California Medical Association

Health Care Reform 2010

Impact on Physicians

Elizabeth McNeil
Vice President
Federal Government Relations

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Health Reform

Historic Legislation

Complex Law-Outcome Unknown

Repeal vs. Incremental Fixes

Focus on Implementation

Physician Opportunities/Challenges

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CMA Principles for Health Care Reform

- Universal Access to Care
- Assistance for Low-income Families to Afford Health Insurance
- Health Insurance Exchange
- Choice, Competition, Insurance Reform
- Broad-based Financing
- Medicare Delivery Reform

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CMA Survey Supports

CMA – 43% Support, 43% Oppose

Insurance Coverage Expansions

Insurance Industry Reforms

Increasing Affordability of Insurance

Health Insurance Exchange

90 – 100% Federal Financing of Medicaid

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Health Reform CMA Supports

Investments in Primary Care

Medicare Primary Care Rate Increase

Medicare General Surgery Rate Increase

Medi-Cal Primary Care Rate Increase

Investments in Prevention & Wellness

Investments in Growing the MD Workforce and its Diversity

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Health Reform: CMA Opposes

HR Provides Expanded Coverage But Does NOT Improve Access to Doctors

IPAB – Independent Medicare Payment Board

No SGR repeal

No SGR update

No Medi-Cal rate increase for All Physicians

No CA GPCI update

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Health Reform CMA Opposes

Reduces Payment for Imaging Services

Bans Physician-owned Hospitals

Allows Nurse Practitioners to "Lead" Medical Homes

No Private Contracting in the Medicare Program

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Politics: Congressional Leaders

U.S. House of Representatives

California Leadership – Clean Sweep

Speaker Nancy Pelosi

Chairman Henry Waxman-Energy Commerce

Chairman Pete Stark-Ways & Means

Chairman George Miller- Ed Labor

Leader Xavier Becerra

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Politics: Congressional Leaders

More Favorable House Bill – HR 3200

$450 Billion in Physician Payment Fixes

Repeal of SGR

Improved Access to Care

Massachusetts Election – Senate Bill

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Politics: Congressional Leaders

President Obama's Leadership

(Help of Wellpoint 38% premium increase)

Willingness to risk his presidency

Speaker Pelosi's Leadership

Willingness to risk a Democratic majority

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Health Reform Summary

- Coverage
- Insurance Industry Reforms
- Health Insurance Exchange
- Medicare Payment Reform-Quality
- Prevention, Wellness, Public Health
- Health Care Professional Workforce
- Revenue

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Health Reform

California's 6.5 million Uninsured

~1.4 million undocumented not covered

~1.7 million to Medi-Cal

~3.3 million to private coverage in Exchange

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Health Reform

Coverage Expansion – 2014

Individual mandate
Individual tax credits 133-400% FPL

Medicaid Expansion to 133% FPL
Primary Care Rate Inc to Medicare
100% federally financed phased to 90% 2020

No Employer Mandate but Penalties
Small Business Tax Credits

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Health Reform

Health Insurance Exchange – 2014

Health Plan Standards & Benefits

Choice of Private Health Plans

Allows Patients to Choose Out-of-Network, Non- Contracted Physicians

Enrollment Initially Limited to Uninsured

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Health Reform

Insurance Industry Reforms 2010/2014

85% Medical Loss Ratio

Adequate Provider Networks

No Bans for Pre-existing Conditions

No Rescinding Coverage

Community Rating with Limits

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Health Reform

Immediate Implementation

Temporary High-risk Pool

Temporary Reinsurance Program

Children Covered on Parent's Plan Through Age 26

Insurance Industry Reforms

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Health Reform

Allows Coops in the Exchange
Consumer Operated and Oriented Plans

Not run by government or insurers
Not for Profit
Licensed to Sell Insurance In CA
Same Benefits Offered
$6 billion loans for start up costs-repaid 5 yrs
Grants to build reserves-repaid 15 yrs
Physicians can form, lead and operate

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Health Reform

Prevention and Wellness

Medical Liability

Physician Workforce Restoration

Redistributes GME slots

Primary care

State grants; NHSC scholarship and loan repayment $$; health professionals & diversity programs; cultural competency

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What Drove Health Care Reform?

Too Many Uninsured and Underinsured

Access to Affordable Health Care Coverage

Escalating Health Care Costs

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What Drove Health Care Reform?

