The link to the event is at: http://healthpolicy.missouri.edu/events/hcreform.shtml

Speaker:
Can you hear me? {pause} My name is Karen Edison and I direct the Center for Health Policy and I am here representing our entire center. We are delighted to offer this presentation today for the healthcare community about Health Reform. We entitled this presentation “Health Reform Explained” and as I was getting my slides together and thinking about it I realized we should’ve entitled it “Health Reform Introduced,” {chuckle} because there are about ten, hour long lectures in this Health Reform legislation. So today what I’d like to do is make them kind of interactive. I really reduced it to an overview. I am going to go through that basic overview of the Health Reform legislation and then hopefully we’ll have some time for Q & A. So jot down your questions as you go. I am sure there will be some because this is a big, complicated piece of legislation.

So as with all federal legislation, they all have titles and this one is called “The Patient Protection and Affordable Care Act”. Many times these titles are abbreviated and become acronyms that we go by later. I am wondering, Chris, if this one is going to be P-PACA {chuckle}? But, most people just call this Health Reform. Depending on your point of view, you might ask is this a step in the right direction and a framework for needed ongoing health reform or is it a government takeover of health care that deprives Americans of their freedom? Hopefully at the end of this talk you can be the judge. I will not ask you to raise your hand on that.

President Obama, the Administration, and the Democrats have been criticized for the process; for some of the fits and the starts and some of the deals that have been made. There have been a lot of criticism to go around. I am sure you’ve read and paid attention to some of this. The Republicans, on the other hand, have been criticized for being the party of no. You’ve probably heard a lot about this in the media as we go through. What I’d like to do today is dispel some myths and hopefully help you understand that some of what you hear in the media is not really what happened in Washington or what goes on in Washington. I was a Robert Wood Johnson Health Policy Fellow in the 106th Congress and had so much fun I stayed for another year. I was there working in the Senate working for Health Education Labor and Pensions from 1999 to 2001. Dr. Kris Hagglund was their Robert Wood Johnson Health Policy Fellow the year after me. He was there when I was working on the same committee from 2000 to 2001. So, you have a lot of health policy experts in the room. For those of us who are health policy junkies, or Wogs if you will, this whole health care legislation was like the Super Bowl for us, was it not? This was bigger than the NCAA tournament. This was bigger than any Super Bowl. This was a lot of fun this year.

I will tell you that Republicans and Democrats for the last few decades have been thinking about this issue. There were lot s of hopes and dreams put in this healthcare legislation; some of them came recently, some of them have been hopes and dreams of people for twenty years. The health policy people got all activated in the early 1990s around Clinton Healthcare and they thought we were really going to have health legislation. When that failed so miserably a lot of people were depressed and kind of went underground. It has really taken almost 20 years for health policy to come back.
When I went to Washington, my boss Paul Harrington came to me and said, and this was 1999, “Karen we are going to work on health reform and these are the pieces, these are the components of what it will take to reform healthcare in this big, huge, complicated representative democracy. We are going to have to expand public programs like Medicaid and Medicare. We are going to have to reform the private market and shore up some of the worst abuses of the healthcare industry, health insurance industry. We are going to have to strengthen and shore up the public health and safety net programs like our community health centers.” In 1999 he said to me, “And you know, we are going to have to have an individual mandate.” He whispered, [whispering] “An individual mandate.” By 2001, by the time I left, it was, “We are going to have to have an individual mandate.” Now keep in mind I worked for the Republicans, actually. My boss was Jim Jeffers who was a moderate Republican at the time. So, it has been known for a long time, in spite of what you hear about this individual mandate, that the whole thing does not work, it will not work without it, without everybody in the system. There have been Republican and Democratic presidents in years past who have tried mightily to move health reform legislation in this country. I will not quiz the young people on who all the presidents are but I’ll assure you there are Republicans and Democrats on this list: Roosevelt, Truman, Eisenhower, Kennedy, Johnson, Nixon, Carter, and Clinton. So a lot of Presidents have tried to move this and here we are today.

Today I am going to talk a little bit about an overview, a little bit about the timeline, give you a little information on some of the key provisions, and something about the winners and losers. What is of interest is that there are many people and constituencies in both columns actually, winners and losers for different reasons. Finally, a few things about what this means for Missouri and then hopefully we’ll have some time for question and answer.

Overarching goals from any health care reform talked about over the last couple of decades have focused on covering either everyone or almost everyone (this is almost everyone), improving the quality of care, and beginning to get some control of these escalated health care costs. Like I said in this 200, 2,500 page piece of legislation, there are many hopes and dreams of different people that have worked in this area for many decades.

Overall, let me stop there for second and ask you a question how many of you are following this very intently and reading everything you can about it? About a third, okay. How many of you really have not followed it much at all? About a quarter. Overall, within the next year or so, children with preexisting conditions will not be able to be denied coverage. Most health insurance care companies are already starting to coming on board with this. Young adults will be able to stay on their parents’ health care coverage until age 26. We already have many of the major companies saying that they will do this or that they have plans to do this by September. People denied coverage due to their health issues will be able to obtain temporary coverage in a high risk pool. These high risk pools can be run by the state. If states do not want to do it the federal government will do it. There will also be a $250 rebate as the first step to senior citizens to fill in what is commonly known as the donut hole in funding for prescription drug costs. I’ll talk a little bit more about these as I go.

