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PBGH Board Policy Update:
The Patient Protection and Affordable Care Act

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PBGH Board Policy Update
May 7, 2010

Overview of Agenda

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- Coverage expansion
- Medical loss ratio
- Early Retiree Reinsurance Program
- Delivery system reform elements
- Unintended consequences & next steps

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Patient Protection and Affordable Care Act Marks the Starting Line for Reform

- Array of provisions related to expanding coverage and changing the rules by which health insurers offer coverage.
- Wide range of provisions intended to control health care costs and improve the health care delivery system.
- Many details still need to be ironed out.
- Implementation will define how they meet the need to deliver high quality and affordable care to all Americans.

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Key Coverage Provisions Effective "Now"

- Small-business tax credits to make employee coverage more affordable
  - Firms that choose to offer coverage will be able to take advantage of tax credits of up to 35% of premiums in 2010. (In 2014, tax credits will cover 50% of premiums).
- Medicare Part D "donut hole" begins to close
  - Medicare beneficiaries will receive a $250 rebate in 2010 when they reach the donut hole, which will be closed by 2020.
  - New guidance issued (comments due May 14, 2010 to partdbenefitimple@cms.hhs.gov): http://www.cms.gov/PrescriptionDrugCovContra/HPMSGH/list.asp#TopOfPage
  - Guidance appears to exclude Employer Group Waiver Plans (EGWPs)
- Within 90 days, the bill gives employers that provide health benefits for retirees ages 55 to 64 help in offsetting the costs of expensive health claims
- Within 90 days, there will be the creation of high-risk pools

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Key Coverage Provisions Effective This Year

- Extends coverage for young people.
  - Up to their 26th birthday, children can be covered under their parents' health insurance policy.
  - Treasury Guidance on Tax Treatment of Coverage for Adult Children http://www.irs.gov/pub/irs-drop/n-10-38.pdf
- Provides coverage protection for the sick.
  - Bans health plans from dropping people from coverage when they get sick.
  - Prohibits health plans from denying coverage to children under the age of 19 with pre-existing conditions. (In 2014, that prohibition would extend to everyone.)
- Prohibits lifetime limits on coverage.
- Tightly restricts new plans' use of annual limits.

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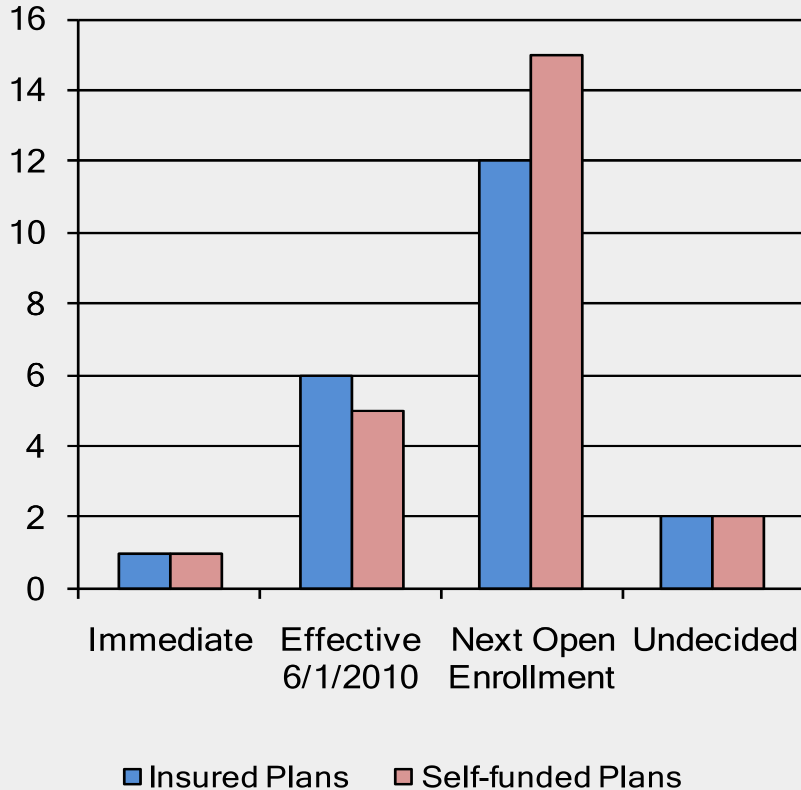
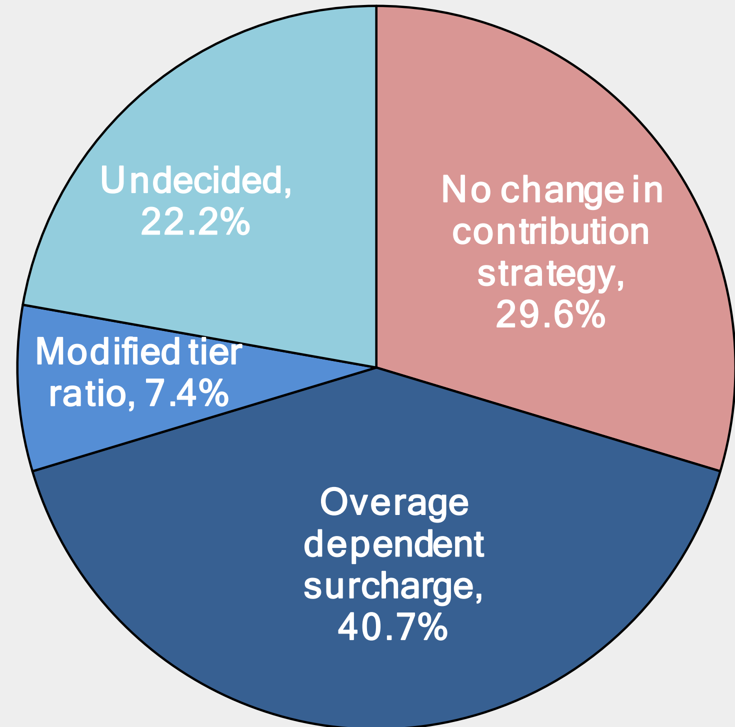
PBGH/SVEF Members & Coverage of Dependents Up to 26 Years Old





