The Affordable Care Act: Early Impacts

Questions and Answers

Special Report

On Sept. 18, 2014 Fitch Ratings held an industry conference in New York to discuss the early effects from implementation of the Affordable Care Act (ACA) on providers, insurers, employers and patients. Certain of the initiatives of ACA intended to improve clinical outcomes have already started to shift the way care is delivered while the impacts from insurance coverage expansion provision are just now coming into focus. While the ACA directly affects Medicare reimbursement methodology and the expansion of eligibility under Medicaid, a more subtle influence arises in individual, small group and employer-sponsored healthcare insurance coverage.

To explore these issues Fitch assembled a group of industry experts to discuss the current state of the ACA and the future changes expected to be driven by continued implementation of the act. Fitch is publishing a compendium of the question and issues discussed by the panelists.

Panel Discussion Questions

Is there beginning to be a credit separation between hospital providers in the states that are participating in expanded Medicaid eligibility versus providers in the states that are not expanding Medicaid coverage?

Has there been a decline in bad debt expense among providers in Medicaid expansion states?

What strategies are providers implementing to manage a higher level of Medicaid patients?

How material an impact has Medicare's focus on value-based reimbursement measures had on volumes?

What impact have public exchanges had on volumes?

How have lower inpatient volumes and a greater emphasis on population health management affected hospitals' interest in aligning with primary care physicians and specialists?

There is a general consensus that the U.S. healthcare system needs to move from a volume-based to a value-based care model. "Value" may have different meaning to employers, insurers and providers. How are providers, insurers, payors and patients embracing value-based reimbursement?

Private exchanges are getting a lot of press these days. What are your feelings about the growth of private exchanges? What are the benefits of private exchanges to employers, employees and providers?

Medicare Advantage plans seem to be preferred among payors and providers. What is your expectation for the future of Medicare Advantage plans?

Related Research

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High Deductible Health Plans: A Key Driver in Growing Health Care Consumerism (February 2014)

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Analysts

James LeBuhn
+1-312 368-2059
james.lebuhn@fitchratings.com

Gary Sokolow
+1 212-908-9186
gary.sokolow@fitchratings.com

Is there beginning to be a credit separation between hospital providers in the states that are participating in expanded Medicaid eligibility versus providers in the states not expanding Medicaid coverage?

At this time, Fitch has not received a sufficient or broad enough slice of interim financial data to draw any quantitative conclusions. Anecdotally, through our routine surveillance process, providers located in Medicaid expansion states are experiencing a meaningful benefit from expanded Medicaid eligibility. However, the level of impact is dependent on a provider's historical payor mix; service area characteristics, which may or may not include a safety net hospital; and the eligibility and benefit guidelines of the state prior to enactment of the ACA. Fitch believes that expanded Medicaid eligibility is beneficial not just from a revenue enhancement standpoint but should benefit providers on the expense side by providing care in more appropriate, less costly settings. Similarly, through creation of medical homes beneficiaries with chronic conditions are likely to reduce costs historically absorbed by providers by reducing the number of acute events requiring surgical intervention and lengthy inpatient stays.

Over time, Fitch anticipates that hospitals operating in states that do not expand Medicaid coverage will be more financially challenged and exposed to more rating pressure than hospitals in states that expand Medicaid. Hospitals will likely be especially challenged in states that have high poverty rates, strict Medicaid eligibility requirements and high uninsured rates. Texas, Florida, Georgia, Louisiana, Mississippi and South Carolina are among the states with the 10 highest uninsured rates and are not expanding Medicaid. These states also have among the most stringent Medicaid eligibility requirements and highest poverty rates in the nation. Therefore, Fitch anticipates that it is more likely that hospitals in these six states will be among the most negatively affected.

However, several mitigating factors exist that could dampen the impact upon each hospital, including the ability of a state to expand Medicaid in the future, the fact that reimbursement reductions will be implemented over a period of time, and the redistribution of disproportionate share hospital (DSH) funds to those hospitals with the highest uncompensated care rates.

Has there been a decline in bad debt expense among providers in Medicaid expansion states?