Within the next year tax credits will become available for certain small businesses offering health care coverage for their employees. Insurance companies will not be able to arbitrarily cancel coverage or cancel coverage when you get sick. It is a process known as rescission or limited coverage due to annual limits or lifetime limits. Preventive methods will begin to be covered, particularly for new plans coming into the system. Medicare will begin doing this January first of next year. Insurers will be required to put
a larger percentage of their premiums into benefits rather than profits. So, there will be rules around how much of the money that they take from you that they can spend on health care for you or on advertising and large bonuses, etc.

Remember 2014 is a big year for Health Reform. A lot of the major pieces of this Health Reform legislation do not fully engage until 2014 and that is a long time from now. If you think about the political cycle or you think about the election cycle, 2014 is a big year. All individuals will be protected from being denied coverage due to preexisting conditions. That includes adults and children starting in 2014. Thirty-two million Americans who do not now have health care coverage will begin to be covered over a ten year period and that will start really in 2014. Individuals, and this is a big deal, up to 133% of the federal poverty level will qualify for Medicaid all through the land. Now as you may know, Medicaid programs are federal state partnership programs and different states have different rules around who they can cover. Missouri has always been generous in terms of our coverage for children, covering up to 300% of the federal poverty level for children in our Medicaid and childrens health insurance programs. We have not always been as generous where adults are concerned. We cover parents of children through Medicaid but only up to about 24% of the federal poverty level right now which is quite a low number (like $4,000 a year in income). If you do not have children and you are low income in Missouri, you do not qualify for Medicaid right now in any case. That is not a safety net for the poor, it is a safety net for people in certain categories. So this is big, this up to 133% of the federal poverty level for all people across the country. Above 133% of the federal poverty level, there will be sliding scale subsidies for the purchase of health insurance through the exchange in other ways. Then there will be the state based exchanges, or market places, in 2014 that they will begin to operate. These are the exchanges where health insurance companies come and they offer health plans that are all grouped together so therefore you have the benefit of the market. If you are an individual right now, you are trying to buy a health plan, and you have an illness, the deck is stacked against you. In this setting, there will be a lot of insurance plans and a lot of different products that you can choose from and they will not be able to deny you because of a preexisting condition. These are big changes. Also in 2014, large employers who do not offer insurance will face a penalty and individuals not carrying health insurance will face a penalty. This has been the most politically controversial piece of this health care legislation. This is what we talk about when we talked about an individual mandate. Individuals will be required to carry health insurance with some exceptions.

Guest:  
{Question Inaudible}

Speaker:  
Pardon me?

Guest:  
What is considered a large employer?

Speaker:  
Fifty or more. I am going to talk about that in just a minute. Overall, we are going to talk about increase in regulation and accountability, we are going to see some increase in federalization, and we are going to see some first steps toward paying for value rather than volume although arguably these are baby steps.
How much will it cost? Almost $800 billion over 10 years {inaudible} expenditures and penalties. Deficit reduction of $143 billion over 10 years is what is expected if there are no changes. If there is one thing I can tell you for sure, there will be changes. Mark my words there will be changes. It imposes taxes on insurers, on the pharmaceutical and medical device industry, on high income individuals, and high cost, what are called “Cadillac” health care plans. I will talk about that in a minute. It assumes, and this is a pretty big assumption, a savings of $500 billion through the Medicare program through 2019. You can imagine that there might be some changes to some of this as it goes along. Libby Reinhart, who is coming at the end of October to be one of our keynote speakers at our Health Policy Summit, talks about this as a spider web and I like this metaphor because it is so true. The whole of healthcare around this huge country is like a spider web; you pull on it over here and it moves the whole thing. Everything that happens affects everything else. What they tried to do is think of all of that and put provisions in place in anticipation, but, in any major piece of legislation affecting 17% of your economy, there will be unintended consequences. There is a federal team of high level people: old veterans, health policy in Washington, Pete Rouse, Nancy-Ann {inaudible} DeParle, we have Kathleen Sebelius, Secretary of Health and Human Services, and the former governor Kansas. Importantly, the secretary can expand provider payment reforms nationwide without Congress’ permission. That is big. If there are dems, and there will be, if they find out there are better ways to pay doctors, hospitals, and others, the secretary of HHS can implement those changes without going back to Congress. Don Berwick, who many of you know is the nominated new head of the Center for Medicare and Medicaid Services, been a real leader and thought leader in institute for healthcare improvements, quality improvements, and innovation in this country. I do not expect a problem with his nomination because he is well respected in Washington. But, we will see. They will oversee the innovation center at CMS. Look for these healthcare innovation zones trying to find better ways to do provider payments and looking for better ways to do health care. Do you all recognize this name, Jay Angoff? He used to be in Missouri with the Insurance Commissioner. He was also here when Blue Cross and Blue Shield went from nonprofit to for-profit and when the Missouri Foundation for Health was formed. He is the Consumer Advocate. He is going to lead regulation around insurers and insurable market. He is the guy tasked with defining unreasonable. Are these premium increases unreasonable? So that was in the details when you were in the federal agency and you are the one responsible for promulgating the rule and issuing the regulations. What does unreasonable mean? He said that is what he’s doing right now, trying to define unreasonable. Jenny Lambrew, an old veteran of the Clinton White House, is going to lead coverage expansion. She is a long term advocate for the underserved. Phyllis Borzi is going to police employers who provide benefits. And like I said, there will be unintended consequences. So, what we know for sure, there will be changes and there will be unintended consequences.