- "Other" responses were re-classified into categories listed above
- 3 companies planning to offer coverage early will consider dependent surcharge in 2011

- 68% current offer coverage up to age 25, primarily subject to student status
- 55% of survey respondents will also extend dental/vision coverage
- 67% of employers with multiple classes of members would apply the same policy for bargained/non-bargained

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Medical Loss Ratio

- Request for comments from the Departments of HHS, Labor, and the Treasury
  http://www.thefederalregister.com/d.p/2010-04-14-2010-8599
  Comments due by May 14, 2010
  http://www.regulations.gov/search/Regs/home.html#docketDetail?R=HHS-OS-2010-0004
- Minimum loss ratio of 80% for individual and small group plans
- Minimum MLR of 85% for large group segment
- Difference must be rebated to policyholders
- "Activities that improve health care quality" may be counted as medical expenses. Examples:
  - Nurse hotline
  - Medical management and health promotion
  - Clinical health policy
- Additional information: Senate analysis

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Early Retiree Reinsurance Program

- Interim rule issued May 5, 2010, comments due by June 4, 2010 http://edocket.access.gpo.gov/2010/pdf/2010-10658.pdf
- Early implementation: June 1, 2010
- Eligibles include retirees age 55 and older who are not eligible for Medicare, and their spouses, surviving spouses, and dependents
  - Claims for “access only” retirees would be eligible
  - Claims for retirees using COBRA to bridge Medicare would not be eligible
- Health benefits that qualify for relief include medical, surgical, hospital, prescription drug, and mental health services.
- Both self-funded and insured plans can apply, including plans sponsored by private entities, state and local governments, nonprofits, religious entities, unions, and other employers.
  - For insured plans, costs = amount “the insurer and the early retiree pay for health benefits net of negotiated price concessions the insurer receives for health benefits.” …the amount of premium the sponsor pays (and premium contribution) is irrelevant for purposes of calculating reimbursement under the program.
- Plan sponsor must have programs and procedures “that have the potential to generate cost savings” for participants with chronic and high-cost conditions (allowing that not every condition is predictable)
- Records must be kept for six years

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Early Retiree Reinsurance Program

