Health Care Reform Overview

Oklahoma Hospital Association
May 6, 2010

For audio: 888-567-1602
Password: “Reform”

Updated Oct. 23, 2012
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<tr>
<td>Introduction                  Craig W. Jones, FACHE, President</td>
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<td>Medicare Payment &amp; Compliance     Rick Snyder, VP/Finance &amp; Information Services</td>
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<td>Quality &amp; Delivery Systems Reform   LaWanna Halstead, VP/Quality &amp; Clinical Initiatives</td>
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<td>Medicaid Expansion               Buffy Heater, Oklahoma Health Care Authority</td>
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<td>Insurance Reforms and “Other”      Patti Davis, Executive VP</td>
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<tr>
<td>Summary and Questions            Craig W. Jones</td>
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**Questions:** Webinar “chat”, or Email: oha@okoha.com, or Operator assisted at end
“It is probably not as bad as the Republicans would have you to believe or as good as the Democrats would like you to believe”

Rep. Dr. Doug Cox
Timeline for Health Care Reform Implementation

Patient Protection and Affordable Care Act (H.R. 3590) and the Reconciliation Bill (H.R. 4872)

April 23, 2010

2010

- Expands the RAC program to include audits of Medicare Parts C and D, and by Dec. 31, 2010, audits of Medicaid.
- Extends the RAC program to include audits of Medicare Parts C and D, and by Dec. 31, 2010, audits of Medicaid.
- Expands 340B drug discounts on outpatient drugs for certain children’s and cancer hospitals, CAHs, SChs and Rural Referral Centers.
- Sets new requirements for nonprofit hospitals, including periodic community needs assessments.
- Extends rural hold harmless payments Dec. 31, 2010, for all SChs.
- Reduces Medicare inpatient, outpatient, IRF, LTCHs and psychiatric hospital payments by 0.25%.
- Provides tax credit of up to 35% of paid premiums to small businesses.
- Extends coverage to those up to age 26 through parents’ insurance.
- Requires health insurance companies to submit justification for unreasonable premium increases to states and to post online.
- Requires new health plans to cover preventive services.
- Bans rescission practices and lifetime limits.
- Extends the RAC program to include audits of Medicare Parts C and D, and by Dec. 31, 2010, audits of Medicaid.
- Provides a $250 rebate to
- Requires health insurance companies to submit justification for unreasonable premium increases to states and to post online.
- Requires new health plans to cover preventive services.
Financing Reform

**Where the Money Will Come From**
10 year total: $1.1 trillion (2010 to 2019)

- 49% Spending cuts
- 51% New taxes and fees

**Where the Money Will Go**
10 year total: $965 billion (2010 to 2019)

- 45% Increased federal spending on Medicaid and CHIP
- 47% Premium and cost-sharing subsidies
- 4% Other
- 4% Small employer tax credits

**Cuts include:**
- Education cuts
- Long-term care insurance premiums
- Cutting payments to private Medicare Advantage plans
- Savings from Medicare, Medicaid, CHIP
- Savings from payments to hospitals serving the poor

**New fees include:**
- Fees on drug and device manufacturers and insurers
- Excise taxes on high-premium insurance plans
- Penalties paid by businesses and uninsured individuals
- Other taxes and fees
Hospital and Health System Provisions

Medicare Payment

Rick Snyder, FHFMA
Vice President, Finance & Information Services
Medicare Marketbasket Update Reductions and Productivity Offsets

**Effective date:**
- 2010—update cuts begin
- 2012—productivity offsets begin

**Impact:**
- $157 billion reduction nationwide over ten years

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**Marketbasket (MB) Update Cuts**
- Applied to: inpatient and outpatient hospital, inpatient rehabilitation, inpatient psychiatric, and LTCH.

