Dr. Seema Sehrawat, Director, Interdisciplinary Center on Aging & Faculty, CSU, Chico School of Social Work>> Good morning, everybody. Thank you so much for coming today for the presentation on Affordable Care Act and how it relates to older adults, and also the Boomer Generation, which is not quite 65 yet. We wanted to be mindful of organizing this in the light of, you know, what about individuals who have just turned 60 or may be 64 and may be looking for some options in the marketplace and may not be eligible for Medicare yet. But we do also have a specialist who will be here and will be talking about Medicare and some facts around Medicare and Affordable Care Act, and has anything changed or not. So just to help dispel some myths around that. So hopefully we'll cover a wide spectrum. We have amazing speakers. It took us some time and really some energy to pull all of them together, but we finally were able to get a strong panel to present on this topic. And as I have spoken to some of you, I know you guys -- you know, there is some confusion. There is still some anxiety around Affordable Care Act. There are things that are coming up, and we don't know what's happening. And it's very common when something new comes in, all these feelings and information that was coming out, and really we have to take some time to make sense of it. So we are very fortunate that we are able to present this workshop to you. My name is Seema Sehrawat, and I direct the Interdisciplinary Center on Aging. And I am the person who clogs your email sometimes and you get all the email blasts from me about the emails that are happening, what else goes on in our community.
So, if I'm clogging your emails, I apologize, but I'm hoping I'm passing lots of good information your way. Today's presentation is sponsored Riverside Tomlinson Hospital, so I really want to thank them for helping us out with putting this presentation together. And we have Michael from Riverside, so let's give him a big hand. Thank you, Michael. [Applause] We have four panelists today, and you might only see three, but we have one more coming. I spoke to Rhonda, and she'll be here. Our first panelist is Stan Salinas. Stan is a lecturer in the Health and Community Services Department here at Chico State, and really well versed in the topic of healthcare reform and why healthcare is important. And he will kind of open up the stage for us and start talking on that topic. Then we have Shannon...

**Shannon Scharnberg**>> Scharnberg [phonic].

**Dr. Seema Sehrawat**>> Scharnberg. I can't do justice to her last name. Shannon is a consultant and goes around all over California really doing these presentations, even in Southern California. I remember, she had this opening -- she was actually scheduled to go down to Southern California and the finally -- all of a sudden, the meeting got canceled and we could have her here. So I'm really happy that that happened, and we could have Shannon here to present for us. And then we have Rose Krepelka, who came all the way from Redding to be here.
Rose is a... Vice President at InterWest Insurance Services Corporation and works with Employment Benefits division. And also is really well versed in Affordable Care Act and different plans and exchange, and you know, how it works and all that. So all your questions hopefully will be answered today. And I will get lot of clarity, [inaudible], as well as you guys. And without further ado, let's just have Stan go ahead and open it up for us. Stan, is your mic open? Or on? Turned on? [Inaudible]

Stan Salinas, Faculty, CSU, Chico Department of Health and Community Services>>
Green is...

Dr. Seema Sehrawat>> Green, yes, that's good. We are videotaping this session -- not the audience; just the speakers. So don't worry about it, don't freak out. It will be available for people who cannot really come here for accessibility reasons or being far away and not [inaudible]. So we usually open these up for people from Redding, Siskiyou County, anywhere that they are living and they can access these presentations. So thank you so much.
Stan Salinas>> So hello, everybody. I'm glad to be here. I think healthcare is unique because we're all going to need it. It's one of the few services we're all going to access, unfortunately, I guess. There are only a few good things that happen in healthcare, and the rest tend to be the other direction. But, so I took an interest in healthcare reform the month that it was passed. I got the 900-page law at that time and read it. So, and I decided that, because I invested that time into it, I might as well keep up with it as the rules get written, and it turns into the 100,000 pages or whatever it's going to end up being. I don't know how far along I am in that process, but anytime something new comes up I try to keep up with it. So what I'm going to do is give you guys just a broad overview of why it was -- why we're in a position in the U.S. where we need healthcare reform, some sort of healthcare reform, and what the real goals of it are, and just a very, very broad view of how it will hopefully get there.
So the current state of U.S. healthcare, I think most people understand this, but we're really, really good at fixing really, really bad things. There's no place in the world that is quite as good... at that as we are, and that's great. We do really well in that. The bad thing is, is we have this value issue, which I teach -- one of the courses that I teach is quality to healthcare administration students, and you know, we -- there's no exact equation for value, right? It's something that we sort of -- a lot of it's our opinion. But it's some equation of equality over cost, right? It's what are you getting out of it versus what you're paying for it.