Economic Recession Makes it Possible

State and federal governments cannot sustain growth

Insurance unaffordable for business

Insurance unaffordable for low income and middle class

-- Political Accomplishment--

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“That we are in the midst of crisis is now well understood. Our nation is at war . . . And, our health care is too costly.”

-Obama Inaugural Address

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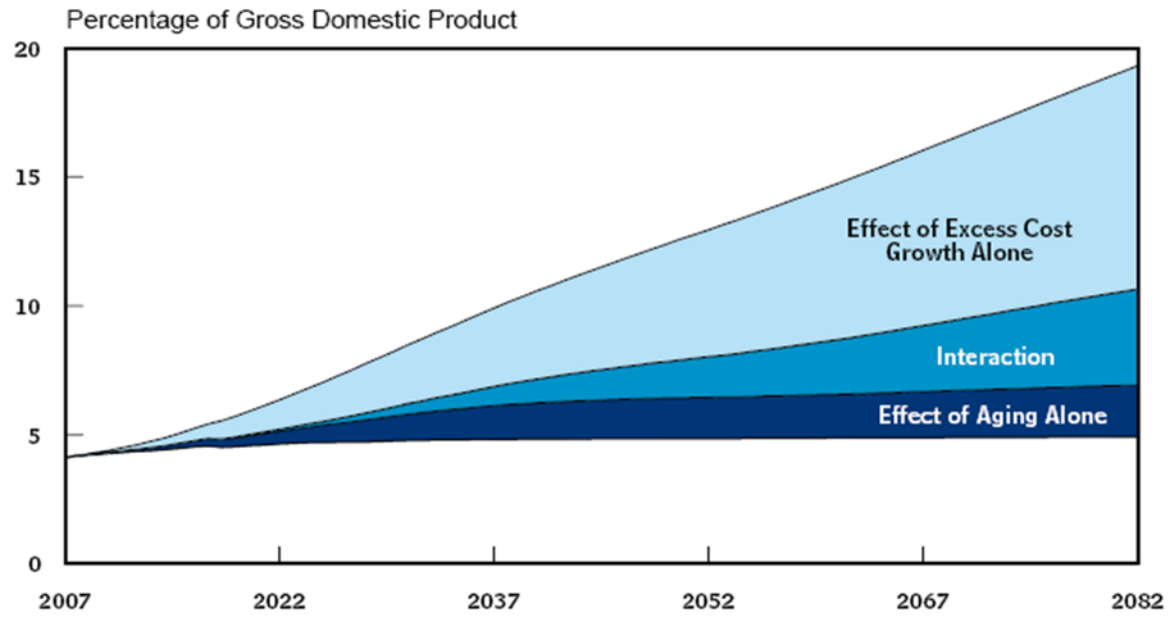
The Influence of Peter Orszag

