Insurance Exchanges and Ending Job Lock

From “CBO report highlights how insurance reform is changing workers’ choices” by Paul Demko and Jessica Zigmond in Modern Healthcare, cover story, 2/8/14:

“CBO Director Douglas Elmendorf said during a recent House Budget Committee hearing that the law could lead to job creation.”

“Philip Murray works part time as a math and science tutor. But the 33-year-old New Yorker’s professional ambition is to develop a software program to help students prepare for the Medical College Admission Test (MCAT) because he sees a big shortage of MCAT tutors.”

“‘I wanted to start a business and fill that void,’ said Murray, who attended one year of medical school before dropping out.”

“Before Oct. 1, when New York state’s insurance exchange opened for business, Murray couldn’t find affordable health coverage and feared he would have to abandon his goal of starting a software company and instead have to get a job with health benefits. But through the new exchange, Murray said he purchased a plan offered by EmblemHealth, with a monthly premium of $330 and a $3,000 deductible. Counting his federal premium subsidy, his cost fell to only $100 a month.”

“The CBO report, its annual budget outlook, also said that 2 million fewer Americans would get coverage in 2014 than previously anticipated, largely because of the troubled rollout of the insurance exchanges. But it projected that private plan enrollment will expand to the previously estimated level of 25 million by 2017. In addition, at least 12 million additional people are projected to qualify for Medicaid by 2015.”

“No Murray thinks he can fulfill his ambition without worrying that a medical problem could bankrupt him. ‘It helps me build a business, be productive, get my product out and possibly even hire some help,’ he said. ‘It’s a huge positive.’”

“Murray’s situation offers a personal spin on the Congressional Budget Office’s report issued last week projecting that the Patient Protection and Affordable Care Act will reduce the total number of hours Americans work by 1.5% to 2% between 2017 and 2024—almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive.”

“The CBO report discussed the complex decisions Americans make about employment and health coverage and how those dynamics are changing because of the ACA. It concluded that the law will result in a decline in the number of full-time equivalent workers of about 2 million in 2017, 2.3 million in 2021, and 2.5 million in 2024.”

“Success is not final, failure is not fatal: it is the courage to continue that counts.” - Winston Churchill
“The law’s coverage provisions will give Americans more freedom of choice, said Sara Collins, vice president of healthcare coverage and access at the Commonwealth Fund. As an example, she pointed to couples who own a small business together and one member works another job simply for the health coverage. In other cases, younger Americans may select the career they truly want or go to graduate school rather than work a job solely for the insurance.”

“The CBO said the law’s premium subsidies and expanded Medicaid program will reduce incentives to work. As people earn more income, they could exceed the income eligibility for Medicaid or premium tax credits. In those situations, some people will choose not to work or will work less.”

“Congressional Republicans cited the CBO report as proof that the ACA will weaken the economy and hurt job growth. But CBO Director Douglas Elmendorf said during a House Budget Committee hearing last week that the law could lead to job creation since many newly insured Americans would have more disposable income from spending less on healthcare.”

“All means-tested programs that phase out at a certain income level contain similar incentives to reduce work, explained Mark Pauly, professor of healthcare management at the University of Pennsylvania. ‘As your income goes up, your subsidy goes down—and that seems to be driving the reduction in employment,’ he said.”

“Other analysts stress that the law reduces ‘job lock,’ which is widely seen as bad for the economy. ‘For those individuals who have been ‘job locked’ because their employer was providing health insurance, the fact that they have alternatives to move out of that job and into an exchange (is) a positive,’ said Bill Hoagland, who served as a senior aide to former Republican Senate Majority Leader Bill Frist and now is senior vice president at the Bipartisan Policy Center.”

“Meanwhile, those Americans nearing retirement who are not yet eligible for Medicare may choose to retire early because they have the option of buying affordable coverage through the exchanges, said Paul Van de Water, a senior fellow at the Center for Budget and Policy Priorities, a liberal-leaning research group.”

“Despite the expansion of coverage under the ACA, the CBO report said 31 million Americans will still lack insurance in 2024. Of that group, 30% will be undocumented immigrants who largely don’t qualify for Medicaid or exchange subsidies. Another 45% will be individuals who have access to affordable coverage through work or the exchanges but opt not to buy a plan.”

“Joseph Antos, a health policy analyst at the conservative American Enterprise Institute, questioned whether the heated political debate over the CBO findings will have much impact on the 2014 election campaign. ‘These are basically technical talking points,’ he said. ‘I think what matters to (voters) is what happens to them.’ ”

“Philip Murray seems to agree. Even though he did not vote for Barack Obama in either 2008 or 2012, he says he’s grateful the government made it possible for him to buy affordable health coverage that will make it easier to pursue his professional goal. ‘It’s the first time the government has done something that’s affected me in an extremely positive way,’ he said.”

