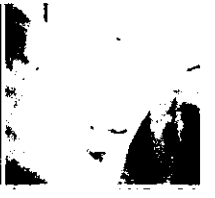
Health Care Reform
When Will Changes Happen?



Year	Coverage Expansion	Financing	Delivery System Reform
2010	• Coverage for non-dependent children through age 26 • Prohibition on denying coverage for children with pre-existing conditions • Small business subsidies to provide coverage to employees • High-risk pools for those denied coverage	• Tanning salon tax takes effect • Market basket adjustment to DRG updates	• Patient-centered outcomes research • Community transformation grants • Gainsharing, global payment demos • Hospital Value-Based Purchasing
2011	• Five-year opt-in long-term care program begins	• Medicare Advantage payments restructured	• Center for Medicare and Medicaid Innovation launched
2012		• First industry fees take effect • Medicare Advantage bonuses take effect • Hospital productivity adjustment	• Medicare Shared Savings Program (ACOs) • Hospital Readmission Reduction Program • Independence at Home demo
2013	• Increased payments to primary care physicians take effect	• New Medicare tax takes effect • Passive income tax takes effect • Excise tax on medical devices takes effect	• Bundled Payment pilot begins
2014	• Health Benefit Exchanges created • Individual, employer mandates take effect • Medicaid expanded to 133% of FPL	• Individual, employer penalties take effect • DSH payment adjustments take effect	• Independent Payment Advisory Board begins submitting recommendations
2015			• Payment adjustment for hospital-acquired conditions takes effect
2016		• Individual, employer penalties rise	
2018	• Excise tax on "Cadillac" health plans		

HEALTH CARE REFORM

Websites with Helpful Information

GENERAL SITES

- **National Association of Insurance Commissioners:** http://www.naic.org/index_health_reform_section.htm
  This site includes Health Care Reform Frequently Asked Questions for Consumers, Employers and Seniors

- **Kaiser Family Foundation:** http://healthreform.kff.org/
  This site includes the following helpful information:
  - Questions About the Temporary High-Risk Pool
  - Key Changes in the Medicare Advantage Program
  - Questions About Health Insurance Exchanges and the Extension of Dependent Coverage to Age 26
  - Glossary of Key Terms in Health Reform

EMPLOYERS

Some of the best information for employers can be found from law firms including:

- http://www.blankrome.com/index.cfm?contentID=37&itemID=2210
- http://www.seyfarth.com/index.cfm/fuseaction/publications.publications_detail/object_id/696586a2-1439-4e95-931b-15f1fcee6747/AnEmployersGuidetoHealthCareReform.cfm

CONSUMERS

- **Consumer Guide to Health Reform** – by Kaiser Health News http://www.kaiserhealthnews.org/stories/2010/march/22/consumers-guide-health-reform.aspx

- **Consumer Reports, Health.org**: http://www.consumerreports.org/health/insurance/health-insurance.htm

- **Healthcare.Gov** - A website managed by the U.S. Department of Health & Human Services: http://www.healthcare.gov/index.html

- **Medicare and the New Health Law** – What it Means for You – an online brochure - http://www.medicare.gov/Publications/Pubs/pdf/11467.pdf

PHYSICIANS

- **American Medical Association:** http://www.ama-assn.org/ama/pub/health-system-reform/resources.shtml

CLINICAL VIEWPOINT
INFORMATION ON HOSPITAL TRENDS

Health Care Reform

By Chas Roades, Chief Research Officer
The Advisory Board Company

HEALTH CARE REFORM will not have one uniform impact on all physicians. Rather, physicians will experience the dual impact of coverage expansion and payment reform in very different ways, based on factors as diverse as their current payer mix, level of integration with other physicians and hospitals, and specialty. In general, policy and reimbursement changes seem to favor primary care physicians (PCPs) more than specialists, and physicians organized into larger groups, whether hospital sponsored or independent, rather than smaller scale independent practices. These difficult generalities notwithstanding, there is no doubt that the practice of medicine will change as the federal government implements the Patient Protection and Affordable Care Act (PPACA) and begins to address the financial challenge of baby boomers aging into Medicare. Some of the most important implications of health care reform include:

For this issue of *Clinical ViewPoint*, I have invited Chas Roades, Chief Research Officer for Health Care at The Advisory Board Company in Washington, D.C., to share his thoughts on health care reform and how changes in legislation will affect physicians and patient care.

[illegible], M.D.
Chief Medical Officer
[illegible] Hospital

Coverage expansion will swell demand for physician ambulatory services: The 32 million Americans newly-insured through the PPACA will seek to exercise their new health benefits starting in 2014, when individual and employer mandates go into effect and health insurance exchanges become operational. Based on the experience of coverage expansion in Massachusetts, which shares many parallels with the PPACA, we expect a surge in demand for primary care services – perhaps as high as 10 percent – and a smaller, but still sizable increase in specialist office visits. This additional demand will introduce an unfortunate corollary: access challenges. Without changes in operations and scheduling, many physician offices will struggle to accommodate these new patients in a timely manner.