Sources of Growth in Projected Federal Spending on Medicare and Medicaid



Former CBO Chair Now Leads OMB

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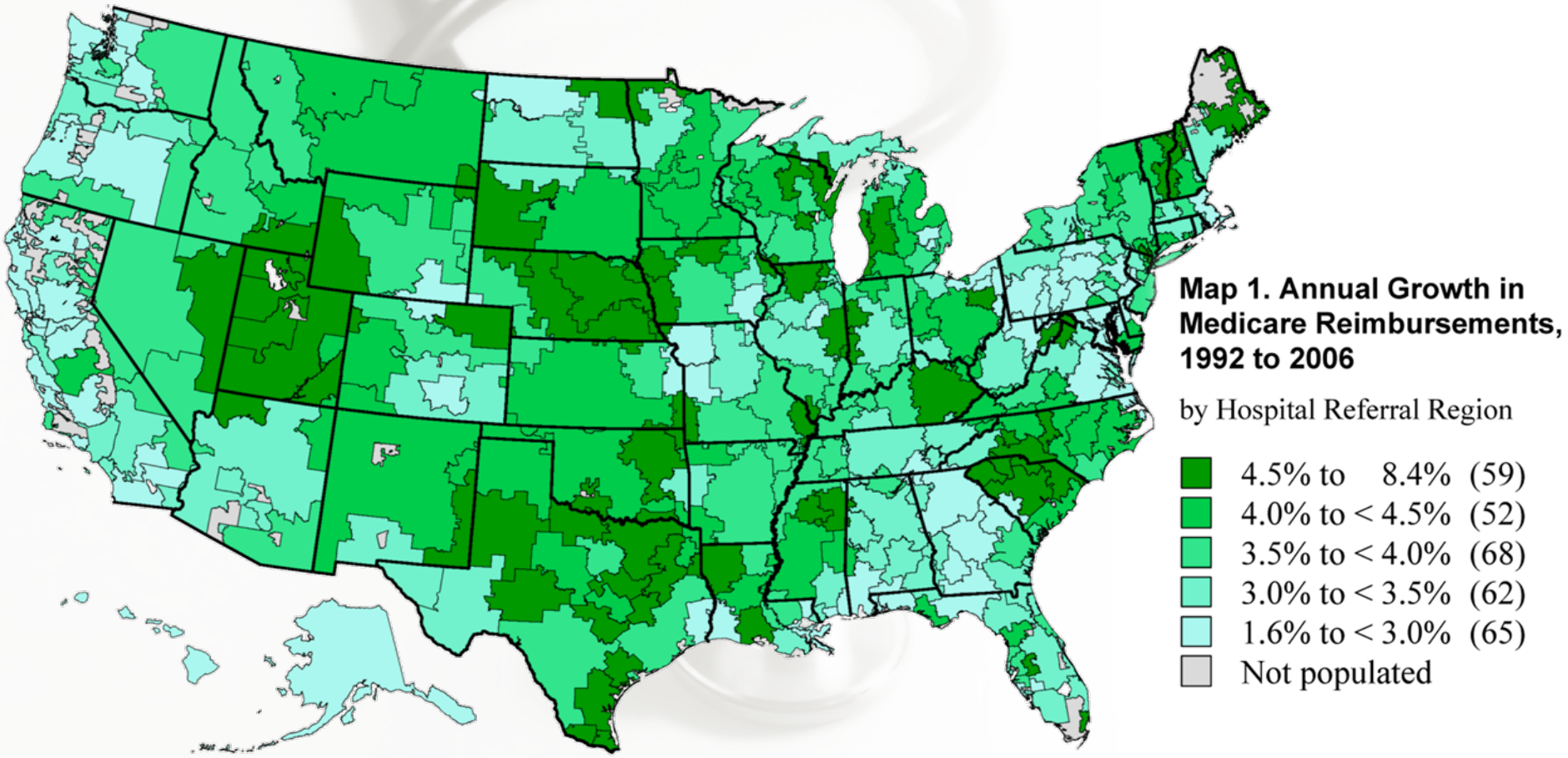
The Influence of Dartmouth

(if the U.S. behaved like San Francisco . . .)



Health Reform

Medicare Reform = Delivery System Reform

What Resonated with Policy-Makers?

Medicare cost growth unsustainable
Medicare's broad influence
SGR is broken
Value over volume
Geographic variation in spending
Rewarding coordination of care
Emphasis on primary care
Quality and accountability

