

Health Reform, Medicare and Cancer Care

Health Policy Alternatives
For ACCC
April 13, 2010



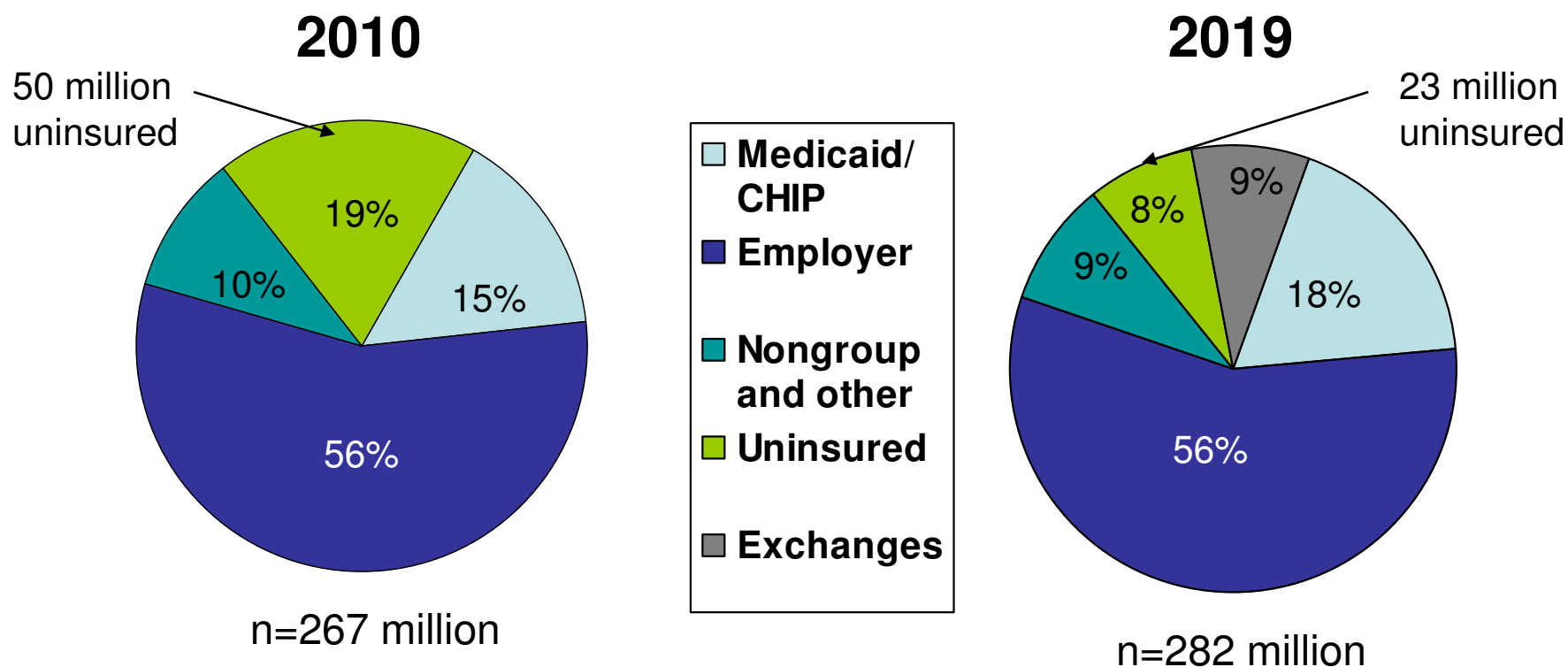
Topics

- Health Reform Coverage Expansions and Insurance Reform – Beth Fuchs
- Delivery System Reform Health Reform Medicare and Medicaid Changes – Tom Ault

Health Reform Timeline

- **March 21**--House approved Patient Protection and Affordable Care Act (PPACA) with a vote of 219 to 212
- **March 23**--President signed into law (PPACA) - P.L. 111-148
- **March 25**--House and Senate passed a “corrections bill” [The Health Care and Education Reconciliation Act of 2010 (HCERA)]
- **March 30th**--President signed into law HCERA

Coverage Among the Non-Elderly Pre- and Post-Health Reform



Note: Nongroup and “other” includes Medicare

Source: CBO scoring of combined effects of HR 3590 and HR 4872 in letter to Speaker Pelosi, March 20, 2010.

