverage through one's place of employment. This combination has the potential to upend existing coverage arrangements.

The analytical point is simple, although the required computations are somewhat complex. For low-wage workers, the PPACA provides substantial subsidies for coverage obtained through the government-regulated exchange. At the same time, the tax code provides only modest subsidies for low-wage workers obtaining coverage through their places of employment. For high-wage workers, the subsidy pattern is reversed. After one factors in the penalty levied on employers whose employees obtain coverage through the exchange, many low-wage workers and their employers turn out to be jointly better off financially if those workers obtain coverage through an exchange. At the other end of the spectrum, high-wage workers and their employers are jointly better off if coverage is supplied through the place of employment.

In practice, employers do not face an all-or-nothing choice, and the opportunities for strategic behavior are numerous. If the employer can design a benefit package that appeals to more low-risk/low-cost employees than high-risk/high-cost employees, members of the latter group will voluntarily drop out of the employer-based plan. By migrating to the exchanges, they make themselves and their employer better off, at the expense of taxpayers (and the risk pool of those enrolled in the exchange) who have to pick up the slack.

These dynamics will place considerable pressure on existing coverage arrangements. Some employers will do nothing. Others will drop coverage for all employees. Many will experiment with fine-tuning the terms of coverage, the boundaries of the firm, and its staffing. The only certain thing is that existing arrangements will prove far from immutable—particularly when employers and employees gain jointly from unbundling and rebundling of coverage. Stated more concretely, the differential subsidies and incentives created by the PPACA are likely to prove extremely destabilizing to the continuation of employment-based coverage, which will, in turn, dramatically increase the on-budget cost of the PPACA.

The Congressional Budget Office and Joint Committee on Taxation recently tried to estimate the impact of the PPACA on employment-based coverage.[8] Their baseline estimate is that "about 11 million people who would have had an offer of employment-based coverage under prior law will not have an offer under the [PP]ACA."[9] Other plausible assumptions resulted in substantially higher estimates.[10] So much for "if you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what."

CONCLUSION

We have already shown that existing coverage programs have not survived the passage of the PPACA intact. More ominously, we believe that no form of private insurance

is likely to survive long under the decision to use the PPACA to impose substantial coverage mandates and price controls, while eliminating the underwriting discretion needed to control adverse selection by employers and employees. Even if employers prefer to keep offering coverage in this hostile environment, only a hardy few sellers of health plans will have the grit and the skill, in the long run, to navigate the extensive administrative guidelines already issuing from a multitude of government agencies.

These harsh conditions will undermine the stability of private plans. The presidential promise that you will not be forced to change your coverage turns out to mean only that the federal government will not flatly *ban* private coverage going forward. Even viewed in the most favorable light, the government's supposed guarantee of plan stability to employers, insurers, or health-care providers is an empty promise. It is more accurate to say that the PPACA deliberately undermines these private plans by disrupting both the demand and supply sides of the market.

In time, high taxes, large subsidies, and extensive mandatory contractual terms in tandem could well drive most private plans out of business. That outcome is a virtual certainty if a public option is added to the mix. The imposition of rate, standards, and reporting regulations will help finish off the job. Where and when the tipping point comes, no one can say in advance, and perhaps some tenacious and well-run private plans may ultimately survive. But in the end, our gloomy prediction is that in the absence of a major change in course, a regulatory cascade will first force some plans to fail, after which other private plans will topple like tenpins.

These multiple machinations seem likely to set the stage for a single-payer system to emerge from the wreckage. It will be no tribute to the democratic process if the single-payer system that could not have been adopted on a straight-up vote becomes the law of the land, without the blessing of reasoned debate, or an actual vote on that outcome.

Richard Epstein is the Laurence A. Tisch Professor of Law at the New York University School of Law and a Manhattan Institute visiting scholar. David Hyman is the Richard & Marie Corman Professor of Law and professor of medicine at the University of Illinois, where he directs the Epstein Program in Health Law & Policy.

Endnotes

[1] Remarks of President Barack Obama, June 15, 2009, at http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association.

[2] David Nather, "Health Care Reform: 4 Inconvenient Truths," Politico, March 16, 2012, at http://www.politico.com/news/stories/0312/74119.html. See also http://www.whitehouse.gov/the-press-office/press-conference-president-6-23-09.

[3] Health Insurance Reform Reality Check, at http://www.whitehouse.gov/realitycheck/3.

[4] See David Hogberg and Sean Higgins, "Keep Your Health Plan Under Overhaul? Probably Not, Gov't Analysis Concludes," *Investor's Business Daily*, June 11, 2010, at http://www.investors.com/NewsAndAnalysis/Article/537208/201006111932/Keep-Your-Health-Plan-Under-Overhaul-Probably-Not-Govt-Analysis-Concludes.aspx. See also http://www.posey.house.gov/UploadedFiles/HealthCareReformDraftRegulations-June-2010.pdf.