Although Medicaid expansion may have improved bad debt expense, the decline is not always apparent as, the benefit of expanded Medicaid coverage is being realized primarily in lower levels of charity care rather than lower levels of bad debt. Given the expanded charity care policies adopted by many providers over the past five to 10 years, patients who would have otherwise qualified for charity care services are now covered under Medicaid, and providers are seeing the benefit in higher net patient service rather than lower levels of bad debt. In addition, the continued shift of healthcare costs from employers to employees through higher deductibles and co-pays and the resulting uncollectible balances from commercially insured patients have to a certain extent offset the benefit of bad debt reduction from the Medicaid expansion.

Related Criteria

U.S. Nonprofit Hospitals and Health Systems Rating Criteria (May 2014)

Revenue-Supported Rating Criteria, (June 2014)

What strategies are providers implementing to manage a greater number of Medicaid patients?

Providers and their aligned and employed physician groups will be challenged to absorb a large increase in new patients who likely have not been receiving regular care. In particular, the

ability to address primary care needs of this new Medicaid population could present access issues in the near term and require further investment in physician employment and alignment over the near to medium term. According to a report by the General Accountability Office, 38 states reported that they experienced challenges securing sufficient provider participation in Medicaid, with the leading reasons being overall provider shortages and low Medicaid payment rates.

However, early strategies that providers and physicians have pursued include the creation and investment in the medical home model, and assistance in the establishment Federally Qualified Health Centers (FQHCs). The medical home model is defined as a philosophy on how primary care services should be delivered. The tenets of the medical home model are patient centered care that is comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It essentially returns responsibility for care coordination back to the primary care "home" to ensure that a patient's care is delivered in the right place, at the right time, and in the manner that best suits a patient's needs. Similarly, the main purpose of FQHCs is to enhance the provision of primary care services in underserved urban and rural communities. Along with primary care services, FQHCs are required to provide additional services (either directly or through an arrangement with another provider) in the areas of preventive health, dental, mental health and hospital and specialty care.

Lastly, providers and physicians are improving their coordination and referral arrangments with social service providers to help with behavioral, cultural, economic and demographic issues which have an effect on health and may present barriers to improving a person's or community's health outcomes.

How material an impact has Medicare's focus on value-based reimbursement measures (e.g. readmissions and VAP, among others) had on volumes?

The focus by hospitals, health systems and their employed and aligned clinicians since the passage of the ACA on measuring and improving clinical outcomes has had meaningful impact on overall patient volumes. The industrywide investment in health information systems and The Center for Medicare and Medicaid Services' (CMS) reporting requirements, combined with the desire to provide improved clinical care, has allowed providers to measure their clinical outcomes against benchmark measures (e.g. rates of pressure ulcers, urinary tract infection and ventilator acquired pneumonia, among others) and work with the community to implement preventive health measures and implement new processes to decrease readmissions.

What impact have health insurance exchanges had on volumes?

At this time there has been little, if any, material impact reported from non-profit providers on patient volumes that can be directly tied to enrollments through the state or federal health insurance exchanges. However, many providers believe the effect will become clearer in the latter half of 2014 as newly insured patients generally take six to nine months before they begin to access the healthcare system for delayed or postponed healthcare services. Providers have reported some confusion among those newly insured through exchanges regarding the network design and limited choice of physician and provider access. Moreover, given that the majority of plans bought through exchanges have been bronze and silver plans and include fairly high deductibles and co-pays, it is likely that volume growth through exchanges is likely to be further delayed relative to traditional open access PPO plans.

How have lower inpatient volumes and a greater emphasis on population health management affected hospitals' interest in aligning with primary care physicians and specialists?

The softness in patient volumes experienced in 2013 and 2014, particularly in inpatient admissions and surgical, has caused hospital providers to rethink their physician employment strategies. While physician alignment strategies have been and will continue to be largely driven by the competitive dynamics in a given marketplace, the softening patient volumes and the expected movement toward population health management models is likely to reduce provider appetite for direct employment, particularly among specialists. However, there seems to be increasing interest in developing tighter alignment with primary care physicians (PCPs). In certain markets, such as southern California, the competition for PCPs is very strong and has been driven by providers and insurers alike.

Hospitals have been able to use their electronic medical record systems and HIT systems to align with physicians or by providing billing and back office services through a management service agreement.