In the United States that's what we pay, and the top two are what we pay and the bottom two are what we're getting. So child mortality, seven per 1,000; life expectancy, 79; and we spend a little over eight and a half thousand dollars a year on it, and 18 percent of our GDP.
If you compare that to our neighbors to the north, we see that they do a little bit better. The two indicators, the life expectancy and child mortality, are sort of well-accepted measures, and obviously there are a thousand more, but you don't want to read them. So, those are the two that, you know, really seem to be good predictors of how well a system's doing.
We can go through and look at the UK. So their percent of GDP is, what, 60, maybe 57 percent of ours, as a percentage -- far less than half is spent and they're getting some more positive outcomes. And I know that some of you may be saying, and I was thinking this, too as I was looking for the most recent data, is, "Okay... those two countries have single-payer systems. They have those nightmare systems where people -- or anyway the perception is, people are waiting in line for appointments, they're waiting months, languishing, waiting for services and medical devices and things like that. So, chose to add a couple others.
Germany. Germany has a system that is remarkably close to what our system will be. That's what they're doing. They're spending about half. They've been doing this for 130 years, this model. And it's working really well for them. And I think we could see that -- I mean, well, we have our differences. The U.S. is unique. We have a lot of cultural similarities to Germany, and our economy is, while they export a lot more than what we do, we have similar economies.
If we take a look at Japan, we see the same type of thing: even lower, and a higher life expectancy.
So we can sort of bash all, you know, our system as much as we want, but what are we going to do about it? And this has been the track through -- and for those of you that are old enough, Richard Nixon made a special address to the Congress pitching a plan just like the Affordable Care Act. He talked about the value in keeping a population healthy, the economic imperative of keeping a population healthy, because the only way you get good production in an economy is by having healthy people. And he talked about the moral imperative of it. And I’m not going to argue that with anybody, but that's what he said. So and then we go into more recent times. I should mention Teddy Roosevelt also proposed a system, a universal healthcare system. So this is the chronological track. The Heritage Foundation and the American Enterprise Institute; I don't think that there's an R big enough or bold enough to fit by the Heritage Foundation. They're an extremely conservative think-tank, and this was their rebuttal to Bill Clinton's proposal. It was basically the Affordable Care Act. And then Newt Gingrich, who was the Speaker of the House, was a champion of it. And then we see the one that isn't like the others that has a D is Barack Obama. So this was a good idea, this was a bipartisan idea; whether people are willing to own it, it is. This was a conservative idea, until very recently. And now it's obviously a socialist idea.
So now we've got it, it's here, what is it going to do? The goal -- and I notice that this is actually -- there's an error here, and the error is it should be "to reduce the growth of expenditures," not "to reduce expenditures." Healthcare grows far, far faster than inflation. And it grows faster than inflation in most industrialized countries, but in the U.S., it's grown pretty consistently between two and three times the rate of inflation. So we have very, very high growth rates in healthcare. And I don't know if you guys heard this, during the debate in, you know, leading up to the passage of this law, there was a lot of talk about bending the curve. So we've got this growth rate, and it goes something like this. It's steeper at the beginning, or -- I mean -- at the end. And, you know, the last 20 years or so, this extreme growth in expenditures and spending. But the idea was to sort of bend that down and even it out. And actually reducing costs is, I think, too lofty of a goal because of where we're at. This seeks to slow down the growth. And we know that some measures in the Affordable Care Act have been implemented over the last couple years, there are some pilot programs that most people don't hear about, but there's also like insuring the dependents up to the age 26 and things like that. So we saw in 2012, we saw the lowest growth rate that we had in about 20 years. And there are just a thousand factors that go into that, and some people will tell you that it's the economy, and that certainly played a part in -- I don't think anybody would deny that that played a role in it.