[5] See, e.g., N. C. Aizenman, "Some Insurers to Halt New Child-Only Policies," *Washington Post*, September 21, 2010, at http://www.washingtonpost.com/wp-dyn/content/article/2010/09/20/AR2010092006682.html; and Julie Rovner, "Health Insurers Skirt New Coverage Requirements for Kids," NPR Shots, September 21, 2010, at http://www.npr.org/blogs/health/2010/09/21/130013723/colorado-insurers-skirt-new-coverage-requirement-for-kids.

[6] "Health Care Reform Law's Impact on Child-Only Policies," August 2, 2011, at http://www.help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf.

[7] PPACA § 5000A.

[8] Congressional Budget Office, "CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance," March 2012, at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance.pdf.

[9] This figure is partially offset by those who will be able to obtain coverage through their place of employment as a result of the PPACA, for a net decrease of 3–5 million. Ibid, p. 4.

[10] Ibid.

Convicts and Convictions: Some Lessons from Transportation for Health Reform

David A. Hyman

University of Illinois College of Law

June 14, 2011

University of Pennsylvania Law Review, Vol. 159, p. 101, 2011
Illinois Program in Law, Behavior and Social Science Paper, No. LBSS11-21

Abstract:
The Patient Protection and Affordable Care Act (PPACA) is a Rorschach test. To its enthusiasts, PPACA is a historic transformation that will dramatically broaden access, lower costs, reduce the deficit, and eliminate health care fraud, waste, and abuse. To its critics on the right, PPACA is a catastrophically misguided, ineffective, and unaffordable monstrosity, crammed down the throats of an unwilling public by special deals and legislative chicanery. To its critics on the left, PPACA is a disappointment of epic proportions; with control of the presidency and the House and a filibuster-proof majority in the Senate, the Democrats couldn't even deliver a public "option," let alone a single payer.

PPACA has given rise to a massive amount of commentary - much of it devoted to an in-depth explication of why the writer's interpretation of PPACA (almost always chosen from one of the three options offered above) is the "correct" one. This Article focuses instead on lessons that reformers should have learned from transportation if they had actually wanted to reform the American health care system. The transportation of convicts from Britain and Ireland to America and Australia between 1718 and 1868 provides a case study of the importance of three "I"s - incentives, institutions, and individuals - to the observed mortality patterns. The article connects these issues to several fundamental design defects in PPACA, and then explores the importance of three additional "I"s - ignorance, incompetence, and ideology - in the design and implementation of PPACA. It concludes by considering whether PPACA is sustainable, even taken on its own terms.

Number of Pages in PDF File: 45

Keywords: Health reform, PPACA, incentives, institutions

JEL Classification: I11, J32, K32

Accepted Paper Series

Minnesota Medical Association Primary Care Physician Workforce Expansion Advisory Task Force