Whether you think like Thelma and Louise, that we are driving off a cliff in a jalopy or you think this whole system has been broken, is out of control, everybody knows we need to fix it, and the people calling the sidelines do not know what they are talking about, you are going to find a lot of other people agree with you. Last week’s poll, University of Indiana, nearly four in ten people want the law repealed right now. Should I ask how many of you want the law repealed? No, I shouldn’t ask. {laughter}. But when you ask people about specific aspects in this legislation, they like them by and large.

Guest:
Yes
Speaker:
The one thing they do not like is the individual mandate. That was the most unpopular thing. And as I said before, that is not going anywhere. Although it is the major target for legislation, a lot of people think it may go to the Supreme Court. Is this constitutional to require people to have health insurance? Fifty nine percent of people in last week’s poll supported the idea of a public option. Is that in this health reform? No. Right. So there is no public option in this health reform legislation. Everyone understand that? A lot of things you hear are about the public option and that was left out a long time ago.

So what are the key components? This is a little bit like getting down into the weeds and I am going to try not to get down too far into the weeds. So do not be upset if I rush through some things a little bit. I am happy and our centers are happy to come back to any group and talk about what it means for consumers, what it means for health care provides, what it means for hospitals, and what it means for business because all of these issues are intensely complicated.

So let’s start with consumers. We talked about immediately if you have preexisting conditions that have made you uninsurable in the past, you will have access to new, high risk pools put together by the end of the year. States can do them themselves but if they choose not to, and I know Nebraska and Georgia recently has chosen not to, the federal government will do it for the citizens in your state. But there is five billion set aside. Some people say that is not enough money. That $5 billion sounds like a lot of money but between now and 2014 it may not be enough money for these people. You have to be uninsured for six months before you can get into the new high risk pool. So a lot of states have high risk pools and these are pretty sick people. So the concern is are they going to go bare without any insurance for six months so that they qualify for the new, cheaper high risk pool? There is a lot of devil in the details here. Members pay no more than 35% of the cost of covered benefits and these go away in 2014 when the health insurance exchanges become operable in the states. Coverage expansions starting in 2014 have 94% of legal residents becoming covered; half of these, 32 million, in Medicaid expansions and half through the exchanges. Twenty-three million Americans will remain uninsured, a third of which are undocumented immigrants who have been in the news lately as I am sure you’ve heard. So up to 133% of the federal poverty level for individuals under the age of 65 in 2014 with the federal government picking up the costs for the states of this new coverage. Importantly, the federal government did not provide funds for operations so there is no new money for the Medicaid program. But they are going to pick up the cost of coverage and then it is going to fade down. So you can see 100% coverage through 2016 and then 95, 94, and finally 93. It is going to fade back and I’ll show you in a minute what that means for Missouri. Premium subsidies above 133% of the federal poverty level will exist and these will be on a sliding scale. This means that the higher your income, the smaller your premium subsidy. These are refundable, advanceable, sliding scale premium credits. The federal poverty level is about $10, 000 for an individual and about $22, 000 for a family of four. So what does this look like? Say you are a 40 year old and you are earning $21, 660 a year. This sets you at 200% of the federal poverty level and your annual premium for health insurance would be $3500. You get a subsidy of $2, 135 but you do not get it, it goes directly to the insurer. Then you pay $1, 365. For a family of four, the family would pay $2, 778, the subsidy would be over $6, 000 from the federal government. Does this make sense? It is a complicated issue but they are great at subsidies as you go up. This proportion of people should not pay more than 6.3% of their earnings at 200% of the poverty level. At higher levels, 300% to 400% of the federal poverty level, families are expected to pay a higher percentage of their income. You can see that from $6, 000 to $8, 000 a year the subsidies go down as income goes up. Anyone who cannot find a premium that cost less than 8% of their income is exempted from the penalty of having individual coverage. So there are exceptions for financial hardship. Does anybody use Flexible
Spending Accounts here? A couple of people, alright. There are new rules on Flexible Spending Accounts. They will not be able to be used to cover over the counter medicines unless directed by a doctor. Does that mean we are going to have to start writing prescriptions for over the counter medicines? A a lot of things to consider. There is also going to be limits in 2013 on how much you can put in that, down to $2500 a year. Preventive Services. New plans are going to be required to pick up 100% coverage for preventive services. It can not apply to your out of pocket or end of year, to your out of pocket limit, or apply to co-pays and things like that. These services are going to cover immunizations and age appropriate cancer screenings. Medicare is going to start doing this in January of 2011 and Medicare is going to cover an annual physical for Medicare beneficiaries and recommended screenings. Now, the standard for the recommended screenings are the Level A & B recommendations of the US Preventative Services Taskforce who has been in the news lately. {inaudible}. That is the standard of what will be coverage 100%, those A & B recommendations.

