Obstetrical Care and the Affordable Health Care Act: Opportunities and Threats

Why Health Reform Now?

- **Access** is worsening
  - 50 million Americans lack health insurance
  - 38 million 10 years ago
  - 1-in-5 women have no health insurance coverage (2008)
- **Health outcomes** are inferior
  - USA: 31st life expectancy, 37th infant mortality
  - Yet, highest per capita health spending in the world
- **Costs** continue to escalate
  - 1993: $1 trillion, 2012: $3 trillion
  - National spending/person
    - 1960: $1,066 → 2010: $8,000 → 2018: $13,100

“Patient Protection and Affordable Care Act” (ACA)

**ACA Step 1: Expanding Access**
A Three Part Formula

1. Insurers must **offer coverage to everyone**, regardless of pre-existing conditions
2. **Federal subsidies** will help people to afford coverage
   - Direct payment of a share of insurance premiums
   - Tax credits for co-payments, deductibles
3. **Everyone must have health insurance**
   - Risk pool must include healthy people...makes premiums more affordable
   - Only way to cover those with pre-existing conditions

The ACA is just the beginning of health reform
**The Individual Mandate**

- All citizens, legal immigrants must have coverage
- Tax penalty if no coverage (by 2016)...
  - $695/person; up to 3 times for a family, or
  - 2.5% of household income
- Exemptions granted for
  - Undocumented persons
  - No coverage for less than 3 months
  - Lowest cost plan > 8% personal income
  - Financial hardship
  - Religious objection

**Is the Individual Mandate Legal?**

**SCOTUS will rule on 4 issues**

- Can the court rule on a tax matter before the tax starts?
- Did Congress exceed constitutional authority with the enactment of the individual mandate?
- Are other parts of the ACA severable; can they remain?
- Does the ACA impose an unconstitutional burden on states because of required Medicaid expansion?

**Is the Individual Mandate Legal?**

- **Arguments for...**
  - Health insurance markets and health delivery systems *are* a form of interstate commerce
  - Compels purchase of coverage that we *all* will need sooner or later...rather than shifting costs to others
- **Argument against...**
  - If the Feds can regulate an activity that is so far reaching, what’s next...requiring us to eat broccoli?

**USSC and the ACA: What Can Happen?**

1. The most *pessimistic* prediction is that the Court strikes down the entire ACA
   - This option is presumed to be fairly unlikely
2. The *individual mandate* itself will be struck down
   - Guaranteed issue and community rating gone
   - Leaves State health insurance exchanges, Medicaid expansion and other features of the ACA intact
3. The most *optimistic* option is that the entire ACA is upheld
If Option #1 Occurs, We Could Lose...

- Preventive services
- Children’s access regardless of pre-existing conditions
- Tax credits for small businesses that offer insurance
- Coverage of children under 26 on their parents’ plan
- Closure of the Medicare D “donut hole”
- Training programs for more clinicians in rural areas
- Federal investment in HIT could decrease or end
- Access to state high risk insurance pools
- Medicaid programs would be cut instead of expanded
- Lifetime limits health insurance would be reinstated

Option #2: What If Only The Individual Mandate Is Overturned?

- Costs would increase, as the uninsured would continue to use the system and shift costs to those with coverage
- Be in jeopardy of being rejected for coverage if you have ever visited a doctor
- If the ACA individual mandate is overturned
  - States could implement their own mandates (like Mass.)
  - Offer larger subsidies to entice people to enroll
  - States could require people to enroll by automatically enrolling them and forcing them to opt out

Linda Bergthold; healthinsurance.org

Affordable Care Act Litigation
The Supreme Court and the Future of Health Care Reform
Gostin LO, Garcia KK. JAMA 2012;307:369-70

- The legal, political, and policy stakes of the Supreme Court’s decision are vast
- The ACA will achieve near universal coverage
- Health reform envisages a social contract in which everyone shares the cost, since everyone will become ill one day
- If the social contract must be accomplished through the private market, then the simple logic of insurance must prevail, which is to spread the risk among the rich and poor, healthy and sick, young and old alike

We’ll know the answer on...