**Productivity Offsets**
- Applied in addition to the Marketbasket cuts
- Productivity offset was 1.0% for 2012; 0.7% for 2013

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**Hospital Update Reductions**

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<tr>
<th>Year</th>
<th>Marketbasket</th>
<th>Productivity</th>
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<tbody>
<tr>
<td>2010</td>
<td>0.0%</td>
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<tr>
<td>2011</td>
<td>0.5%</td>
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<tr>
<td>2012</td>
<td>1.0%</td>
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<tr>
<td>2013</td>
<td>1.5%</td>
<td>0.7%</td>
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<tr>
<td>2014</td>
<td>1.5%</td>
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<tr>
<td>2015</td>
<td>1.5%</td>
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<td>2016</td>
<td>1.5%</td>
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<tr>
<td>2017</td>
<td>1.5%</td>
<td>0.5%</td>
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<tr>
<td>2018</td>
<td>1.5%</td>
<td>0.5%</td>
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<tr>
<td>2019</td>
<td>1.5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Medicare and Medicaid Disproportionate Share Hospital (DSH) Reductions

Effective date: FFY 2014

Impact:
• $36 billion reduction to hospitals nationwide ($22 billion Medicare, $14 billion Medicaid) over ten years

Percent Reduction in DSH

Medicare DSH
• 25% paid using the current methodology
• 75% tied to reflect decreases in the uninsured population; pays for uncompensated care

Medicaid DSH
• Reductions set by the legislation; method to be determined by CMS.

Impact:
• $36 billion reduction to hospitals nationwide ($22 billion Medicare, $14 billion Medicaid) over ten years

Percent Decrease in Uninsured
Medicare Home Health Agency Payment Changes

Effective dates:
• 2014: rebasing begins
• 2011: outlier payments reduced
• April 1, 2010: rural add-on begins

Impact:
• $40 billion reduction nationwide over ten years

Home Health Rebasing
• Reduction phased in over four years
• Reductions cannot exceed 3.5% each year

Cap on Outlier Payments
• 10% cap on the reimbursement a provider can receive from outlier payments

Rural Add-on
• 3% add-on for services provided in rural areas from April 1, 2010 to December 31, 2015

Rebasing Plus Update Cuts

Rebasing (Maximum)  Productivity  Marketbasket

<table>
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<tr>
<th>Year</th>
<th>Rebasing</th>
<th>Productivity</th>
<th>Marketbasket</th>
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<tr>
<td>2019</td>
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Rebasing (Maximum) from 2010 to 2019
Medicare Skilled Nursing Facility Payment Changes

Effective date:
• FFY 2012 implementation of RUGs-IV

Delay in Implementation of RUGs-IV
• Delays implementation of RUGs-IV from FFY 2011 to FFY 2012.
• Requires the Secretary to implement a component of RUGs-IV specific to therapy furnished on a concurrent basis.
• Revises the look-back period

SNF Update Reductions

Productivity

Medicare Rural Provisions

- **Extension of Outpatient Hold-Harmless Payments**
  - Extended until December 31, 2010 by ACA; and through 2012 by subsequent legislation.

- **Extension of Medicare Dependent Hospital Classification**

- **Critical Access Hospital Outpatient Payments**
  - Clarifies that CAHs that elect an all-inclusive OPD payment will receive 101% of reasonable costs for facility services.

- **Low-Volume Hospital Payment Adjustment**
  - Liberalizes the current low-volume adjustment requirements for FFY 2011 and 2012.
Independent Payment Advisory Board (IPAB)

Effective date:
• By 2014 IPAB must begin making recommendations

Impact:
• $13 billion reduction nationwide over ten years

IPAB
• 15-member IPAB appointed by the President
• Must reduce Medicare spending by targeted amounts if it is determined that there is excess cost growth in the Medicare program
• 0.5 percentage point reduction in 2015, increasing to a 1.5 percentage point reduction in 2018.
• Congress may modify or pass an alternative to the proposals, but is required to maintain the targeted level of Medicare savings for the year.
• Should Congress fail to act, IPAB’s original proposal must be implemented.