Insurance Reforms and Coverage Expansions: Overview

- Immediate reforms: between now and Jan. 2011
 - Improvements affecting individual and group insurance
 - Access to preserve and expand coverage (including high-risk pool, small business tax credits, retiree health reinsurance)
- Beginning 2014
 - Insurance market reforms
 - Essential benefit packages
 - State-based exchanges
 - Premium and cost-sharing subsidies for private insurance bought through state exchanges
 - Individual requirement to obtain minimum essential coverage
 - Employer shared responsibility requirement
 - Medicaid expansion to 133% of FPL



Immediate Individual and Group Market Insurance Reforms*

- No lifetime limits or annual limits (as determined by Secretary); certain exceptions apply**
- No rescissions of coverage**
- No pre-existing condition exclusions for children under 19**
- Plans must permit coverage of dependents up to age 26 on parent's plan**
 - Not applicable to adult children with employer offer of coverage
- No cost-sharing for certain preventive services
- Under §1557, a person cannot be excluded from participation, denied benefits, or be subjected to discrimination by certain plans
 - Application of Title VI of Civil Rights Act, title IX of Education Amendments of 1972, Age Discrimination Act of 1975, or §504 of Rehabilitation Act

**Most provisions apply to both insurers and group health plans for first plan year beginning on/after Sept. 23, 2010*

***Applies to grandfathered plans*



Immediate Measures to Preserve and/or Expand Coverage

- **HHS to establish temporary national high-risk pool (June 2010)**
 - For those w/ pre-x condition and without creditable coverage for previous 6 months, standard rate (age 4:1); 65% subsidized premium
 - \$5 billion appropriation (first available July 1, 2010 to the states)
- **Small business tax credit (2010 tax year)**
 - Employer must pay at least 50% of the premium, maximum credit of 35% for firms w/ 10 or fewer FTEs and average FTE wages up to \$25,000
 - Sliding scale reduces credit as average compensation increases, ending at \$50,000. Credit also reduced on sliding scale for firms with more than 10 employees, ending at 25 employees
- **By 6/21/10, provide reinsurance for early retirees w/ employer-sponsored insurance**
 - 55 or older, not Medicare; Federal govt. reimburses plan sponsor for 80% of costs of claim between \$15,000 and \$90,000 (adjusted for inflation)
 - \$5 billion appropriated for program
 - Terminates 1/1/14



Access and Insurance Reform: Beginning 2014

- Insurance market reforms
- Essential benefit package
- State-based exchanges
- Premium and cost-sharing subsidies for exchange coverage
- Individuals must have minimum essential coverage
- Employer shared responsibility requirements



Insurance Market Reforms

- Rating reforms (individual and small group only)
 - Within an area (defined by state), premiums only can vary for:
 - individual/family; age (3 to 1); tobacco use (1.5 to 1)
- Guaranteed issue (GI) and guaranteed renewability
 - Issuers must accept/renew every individual/employer that applies
 - Can limit GI to open or special enrollment periods
- No preexisting condition exclusions (applies to grandfathered plans)
- Group health plans cannot impose more than 90 days waiting period before coverage begins
- No discrimination from eligibility or continued eligibility based on health status
 - “Safe harbor” for certain wellness incentive programs
 - Rewards up to 30% less premium (50% at discretion of implementing agencies (HHS, Labor, Treasury))
 - Grandfathers programs in place prior to enactment if they comply with applicable HIPAA nondiscrimination regulations) for as long as regulations are in place



New Insurance Market for Individuals and Small Firms

- **Choice of plans that meet requirements to be Qualified Health Plans (QHPs)**
 - Private insurance plans
 - CO-OPs (non-profit, run by members)
 - Multi-State plans (administered through OPM)
 - At least 2 through each state exchange
 - Must be licensed in each state where offered and subject to state laws not inconsistent with federal laws
 - Phase-in of number of states in which plan has to be offered
 - Interstate sale of insurance via state compacts (2016)
- **Essential benefits package (similar to typical employer plan; 4 benefit levels + catastrophic plan)**
- **State-based insurance exchanges that meet standards**
 - Individuals
 - Small employers (1 to 100 or 1 to 50 at state option for 2014-15)
 - Larger employers at state option (2017) but up to insurer