**Governors’ Support for Nurse Practitioners**

From “The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care,” a paper from the National Governor’s Association, Dec. 2012:

“With the demand for primary care services already straining capacity in most states, more than 16 million individuals projected to gain health insurance coverage by 2016, and a rapidly aging population, many states are considering options to increase the number and role of primary care providers. One option for states is to reexamine their scope of practice laws governing nurse practitioners (NPs). NPs, the largest group of advanced
practice registered nurses (APRNs), currently serve patients in a wide variety of settings under varying degrees of physician supervision.”

“The National Governors’ Association (NGA) undertook a review of the literature and state rules governing NPs’ scope of practice to answer three questions pertaining to their potential role in meeting the increasing demand for primary care: (1) to what extent do scope of practice rules for NPs, as well as licensure and other conditional requirements, vary across states?; (2) to what extent do states’ rules and requirements for NPs deviate from evidence-based research of appropriate activities for NPs?; and (3) given current evidence, what would be the effect of changes to state scope of practice laws and regulations on health care access and quality?”

“Research suggests that NPs can perform many primary care services as well as physicians do and achieve equal or higher patient satisfaction rates among their patients. The review of state laws and regulations governing NPs reveals wide variation among the states’ with respect to rules governing NPs’ scope of practice, including the extent to which states allow NPs to prescribe drugs, to practice independently of physician oversight, and to bill insurers and Medicaid under their own provider identifier.”

“Sixteen states and the District of Columbia allow NPs to practice completely independently of a physician and to the full extent of their training (i.e., diagnosing, treating, and referring patients as well as pre-prescribing medications for patients); the remaining 34 states require NPs to have some level of involvement with a physician, but the degree and type of involvement varies considerably by state. To better meet the nation’s current and growing need for primary care providers, states may want to consider easing their scope of practice restrictions and modifying their reimbursement policies to encourage greater NP involvement in the provision of primary care.”

“The demand for primary care services in the United States is expanding as a result of the growth and aging of the U.S. population and the passage of the 2010 ACA, and this trend is expected to continue over the next several years. NPs may be able to mitigate projected shortages of primary care services. Existing research suggests that NPs can perform a subset of primary care services as well as or better than physicians. Expanded utilization of NPs has the potential to increase access to health care, particularly in historically underserved areas.”

“NGA’s review of health services research suggests that NPs are well qualified to deliver certain elements of primary care. In light of the research evidence, states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care.”

Rural–Urban Life Expectancy Gap Growing

From “Gap in Life Expectancy Between Rural and Urban Residents is Growing” by Stephanie Stephens, in Health Behavior News Service, 1/23/14:

“Reducing health inequalities and increasing life expectancy in the United States have both been primary goals of the national health initiative, Healthy People 2020. Unfortunately, according to a new study in the American Journal of Preventive Medicine, over a 40-year period, rural residents have experienced smaller gains in life expectancy than their urban counterparts and the gap continues to grow.”
“We’ve had information about life expectancy by gender, racial or ethnic and socioeconomic groups, but to our knowledge, nobody has looked at how disparities in life expectancy have changed over time—whether they’re widening or narrowing,” said the study’s lead author Gopal K. Singh, Ph.D, of the U.S. Health Resources and Services Administration (HRSA). “In fact, disparities have been increasing over the past two decades as opposed to the last four.”

“Understanding the magnitude and causes of these disparities has implications for both public health planning and decision-making, Singh said, as rural residents ‘remain at a higher risk of mortality from major chronic conditions and injuries.’”

“The study notes consistent overall increases in U.S. life expectancy during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. In contrast, the study reveals the rural-urban gap widening from 0.4 years in 1969 to 1971 to 2.0 years in 2005 to 2009.”

“Accidents, cardiovascular disease, COPD and lung cancer accounted for 70 percent of the overall rural–urban gap in life expectancy and 54 percent of the life expectancy gap between the urban rich and rural poor in 2005 to 2009.”

“A number of factors likely explain the disparity,” said Singh. ‘When compared to urban areas, rural areas have higher rates of both smoking and lung cancer, along with obesity, yet reduced access to health care services. Additionally, rural residents have a lower median family income, higher poverty rate and fewer have college degrees.’”

“Seventeen percent of the U.S. lives in rural areas, compared with 83 percent in urban areas, Singh noted. ‘There’s always a temptation to take public health resources away from rural areas and focus on where people actively live, which would reduce the national disease burden but cause even greater rural–urban disparities in health and life expectancy.’”

“In public health, we tend to focus on overall life expectancy and it does move forward a little bit each year,’ said Steven P. Wallace, Ph.D., associate director of the UCLA Center for Health Policy Research and chair and professor in the Department of Community Health Sciences at the university’s Fielding School of Public Health. ‘We have spent a lot of time looking at health disparities over the last 20 years and yet rural and urban disparities haven’t been front and center.’”

