The Affordable Care Act - 2014

- Expand health insurance coverage among the uninsured
- Shift health care in the U.S. to a more patient-centered, multi-disciplinary model (patient-centered medical home)
- Impose free-market rules on health plans
- Expand quality controls on health care delivery
- Reduce overall cost/capita of health care in the U.S.
- Reform private health insurance
- Reinforce evidence-based medicine
The Affordable Care Act - 2014

Patient Protection and Affordable Care Act (P.L. 111-148) signed into law 3/23/2010
http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
amended by:
Health Care and Education Reconciliation Act signed into law 3/31/2010
The Affordable Care Act - 2014

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The Individual Mandate

- Requires U.S. citizens and legal residents to have qualified coverage
- Those that do not pay a tax penalty based on flat tax or % of income up to the cost of the "Bronze Plan" adjusted for inflation

Survived Supreme Court challenge

2014 (enrollment began 10/1/13)

Who?

Bronze, Silver, Gold & Platinum
http://kaiserfamilyfoundation.files.wordpress.com/2013/01/b177.pdf

Premium and cost sharing credits
- Premium subsidy tax credits are refundable to individual or advanceable to the insurer
- Cost sharing happens at point of service
http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf
Qualified Plan

- Ambulatory services
- Emergency visits
- Hospitalization
- Maternity and newborn
- Mental health, substance abuse (mental health parity)
- Prescription drugs
- Rehabilitation
- Laboratory tests
- Preventive health and chronic disease mgmt

Plans

- Bronze: 60/40 with plan covering 60% of health expenditures
- Silver: 70/30 with plan covering 70% of health expenditures
- Gold: 80/20 with plan covering 80% of health expenditures
- Platinum: 90/10 with plan covering 90% of health expenditures

NOTE: Cap limits exist for each plan based on % FPL earnings. Current limits of ~$6,000 individual and $12,000 family
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The Employer Requirement

Originally schedule for 2014; delayed to 2015

- > 200 employees must automatically enroll all employees in a plan (individual employees can "opt - out"

- 50 - 200 employees
  - Offer coverage to all full-time employees (30+ hrs/week)
  - Employer pays a fee (tax) for each full-time employee (first 30 exempt) who does not have a qualified health plan; or for each full-time employee who is taking an individual tax credit (in other words, you offer a poor plan and employees go the HIE, you pay)
  - e.g. $2,000/employee. Business of 60 FT employees would pay (60-30) x $2,000 = $60,000

- < 50 employees exempt
Employer Tax Triggers

- Employer does not offer health insurance which is set up at least at the Bronze level
- Full time employees defined as 30 hours per week
- An employee receives a federal subsidy, eligible if
  - Salary under 400% of FPL (e.g. $46,000)
  - Purchased a health plan on the exchange (can not be paying the individual penalty)
Small Business Incentive

- Applies to business < 25 employees and therefore exempt
- Applies to employees < $50,000/year
- For employers covering 50%+ of employees
- Employer utilizes the Small Business Health Options Program (SHOP) exchange
- Business receives credit on health plan costs of up to 35%
Medicaid Coverage/QUEST Integration

- Children through the Children’s Health Insurance Program (CHIP) using 133% FPL family for children <6; and 100% FPL for children 6 - 18 years.
- Adult caregivers of children (133% FPL family)
- Pregnant women (133% FPL)
- Elderly poor (combined with Medicare for "duals")
- Disabled
- Long-term care

States receive federal funding for some of this
Gaps in Medicaid

- Childless, poor adults (not in mandatory groups) above the state defined income level
  - Individual states set the poverty level
- For example: Hawaii uses 100% of the FPL as the cutoff for Medicaid coverage ($2,000 for a household of 1)
Medicaid Changes (Original Law)

- ALL low-income, non-elderly (covered by Medicare) adults (citizens or legal immigrants) will be covered under Medicaid at the state level
- Standardizes 133% of FPL as the cut point for ALL individuals
- States are to receive 100% federal funding for all additional Medicaid costs incurred as a result of this these added beneficiaries through 2016 with decrease to 90% by 2020
- If a state does not participate in the "Medicaid expansion", they forfeit these additional dollars AND could forfeit federal funding for existing Medicaid programs
- This was challenged by a large number of states
SCOTUS: Ruling on the Affordable Care Act

National Federation of Independent Businesses v. Sebelius & Florida v. Department of Health and Human Services
http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

- The Court agreed to deliberate on two components of the ACA including whether each was severable or if the entire law would have to be declared invalid in wake:
  - The individual mandate (already discussed)
    - Deemed constitutional based on the congressional power to tax (5-4)
      - Did not have to rule on severability although dissenters said it was not therefore had it been the ACA would be entirely invalid
  - The Medicaid expansion
    - Deemed unconstitutionally coercive to the states because ALL Medicaid funding was being revoked, not just the new funding (7-2)
      - This action was severable as a single unenforceable section thereby keeping the rest of the the ACA intact
<table>
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<th>Scalia (Reagan)</th>
<th>Kennedy (Reagan)</th>
<th>Thomas (H. Bush)</th>
<th>Ginsberg (Clinton)</th>
<th>Breyer (Clinton)</th>
<th>Roberts (W. Bush)</th>
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<th>Sotomayer (Obama)</th>
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<tbody>
<tr>
<td>Individual Mandate is a tax and is constitutional</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<td>ACA invalid in it entirety</td>
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<td>Medicaid rule is UNconstitutionally coercive</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Medicaid section is severable and can be remedied with the rest of ACA remainin intact</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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Medicare (Health plan for 65+)

