New Directions in Health Policy: The Affordable Care Act and Medicare Reform*

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* PLUS A GOVERNMENT SHUTDOWN AND DEFAULT RISK, AND A DISASTEROUS ROLLOUT OF COVERAGE EXPANSION!

Agenda

• Gathering perspective
• BREAKING NEWS: SGR Updates
• Analysis of major trends in health care delivery and financing
• Affordable Care Act overview
• The Medicare Reform debate
• Other issues
• Wrap up
SGR Options

**House Energy & Commerce Committee**
- 0.5% updates in 2014-2018
- Beginning in 2019, provide updates of 0.5%, subject to quality adjustments based on performance in the Quality Update Incentive Program (QUIP) and/or some or all services paid under an Alternative Payment Model (APM)

**House Ways & Means Committee**
- 0.5% updates in 2014–2016 and 0% update in 2017–2023
- After 2024, provide updates of 2% for items and services furnished by APM participants, and updates of 1% for non-participants

**Senate Finance Committee**
- 0% updates through 2023
- After 2024, provide updates of 2% for items and services furnished by APM participants, and updates of 1% for non-participants
- **Includes Medicare extenders (~$32B)**

Tri Committee Agreement

- House and Senate agreement on SGR repeal legislation (Feb. 6)
  “SGR Repeal & Medicare Provider Payment Modernization Act of 2014”
- **Key provisions**
  - Repeals the SGR and provides for 0.5% updates between 2014-2018; Beginning in 2018, new merit-based incentive payment system (MIPS)
    - MIPS consolidates Physician Quality Reporting System, Value-Based Payment Modifier, and electronic health records meaningful use incentive payments
  - Beginning in 2018, 5% bonus to physicians who collect at least 25% of their Medicare revenue from an APM in 2018
    - APM models include accountable care organizations, patient-centered medical homes and other public or private payer initiatives; 25% threshold would increase with time
- **Cost:** ~$125-$130B
  - does not include extenders (could cost an additional $30-$40B)
- **“Offsets TBD”**
SGR Legislative Outlook

- Current patch expires on March 31, 2014
  - 23.7% cut scheduled for April 1 (if not further averted)
  - 16 patches in the past (since 2003) totaling $153.7 billion
- Strong push from physician groups to pass full repeal
  - Committees working to find offsets
  - Physician groups will oppose any patch
  - Republicans tie repeal to rejection of individual mandate
- **Most likely outcome:** Short-term patch
  - Leadership focused on 9-month patch, dismissing movement of repeal
  - Impact of SFC leadership and staffing changes
  - Cost: ~$15 billion for 9 months
    - Down payment: Physician Payment Reform Fund ($2.3 B), paid for, in part, by extending the sequester into 2024

Good Time To Gather Perspective

- Supreme Court upholds core of ACA
  - Coverage expansion through mix of private insurance and Medicaid expansion, financed by new fees and taxes and cuts to Medicare provider rates
- Elections validate major first term accomplishment, despite GOP repeal efforts
- Delivery system changes underway: incentives aligned to promote value over volume (bundled payments, shared savings)
- Changes to Medicare contemplated
- New Senate Finance Chair (Wyden)
**Trendwatch**

- The population is aging.
- Growth in health care spending has slowed, but continues to rise.
  - Medicare cost pressures increasing, exposing providers and beneficiaries to new risks
  - Simpson-Bowles, Domenici-Rivlin
    - Bipartisan approaches to reforming Medicare
- Growing movement toward consolidation, collaboration, integrated “accountable” care and patient-centered outcomes
- Adoption of more predictive or precision based tools to enable fraud detection and prevention

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**Trendwatch II**

- Big data becoming effective tool for health care providers and innovators
  - Government incentives promote adoption of electronic health records (EHRs)
    - Hospitals and physician offices only
  - Better results for population health
- Continuing push for expanded scope of practice for non-physician providers
  - Physician assistants, nurse practitioners
- Affordable Care Act compliance
Affordable Care Act

• Employer mandate delayed one year, no enforcement expected until 2015; individual mandate effective 2014
• States and the federal government running insurance “marketplaces” where
  – Issuers offer “qualified health plans” (QHPs)
  – Individuals shop for QHP coverage that best meets their needs based on “metal levels” but all include “essential health benefits”
    • “Navigators” and “in person assisters” provide guidance
  – Tax credits and subsidies available to assist purchasers
  – March 31 deadline: ~6M signed up now

Affordable Care Act II

• States deciding whether to expand Medicaid programs, either through expansion of current programs or “waivers” allowing alternative financing models, including providing premium assistance for use in marketplaces
  – Pennsylvania Governor Tom Corbett became the 10th Republican governor to back the expansion of Medicaid, the joint federal-state health program for the poor, under President Barack Obama’s health care law, proposing a set of reforms that would extend health coverage to more residents of the state. Corbett outlined a plan that includes offering Medicaid to more Pennsylvanians by using private health insurance plans and instituting new requirements for all Medicaid enrollees
  – Enhanced provider and (sometimes) insurer collaboration on quality metrics, disease management and avoidance of readmissions, i.e. “accountable care”
• Onset of new industry taxes/fees, including pharmaceutical, medical technology, health insurance and indoor tanning (not kidding)
The Medicare Reform Debate

- Entitlement reform consensus growing and bipartisan
  - But elections slow progress
  - “Simpson Bowles” did not get a majority vote
- Interest in extending life of trust funds has led to numerous commissions, Congressional hearings and policy analyses
- General view is that program serves beneficiaries well but could be modernized to provide better taxpayer value, and improved quality

The Medicare Reform Debate II

- Major themes of Medicare reform involve some or all of the following:
  - Increase eligibility age
  - Income-relate premiums
  - Combine Parts A and B, single deductible
  - Impose uniform cost sharing
  - Refine “fee for service” and replace with value based purchasing
  - Accelerate delivery system changes
  - Improve performance of post hospital care
The Medicare Reform Debate III

• Summer 2013 included calls from major committees in Congress to examine Medicare system reforms, including post acute care
  – What are the best options for post hospital patients and their families
    • What role do LTCHs, IRFs, SNFs, and HHAs play in improving health and reducing readmits?
  • And draft legislation to fix the flawed physician fee formula (+140-200B/10)

The Medicare Reform Debate IV

• Both parties stay close to their ideological roots, with little crossover opportunity
  – Democrats resist major system change or any new burden on beneficiaries
  – Republicans insist managed care principles, competition and greater patient “skin in the game” will improve long term system performance

• But innovative commercial practices will drive change in Medicare faster than Congress can
Medicare Realities

• In constrained budget environment demands for even more system efficiencies may be impossible to meet
  – 2 percent sequestration
  – ACA and other funding cuts associated with deficit reduction, debt ceiling, government funding

• But public policy will ultimately demand a higher performing system, leading to introduction of further managed care tools, industry consolidation, or both

ACA Exchanges

• 27 Federal Exchanges, 16 States and DC are State Run, 7 Partnerships

[State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, as of September 30, 2013], (The Henry J. Kaiser Family Foundation, [September 30, 2013])
Wrap Up

- The US Federal Government has a number of issues that need to be worked out, including many tied to either the ACA or federal health care programs or both
  - Need to fix the glitches on Exchange websites so that the over 9 million people who have visited them can begin to sign up without problems.
- States will continue to decide, up until January 1 and beyond, whether they want to expand Medicaid programs
- The Medicare SGR still needs to be fixed – and paid for.

Thank You

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