But there are some good indications that some of the pilot programs are working out, and that our three million new 18- to 26-years-old are spreading the risk and, you know, able to save a little bit of money. So how are they going to do it? We just talked about spreading risks. They’re going to shift incentives so we have this, in most places in the U.S. -- we’ve got a lot of managed care in California, but in most places in the U.S., they don’t. In most places, you go to a doctor and every time the doctor sees you, they generate some revenue, right? Episodic care: every time you walk in, they generate revenue. Now, I don’t know any doctors that went to medical school for all those years and did everything that they did to scam people out of money; I’m not saying that that’s what happened. But it is true that in areas where systems are set up like that, the utilization is higher. And that is an indisputable fact. So there are programs in the Affordable Care Act that will shift this to paying for health rather than paying for treating illness. And then value-based purchasing -- and we’ll talk about all these in a little bit more depth without just killing you guys with boredom. And I should say, also, it’s a small enough group that if you guys have questions, I’m happy to take them afterwards, I’m happy to take them anytime you feel like asking. So anything you have, let me know. So value-based purchasing basically says that the government’s only going to pay healthcare that meets certain quality criteria. And then I’ll go over some miscellaneous stuff that will also help it.
So spreading risk. You guys have all heard that one of the big imperatives of healthcare reform is getting young people to sign up, and I think that we understand why that is: they're the people who aren't going to utilize the kind of services, so they can hopefully pay for those of us who will. And that's part of it, the other reason we want to get a lot of people insured is because there is a value in it. There's a value for keeping young people healthy. And it goes beyond, you know, productivity and all those things, but the federal government owns our healthcare at the age of 65. So if you reach 65, and you have not been getting good healthcare, you will enter the Medicare program more sick than somebody who maybe has had good insurance their whole life. So, that's a huge part of it, is getting people into the federal programs healthy, or healthier than they are. And there's a lot of evidence that as intuitive, anyway, but that, you know, people do forego a lot of healthcare when they don't have insurance. It makes sense; it's really expensive to pay cash for it.
So how do they... plan to cover 30 million people? This is the original -- this is as the original law was written so there are a lot of changes that have been with Medicaid expansion and stuff like that. But this is how they planned to do it, and this adds up to just a little under 30 million people. So three million of our young people, dependents, 11 million eligible for subsidies on the exchange, and seven million people will have access to the exchange, and eight million will be eligible for Medicaid expansion. So an important thing to realize about subsidized insurance... is that, I has this conversation actually with my stepfather a couple evenings ago, and he was concerned about the subsidies for insurance. And I said, "Well, your insurance is subsidized." And he said, "No, it's not." And I said, "Yes, it is." And I could tell you how long that went on. But anyway, insurance through employers is subsidized. It's subsidized by the fact that it's pretax income. It's not taxed, so whatever your tax rate is, the federal government's subsidizing it which means taxpayers are subsidizing it. So if you lie in a 35 percent, you know, marginal tax rate that's what -- your insurance is subsidized. So anyway, so Medicaid expansion. who's not.
Now, we now -- I think most of you know that the original law mandated Medicaid expansion for the states. And they said, "We'll pay for roughly 99 percent of it at the beginning," and that goes down to 95, and eventually gets lower. Right now Medicaid is generally a 50/50 split between federal and state. So, and there are some states that get a little bit more than that. But that's how it is, and that is how it has been. So the ACA mandated that states expand Medicare coverage to other people, people who wouldn't have qualified for it: some single people and obviously based on income eligibility. But we saw that in the Supreme Court they said that is not constitutional. You cannot force the States to do that. So now we've got this situation where we've got 26 states that are willing to do it, and Washington D.C., and then 25 states that aren't. So I went to go look for a map of this because I thought that's the easiest way to show who's doing it and
And that's what I came up with, and then I thought, "Gosh, that looks familiar."
So I went and looked at that. And just so everybody knows that there's—
there is no partisanship messing around with healthcare, right? I mean, that doesn’t exist. So I took this map, which -- this is the Medicaid expansion and the notable adopter is
Arizona when you compare -- there's one other but Arizona is the big one that decided to go ahead and take the money. So there's no fiscal reason not to do it. There really isn't. There are some really good studies that indicate that even when they get back to their normal share of costs, the burden that would have been, or that it will be placed on hospitals for uncompensated care and that sort of thing, consumers are going to pay for anyway just -- one way or the other, they're going to pay for it. So I took this one, which is editable, and changed it
to that so we can get away from that. So these are the 26 -- 25 plus D.C. -- that are expanding Medicaid. I read a fairly good article yesterday that said, "Medicaid is going to expand anyway, with or without this." And you heard that we have a low-wage recovery, and they -- people say that that is going to expand Medicaid 14 percent next year in 2014. So-- or that's one of the main reasons for it. So sooner or later, will some of these others adopt it? I don't know. I mean, I don't know how long you can sort of fold your arms and stomp your feet and say no, especially in places like Texas where they have a tremendous amount of people who would benefit from it. Not just a tremendous number of people, but a tremendous percentage of people who would qualify for it. And again the goal, right, we want to reduce costs. We reduce costs by people keeping people healthy.