- Monies will be disbursed on a first come-first served basis
- Reimbursement must be used to reduce health benefit premiums, premium contributions, copayments, coinsurance or other OOP costs
  - No prohibition on benefit design changes that increase cost-sharing
  - No specified time for incorporating reimbursement offset
- Reimbursement amount is up to 80% of claims costs for health benefits between $15,000 and $90,000.
- Claims incurred between the start of the plan year and June 1st are credited towards toward the $15,000 threshold for reimbursement.
  - Only medical expenses incurred after June 1, 2010 are eligible for reimbursement.
  - Claims must be net of "negotiated price concessions."
  - Example: If an individual incurs costs of $30,000 between the start of the plan year and June 1, and $40,000 after that date. The amount which may be reimbursed is 80% of the $40,000 – the costs above the $15,000 threshold that occur after June 1.
- Credit for member OOP expense is subject to the plan sponsor providing prima facie evidence that the retiree (or dependent) paid their portion of the cost… "Such evidence may include an actual payment receipt."

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ERRP: Plan Sponsor Application

- Plan sponsor must complete a participant application and obtain HHS approval of the application in order to file for reimbursement
  - Applicant's Tax Identification Number.
  - Applicant's name and address.
  - Contact name, telephone number and email address.
  - Plan sponsor agreement signed by an authorized representative, which includes--
    - An assurance that the sponsor has a written agreement with its health plan regarding disclosure of information to the Secretary/provision of information, data, documents and records to HHS.
    - An acknowledgment that the information in the application is being provided to obtain Federal funds, and that all subcontractors acknowledge that information provided in connection with a subcontract is used for purposes of obtaining Federal funds.
    - An attestation that policies and procedures are in place to detect and reduce fraud, waste, and abuse,
  - Summary indicating how the reimbursement will be used to meet program requirements
    - Reduce premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs for plan participants;
    - Programs to generate cost savings with respect to plan participants with chronic and high-cost conditions; and
    - How the sponsor will use the reimbursement to maintain its level of contribution to the applicable plan.
  - Projected amount of reimbursement to be received under the program for the first two plan year cycles with specific amounts for each of the two cycles.
  - A list of all benefit options under the employment-based plan that any early retiree for whom the sponsor receives program reimbursement may be claimed.

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ERRP: What You Can Do Now

- Comment on the Interim Rule (due by 5:00 pm ET, June 4, 2010): http://www.regulations.gov/search/Regs/home.html#docketDetail?R=HHS-OS-2010-0011
  - **Collection of Information Requirements** (pp 24460-24462)
  - Application process
  - Undue burden of submitting "prima facie evidence that the early enrollee paid his or her portion of the claim"
  - Maintenance of records for 6 years – could be burden with carrier changes etc.
  - Sponsor's duty to report data inaccuracies – post-sale negotiated price concessions – recommend a materiality threshold (e.g., revisions for pharmacy rebates at the member level would create undue burden)
  - Change of ownership – 60 days advance notice
- Work with your health plan
  - Template contract language and attestations
  - Draft application attestations
  - Segregate early retirees with unique group ID number
  - Obtain "large case" historical claims for early retirees/dependents – cases over $15,000 in the past two years (helpful part of application process)
  - Assess medical plan and carveout vendor data integration issues: medical, pharmacy, behavioral health
  - Consider Member FAQ for Intranet – growing volume of inquiries from retirees about "application" and financial offsets

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Other Key Coverage Provisions

What	When
For individuals – coverage for 95% of Americans • Expansion of access to high-risk pools • Mandate to get coverage • Subsidies to buy or Medicaid for low income • New insurance rules (guaranteed issue, etc) • New taxes (those making more than $200K)	Some soon; most 2014
For Medicare beneficiaries • Additional preventive care coverage • Reduced payments to Medicare Advantage	Starts in 2011
Exchanges For individuals and businesses up to 100, BUT states can allow larger businesses post 2017; funds “co-op plans; many details	Funding 2011; operating 2014

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Other Key Coverage Provisions

What	When
For Large Employers • Benefit design requirements • Requirement to Offer Coverage (or pay for “free-rider”) • Reinsurance for early retiree coverage • Cadillac Tax on “Rich Benefits” • Removal of Part D Tax Subsidy • Paying for expansion through fees/taxes	Some soon; most 2014; others as far out as 2018
For Small Business • Tax Credits • Requirements to offer coverage	2014

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Delivery Reform Elements Hold the Promise of Containing Costs and Improving Quality

