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The Growing Cost of Health Care and the Affordable Care Act

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Over the past several years, the cost of health care has increased considerably and become an even more expensive concern for consumers. According to a report by the Kaiser Family Foundation, in 2010, U.S. health expenditures were near $2.6 trillion, which was over ten times the $256 billion spent in 1980. The report also pointed out that the current higher unemployment and lower incomes for Americans due to the recession has put even more attention on the cost and affordability of health care.

Disagreement exists over what factors are driving health care spending. The Kaiser report noted that some of the major contributing factors include the growth of new medical technology and prescription drugs, the rise in chronic disease in Americans and administrative costs necessary for hospitals to perform.

- Medical technology and prescription drugs – Some people argue that the availability of more expensive and state of the art medical technologies and prescriptions fuels health care spending for development costs because they generate demand for more intense and costly services.
- Rise in chronic diseases – The longer life spans and greater prevalence of chronic illness and disease in Americans has placed even more demand on the health care system. According to Kaiser, it is estimated that health care costs for chronic disease treatments account for over 75 percent of national health expenditures.
- Administrative costs – Kaiser says that at least seven percent of health care expenditures are estimated to go toward the administrative costs of government health care programs and the net cost of private insurance.

How to contain health care costs remains a subject of debate. The U.S.'s past efforts to control health care costs have arguably not been overly successful, and current debates center around having a stronger role for the government to step in and take charge or offer market-based models that encourage greater competition in the market.

The goal of the Patient Protection and Affordable Care Act is to have the government play a more active role in the health care industry and to ensure that every American is insured. According to Kaiser, some of the major measures included in the Affordable Care Act to control cost include:

- Greater government oversight and regulation of health insurer premiums and practices.
- Increasing competition and price transparency in the sale of insurance policies through Health Insurance Exchanges.
- Payment reforms that aim to reduce payments for treatments and hospitalizations resulting from errors or poor quality of care.

The report also cited other proposals and practices directed at controlling costs, such as support for wider use of health IT in the delivery system, increasing consumer out-of-pocket costs, improving health efficiency and quality of care, reforming the tax treatment of health insurance and a single payer plan.

In early March 2013, the U.S. Department of Health & Human Services (HHS) announced its agenda to bring down health care costs and improve the quality of care through the implementation of health IT. The

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Record-Breaking Recoveries Result from Joint Efforts to Combat Health Care Fraud

The U.S. Health and Human Services (HHS) released a report in February showing that for every dollar spent on health care-related fraud and abuse investigations in the last three years, the government recovered $7.90. This is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse Control (HCFAC) Program.

The government's health care fraud prevention and enforcement efforts recovered a record $4.2 billion in taxpayer dollars in Fiscal Year (FY) 2012, up from nearly $4.1 billion in FY 2011, from individuals and companies who attempted to defraud federal health programs serving seniors and taxpayers or who sought payments to which they were not entitled. This is an unprecedented achievement for the HCFAC Program, a joint Justice Department and HHS effort to coordinate federal, state and local law enforcement activities to fight health care fraud and abuse.

Over the last four years, the administration's enforcement efforts have recovered $14.9 billion, up from $6.7 billion over the prior four-year period. Since 1997, the HCFAC Program has returned more than $23 billion to the Medicare Trust Funds.

For the complete report and further information, please visit *http://www.hhs.gov/news/press/2013pres/02/20130211a.html*.

Affordable Care Act Extended Free Preventative Care to 71 Million Americans with Private Health Insurance

The U.S. Department of Health and Human Services (HHS) announced that about 71 million Americans in private health insurance plans received coverage for at least one free preventive health care service, such as a mammogram or flu shot, in 2011 and 2012 because of the Affordable Care Act.

Additionally, an estimated 34 million Americans in traditional Medicare and Medicare Advantage plans have received at least one preventive service, such as an annual wellness visit, at no out of pocket cost because of the health care law.

Taken together, this means about 105 million Americans with private health plans and Medicare beneficiaries have been helped by the Affordable Care Act's prevention coverage improvements.

According to HHS, the Affordable Care Act is giving Americans better value for their health insurance plans by:

- Eliminating lifetime dollar caps on essential health benefits, and phasing out annual caps.
- Prohibiting health insurance companies from denying coverage to children based on a pre-existing condition, such as asthma or cancer.
- And in 2014, it will be illegal for health insurance companies to deny coverage to any American or to charge more because of a pre-existing condition.
- The law will also make it illegal for a health insurer to charge women more simply because they are women.