What about senior citizens? What does this legislation mean for them? Well there are two big things. One is the Donut Hole is going to be gradually closed and I’ll show you what that is in a minute. The Donut Hole refers to federal funding for prescription drugs. The federal government helps senior citizens with their prescription drug costs up to a point, then there is a gap, and then it kicks in again. This is what people call that the Donut Hole. It is quite a shock to some seniors when they hit that Donut Hole and their costs go way way up. Overtime, that is going to be closed. Medicare Advantage is a program that is less common here in the Midwest as it is on the coast but this is managed care within Medicare. This happened when the Republicans were in charge and they wanted to introduce market-based incentives into the Medicare program. So they started paying companies to deliver Medicare services and started paying them in a premium. These have been a target for a long time because there is a lot more tax payer dollars that go to the Medicare Advantage care plans. So what about that Donut Hole? There will be a $250 rebate this summer if you hit the Donut Hole. In 2011 there is going to be 50% discounts on brand name drugs and it will increase up until 2020 when the Donut Hole is completely eliminated. {picture} Those are supposed to be donut holes. {laughter}. So up to $2,700 if you’re a senior citizen, the federal government, through Medicare Part D, subsidizes a large part, 75% or so, of your prescription drug costs. Then there is nothing until you get to $6,154 when catastrophic coverage kicks in and the government provides 95% of that coverage. Okay. That’s the Donut Hole. That is what is going to be closed coming up to 2020; which is a big deal for senior citizens living on limited income who require a lot of medications. What about those Medicare Advantage plans? We as tax payers actually pay them 14% more per patient for care than the traditional Medicare program. Now, if you are in one of those programs, you’re going to get some better services, some services that other people do not get, and some lower premiums. This is going to be politically not pleasant for some of those people. So, vision care, better drug coverage, spas, acupuncture, and a whole variety of things that may not be covered under traditional Medicare. That is why this was phased in over time so there would not be a big backlash. The largest cuts do not really begin until 2015. So over time these cuts will be phased in.

Alright, what about this individual mandate? Those of you who do not have health insurance, which I hope is not a big part of this crowd but may be, the individual mandate does not kick in until 2014. What happens if you do not get health insurance in 2014? Well, that is a $95 penalty so it cost you $95. In 2015, it is going to cost you $325 to go without health insurance. That will go up, all the way to $695 per individual up to a maximum of 2, a little over $2000 per family or 2.5% of household income, whichever is greater. So some people say that is not enough of a disincentive, some people say that is way too much. You can argue.
Guest:
{Question Inaudible}

Speaker:
Right, yes. These are annual penalties and it is supposed to be managed through the Internal Revenue Service. Which is fun {inaudible}. There are exemptions for financial hardship and if you cannot find coverage costing less than 8% of your total income. There are also exemptions for religious reasons. So there are certain categories of exemptions for this penalty. High income earners. This is in that category, “what does this mean for consumers?” So, they are a consumer. The Medicare payroll tax is going to go up from 1.45% to 2.35% of earnings above $200,000 for an individual and $250 for a married couple. The same high income earners will have a 3.8% tax on investment income starting in 2013. That is a lot of money actually. A big source of income for this whole program is high income people. Okay, so that is a little bit about consumers.

How about a little bit about employers? Large employers have an employer mandate. Large employers, 50 or more, are going to be required to provide coverage for their employees or pay $2000 per employee for not providing that coverage. Mid-sized employers do not have a mandate but they do not have incentives either. Small employers, less than 26 employees, this year, tax credits will begin to become available for those who offer coverage for their employees. Companies less than 50 employees make up most of the businesses in the United States and they are exempt from the mandate. So politically, you can imagine how this played out because small business had a fit, you know, “Do not put mandates on us, we cannot afford a {inaudible}.” So small businesses, these credits will be up to 35% of their costs if they are covering at least 50% of their workers’ premiums. In 2014, that credit goes up to 50% of their costs, which is a big deal for some small business owners. The full credit will be available to very small employers, 10 or fewer, and if they have annual wages below $25,000. The credit phases out as the firm size and wages increase. What about large business? I think the details are always interesting. So they are going to pay $2000 for each full time employee not offered health coverage. I just learned recently that there is some large employers who employ mostly part time people. So you can imagine some of the impacts on this. Except for the first 30 FTE, {inaudible} negotiation. So, $2000 on everybody except for the first 30. So you can have 30 full time employees {inaudible}. This fee would then help cover the cost of buying policies and exchange. More fees. If you offer coverage but it is not really that great and you have employees who are entitled to tax credits because they cannot afford it, then you still have to pay a penalty on those employees. Let me do that again. So you are a large employer and you offer coverage but you have a lot of low wage employees and they cannot afford it, you pay a penalty on those employees. Does that make sense?