New payment methodologies will emphasize managing total costs: To reform the fragmented and siloed delivery systems common in most markets, Medicare and commercial payers will emphasize total cost management in their new payment methodologies. For primary care physicians, this might mean new bonus programs that reward them for lowering the costs associated with all services patients receive in their practice, rather than only the care directly provided by the PCP. For specialists, this might mean new gainsharing or "bundled" payment programs that reward them for reducing the facility costs their patients incur during an inpatient stay.

Payment reforms will require greater coordination across the continuum: To eliminate errors and inefficiencies associated with a fragmented delivery system that can lead to sub-optimal quality and cost performance, physicians, hospitals and other providers will have to collaborate to a degree uncommon in most communities today. Under various payment reforms, groups of providers who are partnered based on shared values and mutual reward will have to eliminate the barriers to communication and coordination that hinder successful collaboration.

> Thirty-two million Americans newly-insured through PPACA will seek to exercise their new health benefits starting in 2014.

Physicians and other providers who embrace this transformation will realize substantial competitive advantage over the long run.

The legislation missed many opportunities to redress additional shortcomings in the current health care system. But this fact ought not distract us from the fundamental change in direction the legislation and related policy represents. Payers are rapidly implementing new expectations for greater reliability, lower variability, higher quality, lower cost and more coordination from all providers. Hospitals and physicians who begin to work together to meet this challenge will occupy market-leading positions in the future.

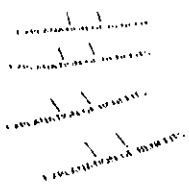
New care models will be needed to address access, quality and coordination challenges: The current models of inpatient and ambulatory care are unlikely to address the staggering access and quality imperatives facing the delivery system. For instance, primary care will have to transform into "medical homes" – proactive care managers in which the PCP "quarterbacks" a team of nurse "health coaches" who provide patient education, proactive outreach and other panel management activities essential to managing patients across the continuum and across time.

Information technology will be the backbone of coordinated networks of providers: It is no coincidence that the reform-minded Obama administration included nearly $40 billion in Meaningful Use incentives in the 2009 stimulus legislation to spur physician and hospital IT adoption—the ambition of a more reliable and coordinated delivery system is nearly unachievable without greater use of IT across care settings. Electronic medical records (EMRs) will improve decision-making at the point of care. Health information exchanges will enhance collaboration among providers and advanced data analytics will foster population health management and proactive quality improvement. Changes to practice patterns are inevitable as IT penetration deepens. We believe that physicians and other providers who embrace this transformation will realize substantial competitive advantage over the long term.

Consumers Guide To Health Reform

TOPICS: HEALTH REFORM, INSURANCE

By Phil Galewitz
KHN Staff Writer
APR 13, 2010



The new health reform law is the most far-reaching health legislation since the crea of the Medicare and Medicaid programs.

The following is a look at the impact of the law, which will extend insurance coverag 32 million additional Americans by 2019, but which will also have an effect on almo every citizen.

Here are some commonly-asked questions about how you might be affected:

Q: I don't have health insurance. Will I have to get it, and what happens if I do

A: Under the legislation, most Americans will have to have insurance by 2014 or pay a penalty. The penalty would start at $ or up to 1 percent of income, whichever is greater, and rise to $695, or 2.5 percent of income, by 2016. This is the individu limit; families have a limit of $2,085 or 2.5 percent of household income, whichever is greater. Some people can be exempt from the insurance requirement, called an individual mandate, because of financial hardship or religious beliefs or if they ar American Indians, for example.

Q: I want health insurance, but I can't afford it. What do I do?

A: Depending on your income, you might be eligible for Medicaid, the state-federal program for the poor and disabled, whic will be expanded sharply beginning in 2014. Low-income adults, including those without children, will be eligible, as long as their incomes didn't exceed 133 percent of the federal poverty level, or $14,404 for individuals and $29,326 for a family of f according to current poverty guidelines.

Q: What if I make too much for Medicaid but still can't afford coverage?

A: You might be eligible for government subsidies to help you pay for private insurance that would be sold in the new state-based insurance marketplaces, called exchanges, slated to begin operation in 2014.

Premium subsidies will be available for individuals and families with incomes between 133 percent and 400 percent of the poverty level, or $14,404 to $43,320 for individuals and $29,326 to $88,200 for a family of four.

The subsidies will be on a sliding scale. For example, a family of four earning 150 percent of the poverty level, or $33,075 a year, will have to pay 4 percent of its income, or $1,323, on premiums. A family with income of 400 percent of the poverty l will have to pay 9.5 percent, or $8,379.

In addition, if your income is below 400 percent of the poverty level, your out-of-pocket health expenses will be limited.

Q: How will the legislation affect the kind of insurance I can buy? Will it make it easier for me to get coverage, ever have health problems?