So... move onto shifting incentives, and these get very, very complex. I'm going to lay out just a couple of them for you. But they have a lot to do with different reimbursement schemes.
and that sort of thing. So the shift from episodic care to healthcare. Don Berwick, who was the head of CMS for a while, you know, he calls it a sick-care system. And that sounds really bad but it kind of is; that's what we use our doctors for. We -- those of us who have good insurance are prompted to go get a physical once a year, and beyond that, we go when we're sick. And that's... okay up to a certain point in your life where you may want to go a little more than that. But, so the -- we have these pockets of managed care that have done really well keeping people healthy. And California has some -- Northern California does not, but the Bay Area and Southern California where most of our population lives, they've done a good job trying to move to a healthcare system, and they've been doing that since the late '70s. And trying to discourage this idea that you go in -- every time the doctor sees you, they get paid more. So one of the big concepts in the ACA is something that they call shared risk and reward. What this does is it basically -- by withholding some prospective reimbursement, so if I'm an accountable care organization, I'm responsible for a certain population's health.
Based on their predictors for what may happen this year -- and believe me: there are really, really good models that can tell us what's going to happen to you this year based on what's happened to you in the last 10 or so. And some things, obviously, can't be predicted, but a lot of things can. So what they do is they say, "You've got X amount of dollars to take care of this population. It doesn't matter what they do: if they go into the hospital, they get orthopedic surgery, whatever it is." So this group of providers comes together and says, "Okay, we will bear the risk for this community. Now, what's the trade-off?" Well, the federal government withholds a percentage of the money and you get to earn it back. Now, the long term -- and you're saying, "Why would a doctor do that," right? Because why not just accept payment that they had been taking? And the reason is because reimbursements are going to fall no matter what. And the very innovative providers are saying, "We need to figure this stuff out before we end up with just reduced reimbursements and no way to get any of it back." So what they do, let's say they take two percent off the normal reimbursement for that group of, say, 5,000 people. In simplistic terms, if the provider is able to provide care to that population of people, meeting a whole slew of quality criteria, for less money than the model shows, or less money basically than they did the year before, they get to get half of it back.
So the incentive is to provide quality; the incentive is to not see you too much but not withhold care either. If they withhold care, they don't meet the quality standards and they don't get their piece back. They don't get their cut. So it creates this atmosphere where organizations are getting really, really creative figuring out how to keep people really healthy. And I think that's what we all want, that's -- I like that idea. We've seen a big expansion of this in Southern California. And this is a complex system to set up, but -- we've seen good success in Southern California, but CalPERS has had a great success with this in the Sacramento area. The first year they did it, they saved about $37 million, and their insured population received better care than they did before. They're expanding it. That was a very small pilot project; they're expanding it. They've been expanding it every year. They've been saving about $900 a year for their people who have been in these accountable -- were you going to ask a question? Yeah? [Inaudible question] Yeah, yes. Kaiser is a great -- Kaiser is the most well-positioned organization probably in the U.S. for healthcare reform and for this type of modeling. They've been doing this for a long time because they've been -- they've always been at risk for almost everything that happens to you, unless it's some crazy emergency that happens where there's no Kaiser.
So they know how to take care of people without overutilization. Yeah, so there's another group like Kaiser called Geisinger, there's a group called Intermountain Health. Those three, with Kaiser being certainly in the lead, are just -- there isn't a better system that could have come for Kaiser or for those groups than what we have. It really fits into their modeling. So we have these accountable care organizations. These doctors are getting their money back. We've seen it work. CalPERS is saving an average of $900 per person, per year. So if you go back to our average spending of $8,600, you can knock that down to $7,500, right? That's a little more than 10 percent of expenditures. That's significant. Now, can they realize that nationwide? Can anybody realize that nationwide? I doubt it. I think CalPERS is good at this. I think that they chose providers that are really good at it. But if you could save $400 a patient you'd still have, you know -- extrapolate that throughout the population, you'd have some really, really significant savings. Bundle payments and global payments sort of work the same way; it's this idea that we're going to give you less and you get to earn some back. So sounds horrible for providers, right? It does. I will say that I've done a lot of research into this, and I have a lot of friends that are providers, and there still isn't a better place to be a doctor if you want to -- I mean, in terms of income.