Guest:
{Question Inaudible}

Speaker:
Well that is one of the concerns and that will be a calculation obviously. Now there are financial calculations and political calculations so you can bet every large business in this country are doing these calculations right now. For employees of big business, if it is too costly, you can buy a policy in the exchange and if it is really too costly, you can be eligible for tax credits. This is kind of in the weeds but let me just say that there is a lot of pressure on employers to offer coverage and there is some help for small businesses to offer coverage. Wellness. Employers can now offer rewards up to 30% of the cost of
your plan to employees who participate in a wellness program and meet certain health-related standards. This is big, 30% of your plan, your premium.

What about health care insurers? Well within six months they have to publicly disclose how much money they are spending on premiums, your premium, how much money they are spending on healthcare, and how much money they are spending on administration, advertising, profits, and bonuses. So you can bet the health insurance companies are scrambling right now to figure out what they have to do. They cannot have lifetime limits on benefits or annual limits on benefits. This is all within the six months. They have to have uniform explanation of coverage documents for enrollees. How many of you had trouble figuring out your health insurance forms and what the benefits are? Supposedly this is going to end. Which I think is kind of fun.

States are going to be allowed, I believe this is 2014, 2015, to form compacts to start looking at the interstate sale of insurance. This is a thoroughly Republican piece of this legislation. New regulations, like I said, will deny coverage or charging higher premiums for gender or health status. You hear a lot about that but what you do not hear is they can still charge you differential for age, geography, and tobacco use. So the devil is in the detail. Again, no exclusions for preexisting conditions for children this year, for adults, in 2014. Also they can not engage in the practice of rescission. I will not name the insurance company that just this week was in the news for targeting breast cancer patients for the practice of rescission. I do not know if you saw that but the HHS said cease and desist. So there is starting to be some battle lines drawn here. Insurers must pay at least 80% of their premiums to claims and 85% if they serve a large group market, otherwise they have to give it back to us. I will not ask how many people from the insurance industry are here but it might be as early as next year that we might get checks from our insurance company if they are not using 80% of our premiums for healthcare. Anybody think that’ll happen? (laughter) You can imagine what is going on.

There is going to be a new independent appeals process for consumers, so effective internal and external appeals. (picture) You can go in there and say, “Your excuses for not providing me coverage has been denied “. (laughter). Kathleen Sebelius has made it clear that the feds are watching and they are prepared to do battle. They do not want to see health insurers abuse consumers between now and 2014 and they are watching carefully. You will get to see this playing out in the news. Like I said, this is better than basketball. (laughter). Ok, Senate discussing. Right now there is discussion, just last week, about new legislation because of this very issue, doing a check on unjustified premium hikes. Twenty-two states in the individual market and 27 states in the small group market do not require a review of premiums before they go into effect. So maybe taking a look at this “what is unreasonable?” earlier. They have to implement uniform standards for the electronic exchange of information and we talked about Flexible Savings Accounts. What are these exchanges? These market places? These state-based market places? They are going to be market places for us all to go in the individual and small group market by 2014. And health plans, in order to participate, have to meet certain qualifications. Large employers are expected to be phased into the exchanges in 2017. The whole primary care medical home that you have been hearing about; this will allow qualified plans to provide coverage through a qualified medical home that meets certain requirements. They also have to publicly disclose information on plans, payment policies, enrollment, denials, rating practices, and enrollee rights. These explanations have to be in plain language. These health plans have to take steps, interestingly, to reduce health disparities, to include the use of language services, community outreach, and cultural competency trainings. This fits, time wise, very nicely with the Joint Commissions new standards on patient centeredness, cultural competency, and health literacy that we are going to see in January of 2011. So
all these pieces really fit together quite nicely. Improvements in the collections of data, what we call real data: race, ethnicity, and language. They have to provide linguistically appropriate information on health insurance options. So if you speak Spanish it has to be provided in Spanish. Plain language is a good idea. They have to use plain language on insurance forms because the average adult in this country reads at an eighth grade level and one in five adults read at or below a fifth grade level. So how can they be expected to figure out these health insurance forms? Have you ever helped your parents with the Medicare D health insurance forms or your grandparents? I mean, it is quite complicated. There will be an annual fee on health insurance providers applied to net premiums based on their market share, a little bit less for nonprofits, and exemptions for those serving mostly low income people, elderly, and the disabled. So fees on health insurance, fees on pharmaceutical companies, based on annual sales, and all these things were negotiated ahead of time. You can imagine if you are the pharmaceutical company you are doing the calculation, “Okay, I am going to pay you fees every year but I am going to have 32 million more customers.” Medical device manufacturers also get in on the action. High cost on “Cadillac Health Plans.” This was politically a big argument because a lot of the unions had plans that were considered high cost because they had negotiated rich benefits over the years and they sort of said, “Whoa, do not tax our high cost plans that we’ve negotiated.” So basically they backed off and you can see this date, 2018, you can imagine there will not be a single high cost plan in the country by 2018. The tax is huge. If you have a high cost plan, the tax is a 40% excise tax on everything above a certain level. I mean that is a big tax. So it is really attempt to drive down these very super rich, high cost insurance plans.