Exemptions From IPAB
• Exempt until 2019: Inpatient PPS, home health, outpatient, psychiatric, rehabilitation, and LTC hospitals and hospices
• Critical Access Hospitals are NOT exempt.
Oklahoma PPS Hospital Medicare Margin Forecast
340B Drug Discount Program

Effective date:
• Begins January 1, 2010

Extension of 340B Outpatient Drug Program

• Beginning January 1, 2010, access to the 340B program is extended to certain children’s and cancer hospitals, CAHs, Sole Community Hospitals (SCHs), and Rural Referral Centers (RRCs).
• SCHs and RRCs must have a DSH adjustment percentage of at least 8%; children’s and cancer hospitals must meet the same DSH requirements as other subsection (d) hospitals—a minimum DSH percentage of 11.75%.
• CAHs are exempted from the DSH requirement.
Tax-Exempt Status of Hospitals

Effective date:
• These provisions apply to taxable years beginning after the date of the enactment, except the community health needs assessment, which is applicable two years later.

New Requirements for Tax-Exempt Hospitals

• Establishes additional criteria for hospitals to maintain their Section 501(c)3 tax-exempt status:
  • Adoption of financial assistance policy that limits charges and prohibits extraordinary collection actions.
  • Implementation of strategies to meet community needs—based on the findings of periodic health needs assessments.
  • Failure to meet the community health needs assessment requirements will result in a $50,000 fine.
  • Requires the Secretary to report to Congress on the levels of charity care, bad debt, unreimbursed costs of non means-tested government programs, and the cost of community benefit activities incurred by tax-exempt, taxable, and public hospitals.
Hospital Price Transparency

Effective date:
• Plan years beginning 6 months after enactment?

Standard Hospital Charges

• Section 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.
• “Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups...”
• Guidelines have not yet been proposed by the Secretary of HHS.
Medicare Inpatient Hospital Readmissions Payment Policy

Effective date:
• FFY 2013 for inpatient acute care hospitals

Impact:
• $7.1 billion reduction nationwide over ten years

• Acute care hospitals with higher than expected risk-adjusted readmissions rates will receive reduced payments for every discharge
• In the first and second years, applies to three conditions: heart failure, heart attack, and pneumonia
• Expand to additional conditions in future years, including all-cause readmissions
• Establish a quality improvement program for hospitals with high severity-adjusted readmissions
• Develop a Community Care Transition Program for hospitals with high readmissions rates
• 50 Okla. hospitals will receive penalties in FFY2103
Medicare Value-Based Purchasing

Effective dates:
- FFY 2013 implementation of VBP for inpatient hospitals
- 2012 establish a CAH and small volume rural hospital demonstration
- By 2016 establish VBP pilot programs for inpatient rehabilitation, inpatient psychiatric, LTC and cancer hospitals and hospice

Inpatient Value-Based Purchasing

- Budget-neutral with each year’s pool fully distributed to hospitals in that same year
- Credit for both improvement and attainment
- Funded by IPPS payment reductions, beginning with a 1.0% reduction in FFY 2013 and increasing to 2.0% for FFY 2017 and subsequent years.
- FFY 2014 include efficiency measures
- Demonstration for CAHs and small volume rural hospitals

Percent Carve-Out for VBP Pool
Medicare Value-Based Purchasing – cont’d

What’s included:

**FFY 2013**
- 12 quality process measures
- HCAHPS

**FFY 2014**
- 12 + quality process measures
- HCAHPS
- Outcome measures – mortality for AMI, HF, Pneumonia
- Efficiency measures – costs per Medicare beneficiary

**FFY 2015 and beyond**
- Quality process measures
- HCAHPS
- Outcome measures – mortality, AHRQ patient safety and quality indicators
- Efficiency measures- costs per Medicare beneficiary
#### the Stakes are High!