Subsidies and Mandates



Individual Subsidies for Private Insurance -- Begins in 2014

- Premium assistance tax credit for individuals up to 400% of FPL
- Available for exchange coverage only; may not be used for catastrophic plan (“young invincibles” plan)
- Tax credit is refundable (i.e., payable regardless of whether taxes are owed) and payable in advance of annual tax filing
- Must be citizen or lawful resident
 - Legal immigrants $\leq 100\%$ of FPL but not eligible for Medicaid due to 5 year waiting period are eligible for subsidies
- Employees offered employer coverage only qualify for credit through the exchange if employer coverage has actuarial value $< 60\%$ or employee contribution is 9.5% or more of income



Cost Sharing Reductions

- Must be eligible for premium assistance tax credit and enrolled in a “silver” plan in the exchange
- Cost sharing reduced to keep total actuarial value of plan within limits by income. Standard actuarial value for silver plan is 70%

100-150% of FPL -- 94%

150-200% of FPL -- 87%

200-250% of FPL -- 73%

250-400% of FPL -- 70%



Small Business Tax Credit

- Available to employers up to 25 FTEs, average wages of \$50,000
 - Employer must pay at least 50% of premium
- Maximum credit for firms of 10 or less and wages under \$25,000; sliding scale for others
- Maximum credit value = 35% of employer premiums for 2010-2013; 50% for 2014 and later
- Beginning in 2014, employers must buy coverage through exchange to qualify
- Credit available for 2 years; years prior to 2014 not counted toward limit



Individual Mandate

- Individuals without minimum essential coverage pay penalty beginning with tax year 2014 (some exceptions)
- Minimum essential coverage excludes accident-only, dental-only, vision-only coverage, but typical public and private health insurance is included



Requirements on Employers

- “Shared responsibility” penalties
- Free choice vouchers
- Automatic enrollment
- Notice and reporting requirements



Implications of Insurance Reform and Expanded Care for Cancer Care: Near-Term

- Patients/survivors with existing insurance will have more adequate coverage
 - e.g., no lifetime limits, fewer annual limits, no rescissions; no pre-x for kids; retiree reinsurance; first dollar coverage of screenings and other preventive services
- More insurance options available for cancer patients and survivors
 - Subsidized high risk pools at age adjusted standard premiums
 - Access to parents' plans for dependents up to 26
- Improved information about value of available options
 - More standardized information
- Some pressure on insurers to keep premium increases more moderate
 - Minimum loss ratios and rate reviews



Implications of Insurance Reform and Expanded Care for Cancer Care: 2014 and After

- Insurance will be available regardless of health status
 - Guaranteed issue and renewability; adjusted community rating; no pre-existing condition exclusions for adults and children
- Insurance may be more affordable
 - Expanded Medicaid eligibility
 - Private insurance premium and cost-sharing subsidies for those below 400% FPL
 - Exchanges will provide for more affordable and accountable insurance options
 - Insurers have to compete more on basis of price and service than on risk selection
- Insurance may be more adequate, especially in individual and small group markets
 - Essential benefit packages meeting defined actuarial values
 - First dollar coverage of preventive services
- Some potential challenges and drawbacks
 - Some may still find insurance unaffordable especially if costs not contained much
 - State-based exchanges may be too small to create sustainable risk pools and states may not provide aggressive oversight needed to ensure fair competition
 - Employer wellness incentive programs may penalize employees for poor health status



Medicaid and CHIP



Major Medicaid/CHIP Changes

- Maintenance of eligibility until exchanges operational; 2019 for children
 - Exception for nonpregnant, nondisabled adults > 133% if state certifies budget deficit
- Mandatory coverage expansion begins 2014 (133% of FPL)
- Eligibility and enrollment changes
- Extension of State Children's Health Insurance Program (CHIP) funding
- Reduced disproportionate share hospital (DSH) funding beginning in 2014
- Prescription drug rebate program changes
 - Federal savings estimated at \$38 billion for 2010-2019
- Delivery system reforms through Medicaid



Delivery System Reform



Delivery System Reforms Enacted Previously

Some pieces already enacted in the February stimulus package (American Recovery and Reinvestment Act of 2009, P.L. 111-5)