Guest:
{Question Inaudible}

Speaker:
Yes?

Guest:
{Question Inaudible}

Speaker:
Because we are all in this together, there are limited dollars, and costs are exponential and out of control. We do not insure almost 47 million of our own citizens. Costs are expected to spike. I did a talk for many of you last fall on why you are doing health reform. We spend twice as much as many developed countries and have poor outcomes. And so, the whole notion is that we are all in this together and we really cannot afford that.

Health Care Providers. There are a lot of health care providers in the room. What does all this mean for us, right? Well in primary care you are sitting pretty good. Medicaid increases are going to go up to 100% of Medicare. I think this is interesting. For 2013 and 2014, those two years, the feds are going to pay 100% of that. And then supposedly the exchanges kick in and so then you will not need that. So funding for community health centers will be boosted. There is going to be a 10% Medicare bonus from 2011-2015 for primary care and general surgery in certain health professional shortage areas. Last time I looked the majority of Missouri counties were health professional shortage areas. So this is a big deal. I mean it is 10% but it is something. So over five years, near double funding for community health centers which are the federally qualified health centers. Our local example is Family Health Center over at Worley. That whole safety net system of clinics throughout the state would be given a boost in funding,
Workforce provision. There will be training programs for primary care doctors, nurses, and public health professionals. There will be a commission appointed by September of this year to advise Congress on workforce needs. A lot of people have complained not enough was in this piece of legislation around workforce. So you are going to have 32 million more people with access to healthcare and there already are not enough of us in any sector of health care. Grants to expand primary care residencies. Whenever they give an example they talk about federally qualified health centers, partnering with community health centers to expand primary care residencies. They really want to do this including grants to provide scholarships for mid career training as well. A little nugget for providers. This is a dream that has been cooking for about eight years. New physicians-owned hospitals will be barred from participating in Medicare. You know those physician hospitals that pop up like The Heart Center and The Eye Center, that’s over. Well it is over if they want to take care of Medicare patients. By 2013, hospitals have to disclose any financial interests that providers or that physicians have in that hospital. It is a big deal.

Now, here is the biggest deal for many providers. This is the Independent Payment Advisory Board, the IPAB, not to be confused with the iPad. The IPAB. This has been very divisive for the House of Medicine. I do not know if many of you have been paying attention but primary care, in general, was very supportive of Health Care Reform legislation. The American College of Physicians, American Academy of Family Physicians, and AMA signed on (inaudible). But a lot of the big specialty groups really were not and a lot of the fear, mostly it is fear, centered around this provision. I’ll tell you a little bit about it. Have you heard of this? Okay, you will. This is 15 fulltime, members. It is a big deal to have a Washington commission where they demand fulltime service. That tells you right there that there is something special about this commission or this board. This independent board is going to be able to put proposals in place nationwide unless Congress objects within 30 days and this is all around provider payment; except it is not around hospitals until 2019 because they made a special deal. Let’s say for example they say, “Okay, we are going to pay primary care 50% more and we are going to pay all specialty care 50% less” just for example. Those 15 individuals decide if that is a good idea. If Congress does not get its act together and object or modify within 30 days, then it goes into effect nationwide. Even then the President can disapprove of and it takes two-thirds of the House and the Senate to override it. This is a big deal because this is a lot of power in 15 fulltime people. As Peter Orszag, the director of the Office of Management and Budget, which is the White House’s budget arm, kind of like the Congressional Budget Office is for Congress, said recently, “It is a very muscular provision.”

Yes.

Guest:
{Question inaudible}

Speaker:
Yes, this is Medicare. This is focused on Medicare because private health insurance does its own thing. So right now, we have Medpact. We have the Medicare Payment Advisory Commission. Which is a similar kind of deal but it is advisory, it has no teeth. So about half the time, and I remember being there, about half the time we took their advice and about half the time we ignored it for political reasons. This does not have to go through Congress. The only impact Congress can have is to object to it. So this is a big deal. You did not hear a lot about this on purpose I think. It is supposed to extract $15.5 billion savings of the $500 billion projected for Medicare through 2019. So it can alter payment for
Doctors but not hospitals and it cannot change benefits or out of pocket costs for Medicare recipients. So if you are not a hospital and you are not a Medicare recipient, you could be in the crosshairs.