Jeremy Springer, MD, Chair

Health Law Institute Symposium

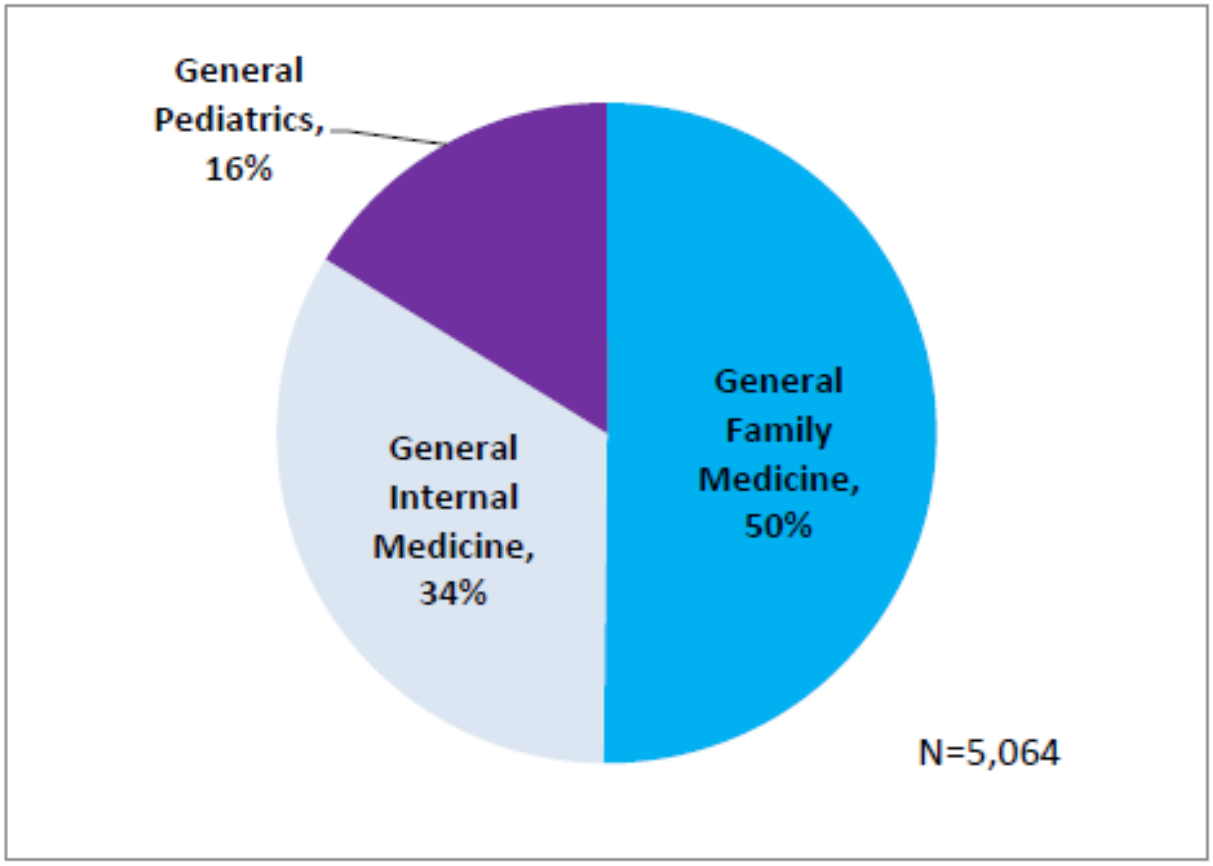
Hamline University School of Law

October 24, 2014

Minnesota Medical Association

Primary Care Physician Workforce Shortage

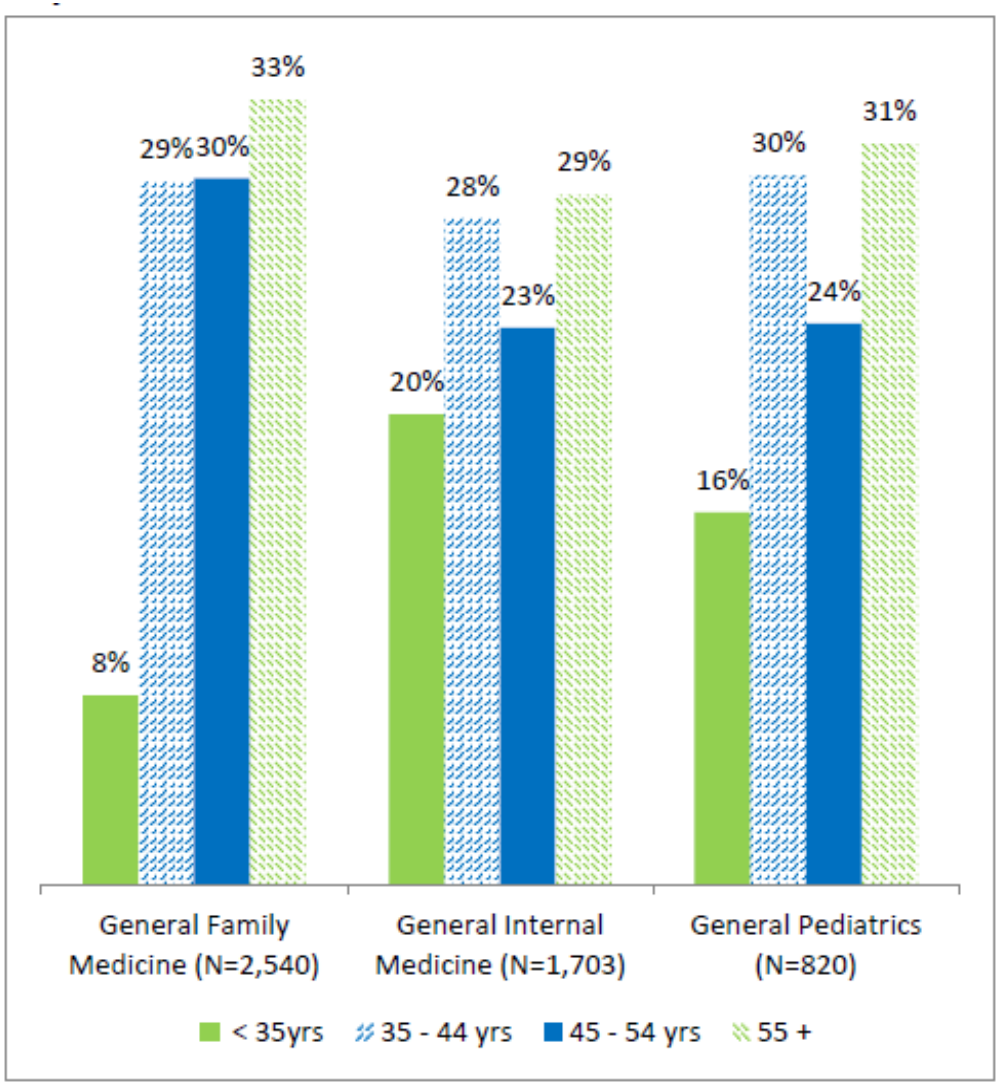
Primary Care Physician Mix in Minnesota (2011-2012)



Source: BMP and MDH

Source: Minnesota's Primary Care Workforce (2011- 2012), MDH, Office of Rural Health and Primary Care