- Comparative effectiveness research funding (\$1.1 billion)
- Health Information Technology funding (net \$19 billion)
 - Promises Medicare & Medicaid financial incentives totaling a net \$14 to \$27 billion over 10 years for eligible professionals and eligible hospitals



Delivery System Reforms Through Medicaid

- **Increased payment to primary care physicians – Medicare rates apply in 2013 and 2014; 100% FMAP (+\$8.3 billion)**
- **Healthcare-acquired conditions: no payment for Medicare HACs adapted to Medicaid (7/1/2011) (\$0)**
- **State option for “health homes” for chronic diseases (1/1/2011) (+\$700 million)**
- **Demonstrations:**
 - **Hospital–physician bundled payment, up to 8 states (2012-2016) (\$0)**
 - **Medicaid global payment for safety net hospital systems, up to 5 states (2010-12) (\$0)**
 - **Pediatric Accountable Care Organizations (2012-2016) (\$0)**
- **New Medicaid adult quality measures (+\$300 million)**
- **Expands coverage of preventive benefits and adult immunizations and offers grants to states for healthy lifestyle programs (+\$100 million each)**

Cost figures are Congressional Budget Office estimates for fiscal years 2010-2019



Delivery System Reforms Through Medicare

- Higher payment for primary care physicians
- Payments to medical homes
- Pilot program for bundling
- Accountable care organizations
- Lower payment for preventable hospital readmissions
- Payment reduction for healthcare-acquired conditions
- Move from pay-for-reporting to pay-for-performance/value-based purchasing
- Address geographic variation
- Medicare Innovation Center



Medicare Payment for Primary Care and Psychiatric Therapeutic Procedures

- PPACA provides a 10% bonus for office, SNF, home, rest home and other specified visits for family medicine, internal medicine, geriatric medicine, pediatric medicine if at least 60% of total Medicare payments are for bonus-eligible services
 - Effective 1/1/2011 through 12/31/2015
- Also provides 10% bonus for major procedures furnished by general surgeons in HPSAs
- Existing 5% bonus payments for certain psychiatric therapeutic procedures extended through 12/31/2010



Supporting Medical Homes

- New grant or contract program to establish health teams that support primary care (including OB/GYN) practices.
- Teams will assist with care coordination, case management, and support during transitions in care settings.
- Grant/contract recipients must be a state or state-designated entity, or Indian Tribe or Tribal Organization.
- Funds can also be used to provide capitated payments to primary care providers as determined by the Secretary.



Medicare Bundling Pilot Program

- Voluntary 5-year pilot program—begins by 1/1/2013; may be expanded after 2016 (conditional on actuary certification)
- Single payment for bundle of services around hospital stays-- 3 days prior and 30 days post-discharge
 - Inpatient and outpatient hospital services, including emergency room
 - Physician services
 - Post-acute care services
 - Care coordination, medication reconciliation, discharge planning, transitional care services
 - Other services identified by the Secretary
- Applicable to 10 patient conditions to be identified by the Secretary
- Requires quality measures, working with AHRQ, NQF and stakeholders
- Issues to be addressed during implementation
 - Applicable patient conditions
 - Application process and criteria
 - Payment rate for the bundle
 - Performance measures and beneficiary protections
- CBO scores no 10-year savings for bundling



Medicare Shared Savings Program (AKA Accountable Care Organizations)

- Begins 1/1/2012—this is not a pilot!
- Providers meeting certain criteria can be recognized as accountable care organizations (ACOs) and allowed to share savings if they exceed more than some minimum level determined by the Secretary
- ACOs are groups of providers and suppliers with an established mechanism for shared governance
- Each ACO must have a minimum of 5,000 Medicare beneficiaries (Secretary to determine method for assigning beneficiaries to an ACO based on their utilization of primary care services)
- Secretary also authorized to use a partial capitation model or other payment model that will improve quality and efficiency, in addition to the option of paying ACOs on a fee-for-service basis
- CBO scores 10-year savings of \$4.9 billion



Reductions for Preventable Readmissions

- Payments for all DRGs are reduced to account for “excess, preventable readmissions”
 - Effective 2013
 - Reduction is limited to 1%, 2%, and 3% in initial years
- Based on National Quality Forum (NQF)-endorsed measures which exclude readmissions unrelated to the prior discharge
- Readmission time window specified by Secy., but is 30 days in NQF measures
- Initially applied to heart attack, heart failure and pneumonia
 - Expanded to 4 additional conditions identified in MedPAC June 2007 report
- Provides assistance to hospitals with high readmission rates through Public Health Service Act program
- CBO scored 10-year savings: \$7.1 billion