Monday
- June 11
- June 18
- June 25
**The Impact of the ACA on Ob-Gyns**

- **Direct access to Ob-Gyns**
  - No referrals or pre-authorizations permitted
  - No restriction on number of visits or types of services

- **Patient centered medical home**
  - IM, FM, pediatricians…and OBGYNs

- **Increased support for**
  - CNMs: Medicare payment equivalent to physicians
  - Free standing birth centers (Medicaid)
  - Tobacco cessation in pregnancy (Medicaid)
  - Maternal Infant Home Visiting Program

**Promoting Prevention through the Affordable Care Act**

- Specified preventive services must be covered with no cost-sharing (no out-of-pocket costs)
- Applies to private and public programs
  - (New) Private insurance policies 2010
  - Medicare, Medicaid 2011
  - State insurance exchanges 2014
- Improves coverage for preventive services in many individual and small group plans

**Institute of Medicine**

- Committee on Preventive Services for Women
- “Closing the Gaps” released July 20, 2011
- 16 member panel

**Promoting Prevention through the Affordable Care Act**

- Preventive services include all services
  - USPSTF grade [A] or [B] recommendations
  - AAP Bright Futures recommendations for adolescents
  - CDC ACIP vaccination recommendations
- IOM recommended to HRSA additional women’s prevention benefits not addressed by USPSTF…intended to “close the gaps”
• Non-grandfathered plans are required to provide coverage without cost sharing in the first plan year that begins on or after January 1, 2013

IOM: Women’s Preventive Services

• Wow: important advances
  – Contraceptive counseling and methods
  – IPV screening and counseling
  – Breastfeeding support
• Helpful: facilitates improved provision of care
  – Well woman visit

IOM: Women’s Preventive Services

• Yawn: no change from what we are doing already
  – GDM screening
  – Counseling for STIs
• Grrrr: if services over-utilized, may make things worse
  – Annual counseling and screening for HIV
  – Cervical cytology + HPV testing every three years for women 30 and older

Women’s Preventive Services

<table>
<thead>
<tr>
<th>HHS Guideline for Insurance Coverage</th>
<th>Frequency</th>
<th>USPSTF</th>
</tr>
</thead>
<tbody>
<tr>
<td>All FDA approved contraceptive methods, sterilization procedures, and patient education &amp; counseling for women with reproductive capacity</td>
<td>As prescribed</td>
<td>Not addressed</td>
</tr>
</tbody>
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• All methods must be covered, but not all products
• Limited exclusion for religious institutions (e.g., churches) from providing contraceptive coverage for insured employees
Contraception as a Preventive Service
What Happened?

- July 2011: IOM recommendations published
- Aug 2011: HRSA adds 8 women’s health benefits
- Feb 2012: Religious exemption regulations published
  - Narrow interpretation of “religious employers”
- Within hours
  - Public objection from US Conference of Catholic Bishops
- 4 days later...
  - White house responded with new regulations stating for a broader array of religiously affiliated institutions, the health insurance plan will pay all contraceptive costs

How to Respond to Public Objections?

- This is a government handout of free contraceptives!
  - No, this is a mandate that health plans cover all of the costs of contraceptives rather than some of them
- I don’t want to pay for “her” lifestyle drug
  - The costs of contraception are shared between the employer and the employee
  - Women are receiving this drug coverage benefit as a form of payment for the work that she does...
- Tell women to buy their own contraceptives!!
  - Even small cost-sharing requirements dramatically reduce preventive health care, esp among lower-income

Contraception as Prevention

- Individuals and couples
  - Sexual relationships improve both the emotional health and the physical health of individuals
- Maternal health
  - Prevents abortions and their rare complications
  - Prevents OB complications of unintended pregnancy
- Families
  - Planning the timing and spacing of pregnancies supports
  - Education and work opportunity for women
  - Better educational and life prospects for their children

Contraception as Prevention

- Cost aversion
  - $5-9 saved for every dollar invested, based upon fewer pregnancy and abortion services; less NICU care
- Populations and society
  - Reduction in maternal morbidity, mortality rates
  - Equity in access to contraceptive services
  - Population stabilization → sustainable environmental impact
Re: “The Campaign Against Women”  
(NYT editorial, May 20)

- The onslaught of laws focusing on denying reproductive health care rights is a concerted campaign against women. These laws are not grounded in science or evidence-based medicine.
- ACOG believes that access to family-planning counseling and to the full array of contraceptives is a basic and essential component of preventive health care for women.

JAMES T. BREEDEN  
President, ACOG  
Washington, May 22, 2012

Re “The Campaign Against Women”  
(NYT editorial, May 20)

- As physicians for women’s health care, ob-gyns see firsthand the havoc that punitive ideology-based laws have on the health of women and their families.
- Decreasing access to family planning and contraception will only increase unintended pregnancies and negatively affect family and societal health.
- Our message to politicians is unequivocal: Get out of our exam rooms.