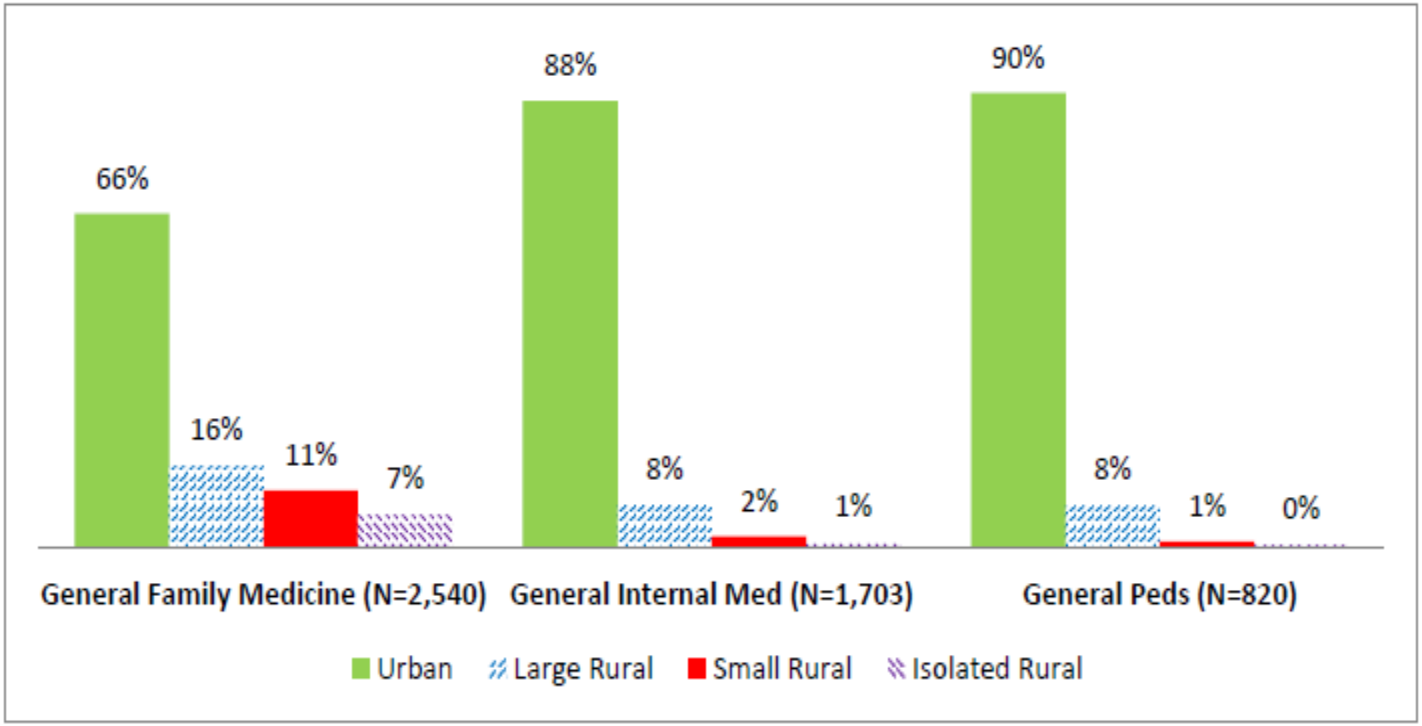
Age Distribution of Primary Care Physicians in Minnesota



Source: BMP and MDH

Source: Minnesota's Primary Care Workforce (2011- 2012), MDH, Office of Rural Health and Primary Care