24 States Have Selected Their Benchmark Health Insurance Plan for Essential Health Benefits

Twenty-four states and the District of Columbia have selected the health insurance plan in their state that will serve as the "essential health benefit" package sold by all insurers participating in the new health insurance marketplace and the individual and small-group markets beginning January 2014, according to a Commonwealth Fund study announced on March 13, 2013. The essential health benefit covers 10 broad service categories, including ambulatory patient care, hospitalization, maternity and newborn care, and prescription drugs. The federal government allowed each state to choose a benchmark plan to help meet the Affordable Care Act requirement that the essential health benefit reflect a typical employer health insurance plan.

The authors of the study found that 19 of the states that selected plans chose existing small-group plans—typically employer-based plans for businesses with fewer than 50 employees. The remaining five states selected HMO or state employee benefit plans.

For states that did not select a benchmark plan, the federal government will designate the largest small-group plan in the state as the benchmark, meaning that the majority of states will have the most widely purchased small-group plan in the state as the basis of their essential health benefit.

In an in-depth investigation into how 10 states arrived at their benchmark plan, the authors found that states conducted analyses of plan enrollment and costs, and engaged consumer and patient groups, insurers, and specialty physicians in their decision-making process. The desire to preserve state benefit mandates not included in the federal essential health benefit package was also a factor in choosing benchmark plans.

The Department of Health and Human Services (HHS) will evaluate the benchmark selection process and may choose to revisit it in 2016. If that is the case, the authors recommend that the federal government establish minimum standards that states must use when selecting their benchmark plans.

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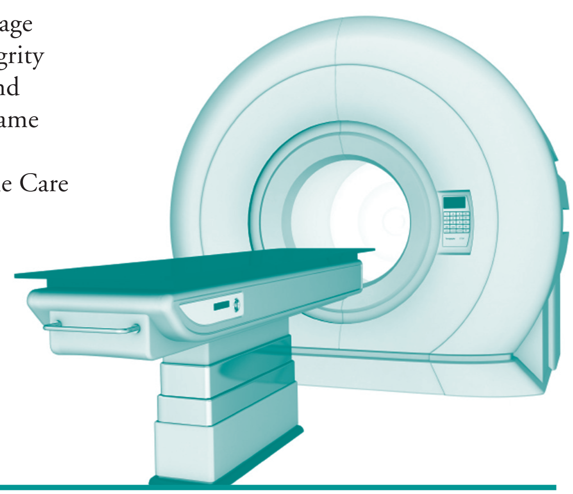
plan is to accelerate health information exchange and build a seamless and secure flow of information that HHS claims is essential to transforming the health care system.

HHS has set aggressive goals for the rest of the year and aims to have 50 percent of physician offices using electronic health records (EHR) and 80 percent of eligible hospitals receiving meaningful use incentive payments by the end of 2013. HHS also hopes to increase the emphasis on ensuring electronic exchange across providers to ensure that patients' health care information is assessable wherever they access care. Other goals for HHS in 2013 include enhancing the effective use of EHRs through initiatives like the Blue Button initiative, implementing Meaningful Use Stage 2 and underscoring program integrity to ensure the program is sound and technology is not being used to game the system.

As the effects of the Affordable Care Act continue to unfold over the next few years, the debate over how to control and contain the cost of health care is bound to continue. HHS's goals to improve the way health care is delivered while also lowering its costs are a definite start, but other areas will also need to be looked at to tackle the growing problem of health care costs.



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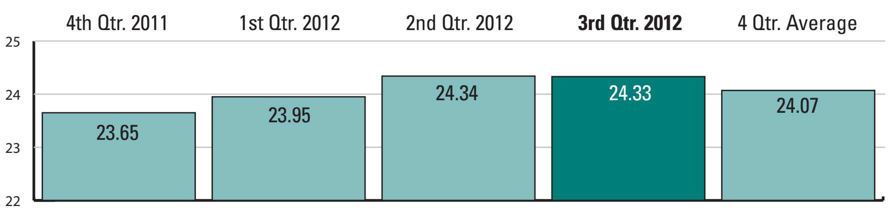
DATA WATCH

A/R Aging Stable

U.S. hospitals held the line in third quarter 2012 on the percent of accounts receivable (A/R) aged greater than 90 days. Nationally, hospitals reported 24.33 percent of third quarter A/R aged more than 90 days, nearly identical to second quarter 2012. The third quarter results and the four-quarter A/R aging average, which now is at 24.07 percent, both hit the benchmark of holding A/R aged more than 90 days to 25 percent or less of total A/R.



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