There is a general consensus that the U.S. healthcare system needs to move from a volume-based to a value-based care model. "Value" may have different meaning to employers, insurers and providers. How are providers, insurers, payors and patients embracing value-based reimbursement?

Everyone is in agreement that the U.S. healthcare system needs to produce greater value; we need to spend less for better care. However, value may have different meanings depending on whether you are a hospital, a physician, an insurer, a patient or an employer. Non-profit hospitals and their clinicians see providing better value as part of their mission. Better value includes not just reducing the unit cost of care but also improving patient experience and satisfaction and positively impacting the health of given population or community. Similarly, for employers and insurers value incorporates the goal of reducing or retarding cost inflation in medical care. However, for employers, it incorporates keeping employees healthy and more productive by reducing paid time off due to illness and/or managing care for themselves or family members. Thus, ease of access through more timely scheduling, shorter wait times for physician visits or wider geographic access points become a part of delivering better value and has led to more and more employers participating in narrow networks, which helps to manage a population while controlling costs. Similarly, insurers are looking for ways to provide better value through: network designs that find the right balance between cost and access; tools to help employers and employees make more informed decisions on cost versus convenience versus clinical quality; and, more recently, development of reimbursement models aligning interests of employers and patients with interests of providers and physicians.

Slowly commercial insurers providing claims processing and third-party administrative services to self-insured employer groups are being challenged by hospitals with employed/aligned physician staff who are willing to share the financial risk in managing the clinical outcome of a given employee or insured population. There is a renewed sense of interest among providers in developing insurance products and service capabilities in an effort enter into direct contracting arrangements with employers. However, providers with their aligned physicians will be somewhat limited in entering into risk-sharing agreements until they can develop or have access to historical claims data, which remain tightly guarded by the health insurance companies.

Private exchanges are getting a lot of press these days. What is the expectation for the growth of private exchanges? What are the benefits of private exchanges to employers, employees and providers?

Private exchange growth is expected to continue among large- and medium-sized employers as private exchanges help to shift the decision-making on health plan choice from the employer to the employee. PricewaterhouseCooper's 2014 Touchstone survey found that 33% of employers are considering moving their active employees to a private exchange in the next three years, and this strategy tends to accelerate employee adoption of higher deductible plans. For employers private exchanges provide the benefits of providing their employees greater choice in selecting their health plan coverage. For employees, the ability to choose how much coverage and what level of access relative to their share of cost may be viewed as a benefit compared with a one-size-fits-all approach. Interestingly, the PWC Touchstone reported more than 40% of employees participating in Aon Hewitt's Corporate Health Exchange chose a less expensive plan than they had before, suggesting that consumers are willing to buy down to less coverage when responsible for more of the costs. For hospitals and health systems, private exchanges may translate into increased financial risk due to less predictable patient volumes and more difficult collection of patient co-pays and deductibles. Moreover, claims data are being used to provide pricing and clinical outcomes information to the consumers (employees/patients) of healthcare services to shop for the best combination of cost and quality. Clearly, this movement towards greater transparency is likely to erode various clinical service lines and pressure overall hospital margins.

Medicare Advantage plans seem to be preferred among payors and providers. What is the expectation for the future of Medicare Advantage plans?

According to a May 7 report by the Kaiser Family Foundation, the number of Medicare beneficiaries in Medicare private plans reached an all-time high this year of nearly 16 million beneficiaries, 6.3 million higher than the Congressional Budget Office (CBO) had projected in 2010 soon after passage of the ACA. The CBO now projects Medicare Advantage (MA) enrollment to reach 22 million beneficiaries by 2020, more than double the number projected shortly after the ACA was enacted. Despite CMS's reimbursement reductions to MA plan sponsors, the popularity of the program among enrollees, insurers and providers remains solid. Certain hospital providers that participated (and later decided to terminate) in Medicare's Pioneer ACO program have stated their preference for MA plans due to the closed or narrow network design. The closed network design (in which insurers, hospitals and clinicians are responsible for managing the care of an attributed Medicare population) has allowed providers with strong market coverage greater confidence in managing the health risk of that population. Nearly all of the MA plans qualified for bonus payments under a demonstration project implemented by CMS between 2012–2014, which helped to offset more than one-quarter of the projected MA reimbursement reductions over that period.