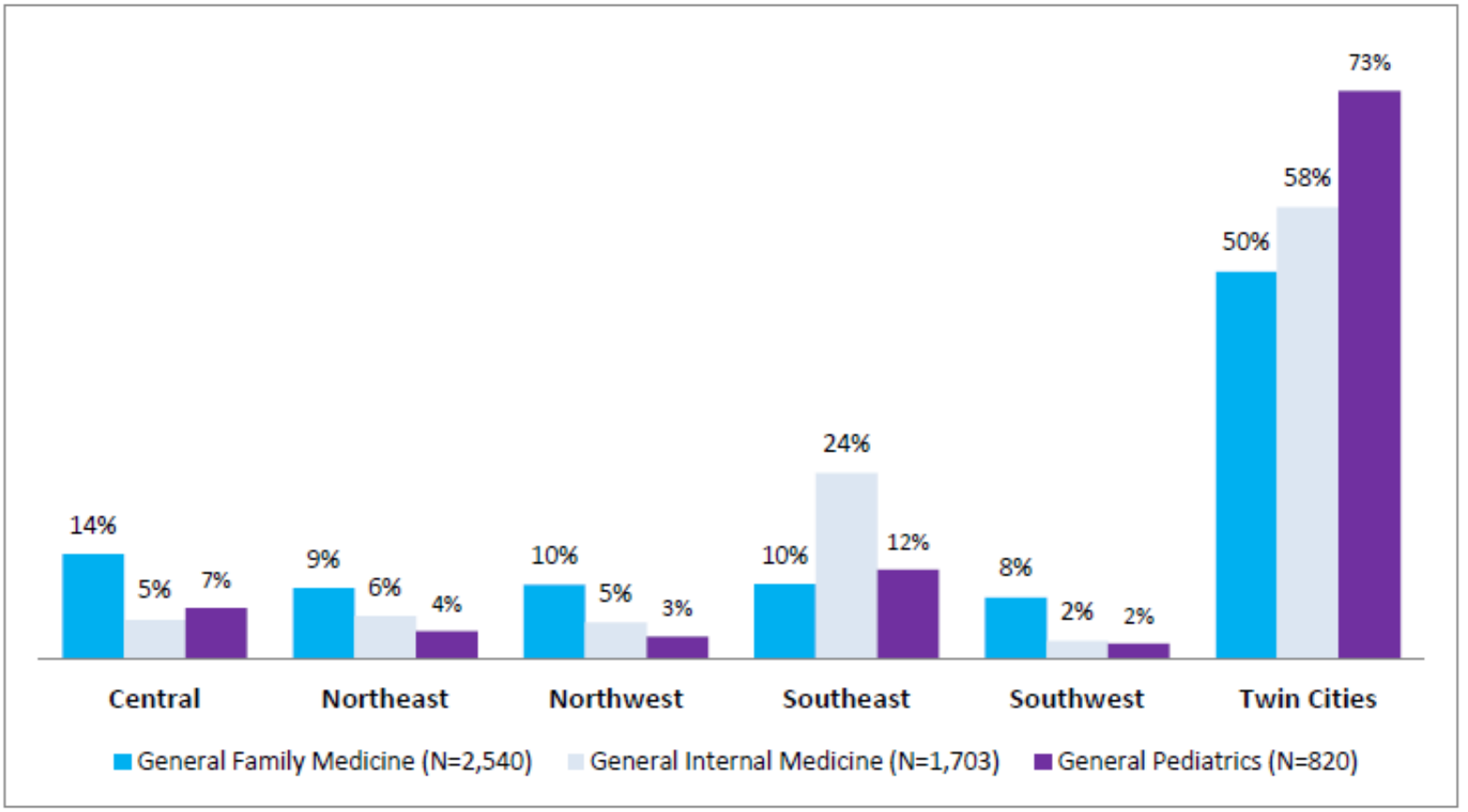
Rural - Urban Distribution



Source: BMP and MDH

Source: Minnesota's Primary Care Workforce (2011- 2012), MDH, Office of Rural Health and Primary Care