- Payment Reform to Improve Quality and Value
- Priority Setting, Measurement & Quality Improvement
- Public Reporting to Promote Transparency
- Promoting Population Health & Wellness
- Comparative Effectiveness Research (CER)
- Health Information Technology

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Payment Reform to Improve Quality and Value

- **Independent Payment Advisory Board**
  - Establishes a new Board which includes reporting on cost and quality trends in Medicare and the private sector as well as making recommendations regarding policies in the private sector.
  - Proposals to Congress begin in 2014.
- **CMS Innovation Center**
  - Establishes an Innovation Center with the capacity to implement innovations program-wide that require review and assessment by the Office of the Actuary.
  - Center must be established by 2011.
- **Piloting of New Programs**
  - Authorizes a multitude of payment redesign programs to be rapidly tested and, as proven, expanded.
  - Accountable Care Organizations, Bundled Payments, Shared Decision-Making, etc.
- **Alignment between Public and Private Payers**
  - Includes multiple provisions that advance the goal of aligning payment between public and private payers.

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Payment Reform to Improve Quality and Value

- **Physician Payment**
  - Provides 5-year, 10% bonus for primary care and general surgeons in health professional shortage areas beginning in 2011.
  - Medicaid primary care rates will be 100% of adjusted Medicare rates for 2013 and 2014.
  - Secretary establishes a payment modifier that provides for differential payment to physicians based on quality of care compared to cost. Must be budget neutral and program starts in 2013.
- **Hospital Payment**
  - Reduces payments for “excess” readmissions in selected conditions starting in 2012.
  - Reduces payment for hospitals in top quartile of national health care acquired conditions rate by 1% starting in 2015.
  - Establishes a hospital VBP program to start in 2013.
- **Expansion of Value-based Purchasing (VBP)**
  - VBP pilots for long-term care; rehabilitation facilities; PPS-except cancer hospitals; and hospice to be implemented by 2016.

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Priority Setting, Measurement & Quality Improvement

- **Priority Setting**
  - Requires Secretary to develop and implement a national strategy to improve delivery, outcomes, and population health. First strategy due 2011 and annually thereafter.
- **Measure Development / Endorsement**
  - Supports the development and maintenance of measures to evaluate care (e.g., outcomes, patient experience, care coordination, resource use). Measure development funding is $75 million for each FY 2010 – 2014.
  - Fosters use of nationally standardized measures endorsed by a multi-stakeholder body.
- **Data Collection and Aggregation Processes**
  - Requires CMS to collect quality and resource use data. Medicare data will be released to support better transparency of provider performance with full protections of patient privacy as early as January 2012.
- **Quality Improvement Support**
  - Center for Quality Improvement and Patient Safety at AHRQ will support research on best practices for quality improvement. Grants for technical assistance support for providers with limited infrastructure and financial resources for quality improvement.

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Public Reporting to Promote Transparency

- **Broad Plan for Public Reporting**
  - Requires a clear federal plan to make performance information widely available.
- **Hospitals and Ambulatory Surgery Centers**
  - Expands Hospital Compare; includes information on the VBP program; report on health care acquired admissions, hospital readmissions, and hospital charge data.
- **Physicians**
  - Requires development of Physician Compare website by January 2011.
  - Annually, physician ownership or investments in hospitals and manufacturers (by September 2013) will be published.
- **Nursing Homes, Skilled Nursing Facilities, LTC Facilities**
  - New information will be added to Nursing Home Compare by March 2011. Nursing home ownership by March 2012.
- **Release of Medicare Data**
  - Medicare data will be released to support better transparency of provider performance with full protections of patient privacy as early as January 2012.

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Promoting Population Health & Wellness

- **Implement a National Wellness Plan**
  - The Secretary shall develop and support a broad effort to promote population health and wellness by March 2011.
- **Benefit Designs to Promote Wellness**
  - Coverage for preventive services and incentives for wellness are fostered in Medicare, Medicaid and for private coverage.
- **Encourage Employer Wellness Programs**
  - Employers' efforts to promote wellness are fostered through multiple vehicles.

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Comparative Effectiveness Research (CER)

- **Independent Governance**
  - Establishes a new independent entity to support and oversee comparative effectiveness research. Funding starts in 2010.
- **No Restrictions on Use of Results**
  - The purpose of comparative effectiveness research is for findings to be used by clinicians, patients and others.
- **Effective Conflict of Interest Provisions**
  - Protections are in place and need to ensure that self-interested individuals and entities do not overly influence the CER research agenda and related processes.