What about quality? There is going to be a national plan to improve quality that has to be submitted by January of next year. Grants to community-based networks of hospitals and health centers to improve coordination. All kinds of little nuggets like this all through the legislation. This is a big deal. A lot of focus on bundling payments. You have heard of accountable care organizations, really changing the way we pay for health care. Paying doctors and hospitals and long term care, and therapists, and pharmacy, paying everybody in a bundle. That is really a theme. There is going to be demonstration projects in up to eight states and remember, the secretary of HHS has the ability to make that nationwide. Remember that from earlier in the talk? So this is a big deal. Fred Turton, he is the Chair of the American College of Physicians Board of Regents, recently said, “This takes the first steps toward breaking the link between pay and volume of services.” By March 23, federal agencies had to start collecting better statistics on the population, including language and disability status. A lot of little nuggets on quality throughout this whole piece legislation. Ever wonder whatever happened to comparative effectiveness research? Remember this? The big debate about comparative effectiveness research is back and it is called Patient-Centered Outcomes Research Institute. Most of this is going to run through the Agency for Healthcare Research and Quality (or AHRQ) to examine the comparative effectiveness of different medical treatments using existing studies and conducting their own. It is a 19 member, board appointed by the Comptroller who runs the Government Accountability Office. It includes doctors, hospitals, drug makers, device manufacturers, and health experts. They cannot mandate or endorse coverage rules or reimbursement for any particular treatment. Medicare can take them into account as long as it is just does not take them into account as the only provider of information. This is the political deal that was crafted. But watch this carefully because if you are doing research on comparative effectiveness of medical treatment and you are a major payer, are you not going to pay attention to that research? This reduction in disproportionate share or DSH payments is kind of a big deal and something they have been talking about this for over two decades. That is sort of rationalizing the monies that go out for uncompensated care, out into the state because not every state actually uses there DSH payments for that purpose; so looking at $22 billion over ten years out of Medicare and $14 billion over ten years out of Medicaid. They want to reduce payments that are not “empirically justified”.

For hospitals, there are payment penalties for readmissions. Later in the Fall of 2012, they are going to quit paying for the 30 day readmissions for heart attack, heart failure, pneumonia. There are some unexpected provisions in this whole health care legislation, well, there are a lot of them throughout. But one that is kind of fun is, if you have heard about this, is it is going to require chain restaurants, those with more than 20 stores, and foods from vending machines to disclose the nutritional content on each item. So you are going to know how many calories are in that plate of nachos you are ordering at TGI Fridays. Oh wow, can you imagine how many that would be? {laughter}. So this is a big deal, this is the dream child of Margo Wootan at the Center for Science in the Public Interest. They really pushed hard for this provision. You see little pieces of things pushed by different people in this. Then the whole idea about tagging on student loans was a little bit unexpected. Do not ask me any questions about this because I do not really know much about this. {laughter}

What is my favorite provision? A 10% amount paid on indoor tanning services. {laughter}. For those of you who do not know, I chair the Department of Dermatology. Maybe my least favorite provision is 12 years of exclusivity on the makers of biologic medicines. We have a lot of patients who really really need
their biologics who cannot afford them and so having 12 more years of struggling with this is not something I look forward to.

Who are the winners in all of this? Well the uninsured clearly; the currently uninsured and uninsurable people are winners. Healthcare providers are winners, all kinds of healthcare providers, because we are going to be able to take care of patients who may have health insurance where they did not before. We all know how heartbreaking it is to take care of people who do not have access to healthcare, cannot afford their prescriptions and treatments, and cannot afford to come back and see us. So this is a big win for us in that way. Hospitals and Clinics; more patients, more people in the door, and more insured people. Pharmaceutical industry; more customers, 32 more million people to take their medications. Private insurers; they came out pretty good in all of this. They have a lot more regulation and things they cannot do but they have 32 million more customers. Employers, especially small employers that are offered the tax credits. Primary care providers. We do not see it, we just see these little 10% increases now, but if you read the tea leaves going forward, we are going to pay more for primary care and we are going to pay less for these high cost specialty areas. Young people are winners because they get to stay on their parents insurance up until the age 26. Seniors who take medication, particularly those who require many medications that end up in that donut hole. Those are all winners. And there are more.

Losers? Private insurers who now have to cover everybody regardless of their health condition, who have to tell us how much money they are spending on profits, who have to use plain language, and can not confuse us anymore. High income Americans who are going to pay more taxes and more taxes on their investment income, it is quite a chunk actually. Specialty providers who are going to take cuts in payment moving forward to rationalize how we pay for healthcare. Employers, especially large employers, 50 or more, they are going to have to pay a penalty if they do not offer coverage to their employees. Young people, losers right? Because they have to health insurance if they are young and healthy. We have to have all of them in the system. So you can argue that they are losers in a way; they cannot just not get it until they need it. Older Americans using the managed care plans will feel this for sure. If you had a really wonderful plan and you are going to have less benefits now, you are going to feel this. And generic drug makers who did not negotiate quite as well.

Guest:
[Statement inaudible] undocumented immigrants in this country.

Speaker:
They are losers because they did not get coverage, they are not included. I said that in the beginning. They are losers for sure.