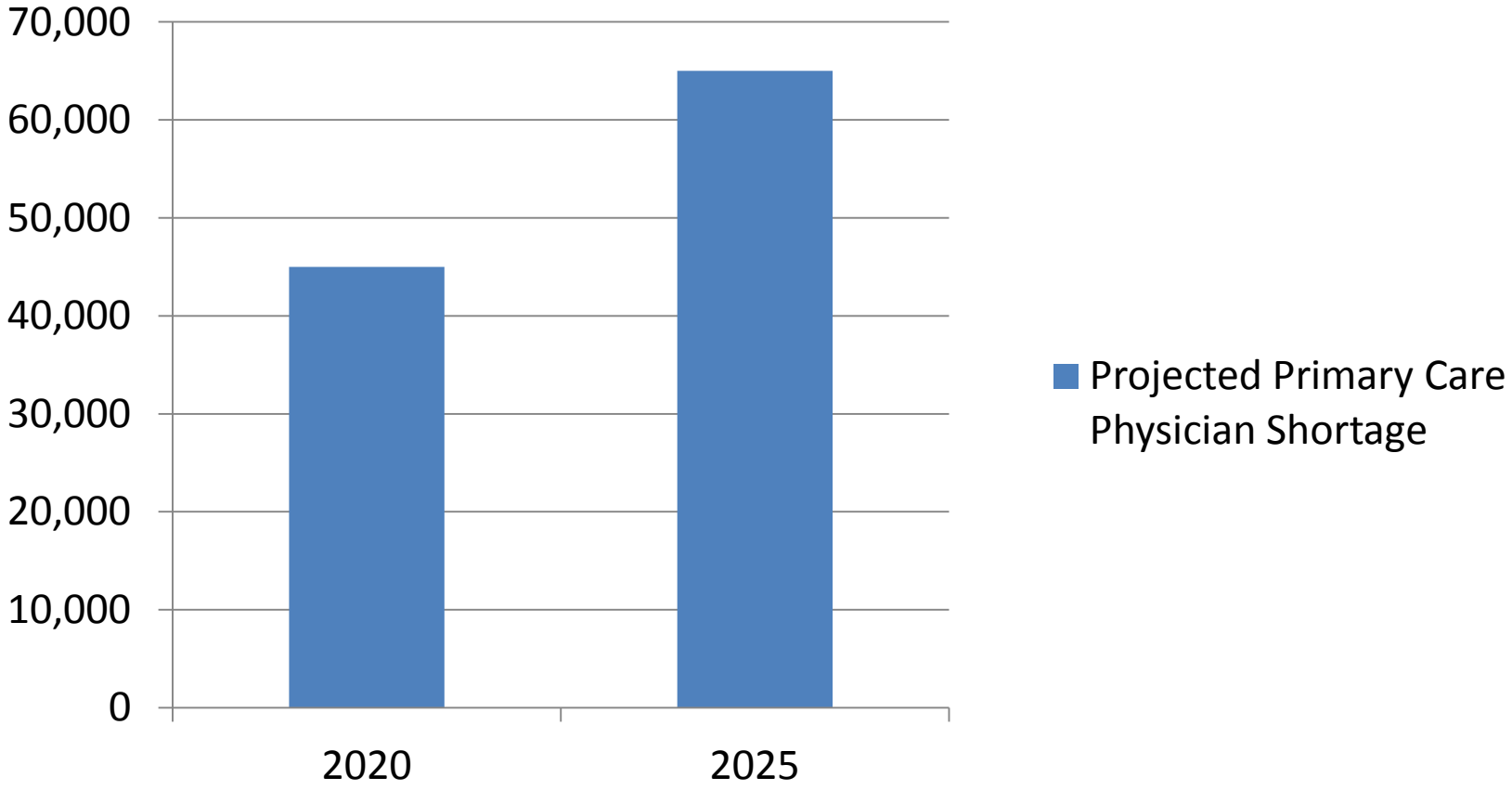
Regional Distribution



Source: BMP and MDH

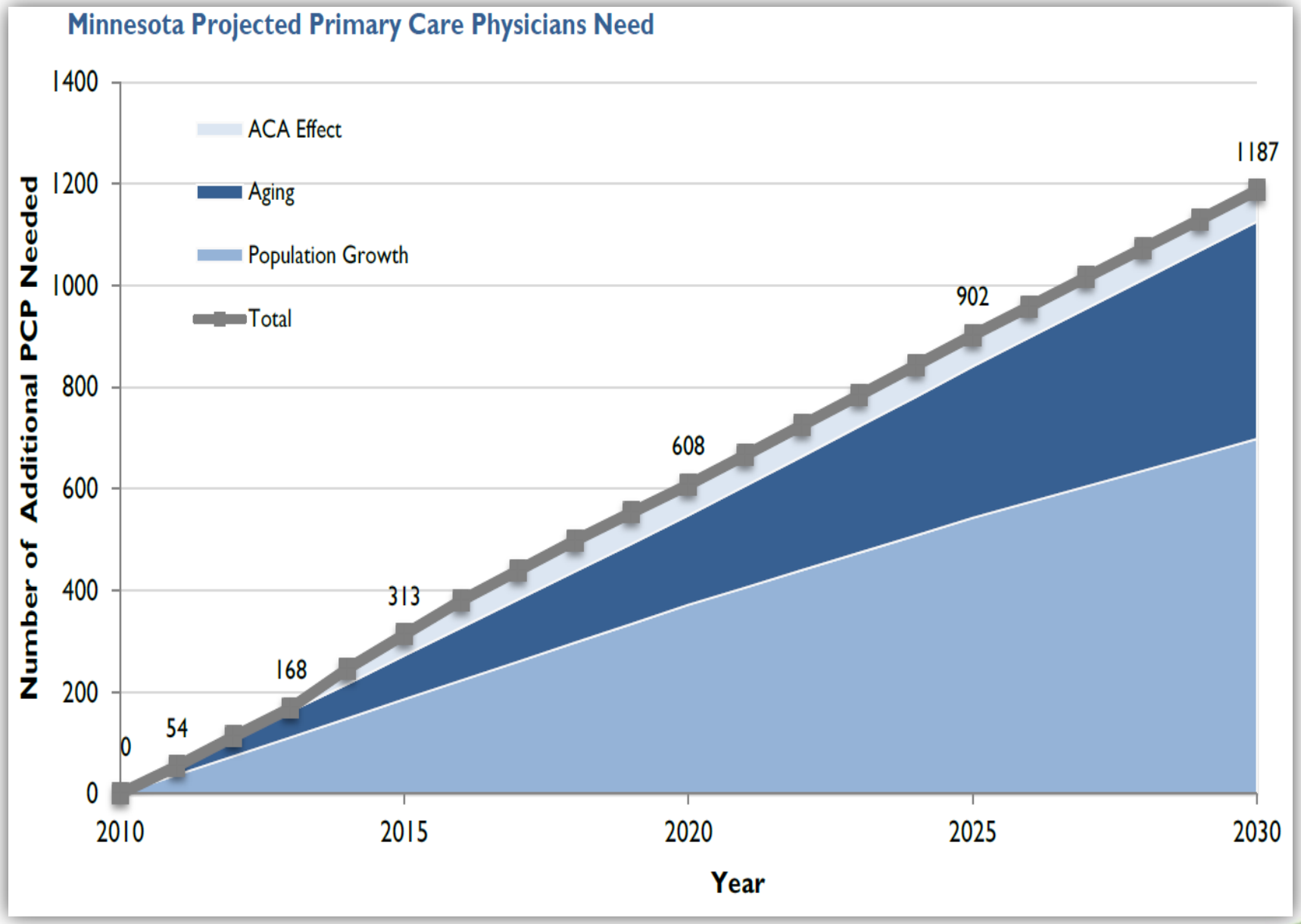
Source: Minnesota's Primary Care Workforce (2011- 2012), MDH, Office of Rural Health and Primary Care