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Influence of Dartmouth

Dartmouth Researchers

Wide Variation in Medicare Spending

ICU vs. hospice

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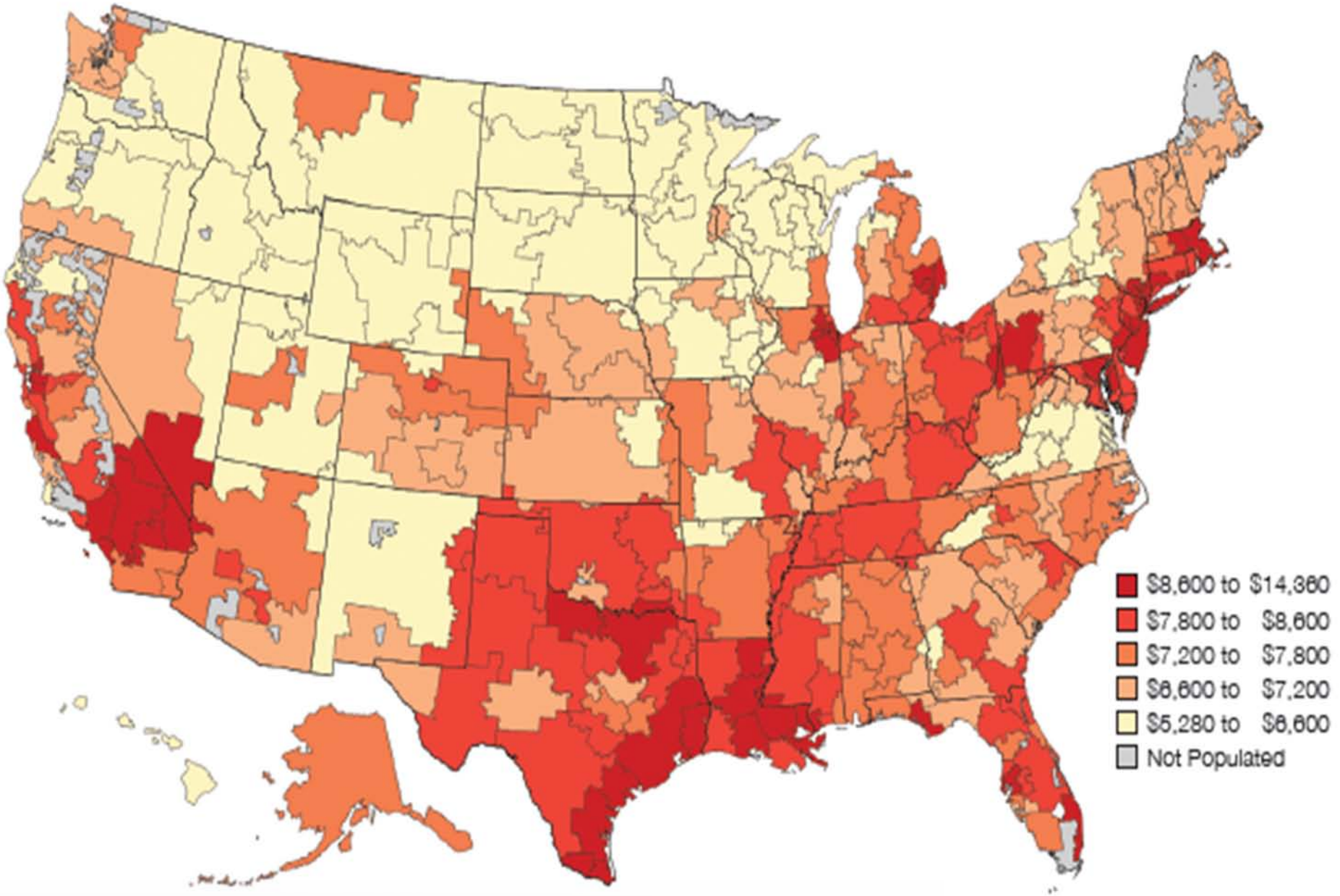
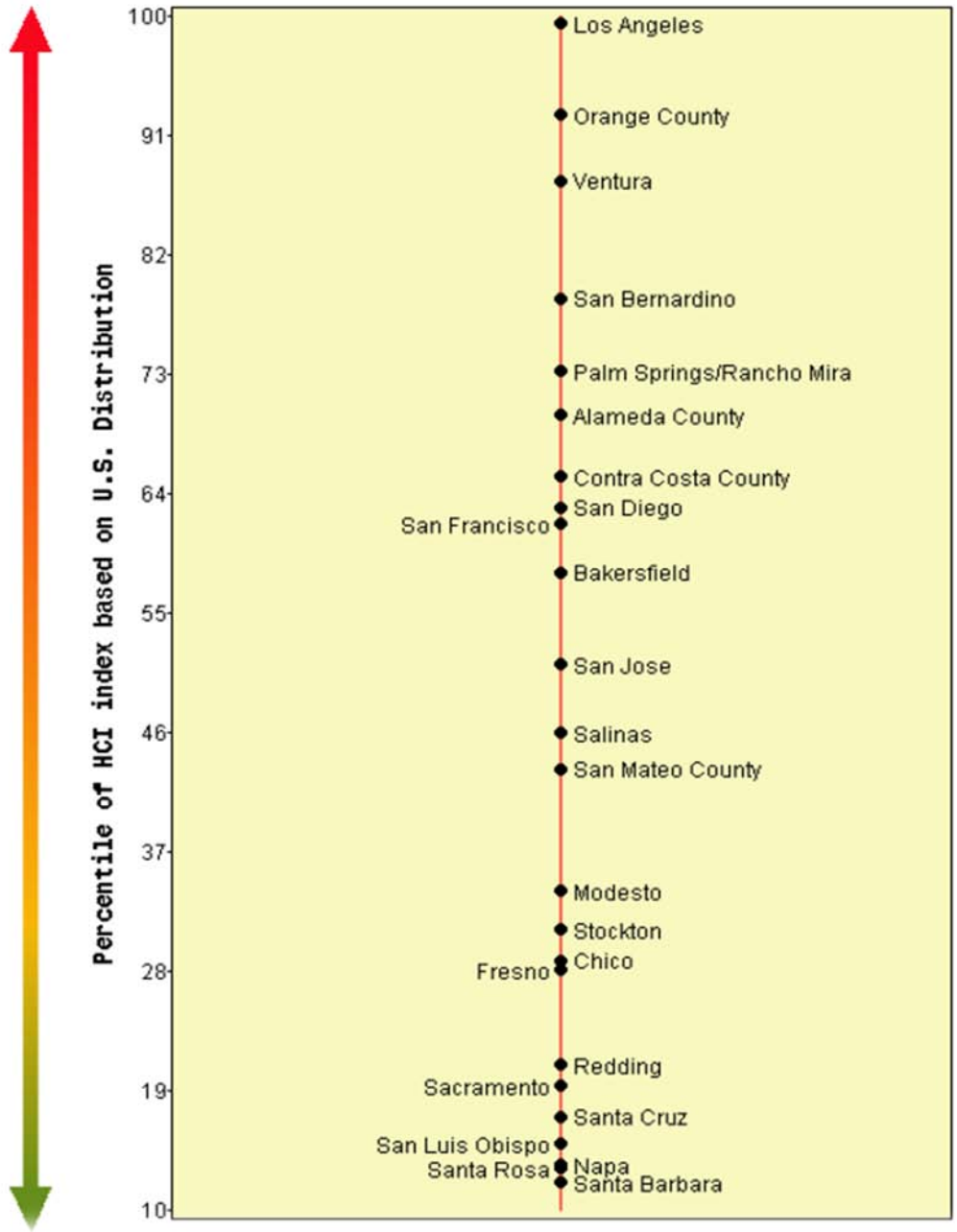
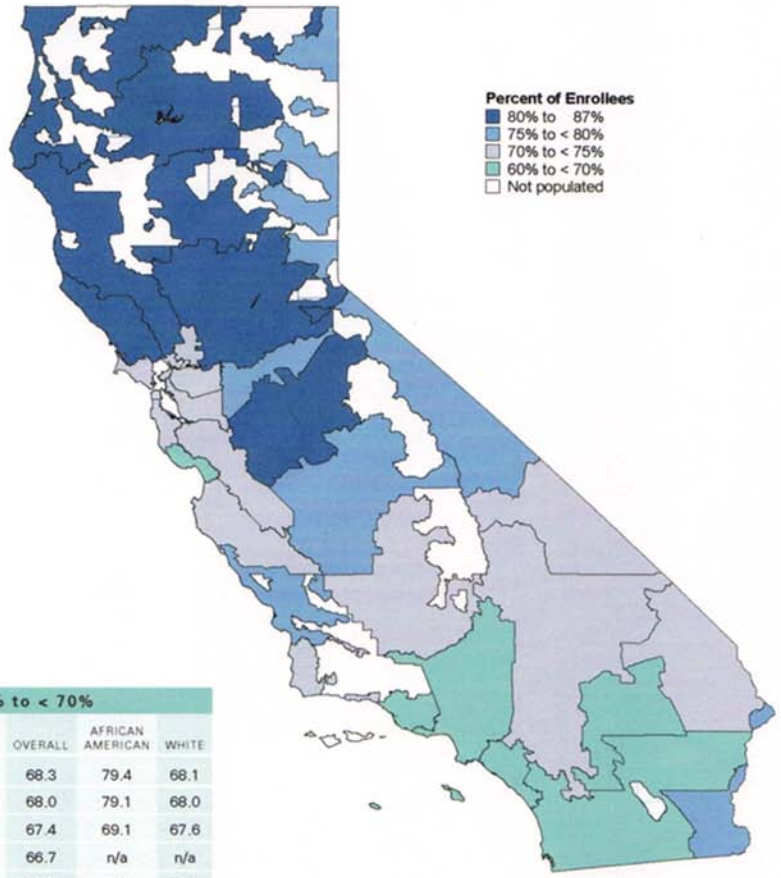
Medicare Spending per Beneficiary, 2005