And there will not be a better place -- after all the cuts that are going to come, there's still not going to be a better place financially to be a doctor. I'm sure there are better qualities of life, but they're still going to make a good amount of money. But they will take cuts, and that's just part of it. On average, compared to other industrialized countries, our doctors make 30 percent more than their counterpart.
So moving on to value-based purchasing.
Reimbursements, especially in hospitals, will be based on patient experience and quality outcomes. This is the same type of situation: Medicare/Medicaid will withhold three percent of reimbursements pending the data on patient experience and quality. And it's not just your patient experience; it's everybody's patient experience aggregated in that facility. So if any of you have had a overnight stay in a hospital recently, you may have gotten a survey, either in the mail or administered by telephone. And it's, now it's 32 -- or for 2014, it's 32 questions. And it talks about things like, "Was your room quiet?" "Was your room clean?" "Did the nurse explain things in a way that you understood?" "Did you understand the medications that you were sent home with?" It goes on and on. And this is not -- when I introduce to my students, their concern is, "Well, how can you withhold a significant patient experience accounts for one percent of total reimbursement? But how can you withhold that just based on somebody's opinion? And the answer is that this -- they've been working on this survey for quite a while, let's put it that way. They've been working on it for 18 years or so. And people who answer "yes" to these questions typically got really good care behind that. So every question there are, you know, a couple hundred indicators behind it that people who answered "yes" got this. So that's how they're able to justify doing that. It still doesn't satisfy hospital administrators when I tell them that, but -- and if I were in that position it wouldn't either.
But quality outcomes, there are a lot of quality outcomes that need to be checked in order to not be cut as much. Things like this, though, there are a lot of things like this. No pay for 30-day admissions. So if you are discharged from the hospital with a specific -- you went in the hospital with a specific illness. If you come back in 30 days with the same illness, they're not going to pay for it. The hospital needs to take care of you, but they're not going to pay for it. So you'll see an expansion in post-discharge counseling, you know, home care, to make sure that -- you know, medication errors are a big reason that people get readmitted. That's something that's really being focused on: do people understand their medications? If they don't, is there somebody who will be there to help them? And if there isn't, hospitals will be sending people or calling to make sure that errors aren't being made in your home. So those things make sense, right? That's just the quality issue; we don't want to go back with the same thing that we... went in for. There are really silly things, things called "never events," like amputating the wrong leg, stuff like that. They're not going to pay for it. That kind of makes sense. We don't pay for a surgery that you'd made in error. Now, those things don't happen too often, but it's kind of a silly thing that they were paying for it. You know, I mean, I don't know too many businesses where you can make that grievous of an error and expect to send a bill for it, right?
But anyway, there are a lot of pilot programs, there are a lot of programs that they worked on for a year and they went away. And then there are these few that have realized some pretty big savings that have a great potential that'll hang around.
So I just threw in a couple other ones. Medical loss ratio. Medical loss ratio, as you are familiar with, basically is this percentage that insurers have to pay directly to healthcare, directly to administering healthcare. So for small-group insurers, they need to spend 80 percent; and for large-group insurers, they need to spend 85. Medicare runs at something like 97 or 98 percent. So when -- I don't see anybody here that is old enough to have Medicare, but when you get there, you can rest assured that there is some efficiency. Our government doesn't do everything well, but this is something that they've done pretty well. So now, what you think about that from a capitalist perspective, we're limiting the administrative costs and profits of insurance companies through this law.
And then -- and I'm not going to go through each one of these, these basic preventive care elements in insurance policies. You guys have heard a lot lately that people are getting notices saying, "We can't offer this insurance anymore," and they were promised that they would be able to keep it. So part of that is stuff like this: the existing plans or the previous plans didn't have
these preventive services in them. And these are "no co-pay" services, by the way. There are a lot of others that are required; these are "no co-pay." And so part of that is this. New insurance plans have to comply with the law. And the other part of it, there was a clause to grandfather in insurance policies that didn't have this stuff. But there were only so many changes the insurance companies would make -- could make to them, and some insurance companies just decided they weren't going to renew those policies. So the grandfather clause does not work, and you have to buy new insurance if you're one of those people.
Basic Preventive Care Requirements

Women
Mammography
Breast Feeding Counseling
Breast Cancer Genetic Testing (high risk)
Cervical Cancer Screening
Contraception
Domestic Violence Screening and Counseling
Well Women Visits
And that's all I have. I'm happy to take questions now, I'm happy to take questions after the rest of the panel presents. But I thank you guys for listening. I hope it wasn't too long, because this stuff can get tedious for people. I understand that, so.