Reductions for Hospital-Acquired Conditions

- Effective 2015
- Reduces payments by 1% for all DRGs for hospitals in highest quartile on rates of hospital-acquired conditions
- Applies irrespective of hospitals' absolute level of performance
- CMS must publicly report on hospital-acquired condition measures used for Medicare payment adjustments to hospitals for rates of hospital-acquired infections
- CBO scored 10-year savings: \$1.4 billion



Value-Based Purchasing (VBP) for Inpatient Hospital Services

- Beginning in FY 2013, 1% of hospitals' base DRG payments are set aside for VBP program, with payments based on performance in 2012
 - Excludes IME, DSH, outliers, special rural payments
 - Phases up to 2% in FY 2017 and thereafter
- Initial measures are ones currently reported, including patient perception of care
- Beginning 2013, outcome measured to be risk-adjusted and all measures endorsed by NQF (with possible exception); beginning 2014, efficiency measures to be added, including spending per beneficiary
- VBP payments are based on performance measured by a single composite score; adjustment is applied to all DRGs
- VBP payments are determined by performance against standards established in advance by the Secretary
 - No VBP payment for hospitals below minimum threshold
- Program is budget neutral: all incentive pool funds must be paid out to hospitals in year they are withheld



Medicare Delivery System Reforms

Value-Based Purchasing

Other Providers

- Annual payment updates tied to quality reporting beginning 2014
 - Long-term care hospitals,
 - Inpatient rehabilitation facilities
 - Psychiatric hospitals and units,
 - Hospice providers
- Quality reporting required for exempt cancer centers as a condition of participation
- Secretary to develop VBP programs for:
 - Ambulatory Surgery Centers
 - Skilled Nursing Facilities (SNFs)
 - Home health agencies
- Secretary to pilot test VBP for long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and units, exempt cancer centers, and hospice providers



Quality Reporting and VBP – Physicians

- **Quality Reporting:** Makes Physician Quality Incentive Program (PQRI) permanent
- Provides 1% bonus in 2011 based on successful reporting in designated period and provides a bonus of 0.5% in 2012-2014
- Imposes 1.5% penalty in 2015 for failure to report successfully; penalty increased to 2% in subsequent years
- Beginning in 2011, allows registry reporting through a Maintenance of Certification program operated by a specialty body of the Board of Medical Specialties
- Provides an additional 0.5% in 2011-2014 for participation in qualified specialty Maintenance of Certification (MOC) programs
- Requires timely feedback on likelihood of receiving incentive payment and an appeals process
- Requires plan from Secretary to integrate clinical reporting with electronic health records (EHR)
- **Physician Feedback Program:** Requires confidential feedback reports to physicians comparing their performance on quality and efficiency to peers
- **VBP for Physicians:** Adjusts 1% of physician payment based on value index (quality and efficiency) beginning 2015



Studies and Adjustments to Address Geographic Variation

- Physician practice expense geographic adjuster will reflect 50% (rather than 100%) of the variation in rents and employee wages beginning in 2010
- Additional PPS payment for hospitals located in counties that rank in the lowest quartile of risk-adjusted Medicare spending per enrollee
 - \$400 million for FYs 2011-2012
- Two Institute of Medicine (IOM) studies (Sibelius letter)
 - To study geographic adjustment factors in Medicare payment systems and make appropriate changes by 12/31/2012
 - To study geographic variation and consider payment changes to reward value and quality
 - Secretary will urge IPAB to consider changes



Medicare Delivery System Reforms

Center for Medicare and Medicaid Innovation

- Test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care
 - Medicare, Medicaid, and CHIP
- Models must address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures
- Menu of 20 possible models
- May be limited to certain geographic areas
- \$10 billion available 2011-2019 through direct appropriation
- May be expanded--duration and scope without legislation if:
 - Model reduces spending without reducing quality or
 - Model improves care without increasing spending