<table>
<thead>
<tr>
<th>Inpatient Prospective Payment System (IPPS) Policy</th>
<th>Fiscal Year</th>
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<tbody>
<tr>
<td>Market Basket (MB) Cuts for Productivity Adjustment (P) and Medicare Savings</td>
<td>MB – 0.25</td>
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<tr>
<td>Hospital Acquired Conditions</td>
<td>MB – 1.0 For Bottom Quartile Hospitals</td>
</tr>
<tr>
<td>Health Information Technology Meaningful Use5 (MU)</td>
<td>MB – ¼ of MB If Failure to Meet MU</td>
</tr>
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Note: all numeric reductions represent a percentage point reduction from the market basket rate. For example if the market basket is projected to be 3% and the reduction is 2 percentage points, then the remaining amount for the update is 1%.
Expansion of Medicare and Medicaid Quality Reporting Programs

**Pay-for-Reporting**
- Pay-for-reporting programs for long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and hospice providers in 2014
- 2% reduction for not reporting
- Requires quality reporting by cancer hospitals in 2014

**Public Reporting**
- Make all data reported by providers under the pay-for-reporting program available for public inspection via the quality comparison Web sites
- By January 1, 2013, implement a plan for making publicly available information on physician performance, including quality and patient experience measures

**Medicaid Quality Measures**
- Establish a core set of quality measures for adults in the Medicaid program and initiate a Medicaid Quality Measurement Program.
Medicare and Medicaid Health Care-Acquired Conditions (HACs) Payment Policies

Effective dates:
New Medicare HACs inpatient hospital policy begins FFY 2015
By January 1, 2012, the Secretary must report to Congress on current hospital policy and recommend extension of it to other care settings
Medicaid HAC policy begins July 1, 2011

Medicare HACs

• FFY 2015, inpatient hospitals in the worst 25th percentile of risk-adjusted HAC rates will be subject to a 1.0% penalty
• The reduction will be applied in addition to current CMS payment adjustments for HACs

Report to Extend the Current Medicare HAC Policy

• Report-Jan. 2012 - dialysis ctrs, in-pt rehab, long term care
• Report-Jan, 2013-OP Surg. ACS

Medicaid HACs

• Beginning on July 1, 2011, states must adopt policies ensuring that higher Medicaid payments are not made for cases with conditions covered by the Medicare HAC policy.
• OHCA implemented this policy June 11, 2010
Current Hospital Acquired Conditions

- Blood incompatibility
- Air embolism
- Stage III and IV pressure ulcers
- Falls and trauma
- Manifestations of poor glycemic control
- DVT and PE with certain procedures
- Catheter-associated urinary tract infections
- Vascular catheter-associated infection
- Surgical site infection with certain procedures
- Foreign body retention
**Geographic Variation in Medicare Spending**

**Effective dates:**
- Efficiency measures to be added to inpatient hospital VBP by FFY 2014
- Temporary payment increases to hospitals beginning FFY 2011

**Use of Efficiency Measures in VBP**
- Include efficiency measures in the inpatient hospital, budget-neutral, value-based purchasing (VBP) program by FFY 2014
- Medicare spending per beneficiary adjusted for age, sex, race, severity of illness, and other factors

**Temporary, Increased Payments to Hospitals in Low Spending Counties**
- Beginning in 2011, provides $400 million in new funding over two years to hospitals in counties in the lowest quartile of Medicare Part A and Part B spending per enrollee
- Spending adjusted for age, sex, and race

**Secretary Sebelius will commission an Institute of Medicine (IOM) study on Medicare hospital wage index and the establishment of a value index adjustment.**
• Demographically adjusted Part A&B spending per beneficiary (2007)
• Lowest cost quartile counties in Oklahoma: Harper, Ellis, Noble, and Craig
Medicare Payment Bundling Pilot

Effective dates:
By January 1, 2013
By 2016, CMS must report results of pilot, making recommendations to Congress for its expansion.