2005 Dartmouth Atlas Total Medicare Expenditures Comparison – California



Primary Care in California



60% to < 70%

	OVERALL	AFRICAN AMERICAN	WHITE
San Diego	68.3	79.4	68.1
Orange County	68.0	79.1	68.0
Los Angeles	67.4	69.1	67.6
Santa Cruz	66.7	n/a	n/a
Ventura	65.4	n/a	n/a
Palm Springs/ Rancho Mirage	60.3	n/a	n/a

70% to < 75%

	OVERALL	AFRICAN AMERICAN	WHITE
Salinas	75.0	n/a	n/a
Santa Barbara	74.3	n/a	n/a
Bakersfield	74.2	73.4	74.2
San Francisco	73.7	79.6	73.7
Alameda County	73.0	76.2	73.2
San Bernardino	72.2	78.9	71.9
San Jose	71.8	n/a	n/a
San Mateo County	70.8	78.6	70.6
Contra Costa County	70.4	68.7	70.5

75% to < 80%

	OVERALL	AFRICAN AMERICAN	WHITE
Fresno	78.7	84.5	78.6
Stockton	78.0	74.7	78.4
San Luis Obispo	77.1	n/a	n/a

80% to 87%

	OVERALL	AFRICAN AMERICAN	WHITE
Redding	86.8	n/a	n/a
Modesto	83.1	84.6	83.1
Santa Rosa	82.4	n/a	n/a
Chico	81.9	n/a	n/a
Sacramento	81.0	81.4	81.0
Napa	80.6	n/a	n/a

Source – CHCF Dartmouth Report November 2008

Dartmouth Solutions

Midwest Providers Propose “Value Index”

Reward Efficient Providers; Penalize Inefficient

Need Profound Dramatic Change in Health Care Delivery System

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Dartmouth Critics

Several studies show that Dartmouth researchers did not take into account socioeconomic/health status of patients.

Dartmouth researchers did not factor in regional practice costs – rent and wages.

NEJM & MedPAC studies show these variables may account for all the geographic variation in spending.

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CA DATA

For instance, CA monthly rents are twice as high as rents in Midwest states:

San Mateo, CA $1,658

San Diego, CA $1,418

Marshfield, WI $586

Des Moines, IA $579

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LA County vs. Minnesota

UCLA researchers show socioeconomic differences which impact costs:

LA County/Inner-city LA	MN
Average income: $24,705	*$37,373*
Below FPL: 38%/56%	*11.6%*
Black/Latino: 57%/80%	*9%*
Uninsured: 24%/41%	*8.8%*

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LA County vs. Minnesota

Hospital Days per 1,000 Medicare Patients

2,429 Central LA County

1,777 in rest of LA County

1,613 in MN

LA looks like MN if the Core Poverty Areas are eliminated

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Health Spending Growth

Midwest states argue that paying for value is the best approach to bending the cost curve in US health spending.