Examples from the Statutory Menu of Models for the New Innovation Center

- Aligning guidelines of cancer care with payment incentives under Medicare in the areas of treatment planning and follow-up care planning
- Contracting directly with groups of providers and suppliers, such as through risk-based comprehensive payment or salary-based payment
- Paying providers and suppliers for using patient decision-support tools
- Supporting care coordination for individuals at high risk of hospitalization through an HIT-enabled provider network that includes home tele-health technology
- Varying payment to physicians who order advanced diagnostic imaging based on their adherence to appropriateness criteria
- Allowing states to test all-payer payment reform



Observations on Delivery System Reforms

- Delivery system changes are key element of health reform legislation
- Focus generally on setting up long-term shifts rather than short-term budget savings
- Cautious CBO scoring due to lack of experience
- Experimentation with specifics – demonstrations, pilot projects with regulatory authority to move forward
- Implementation details to be worked out; very broad agency discretion
- Challenges and opportunities for providers



Other Medicare Payment Changes



Medicare Provider Update Reductions

- Hospitals--Annual update reductions
 - 2010-2011 -0.25 percentage points (4/1/10)
 - 2012-2013 -0.1 percentage points
 - 2014 -0.3 percentage points
 - 2015-2016 -0.2 percentage points
 - 2017-2019 -0.75 percentage points in
- Applied to inpatient and outpatient hospitals, inpatient rehabilitation, and psychiatric hospitals and units
- Same for long-term care hospitals, except for a -0.5 percentage point reduction in 2011
- NOTE: Reductions can cause a negative update
- NOTE: Productivity offset will apply to all payment updates



Medicare Provider Update Reductions (Continued)

- **Laboratory services:**
 - eliminates 0.5 percentage point reduction for 2011-2012
 - Implements 1.75 percentage point reduction for 2011-2015
- **Home health agencies** 1.0 percentage point reduction for 2011-2013
- **Hospice:** 0.3 percentage point reduction for 2011-2019, subject to waiver
- **Skilled Nursing Facilities:** no reductions except productivity adjustment
- **Dialysis facilities:** eliminates 1.0 percentage point reduction for 2012 and beyond



Medicare Productivity Offsets

- Productivity offset applied to all Medicare annual updates
 - Based on 10-year moving average of change in annual economy-wide private non-farm business multi-factor productivity
 - Same as the productivity adjustment in the MEI used to update physician fees
 - Likely range: 1.0 to 1.5% each year
- Beginning 2011: Applies to all Part B items and services
- Beginning 2012: Applies to hospitals and SNFs
- Beginning 2013 Applies to hospice providers



Reduction in Medicare Hospital Disproportionate Share Adjustment

- Begins in FY 2014
- 75% reduction in current payment
 - reflects “empirically justified” level
- Additional payments will be made to reflect uncompensated care costs
- Aggregate amount of additional payments determined by percent reduction in the national uninsured population
 - e.g., if uninsured rate falls by 20%, only 80% of the 75% reduction would be returned to hospitals based on each hospital’s share of total uncompensated care provided by all hospitals



Other Medicare Hospital Provisions

- Hospital wage index (costs \$2 B)
 - Wage index floor of 1.00 for hospitals located in “frontier” states (Wyoming, Montana, North Dakota, South Dakota and Utah)
- Extends Sec. 508 hospital wage index reclassifications through FY 2011
- Extension of Outpatient Hold Harmless Provision
- Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas
- Extension of the Rural Community Hospital Demonstration Program
- Extension of the Medicare-dependent hospital (MDH) program
- HHS Study on urban Medicare-dependent hospitals
- Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals
- Technical correction related to critical access hospital services
- Extension of and revisions to Medicare Rural Hospital Flexibility Program



Non-profit Hospitals

- Imposes new standards for the tax exemption of nonprofit hospitals
 - Requires that a hospital complete a community needs assessment once every three years
 - Requires hospitals to adopt and publicize a financial assistance policy
 - Prohibits billing patients who qualify for financial assistance the top rates
 - Prohibits a hospital from taking extraordinary collection actions if the hospital has not made reasonable efforts to notify patients of its financial assistance policy



Effective Dates for Key Medicare Hospital Provisions

<u>Year</u>	<u>PPACA (as amended by HCERA)</u>
2010	Provider update reductions
2011	Initial national quality strategy; Make hospital charges public; Medicare Innovation Center (not later than 1/1/2011)
2012	Productivity offset; ACOs
2013	Reductions for preventable readmissions; Bundling; Value-based purchasing (VBP); physician misvalued codes
2014	Medicare and Medicaid DSH reductions; Mandatory quality reporting for IRFs, LTCHs and IPFs; IPAB
2015	Reductions for hospital-acquired conditions; Independent Payment Advisory Board; physician value-based modifier
2016	VBP pilot programs for IRFs, LTCHs and IPFs
2020	1 st year that IPAB recommendations can affect hospitals

Note: policy development and proposed rules will commence at least a year before each provision's effective date.