Payment Bundling Pilot

- Voluntary, five-year program
- Bundle payments for ten conditions
- Cover three days prior to hospital admission to 30 days following discharge
- Include:
  - acute care inpatient;
  - outpatient, including ED;
  - physician services in and out of the hospital; and
  - post-acute care
- Secretary will develop bundled payment rates and will test payments based on bids.
- Payments cannot exceed what would otherwise be paid for the same services under current Medicare.
- After January 1, 2016, the Secretary may expand the program.
Medicare Shared Savings Accountable Care Organization (ACO) Program

Effective date:
By January 1, 2012 the Secretary must establish the program

Impact:
$4.9 billion in shared savings between ACOs and the Medicare program nationwide over ten years

Medicare Shared Savings Program

- Groups of providers and suppliers can apply to be recognized as ACOs
- ACOs must act as the primary care provider for at least 5,000 Medicare fee-for-service beneficiaries and agree to do so for at least three years
- Share in savings achieve for the Medicare program
- Hospitals can take the lead in establishing ACOs
- ACOs may include:
  - group practice arrangements;
  - networks of individual physician practices;
  - partnerships or joint venture arrangements between hospitals and practitioners;
  - other groups of providers and suppliers; and
  - hospitals employing practitioners.
Center for Medicare and Medicaid Innovation (CMI)

Effective date:
• CMI to be established by January 1, 2011

Impact:
• $1.3 billion in savings nationwide over ten years

Center for Medicare and Medicaid Innovation

• Test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to Medicare and Medicaid beneficiaries
• Provider participation is voluntary
• The Secretary may expand, including on a nationwide basis, the duration and scope of a model being tested, provided it reduces spending while maintaining or improving care quality.
• Funding is set at $5 million in FFY 2010, $10 billion for the period FFY 2011 through 2019, and an additional $10 billion for each subsequent ten-year period.
Health Care Reform: What We Know Today

Buffy Heater, MPH
Planning & Development Manager
Oklahoma Health Care Authority

Presented to OHA Members
May 6, 2010
Federal Medicaid Categories: Who Deserves Access?

(Members as of March 2010)
Challenge: Oklahoma’s Uninsured

Oklahoma Uninsured 2008
Total 14% (494,114 persons)
Children (0-18) 7% (67,200 children)
Adults (19+) 16% (426,914 adults)

Children and Adults Uninsurance Rates by FPL in Oklahoma (2008)

Distribution of Oklahoma’s Uninsured Children and Adults by FPL (2008)

Source: US Census Bureau, CPS Table Creator.
http://www.census.gov/hhes/www/cpstc/cps_table_creator.html
National Reform: It’s About Affordability

(Members as of March 2010)
Oklahoma FMAP Outlook: Newly Qualified

Source: CMS, Regular reflects FY 2010 FMAP Estimates
## Potential Oklahoma Impact

### Estimated Annual State Costs - Newly Qualified / Woodwork

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<tr>
<td>FMAP</td>
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<td>Total State Cost (in millions)</td>
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<td>$67</td>
<td>$73</td>
<td>$79</td>
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<td>$23</td>
<td>$25</td>
<td>$27</td>
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Source: OHCA, per analysis of HCR bill as signed by the President on 3/23/10.
Population figures estimated with US Census Bureau uninsured data. Cost figures estimated with average SoonerCare expenses and include 3% administration.
Uncompensated care figures estimated with cost-reports from 103 Oklahoma hospitals, and national study conducted in 2005 by Dr. Kenneth Thorpe, PhD.
### Impact Analysis for Planning