U.S. Projected Primary Care Physician Shortage



Source: Association of American Medical Colleges

Minnesota Medical Association



Source: Robert Graham Center, *Minnesota – Projecting Primary Care Physician Workforce*, 2013

Factors Influencing Shortage

MMA Primary Care Physician Workforce Expansion Advisory Task Force

Minnesota Medical Association

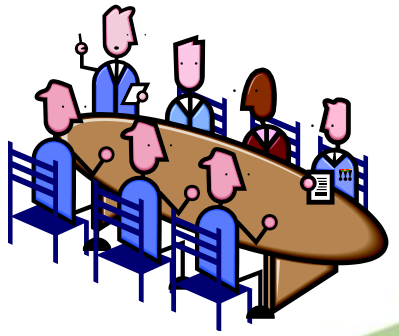
Task Force Summary

- MMA's Strategic Plan
- Membership: 14 physicians
- 6 meetings (May 2013 – May 2014)
- Recommendations approved May2014
- Implementation plan in progress

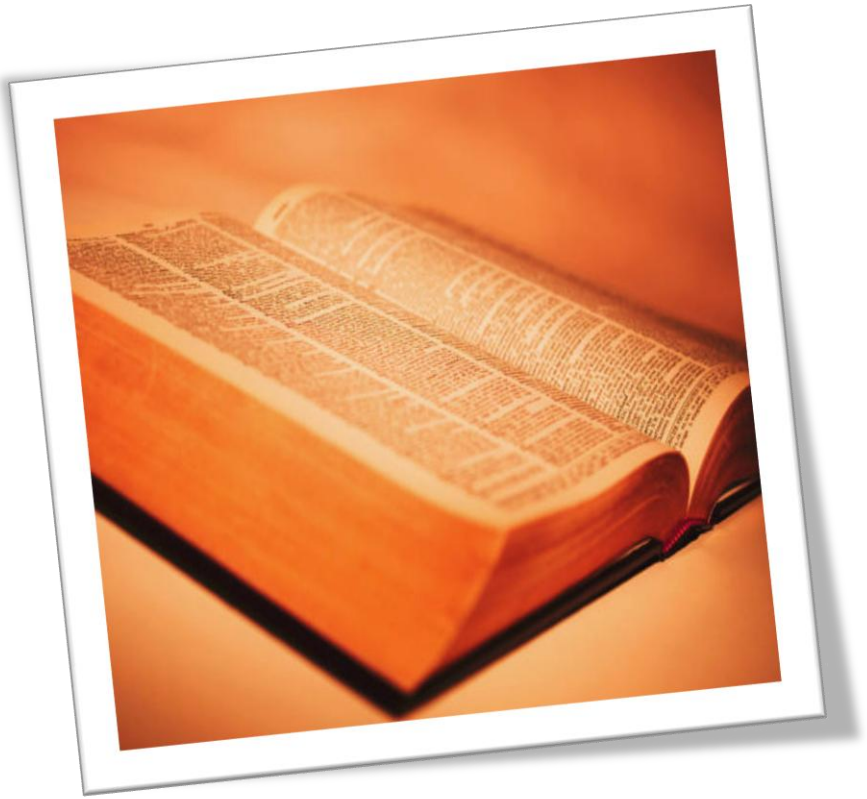
Minnesota Medical Association

Task Force Charge

- Understand the various drivers affecting the capacity and future supply
- Identify strategies
- Determine roles
- Recognize the relationship between related efforts
- Partner with others