JAMES T. BREEDEN  
President, ACOG  
Washington, May 22, 2012

ACOG and the ACA: Pros for Ob-Gyns

- Fewer uninsured patients  
  - 15 million uninsured women gain coverage by 2014
- National direct access to Ob-Gyn care
- Mandated maternity, women’s preventive health
- Insurance reforms  
  - No gender-rated premiums
  - No pre-existing condition exclusions
  - By 2014, improves coverage for 14 million women

ACOG Government Affairs September 2010

ACOG and the ACA: Pros for Ob-Gyns

- Ob-gyn participation in medical homes for women
- Wider Medicaid coverage of family planning
- Medicaid payment for smoking cessation counseling
- More research into postpartum depression
- Standardized health information technology (HIT)

ACOG Government Affairs September 2010
ACOG and the ACA: Problems for Ob-Gyns

- A shift to large group practices
  - Support of vertically integrated ACOs
- Roadblocks to abortion coverage
- Increased inclusion of lay midwives
- Cons for all physicians
  - The IPAB, the 15-person Medicare cost-cutting body
  - No repeal of M’care sustainable growth rate formula
  - No meaningful medical liability reform

ACOG Government Affairs September 2010

10 Steps for ObGyns... Prep for the ACA

- Assumes that the ACA will be implemented as passed
- Bet on the winners
  - Primary care providers and clinics
  - Direct access of ObGyns
  - Newly insured consumers
  - Emphasis on systems of care and quality
  - Advanced practice clinicians (CNMs, NPs, PAs)
- Mitigate losses on the losers
  - Specialist reimbursement
  - Women needing abortions
  - ObGyn as primary care providers

10 Steps for Ob Gyns... Prep for the ACA

1. Primary care will be the center of the clinical universe
   - Cultivate and facilitate consultations from PCPs
   - Embrace coalitions with community clinics and free-standing family planning clinics
     - Expedite referrals to GYN, OB, and specialty clinics
     - Subspecialty attending rotations at community clinics to “carry the flag”

2. Take advantage of “direct access” to Ob-Gyn rules
   - Collaborate with health plans to define direct access
   - Market direct access (and preventive services without cost-sharing) to women
   - Coordinate care with each patient’s PCP to minimize fragmentation of care
     - All necessary preventive services provided
     - Test results and treatment plans are shared
     - Duplication of services avoided
10 Steps for Ob Gyns... Prep for the ACA

3. Welcome new revenue producing opportunities
   – Of uninsured, ½ will gain Medicaid and the other ½ will have private insurance through Exchange
   – Other providers will compete for their business
     • If you now provide services to many Medicaid patients, you will need to compete to retain them
     • If you do not provide services to Medicaid patients, consider as source of additional volume + income
     • Focus on cultural competence + welcoming attitude

4. Consider “systems of care” as a coequal to other skills
   – Rewards for expansion of health information technology (HIT), including an office EHR
   – Every physician and APC must be a skilled coder
   – New focus upon, and rewards for, Quality Improvement initiatives in hospitals
   – Participation in the development of Accountable Care Organizations (ACOs)

5. Be at the table in health policy decisions
   – OBGYN docs have immense credibility...use it!!
   – Be a participant and a listener
     • Local, regional, and statewide health plan committees: QI, UM, P&T
     • State: health advisory committees, leg. advocacy
     • Federal: health advisory committees, leg. advocacy

6. Develop a strategic plan and then cultivate, support & reward organizational leadership (champions)
   – Departmental/group medical director
   – Health information technology (HIT)
   – Quality Improvement, including practice guideline Coding for surgery, OB care, outpatient encounters
   – Product line development and marketing
   – Contracting with health plans
7. If you are short-handed, maximize the use of CNMs and Nurse Practitioners
   - ACA strongly supports utilization of and payment for services by advanced practice clinicians
   - The ACA places great emphasis on “care teams” including APNs, care coordinators, dieticians

8. Plan on less income per delivery and surgical case
   - Make it up in volume: marketing and outreach, as described above
   - Develop market niche products offered to consumers and health plans
     • Make yourself indispensible
     • Price products competitively, e.g., case rates

9. Expect little or no insurance payment for abortions
   - Includes 2nd trimester TABs for fetal anomalies or non-life threatening maternal conditions
   - Develop case rates and payment plans
   - Philanthropic fund for women with no ability to pay
   - Use the exceptions in the Hyde Amendment to bill Medicaid for terminations

10. Restructure the concept of OBGYNs serving as primary care providers
    - Be restrained in developing the PCMH model unless you have on-site primary care providers
    - ACOG, CREOG, and ABOG should reconsider long term strategy for training and practice of OBGYNs in non-reproductive primary care
2014 is tomorrow
The Window of Opportunity is Open

Kim Belshe TCWF Conf 10/2011

http://www.acog.org
Advocacy → Health Reform Center

http://www.healthcare.gov/"