- Part A: Hospitalization
- Part B: Physician visits, home health care, preventive services
- Part C: Medicare Advantage
- Part D: Prescription drugs
Medicare Changes

- A number of payment cuts and payment restructuring
- Oversight board responsible for recommending changes to reduce per capita costs
- In-Home demonstration program intended to promote independence, treat high-use beneficiaries and reduce hospitalization/long-term care
- Better coordinate care to "duels"
- Improve coverage (Part D) in the "doughnut hole" with a phase out of the "coverage gap" by 2020

Accountable Care Organizations

Medicare Accountable Care Organizations (ACO)
- Grouping of primary care physicians, specialists, hospitals and other health professionals who are held accountable for ensuring the quality of care provided to Medicare beneficiaries
- Have a defined process for establishing evidence-based medical practices, coordinate care & report on the quality of patient-centered care

- Payment for physician services, hospital care, rehab, follow-up
- Quality measures reported each quarter with additional $5 to top 25% who achieve target

Benefits of Medicare ACO:
- Patients: Improved care coordination, reduced hospitalizations
- Providers: Increased reimbursement
- Medicare: Reduced costs, improved outcomes

*Please note: Benefits are subject to change and may be adjusted by Medicare*
Medicare Accountable Care Organizations (ACO)

- Grouping of primary care physicians, specialists, hospitals and other health professionals legally joined (doesn't have to be a health system) and covering a minimum of 5,000 beneficiaries
- Have a defined process for establishing evidence-based medical practice, coordinate care & report on the quality of patient-centered care

- Payment for physician services, hospital care, rehab, follow-up
- Quality measures reported each quarter with additional $$ to top 25% who achieve target

- Base payment reduced where there are excessive readmissions (MI, heart failure, pneumonia, COPD, cardiac and vascular surgery
- Reduced payment based on top 25% of hospital-acquired conditions (e.g. infection)
- Prohibits Medicaid payment for hospital acquired conditions (may be adopted by Medicare)

ACO Impacts on Pharmacists
- Pharmacists as part of the health care professional team
- Increased emphasis on accurate medications to patients at discharge (many of the programs have gone away due to pharmacy costs)
- Follow up with patient post discharge on medication compliance of adherence
- Improved communication with providers (e.g. does this warrant retail pharmacist communicating with the physician directly)
ACO Impacts on Pharmacists

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Private Insurance Changes

- Dependent coverage for children to 26 years old
- No lifetime insurance cap limits/no annual limits (this starts 1/1/14)
- No pre-existing condition exclusions for children
- Limits on the annual deductibles for beneficiaries
- Waiting period for beginning of coverage limited to 90 days
- Prohibits plans from rescinding coverage except for fraud
- Depending on whether the health plan handles small or large employers, they are required to spend 80-85%, respectively, of revenues on health services (Medical Loss Ratio - MLR)
State-Based Health Insurance Exchanges

- Web portals used as an access point for those that need health insurance
- Can be accessed by:
  - Individuals (U.S. citizens and legal immigrants)
  - Businesses up to 100 employees
    - Small Business Health Option Program (SHOP) Exchange
    - Businesses with >100 employees can't use SHOP until 2017
- Must include at least 2 multi-state plans
- Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster development of non-profit, member-run health plans with $4.8 billion in seed money
Hospitals 501 (c) (3) Tax Exempt

- Must limit charges in Emergency Departments and medically necessary care to indigents
- Assess individuals financial assistance eligibility before turning charges over to collections
- Conduct community needs assessment and implement strategies within 3 years or pay excise tax
How is this paid for?

- Additional fees to the pharmaceutical industry and to the health insurance industry
- Increase in the Medicare tax
- Tax on medical devices (DME)
- etc
New Agencies (Bureaucracy)

- Patient-Centered Outcomes Research Institute (PCORI)
  - To assist patients, clinicians and policy makers in making informed health decisions by advancing clinical effectiveness research
  - Paid for by a $1/covered life fee on health and major medical insurance, COBRA or accident coverage, Health Reimbursement Arrangements (HRA), Flexible Spending Arrangements (FSA) and state and local government health plans
- Center for Medicare and Medicaid Innovation (CMMI)
  - Under the Center for Medicare and Medicaid Services (CMS) which traditionally needs congress' approval for innovations that must be budget neutral
  - CMMI can enact innovations that are not budget neutral without congressional approval
How is this paid for?

- New investment income tax (...increase taxes on the wealthy) targeting married individuals with income greater than $250,000/year or singles with income greater than $200,000/year
- etc.
How is this paid for?

- Qualified employers who have not provided health insurance to their employees (the have to pay a fee)
- Individuals who are required to carry health insurance but do not (through annual tax penalty)
- ...
How is this paid for?

- Excise tax on tanning salons
- Does not apply to "spray-ons", topical creams or phototherapy
- The tanning salon tax replaced a 5% tax that was going to be placed on cosmetic surgery. The "Botax" disappeared two days after the AMA came on-board for the ACA.
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