www.implan.com

**New Members: 200,000 newly qualified 50,000 woodwork effect**

<table>
<thead>
<tr>
<th>Years</th>
<th>State Dollars</th>
<th>PMPM</th>
<th>Federal Dollars</th>
<th>Total Dollars</th>
<th>Total PMPM</th>
<th>Jobs</th>
<th>Earnings</th>
<th>Tax Rev</th>
<th>Other Business Activity</th>
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<tbody>
<tr>
<td>2014 - 2016</td>
<td>$127 Million</td>
<td>$15</td>
<td>$1.8 Billion</td>
<td>$1.9 Billion</td>
<td>$220</td>
<td>22,500</td>
<td>$1.6 Billion</td>
<td>$215 Million</td>
<td>$188 Million</td>
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<tr>
<td>2017 - 2019</td>
<td>$219 Million</td>
<td>$25</td>
<td>$1.8 Billion</td>
<td>$2 Billion</td>
<td>$234</td>
<td>23,900</td>
<td>$1.7 Billion</td>
<td>$228 Million</td>
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<td>2020</td>
<td>$95 Million</td>
<td>$33</td>
<td>$607 Million</td>
<td>$702 Million</td>
<td>$243</td>
<td>24,800</td>
<td>$574 Million</td>
<td>$79 Million</td>
<td>$69 Million</td>
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**Uncompensated Care Cost Shift**

| Annual Total Cost of 500,000 Uninsured | $1 Billion |
| Additional Premium Cost Per Insured Family | $1,000.00 |

Source: IMPLAN methodology used by the National Center for Rural Health Works, OSU and the report issued in January 2007 entitled “The Economic Impact of the Medicaid Program on Oklahoma's Economy.”
Insurance Reforms

Patti Davis
Executive Vice President
Oklahoma Hospital Association
Effective upon enactment....

- HHS review of “unreasonable” premium increases
- State consumer assistance
- Coverage for kids with pre-existing conditions
- Tax credits for small business

Insurance Reforms
Effective 90 days after enactment

• Temporary high risk pools

Provides federal funding for folks who have pre-existing conditions and have been uninsured for at least 6 months.

Oklahoma currently has a high risk pool.

• Temporary reinsurance for early retirees

Reimburses employers who provide coverage for retirees age 55-64 who are not yet eligible for Medicare for 80% of retiree claims between $15,000-$90,000
Effective 6 months after enactment
• Coverage for preventive services without cost sharing
• Prohibition against unwarranted recissions
• Prohibition of lifetime dollar limits
• Prohibition of preauthorization for emergency treatment
• Adult dependent coverage to age 26
Insurance Reforms cont.

Effective 12/31/10

• Transparency of medical loss ratios

Effective 2011

• Administrative simplification
• Rebates for excess medical loss ratios
• Prohibits OTC drugs from reimbursements on HSA/FSA
• Long Term Care (Class Act)
2013
• Limit on FSA $2500
2014
• Individual mandate penalty starts-phased in
• Individual incentives/premium credits/subsidies begin
• Employer mandate
  Employers with 50+ employees must offer coverage or face a penalty
• Employer incentive-small business tax credit
• Guaranteed Issue, Renewability, Pre-existing conditions
• Fair premium rating
• Excessive waiting periods prohibited
• Essential benefits and cost sharing limits
• Premium discounts, rebates, wellness promotion
Essential Benefit Requirements

- Benefit package=full range of services, including:
  - IP, OP, and ER services
  - Rehab, mental health and substance abuse
  - Maternity/newborn care
  - Prevention/wellness services
  - Chronic disease management
  - Prescription drugs
State Based Insurance Exchanges

Beginning in 2014

- Essential health benefit plan
- Benefit tiers with 4 different cost sharing levels
- Catastrophic plan options for 20s.
- Guarantee Issue
- Prohibition on annual dollar limits
- Reinsurance pool for high dollar claims
Function of State Exchanges

• Facilitate and manage enrollment
• Management of tax based premium subsidy and eligibility determinations
• Will also enroll eligible individuals in Medicaid or CHIP or other programs
• Establish a Navigator program for education and enrollment
• Empowering consumer choice
Additional Features

• Sale of insurance across state lines
• Health Care Co-Ops
• State waiver of individual mandates
• Hospitals with more than 50 beds will have to participate in PSO
• No coverage for abortion services
• No coverage for illegal immigrants
Tax on High Cost Plans
Effective 2018

• “Cadillac Plans” — 40% excise tax assessed on high cost employer sponsored health coverage
• “High cost” —$10,200 individual/$27,500 family annual premiums
Premium Tax Credits
For Individuals and Families