Yet rates of spending growth are higher in Midwest states

Minneapolis, MN -- 4.3%, LA -- 3%

Marshfield, WI -- 4.02%, SF -- 2.4%

Iowa -- 4.1%, Boston -- 3%

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Compromise

Senate Cost/Qualty Value Modifier

Pays for low cost and high quality

Must take into account practice costs and socioeconomic/health status factors

Secretary HHS Study IOM Study

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Health Reform

Medicare SGR Reform NOT in Senate Bill

HR 3961 House Bill

Rebase the SGR formula

Wipe-out $200+ billion in future MD payment cuts

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Health Reform

Medicare SGR

2011 Deal

Stopped 21% Cut

2.2% Payment Update

Facing 30% Cut 2012

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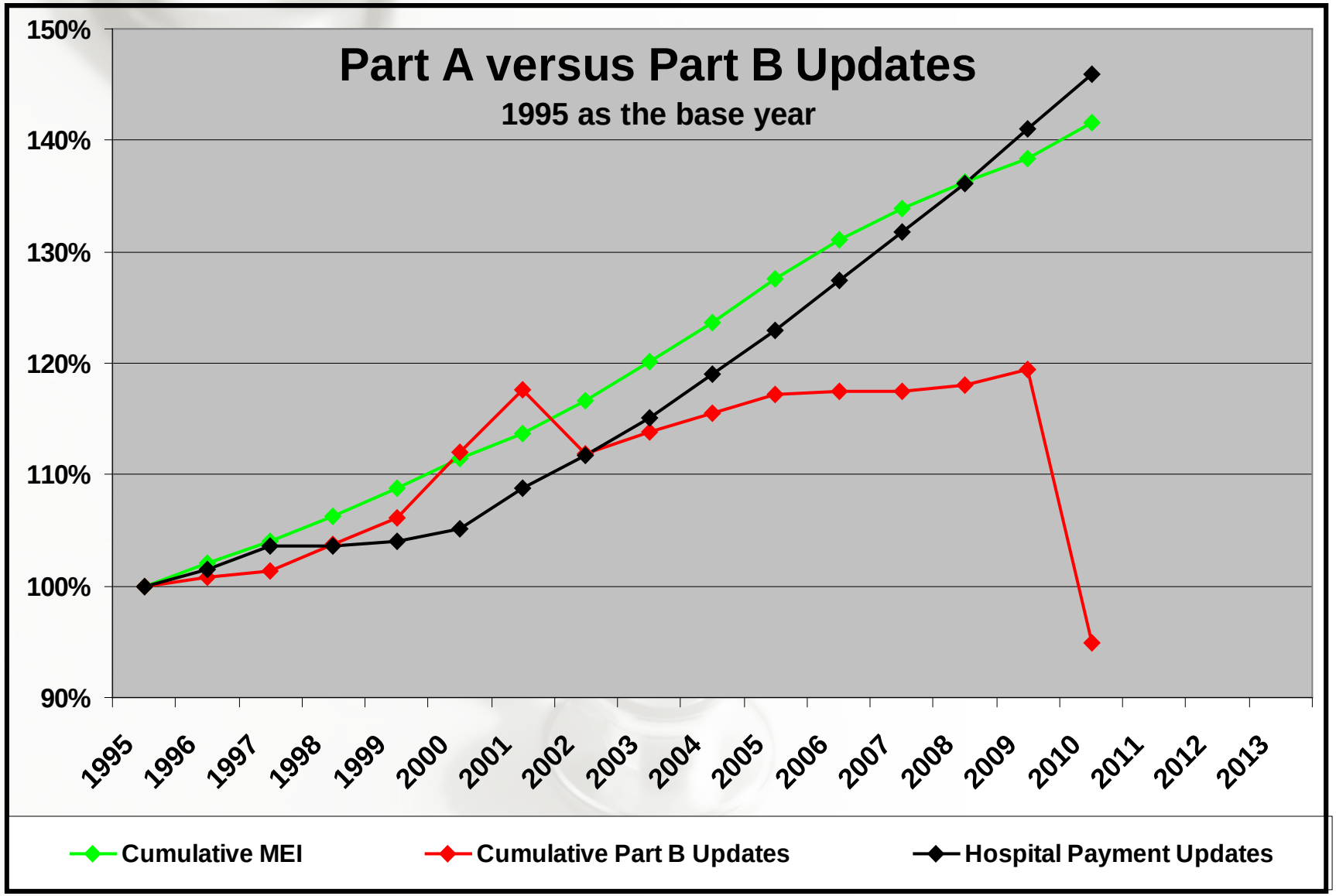
SGR vs. MEI


Part A versus Part B Updates
1995 as the base year
150%
140%
130%
120%
110%
100%
90%
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
Cumulative MEI
Cumulative Part B Updates
Hospital Payment Updates

Health Reform

Medicare Reform

10% Primary Care Bonus 2011 -- 2016

For internal medicine, family practice, geriatrics and pediatrics

For office visits, home visits, nursing facility visits

60% of Part B Charges

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Health Reform

Medicare Reform

10% Rural General Surgery Bonus 2011 -- 2016

Surgeons in HPSAs billing 10 or 90 day global

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Health Reform

Medicare Reform

- *Medical Homes*
- *Accountable Care Organizations*
- *Hospitals: Bundling, Hospital-acquired Infections, Readmissions, DSH*
- *Medicare Advantage Cuts but Bonuses for Meeting Quality Standards*