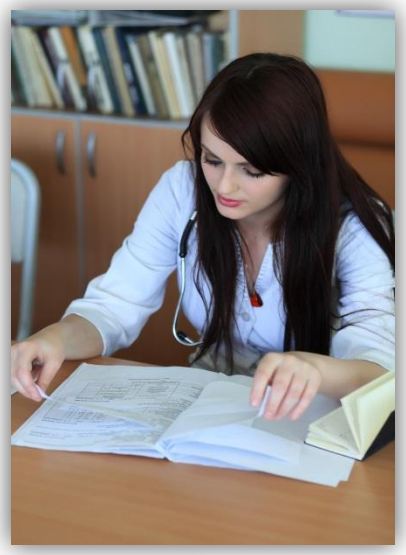
Definition of Primary Care Physician



Minnesota Medical Association

Barriers to Expanding the Primary Care Physician Workforce

Surveys and Interviews



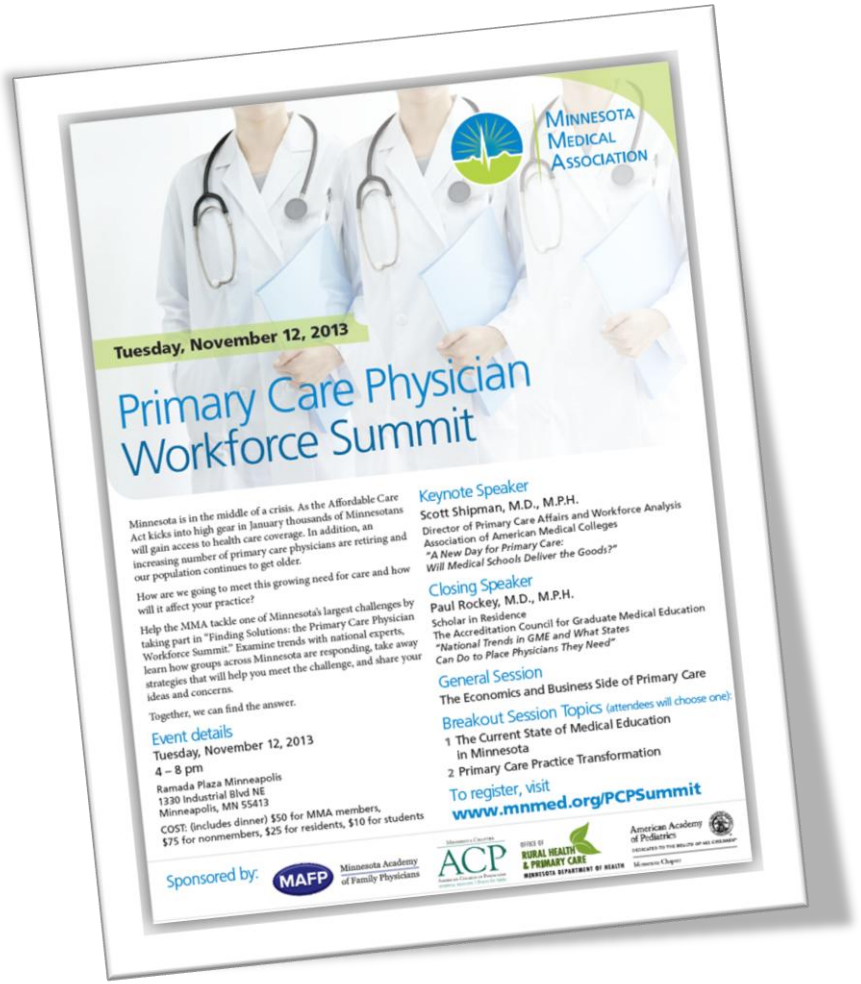
- Medical Students

  (Perception of Primary Care)

- Clinical Preceptors

  (Role of Preceptor)

Primary Care Physician Workforce Summit – 11.12.13



Minnesota Medical Association

Task Force Recommendations

Recommendation for Highest MMA Priority

- The Minnesota Medical Association will work with health systems, hospitals, large practices and the state's medical schools to examine ways to **increase the number of available clinical training sites in Minnesota**, and examine ways to remove barriers that exist in allowing medical students to have more meaningful experiences.

Minnesota State Legislative Package

- The Minnesota Medical Association will address the high cost of medical school and the resulting medical school debt by **supporting efforts that target loan forgiveness and loan repayment programs specifically to primary care, and that restores funding to levels equal to or greater than those of 2008**.
- The Minnesota Medical Association will **support efforts to sustain beyond 2014 the ACA-required Medicaid payment bump for primary care**, which increases primary care Medicaid rates to Medicare levels for 2013-2014.

- The Minnesota Medical Association will further examine the feasibility of **seeking a waiver from the Centers for Medicare & Medicaid Services (CMS) that would provide for state management of GME distribution in Minnesota.** For example, the waiver could link GME funding to Minnesota's primary care physician workforce needs and set up a distribution mechanism.
- The Minnesota Medical Association will promote the **creation by the state legislature of a state medical education council** that includes a representative from each of the state's medical schools, representatives from teaching hospitals and clinical training sites, and other relevant stakeholders. The council would serve the purpose of providing analysis and policy guidance on how Minnesota can meet its physician workforce objectives.

Federal (AMA) Legislative Package

- (1) The Minnesota Medical Association will advocate that the **2011 Budget Control Act cuts to funding for Medicare-supported graduate medical education (GME) be restored and maintained at levels prior to the sequestration**, which took effect in April 2013.

  (2) The Minnesota Medical Association should **take a leadership role in advocating for an adequate number of residency slots, adequate number of faculty and adjunct faculty support, and the required resources** to increase the number of primary care residency slots.

MMA Policy Position – No Action Required

- The Minnesota Medical Association acknowledges the role that income plays in specialty choice and believes that primary care physician capacity could be improved if this disparity was addressed.

QUESTIONS

Minnesota Medical Association