“People who live in rural areas have a lot of the same challenges as inner city people, Wallace said. ‘These include safety, getting enough physical activity and even getting good nutrition—in spite of all the food growing around many of them—the more rural the location, the more difficult it often is. Also, young adults have migrated from rural farming areas, leaving people with the lowest incomes and the least opportunity—both factors correlate strongly with life expectancy.’”

WI Collaborative for Rural GME Taking Off

By Kara Traxler, WI Collaborative for Rural Graduate Medical Education (Collaborative), Development & Support Manager, and Jennifer Crubel, Collaborative Program Assistant:

In order to assess the results of the efforts of the WI Collaborative for Rural Graduate Medical Education (Collaborative) and to establish a baseline for graduate medical education (GME) growth for its members, a data survey was recently conducted with encouraging results. Eight organizations responded to the survey, seven of which are inaugural members of the Collaborative. The remaining Collaborative organizations were too new to GME development to be included in this survey cycle.

The survey was broken into five main categories: rural resident rotations, rural fellowships, rural training...
tracks (RTTs), rural medical student rotations, and recruitment. It measured changes in rural GME opportunities and experiences for the July 1 – June 30 academic years of 2010-11, 2011-12, and 2012-13.

Of significant note is the more than doubling of the number of weeks residents spent at Collaborative member rural rotation sites from 77 to 161. One of the major factors for this is the expansion of the number of rural rotations (8 to 25) offered.

Understanding the importance of “filling the pipeline” with medical students to recruiting for resident rotations and residency slots, some sites have also boosted their medical student rotation options which has led to increased number of students completing rotations at Collaborative sites (13 to 23).

Starting RTT Residency Programs is another main objective for the Collaborative. During this survey period, one site made the commitment to start this process. That same site also developed two fellowship programs.

From this survey it appears that increasing rural rotation options has achieved the anticipated result of having residents spend more time training in rural places, experiencing first-hand both rural practice and the rural communities of Wisconsin. In future surveys, we hope to see the number of weeks in rotations, the number of residents returning to sites, and the number of residents hired into these rural sites increase.

We have also begun tracking the change in the amount of time our urban members have residents rotating in rural locations in anticipation of its growth as their relationships with rural sites develops.

Contact Kara Traxler at ktraxler@RWHC.com or Jennifer Crubel at jcrubel@rwhc.com for more information. Both can be contacted at 608-643-2343.
Trusted Sources of Vaccine Information

From Ann Lewandowski, RWHC’s Coordinator for the Southern Wisconsin Immunization Consortium:

**Immunization Action Coalition (IAC):** A nationally recognized resource for parents and providers on vaccines at [www.immunize.org](http://www.immunize.org).

**Vaccine Education Center (VEC):** The goal of the VEC at Children’s Hospital of Philadelphia is to accurately communicate the facts about each childhood vaccine. VEC publishes a monthly vaccine e-newsletter for parents titled Parents PACK. VEC also has an excellent mobile app “Vaccines on the Go: What you need to know.” Both resources are available at [www.vaccine.chop.edu](http://www.vaccine.chop.edu).

**Every Child by Two (ECBT):** Founded by Rosalynn Carter and Betty Bumpers, ECBT provides educational materials and information about vaccines, their safety, vaccine research and science, and vaccine misconceptions to help clinicians and parents at [www.ecbt.org](http://www.ecbt.org).

**History of Vaccines:** Interactive website from the College of Physicians of Philadelphia includes games, videos, and fun facts at [www.historyofvaccines.org](http://www.historyofvaccines.org).

**Families Fighting Flu:** A non-profit with personal stories of families who have lost children to the flu at [www.familiesfightingflu.org](http://www.familiesfightingflu.org).

**Voices for Vaccines:** Voices for Vaccines (VFV) is a parent-driven organization supported by scientists, doctors, and public health officials that provides parents clear, science-based information about vaccines and vaccine-preventable disease, as well as an opportunity to join the national discussion about the importance of on-time vaccination at [www.voicesforvaccines.org](http://www.voicesforvaccines.org).

**Meningitis Angels:** Educates the public, health professionals, child care facilities, schools and universities on not only meningitis but other vaccine preventable diseases and the prevention including vaccines, though personal stories, our educational brochures, posters and videos at [www.meningitis-angels.org](http://www.meningitis-angels.org).

*To join or support SWIC or for more information contact Ann at alewandowski@rwhc.com.*

**RWHC Quality Indicators Program**

Whether your hospital is PPS or a CAH, RWHC can help you design a group of measures that meet your participation requirement for Medicare, The Joint Commission*, or other public-reporting agencies. We help make sure you “get it right.”