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Health Reform

Medicare Reform

Comparative Effectiveness Research

Clinical tool for physicians

Prohibition on using information to make coverage, benefit and payment decisions

Quality Improvement

PQRI bonuses 0.5 – 1%; penalties 2014

Public reporting Medicare & Private 2013

CMS Innovation Center; National strategy

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Health Reform

Medicaid Rates

Increases Medi-Cal rates for primary care up to Medicare levels 2013 -- 2014

Family practice, internal medicine, pediatrics

E & M services and immunizations

100% federally financed

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Health Reform

Medicare Reform

Accountable Care Organizations-ACOs

Physician-led; No hospital involvement required

Loose affiliation, large medical groups, integrated systems

Coordinate care & report on quality

Shared savings to ACO for reducing Part A & B expenditures in region: Benchmark

Pathway to anti-trust relief

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Health Reform

ACO

Traditional FFS

Multi-specialty – 5,000 patients

3 year Commitment

Legal and Financial Structure

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Health Reform

- ACO Regulations
- Burdensome Requirements
- Governance
- 65 Quality Measures – PQRI/Hospital
- Spending Benchmark Good for California
- Risk/Cost Adjusted; National Growth Rate
- 2 Payment Tracks:50-65% Shared Savings
- Downside Financial Risk

Health Reform

- ACO Regulations
- Patient Assignment
- Anti-Trust Relief
- Fraud and Abuse Waivers

Health Reform

ACO

Education Briefs and Webinars

Legal and Financial Models

CMA Principles for ACOs

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Profound Changes

- Driven by Private Sector
- Accelerated by Health Care Reform
- Predictions: Physician Consolidation
- Independent Practice Model in Decline
- Larger Physician Groups
- Physicians Aligning with Hospitals
- Foundations, ACOs, Medical Homes
- Concierge Direct Practice Physicians

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Profound Changes

- Required Capabilities:
- Coordination of Care
- HIT-reporting and communication
- Quality Improvement/Quality Reporting
- Private Sector/Medicare: PQRI&Value Modifier/Health Exchanges/Public Website
- Reduce Clinical Variation
- Achieve Efficiencies and Show Value

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Profound Changes

- New Payment Models in Health Reform
- SGR Transformation
- Independent Medicare Advisory Board (IPAB)
- Medical Home
- Partial and Full Capitation
- Shared Savings Payments

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Profound Changes

- New Payment Models Continued
- Value Modifier Payment Methodology
  Payment based on quality reporting and individual physician spending above or below the national per capita level.
- Quality Reporting Bonus
- E-Prescribing Bonus
- HIT Adoption Funding
- Primary Care Bonus

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Profound Changes

- New Hospital Payment Changes Impacting Physicians:
- Bundling
- Hospital Readmissions
- Hospital Acquired Infections
- Reduced DSH Payments
- GME Funding

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Health Reform Profound Changes

- CMS Innovation Center
- CMA Draft "Unofficial" Proposals
- Registries
- Reducing Clinical Variation
- ACO Transition Model for Solo/Small Groups
- Feedback Bonus Program (Util/Quality)
- Role for Specialties and Local Medical Societies

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Profound Change
Medicare/Private Market

CMA Helping Physicians

Succeed
In the Era
of Health Care Reform

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Health Reform

Revenue

Medicare cuts (mostly to non-MDs)

Fees on HP, Pharma, device manufacturers

Cadillac tax on health plans

Increase in Medicare tax

Higher income earners $250,000

Tax on net investment income & capital gains from certain sources

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Goal of Policy-Makers

Shared Responsibility

Everyone Must Contribute

Individuals Must Purchase Insurance

Employers Must Offer Coverage or Pay

Insurers Must Meet Market Reforms and Benefit Requirements

Providers Must Be More Accountable, Efficient and Coordinate Care

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What You Can Do
Meet with Your Representative

THEY MUST FULFILL THE PROMISE OF UNIVERSAL COVERAGE BY ENSURING THAT EVERYONE HAS A DOCTOR

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They Must Improve Access to Care

Repeal SGR/Stable Reimbursement

Eliminate the IPAB

Adopt the CA GPCI fix

Implement MD quality reporting protections

Increase Medi-Cal rates for All Physicians

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