Payment for Medicare Imaging Services

- **2010 Physician Fee Schedule Final Rule**
 - Reduces payment for services that require the use of “expensive” equipment (>\$1 million) by increasing the equipment utilization assumption in the practice portion of the physician fee schedule from 50% to 90% over 4 years
 - redistributes savings to other services such as primary care
 - final rule exempts therapeutic services and applies only to MRI and CT
- **Health Reform**
 - Beginning 1/1/2011, sets the equipment utilization assumption equal to 75% for expensive equipment (>\$1 million)
 - Beginning in 7/1/2010, increases the multiple imaging discount for certain procedures involving contiguous body parts from 25% to 50%
 - Excludes reduced expenditures from calculation of budget neutrality



Other Medicare Physician Payment Changes

- No provision on physician update and SGR
- Requires periodic review by the Secretary to identify and adjust for mis-valued codes in the physician fee schedule (2013)
- To assist lower cost areas, extends 1.00 floor in geographic adjuster for work through 2010 and makes changes in the geographic adjuster for practice expense
 - temporary adjustments for 2010 and 2011
 - permanent changes beginning in 2012



Personalized Prevention Plans for Medicare Beneficiaries

- Effective 1/1/2011
- NEW annual wellness visit providing a personalized prevention plan
- Includes:
 - health risk assessment,
 - personalized advice, and
 - appropriate referral to health education or preventive counseling services
- May be furnished by a wide range of individuals (e.g., physicians, nurse practitioners, registered dietitians, or teams of professionals).
- Secretary to establish guidelines for health risk assessments and develop a health risk assessment model
- No Medicare deductible or coinsurance for these services



Medicare Advantage Plans

- New method for calculating private plan payment rates
 - Saves \$138 billion 2010-2019
- Effective 2014 -- 85% minimum medical loss ratios required; imposes penalties for failure
- Changes in enrollment period
- New limits on cost-sharing
- New quality incentive payments



Other Provisions

- Independent Payment Advisory Board (IPAB)
 - Beginning in 2014
 - Required to make proposals to reduce Medicare spending growth
 - Hospitals not affected until 2020
 - Beneficiary protections
 - Automatic effect unless Congress acts
- Comparative Effectiveness – “Patient-Centered Outcomes Research”
- Alternatives to malpractice mitigation: \$50 million authorized for 5 years beginning FY 2011 for demonstration grants to states
- HHS will license a biological product as a biosimilar if FDA determines it and the reference product to be biosimilar or interchangeable



340B Program—Expansion

- Expands covered entities under the program to include:
 - Children’s hospitals and free-standing cancer hospitals
 - Critical access hospitals
 - Rural referral centers and sole community hospitals that have a disproportionate share adjustment of 8% or more
- Excludes orphan drugs for rare diseases or conditions for these expansion covered entities
- Section 2302 of HCERA struck provisions relating to expansion of the 340B program to inpatient hospitals and permissive use of group purchasing organizations that were included in the enactment of PPACA



Major Medicare and Medicaid “Savings” (Ten-year total, 2010-2019)

Provision	Savings (in billions)
Productivity adjustment and other update reductions	\$196
Medicare Advantage payments	\$138
Disproportionate share hospital payments Medicare (\$22b) and Medicaid (\$14b)	\$36
Medicaid prescription drug payments	\$38
Independent Payment Advisory Board	\$16
Total	\$455

Source: CBO Letter to Speaker Pelosi, March 20, 2010.