Guest:
[Question inaudible]

Speaker:
Right.
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So what is not included in health care? The other thing I should have put on this list is all the stuff you hear about HIT. That all came from the Stimulus Fund. That is not healthcare reform, okay? All that coming down around adopting electronic health records and health information exchange is not part of healthcare reform really. It is related, it was in the aura, it was in the Stimulus Fund.

Guest:
How will the Medicaid program {statement inaudible} ... Aren’t state governments really a loser in this?

Speaker:
Well remember what I said before, the things I know for sure, is that there will be changes, right? This is a dynamic piece of work so you can see, and I will show you a little bit about Missouri and our Medicaid program in just a second and you will see how that will work.

So, the public plan is not included. Did everybody get that? If you do not remember anything else I say, there is no public plan in Health Reform. Significant liability reforms are not included. There is a little demo I will show you but provider payment reform was expected but it was not really included. A fix for the 21% Medicare cut for physicians that is looming. So it is hard to focus people on one and two percent cuts and things like that when they are looking at a 21% cut in Medicare that just gets extended month by month or two months by two months. So this whole fix to the sustainable growth rate methodology on how physicians get paid, that was not included. And major cost controls were not included, arguably. Hopefully you know that the death panels were not included and never existed in the first place.

Alright, so what about fear of lawsuits? A recent Gallup poll interviewed a lot of doctors across a lot of specialties and found that doctors think maybe a quarter of healthcare cost can be attributed to the practice of defensive medicine. And what was in health reform? Just a little bit, $50 million dollars which is budget dust in Washington. When I was in Washington anything that was $50 million and below we did not count it. So really it is budget dust. So $50 million dollars over five years grants to states to do alternative methods to resolve medical malpractice claims. Not much on medical liability and all this.

What about Missouri? We have a high an existing high risk pool and these are some details. Deductibles from $500 to $5,000. Out of pocket costs up to $5,000, which is too high for a lot of people honestly. It does not cover any cost incurred the six months before coverage. To make a new high risk pool for this new plan, a part of this $5 billion dollars, it has to be a separate high risk pool. We have to tell the feds we are going to do this on the state level by April 30th. Okay, this is what? April 28th. So in two days, we have to decide whether Missouri is going to administer our own high risk plan or, if we do not, the feds will do it. As I said previously, it cannot be used to cover people who are on our risk plan. So they would have to go naked for six month which is a big deal if you have a lot of chronic conditions. I really hope people do not do that but they might and so it is something that providers need to know about. It
cannot be used to cover patients currently covered and as many as 20,000 Missourians are expected to qualify.

What about Medicaid in Missouri? So again, 133% of the federal poverty level, 2014, expected to cover an additional 255,000 Missourians. Feds are going to pay 100% of it for the first three years only and so that is what this looks like. {picture} You can see the state costs on the top line, do not know if you can see that, but out at 2017 we start picking up part of the costs and the numbers are pretty big in this budget environment. Ninety-nine million, now these are real numbers on the state level, $99 million, $124 million, and you can see the federal costs for Missouri expansion of Medicaid. Again, it did not give any more money to the Medicaid program to run these expansions. So there is the pie showing how much the feds will cover, how much the state will cover, and 10 years of Medicaid expansions for eligible adults. There are a lot of people in Missouri.

What else about Missouri? We have this foundation funded, Health Literacy Missouri Initiatives. With these 255 new people on Medicaid, a lot of them are going to have health literacy challenges and we have quite a resource here in Missouri to help them. What about what is going on in the state assembly? We have people in the assembly who want to opt out of all this Health Reform legislation entirely. There was a Joint Resolution passed in the House and there is a Senate Joint Resolution on the calendar so there is a lot of talk in the state assembly saying, “Missouri’s Out”. There are a lot of other states that are having these discussions as well. Peter Kinder, our Lieutenant Governor, has joined a lawsuit challenging the constitutionality of the individual mandate on behalf of Missourians and they are using private money to do this. So these are things to watch. Many people think this is the piece that might go up up up up up in the court system in terms of a challenge.

In review, summarizing, in the next year children with preexisting cannot be denied, young people will be able to stay on their parents insurance, high risk people who have not been able to be insured can enter into a new high risk pool, and seniors in the Donut Hole get a $250 rebate. Tax credits for small companies, new rules for insurance companies, new coverage of preventive measures, and insurers have to put more money into benefits rather than profits. Adults and children cannot be denied in 2014, more people covered, Medicaid up to 133% of poverty, subsidies up to 400% of poverty, and state exchanges begin operating in 2014. Also in 2014, large employers not offering coverage get a penalty and individuals not carrying insurance face a penalty.

In summary, it is comprehensive health reform, there will be changes as it rolls out, provider payment reform will be messy, and politics and the election will continue to influence this higher process.

I will point you to our 8th Annual Health Policy Summit October 29th at the Hilton Garden Inn here in Columbia where we are going to be talking about Health Reform and social determinants of health. We also have quite a line-up of speakers. I am going to stop there and open it up for questions.

Thank you for your attention. {applause}