A: If you have a medical condition, the law will make it easier for you to get coverage; insurers will be barred from rejecting applicants based on health status once the exchanges are operating in 2014.

MOST POPULAR

In the meantime, the law will create a temporary high-risk insurance pool for people with medical problems who have been rejected by insurers and have been uninsured at least six months. This will occur this year.

Starting later this year, insurers can no longer exclude coverage for specific medical problems for children with pre-existing conditions nor deny coverage to children with pre-existing illnesses.

Insurers later this year will also be barred from setting lifetime coverage limits for adults and kids. In 2014, annual limits on coverage will be banned.

New policies sold on the exchanges will be required to cover a range of benefits, including hospitalizations, doctor visits, prescription drugs, maternity care and certain preventive tests.

Q: How will the legislation affect young adults?

A: If you're an adult younger than 26, you'll be able to stay on your parent's insurance coverage as long as you are not offe health coverage at work. This provision officially takes effect in September, but insurers may not have to comply until the beginning of a new health plan year - which often happens in January.

In addition, people in their 20s will be given the option starting in 2014 of buying a "catastrophic" plan that will have lower premiums. The coverage will largely only kick in after the individual has $6,000 in out-of-pocket expenses

Q: I own a small business. Will I have to buy insurance for my workers? What help can I get?

A: It depends on the size of your firm. Companies with fewer than 50 workers won't face any penalties if they don't didn't of insurance.

Companies can get tax credits to help buy insurance if they have 25 or fewer employees and a workforce with an average wage of up to $50,000. Tax credits of up to 35 percent of the cost of premiums will be available this year and will reach 50 percent in 2014. The full credits are for the smallest firms with low-wage workers; the subsidies shrink as companies' workforces and average wages rise.

Firms with more than 50 employees that do not offer coverage will have to pay a fee of up to $2,000 per full-time employee any of their workers get government-subsidized insurance coverage in the exchanges. The first 30 workers will be excluded from the assessment.

Q: I'm over 65. How will the legislation affect seniors?

A: The Medicare prescription-drug benefit will be improved substantially. This year, seniors who enter the Part D coverage gap, known as the "doughnut hole," will get $250 to help pay for their medications.

Beyond that, drug company discounts on brand-name drugs and federal subsidies and discounts for all drugs will gradually reduce the gap, eliminating it by 2020. That means that seniors, who now pay 100 percent of their drug costs once they hit doughnut hole, will pay 25 percent. Beginning in 2011, drug companies will be required to give a 50 percent discount on br name drugs for prescriptions filled in the doughnut hole.

And, as under current law, once seniors spend a certain amount on medications, they will get "catastrophic" coverage and only 5 percent of the cost of their medications.

Meanwhile, government payments to Medicare Advantage, the private-plan part of Medicare, will be frozen starting in 2011 and cut in the following years. If you're one of the 10 million enrollees, you could lose extra benefits that many of the plans offer, such as free eyeglasses, hearing aids and gym memberships. To cushion the blow to beneficiaries, the cuts to health plans in high-cost areas of the country such as New York City and South Florida — where seniors have enjoyed the riches benefits — will be phased in over as many as seven years.

Beginning this year, the law will make all Medicare preventive services, such as screenings for colon, prostate and breast cancer, free to beneficiaries.

Q: How much is all this going to cost? Will it increase my taxes?

A: The package is estimated to cost $938 billion over a decade. But because of higher taxes and fees and billions of dollar: Medicare payment cuts to providers, the package will narrow the federal budget deficit by $143 billion over 10 years, accor to the Congressional Budget Office.

If you have a high income, you will face higher taxes. Starting in 2013, individuals with earnings over $200,000 and marriec couples earning more than $250,000 will pay a Medicare payroll tax of 2.35 percent, up from the current 1.45 percent. In addition, high-income taxpayers will face a 3.8 percent tax on unearned income such as dividends and interest over the threshold.

Starting in 2018, the law will also impose a 40 percent excise tax on the portion of most employer-sponsored health covera (excluding dental and vision) that exceeds $10,200 a year for individuals and $27,500 for families. The tax is often referred as a "Cadillac" tax.

The law also will raise the threshold for deducting unreimbursed medical expenses from 7.5 percent of adjusted gross inco to 10 percent.

The law also will limit the amount of money you can put in a flexible spending account to pay medical expenses to $2,500 starting in 2013. Those using an indoor tanning salon will pay a 10 percent tax starting this year.

Q: What will happen to my premiums?

A: That's hard to predict and the subject of much debate. People who are sick might face lower premiums than otherwise because insurers won't be permitted to charge sick people more; healthier people might pay more. Older people could still charged more than younger people, but no more than three times as much.

The bigger question is what happens to rising medical costs, which drive up premiums. Even proponents acknowledge that efforts in the legislation to control health costs, such as a new board to oversee Medicare spending, won't have much of an effect for several years.