Implications of Delivery System Reform and Medicare Changes for Cancer Care

- Physician updates may continue to be year to year
 - likely would result in perpetuation of the current pattern of uncertainty and very low updates
- Hospital updates for FY 2011-2015 are at risk
 - due to statutorily required coding-related adjustments, which are in CBO baseline
 - reductions of 2% to 3% each year could be justified (and may be necessary)
 - with health reform rate reductions and productivity offset, updates could be 0% to 1% for next several years – and could be negative
 - outpatient hospital updates affected only by health reform rate reductions and productivity offset



Implications of Delivery System Reform and Medicare Changes for Cancer Care (cont'd)

- Quality of care will affect payments and public perception
 - value-based purchasing combined with reductions for preventable readmissions and hospital-acquired conditions
 - public release of data
- Additional financial pressure from...
 - Recovery audit contractors (RACs) – e.g., review of medical necessity of hospital admission; extended to Medicaid by health reform law
 - coverage and comparative effectiveness
 - enhanced fraud and abuse enforcement
- Opportunities and risks
 - licensing of biosimilars
 - bundling; accountable care organizations
 - Medicare and Medicaid Innovation Center
- Must keep a wary eye on...
 - adjustment for geographic “inequities”: IOM studies
 - Independent Payment Advisory Board (IPAB)



Looking Ahead: Potential Strategies

- Premium on exerting administrative influence
 - legislative change will be difficult, especially with “pay-go” rules
- Identify opportunities and risks presented by major provisions
- Work with CMS to gain favorable interpretations
- Continue to raise awareness of physician and provider concerns, especially as they affect cancer care
- Continue to partner with other interested parties such as patient groups



Revenue Provisions and Financing



Excise Tax: Employer-Sponsored Health Coverage

- Imposes nondeductible 40% excise tax on the aggregate value of employer health coverage above a threshold amount; applies to active employees and retirees/surviving spouses
- 2018 threshold amount equals: \$10,200 (individual)/\$27,500 (family) increased by any growth in cost of FEHBP Blue Cross standard option from 2010-2018 above 55% and adjusted for age and gender of employees
- For 2019, thresholds are increased by CPI-U +1; for years after 2019, by just CPI-U
- Thresholds increased for certain retirees and high risk professions
- Excludes certain coverage, including separate dental or vision, long-term care
- Tax paid by health insurance issuers and plan administrators (mostly employers)
- Effective: January 1, 2018



Annual Tax on Medical Device Manufacturers & Importers

- Imposes 2.3% tax on the sale of taxable medical devices by a manufacturer, producer, or importer
- With certain exceptions (mostly on the sale of items generally purchased by the public as general retail) taxable medical devices include any device as defined by the FDA intended for humans
- Effective: January 1, 2013.



Annual Fee on Branded Prescription Drug Makers and Importers

- Imposes an annual nondeductible (US) aggregate sector fee on makers or importers of branded prescription drugs, including foreign corps.
 - \$2.5 billion for 2011
 - \$2.8 billion for 2012 & 2013
 - \$3 billion for 2014 through 2016
 - \$4 billion for 2017
 - \$4.1 billion for 2018
 - \$2.8 billion for 2019 and thereafter
- Includes drugs/biologics sold to/covered by government programs.
- Fees will be apportioned to each entity based on the entity's share of the total annual branded drug sale.



Health Reform Costs and Financing

- CBO Estimate of federal cost of coverage expansions: ~\$938 billion/ 10 years
 - ~\$434 billion for Medicaid expansions
 - ~\$504 billion for tax credits, exchange start up costs
- Financing totals more than \$1 trillion -- net deficit reduction about \$124 billion
 - ~\$455 billion from Medicare and Medicaid “savings”
 - ~\$563 in revenue
 - ~\$40 other savings



Major Revenue Provisions

Ten year total (2010-2019)

Provision	Revenue (in billions)
Medicare tax on high earners: Additional tax of 0.9% on income >\$200k/\$250k couple; 3.8% tax on unearned income of these taxpayers	\$210
“Shared responsibility” penalties on individuals and employers	\$65
Tax on health insurance providers	\$60
Tax on high-cost health plans (begins 2018); 40% tax on amounts >\$10,200/\$27,500 family, indexed prior to 2018; premiums adjusted for age and gender; extra \$1650/\$3450 for retirees and high-risk professions	\$32
Tax on branded drug manufacturers and importers	\$27
2.3% excise tax on device manufacturers and importers	\$20
Total	\$563

Source: Joint Committee on Taxation, March 20, 2010.



Health Policy Alternatives, Inc.