RWHC submits your Core Measures, Non-Core Measures, and your ICD Population and Sampling reports for you, in plenty of time so that any last minute changes or edits can be done without panic.

We offer a secured environment with minimal computer system requirements. Our web tools are easy to use and meet CMS and The Joint Commission’s requirements. We can work with your EHR system to import demographic and clinical data directly into our database, reducing your abstraction time and increasing accuracy. Our re-abstraction service complements your abstractor training programs and data validity needs.

RWHC has developed clear, concise, at-a-glance and on demand reports so that you and your stakeholders can easily identify areas of strong performance as well as opportunities for improvement.

By partnering RWHC’s Core Measures service with our Meaningful Use Solutions, we can offer a state of the art product at a competitive price. Let us maximize your investment dollars by building a total quality reporting package, tailored to your unique needs.
**RWHC has met the criteria for inclusion in the accreditation process and is included on The Joint Commission’s list of acceptable vendors. RWHC is committed to meeting future criteria established by The Joint Commission.**

For more information, please contact Beth Dibbert at bdibbert@rwhc.com, or 1-800-225-2531.

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**Leadership Insights: “We”**

The following is from RWHC’s Leadership Insights newsletter by Jo Anne Preston, RWHC Organizational Development Manager. Go to [www.RWHC.com](http://www.RWHC.com) for back issues.

**WE–Not THEY:**

“Listen… which word do your employees use when speaking about your organization? ‘We’ are offering a new service here at our hospital’ has a whole different tone than ‘Sounds like they are going to start a new service at the hospital.’ The former has a ring of pride, the latter, mild curiosity.”

‘We’ says:

- I belong.
- My voice matters.
- I’m committed and engaged in my work, I’m ‘all in.’”

‘They’ sounds a little more tentative. It implies:

- I work here, this is my job but I could just as easily work someplace else.”

Employee engagement is critical to organizational success, so how can we motivate the move from thinking in terms of ‘they’ to ‘we’?”

**Increase autonomy.** “Engagement goes up when we stop over-managing employees. Some jobs just don’t have a lot of flexibility, but where can you give up some control and let employees decide?”

“Daniel Pink describes in his book, Drive—the Surprising Truth About What Motivates Us, four specific ways we can offer autonomy:

- **Time**–can you give freedom to the employee to decide when something is done?
- **Task**–can the team decide for themselves what tasks they will do to make the most of their strengths?
- **Team**–are there opportunities for people to choose with whom they work?
- **Technique**–even if you define the final outcome you have to have, is there a way you can give the employee the choice of how he or she will get there?”

**Keep the toolbox full.** “When assigning work, make sure to ask if people have the materials, resources, tools, and access to information that they need. Get the kind of reputation as a leader that people know you will unearth the resources needed to complete a task and not leave them stranded.”

**Watch your own language.** “What do you say in reference to your organization, or about those senior to you in position? It’s a subtle thing, but it matters. If you find yourself saying ‘they’ what does that mean for you? It may be that the environment is not as engaging as it could be, and it might also mean that you can do something to change that.”

**De-jargonize yourself.** “Another note on your language, watch out for your use of job specific lingo. Jargon implies that there is an in group (those who know what the lingo means) and an out group (those who don’t). You run the risk of excluding - and disengaging those who don’t know what you are talking about and don’t feel invited to ask.”

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**Support NRHA Rural Leadership Development**

The National Rural Health Association has launched a permanent endowment for programs that identify emerging leaders from and for rural communities. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to [http://ow.ly/ejmLj](http://ow.ly/ejmLj) to learn more.
Give stuff away. “Go ahead–share what you know and delegate the fun assignments. If something works for you and someone shows an interest, give them the opportunity to try it or learn it. Tell people your secrets of success and help them try it, too.”

Think about other departments. “For broader organizational engagement, what could you do to shine a light on other departments? Consider departments that you hardly ever think about–where do you intersect? What opportunities can you take advantage of to thank, recognize or speak well of them and the work they contribute to your organization’s successes? What invitation might they need from you to feel more connected to and valued by your department?”

Call people by name. “Do you know and use the name of the person who checks you out in the cafeteria line? The person who cleans your office? Nothing is as validating to someone as saying their name when you greet them.”

Talk about the why. “Why does it matter that I do this report, fill out this form, or finish this project? Help connect the meaning behind the tasks so that people feel a sense of purpose vs. crossing something off their task list.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

Upcoming RWHC Leadership Programs
- Feb 27: Primary Project Management for the Busy Manager
- Mar 6: Monkey Management (Based on The One Minute Manager)
- Apr 3: Lateral Violence: Empowering Staff to Stop Bad Behaviors

Go to www.rwhc.com/Services.aspx to register and for upcoming events.

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