• Eligibility 133-400% federal poverty limits
• Tied to sliding scale
• Out-of-pocket costs also capped and tied to income on sliding scale
• Streamlined enrollment process
Small businesses are eligible for subsidies to offer insurance and have access to exchanges

- Employers with 10 or fewer employees who earn, on average, less than $25K per year can get 50% tax credit
- Employers with 25 or fewer employees who earn, on average, less than $50K can receive partial tax credit
- This provision is in two phases with different tax credit amounts
“Free Rider Assessments”- begins in 2014, businesses with 50 or more employees will be fined if their employees purchase health care coverage through the new exchanges and receive federal help to pay premiums.

- Penalty for noncompliance: Lesser of $3,000 for each employee who receives a premium credit or $750 per each full time employee.

- Employers with more than 200 employees will have to have an auto enrollment for health plans.

- Free choice vouchers.
• Penalty for noncompliance:
  $95 in 2014 (or 1% taxable income)
  $325 in 2015 (or 2% taxable income)
  $695 in 2016 (or 2.5% taxable income)

• After 2015, penalty will be increased at the COLA rate
Physician Provisions
• States to increase Medicaid rates to primary care physicians to Medicare levels in 2013 and 2014-100% federal funds
• 10% bonus in Medicare payments to primary care and general surgeons in health-professional shortage areas from 2011 – 2015
• GME – increases GME training positions by redistributing 65% of unused slots – priorities to primary care & general surgery
• Oklahoma ranks 40th in number of patients per primary care physicians
Physicians cont.

- Physician “fix” is not included in this bill
- Pay for reporting begins in 2015
- Budget neutral pay for performance in 2017
- Physician owned hospitals and self referral
- Payment reduction for advanced imaging services
Workforce Provisions

- State health care workforce grants
- Numerous repayment programs and scholarships for physicians, dentists and allied health care workers
- Loans for nurses to increase teaching faculty
Other Provisions

• Medical malpractice grants
• Comparative effectiveness research
• Wellness and preventive care
• Emergency room and trauma
• Nutritional information requirements
Oklahoma Impact of Health Care Reform
Pain vs. Gain

• 319,000 could qualify for premium tax credits to help them buy insurance
• 575,000 seniors would receive free preventive services
• 102,000 seniors would benefit from the donut hole provisions
• 45,000 small businesses could receive small business tax credit for premiums
• 600,000 could get affordable insurance through the exchanges
Timeline for Health Care Reform Implementation

Patient Protection and Affordable Care Act (H.R. 3590) and the Reconciliation Bill (H.R. 4872)

April 23, 2010

Color Code: Hospitals Insurance Coverage Other/Workforce Delivery System

2010

Expands the RAC program to include audits of Medicare Parts C and D, and by Dec. 31, 2010, audits of Medicaid.


Extends Section 508 hospital recategorization until Sept. 30, 2010.

Expands 340B drug discounts on outpatient drugs for certain children’s and cancer hospitals, CAHs, SCHs and Rural Referral Centers.

Sets new requirements for nonprofit hospitals, including periodic community needs assessments.

Extends rural hospital payments Dec. 31, 2010, for all SCHs.

Reduces Medicare inpatient, outpatient, IRF, LTCHs and psychiatric hospital payments by 0.25%.

Requires health insurance companies to submit justification for unreasonable premium increases to states and to post online.

Provides tax credit of up to 35% of paid premiums to small businesses.

Requires new health plans to cover preventive services.

Extends coverage to those up to age 26 through parents’ insurance.

Provides a $250 rebate to

 restricts use...
Resources

- American Hospital Assn: www.aha.org
- Federal government: www.healthreform.gov
- Kaiser Family Foundation: http://healthreform.kff.org
- AARP: www.aarp.org
- Library of Congress: HR 3590
  http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:
- HR 4872
  http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.4872:
Questions?

- Webinar “chat”
- Operator assisted
- Email: oha@okoha.com