Healthcare Reformed
2010

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Objectives

- Describe the scope of the recently passed healthcare reform legislation
- Discuss overall implications of the healthcare reform laws for the healthcare system
- Explore explicit and implicit outcomes for pharmacists under the new healthcare laws
- Develop strategies for your own practice to incorporate the immediate and phased in changes of the healthcare reform laws
Healthcare Spending as % GDP

Note: For countries not reporting 2006 data, data from previous years is substituted.
March 23, 2010 – “Today, after almost a century of trying. Today, after over a year of debate. Today, after all the votes have been tallied, health insurance reform becomes law in the United States of America... We are a nation that faces its responsibilities and faces its challenges. Here in this country we shape our own destiny... That’s what makes us the United States of America.”

– President Obama
Patient Protection and Affordable Care Act

*March 30, 2010*
Health Care and Education Affordability Reconciliation Act of 2010

Narrow Victory 219 to 212 HR
What did we get?

- Coverage expansion
- Health insurance reform
- Medicare/Medicaid reform
- Health IT mandates
- Prevention services
Getting their act together

- 95% of Americans will be covered
  - covers 34 million of 54 million uninsured
- $143 billion deficit reduction over 10 years
CA Specific Numbers

- 9.4 m children w/ pre-existing conditions
- 4.5 m in the donut hole
- 3 m seniors not in MA plans get reduced premium
- 7.3 m uninsured
- 3.8 m stay on parents plan
- Reduce premiums by $1,450 - $2,080/family
2010 Changes

- New federal rate review process established
- Children may stay on parents’ policies until age 26 and no pre-exclusions for children until age 19
- Lifetime benefit limits prohibited
- Limited small business tax credits established
- Part D rebate for beneficiaries in the gap
- Temporary high risk pool created
- Statutory Medicaid drug rebates to states for drugs provided in managed care
- Funds for Community Health Centers
- Rescissions prohibited except for fraud
Medicare Part B DME

- Sec. 3109
- Exempt from competitive bid accreditation if:
  - <5% DME sales over 3 yrs
  - ≥ 5 yrs as DME provider with provider number
AMP Pricing

- Sec 2503
- No < 175% of weighted avg of monthly AMP
- In effect 6 months after enactment (Sept. 2010)
- Does NOT include mail order, PBMs, SNFs, Hospital
Medicare Part D

- $250 rebate check in the donut hole
- No donut holes in 2020
- Reduced premiums for non-medicare advantage members
Immediate California Fixes

- Forming a health care reform task force
- Establishing a health insurance purchasing pool
- Requiring insurers to allow young adults to remain on their parents' policies until age 26
- Banning insurers from denying coverage to children
- Prohibiting retroactive policy rescissions
- Removing lifetime limits on health insurance coverage
2011 Changes

- MLR mandated: 85% for large group and 80% for small group and individual (nongroup)
- Uniform coverage documents and standard definitions developed
- HSAs & FSAs limited
- Discounts in Part D “Donut Hole”

- Annual fee on pharmaceutical manufacturers begins
- Physician Quality Reporting Initiative bonuses
- Coverage for preventative services in Medicaid begins
- Reimbursement rates for primary care increased
Preventative Services

- Sec 2713
- United States Preventive Services Task Force recommended services
- Immunizations
- Women (e.g. osteoporosis, mammograms, etc)

- NO cost sharing allowed!
2012 Changes

- Medicare Advantage phase-in of capped FFS rates begins
- Quality bonus begins to be phased in for Medicare Advantage plans
- Plans to merge Medicare incentives for physician quality reporting and for meaningful use of electronic medical records
- MTM enhancement for Part D
Medicare Part D MTM

• Sec 10328
• Elements of MTM review
  ➢ targeted beneficiaries
  ➢ Annual comp MTM review
    ○ face-to-face or telemed
    ○ written report to pt
    ○ pharmacist OR other HCP
• Creates *Opt Out* rule
2013 Changes

- State Medicaid plans are required to pay primary care providers at Medicare rates
- Deduction for expenses allocable to the Part D subsidy for “qualified prescription drug plans” is eliminated
- High earner tax begins
- FSA contributions limited
- Annual fee on medical device sales begins
- Public reporting of physician performance information begins
2014 Changes

• Annual insurance industry tax begins
• Exchanges established
• Guarantee issue requirements
• Standardized minimum benefit offerings
• Prohibitions on annual limits, preexisting condition exclusions, and rating based on health status
• Medicaid expansions become effective
• Individual and employer responsibility requirements begin
• Independent Payment Advisory Board presents first proposals
Health Insurance Exchange

- Federal or state run
- Mainly for those who work for small businesses
- Designed to increasing buying power and efficiency
- Must avoid “cherry picking”
2015 +

- Physician value-based payment program to promote quality for Medicare beneficiaries created in 2015
- States have flexibility to provide CHIP eligibles coverage in the Exchanges in 2015
- High-value plan excise tax begins in 2018
- “Donut hole” closed by 2020
Cost Containment Strategy

- **Health Insurance**
  - Limit administrative costs

- **Providers**
  - Electronic transactions
Controversial Issues

• Abortion
  ➢ No federal funds can be used
  ➢ Must send separate check for abortion coverage
• No Republicans voted for either bill
• Cannot increase the deficit
Funding Opportunities

- Community Transformation Grants
- Patient Centered Outcomes Research Institute
- MTM Grants
Sec. 935 – MTM Grants

• Patient Safety Research Center (via AHRQ)
• Starts May 1, 2010
• Service description…
  ➢ pharmacist provided MTM
  ➢ collaborative care for chronic diseases
  ➢ Targeted pts (any one of the following)
    ○ > 4 meds (including OTCs)
    ○ any “high risk” medications
    ○ >2 chronic diseases
    ○ HHS secretary to determine other factors
  ➢ Services by the RPh include…
Covered MTM Services

(1) **performing or obtaining necessary assessments** of the health and functional status…
(2) formulating a **medication treatment plan** according to therapeutic goals agreed upon by the prescriber and the patient…
(3) **selecting, initiating, modifying**, recommending changes to, or administering medication therapy;
(4) **monitoring**, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;
(5) performing an initial **comprehensive medication review** to identify, resolve, and prevent medication-related problems;
(6) **documenting the care** delivered and communicating essential information about such care... to other appropriate health care providers...;
(7) **providing education and training** designed to enhance the understanding and appropriate use of the medications ...
(8) providing information, support services, and resources and strategies designed to **enhance patient adherence** with therapeutic regimens;
(9) **coordinating and integrating MTM services** within the broader health care management services provided to the patient; and
(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.