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Health Information Technology

- **Builds on the HITECH incentives**
  - The existing law provides incentives for the adoption of "meaningful use" of health information technologies is maintained.
- **Promotes Telehealth**
  - Encourages the use of telehealth in a couple provisions.
- **Supports Administrative Efficiency**
  - Important provisions support reducing burden on providers and saving resources by standardizing claims, utilization and credentialing processes.

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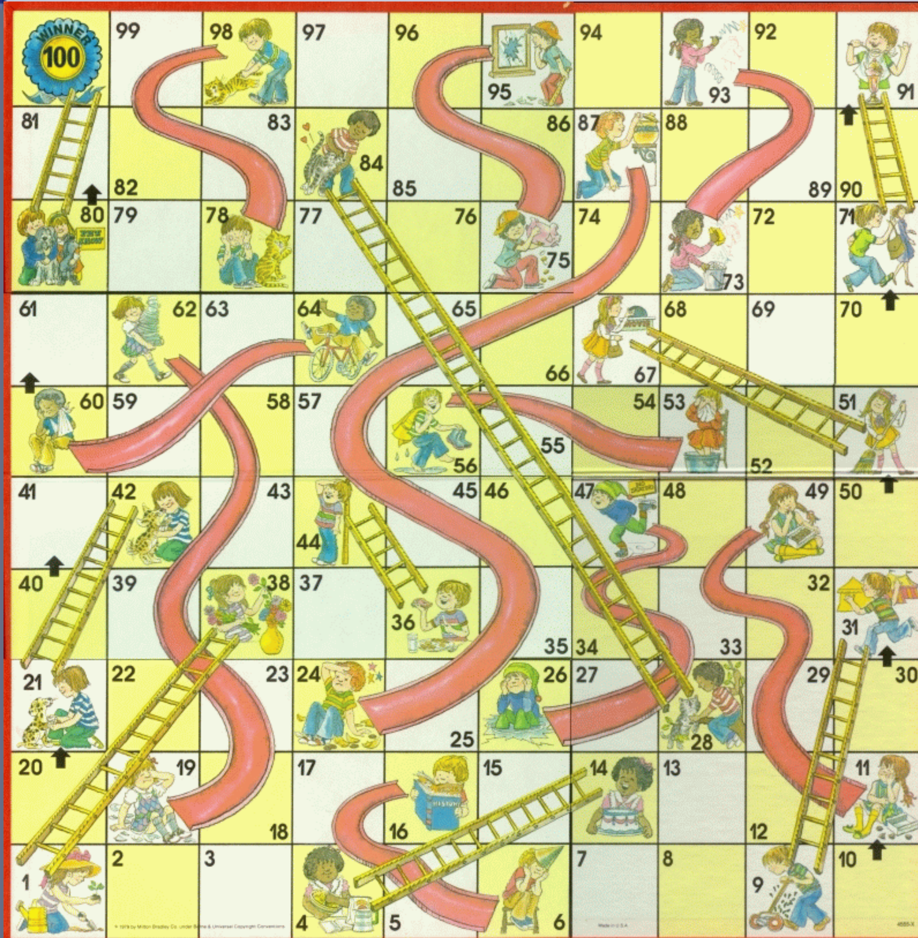
Shaping Implementation of PPACA: Chutes & Ladders Continues



Shaping Implementation:

- **Federal Level:**
  - Help the "Secretary Shall…" be thoughtful
  - Get good advocates on key committees
  - Monitor and engage in "Clean-up" Legislation
- **California:**
  - Shaping Health Information Exchange
  - Shaping the new Exchanges
  - Medi-Cal Rules

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Selected Resources

PBGH Members Only

- http://www.pbgh.org/members_only/policy/resources.asp

Patient Protection and Affordable Care Act of 2010 Legislative Text

- http://www.healthcaredisclosure.org/docs/files/PPACA_Text.pdf

Summary of the Delivery and Payment Reform Elements of the Patient Protection and Affordable Care Act of 2010

- http://www.healthcaredisclosure.org/docs/files/Disclosure_PPACA_SummaryDeliveryPaymentReform.pdf

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