ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

The Affordable Care Act
You, Your Practices, Your Patients

Prepared for
The New England Ob/Gyn Society
April 2013

Presenter:

Lucia DiVenere
Senior Director for Government Affairs
American College of Ob-Gyns

No conflicts

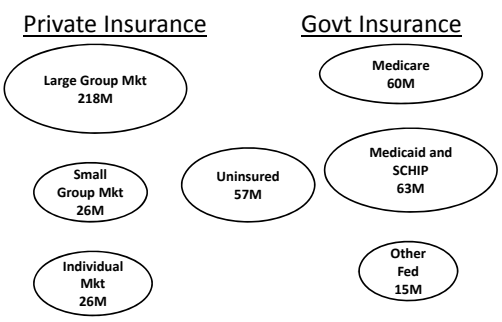
Special Thanks to
Dr. Mark DeFrancesco and
Dr. Patrick Sweeney

Objectives

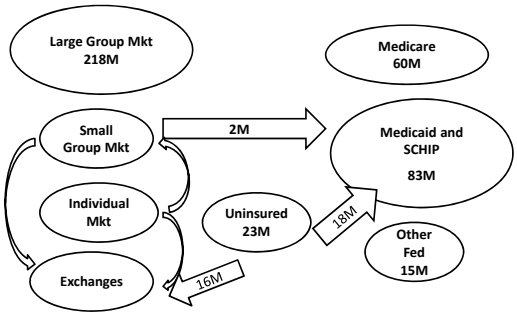
1. **Explain ACOG's position on the Affordable Care Act.**
2. **Describe three benefits of the ACA to ob-gyns and our patients.**
3. **Explain the relevance of 2014 in health care reform.**

I. ACA Context

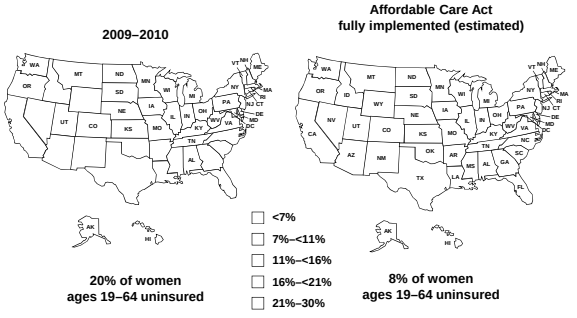
2019 Without the ACA



2019 With the ACA



Percent of Women Ages 19 to 64 Uninsured by State, 2009–2010 and Under the Affordable Care Act When Fully Implemented



Sources: Analysis of the March 2011 and 2010 Current Population Surveys by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund; uninsured rates are two-year averages. Estimates for the Affordable Care Act when fully implemented by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

ACOG's Position on the ACA

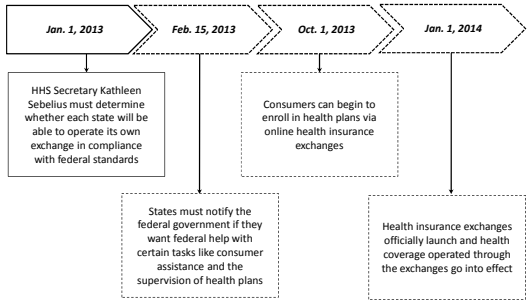
- **Didn't support enactment**
  Reluctant Opposition
  Our dual integrated missions: pts & ob-gyns
  SGR and MLR
  Stayed engaged, won important amendments
- **Don't support full repeal**
  Important women's health improvements
  Repeal of elements, incl IPAB

II. 2014: The Magic Year

State Exchanges – Health Insurance Marketplaces

- Up & running January 2014. Enrollment begins October 2013.
- If employer doesn't offer health insurance
- Individual and small market purchasers
- MCs will get their insurance here too
- Standard benefit packages
- Individual Mandate
- Insurance Protections

Health Exchange Implementation Timeline



Source: "Most Governors Refuse to Set Up Health Exchanges," Robert Pear, The New York Times, Dec. 14, 2012.

8

Patient Protection Insurance Reforms

Ins Co Prohibitions, vary on implementation

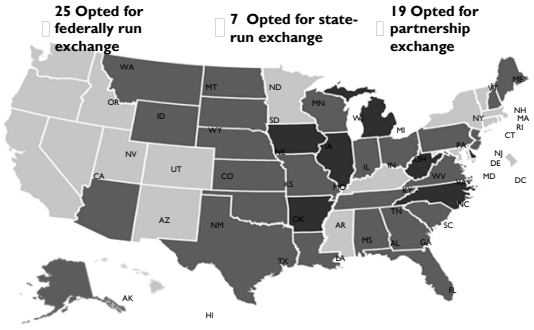
- no preexisting condition exclusions
- no gender rating differences
- no 9 month waiting periods
- no annual lifetime limits
- no rescissions unless for fraud

- **Ins Cos Required to Meet 80% MLR**

Insurance Reforms

- **Nearly 1 million adult children up to age 26 can join or stay on their parents' health insurance plan.**
- **Health care coverage for about 10,000 *insured* women is no longer subject to an annual lifetime coverage limit.**
- **Private insurers can't drop coverage, a change that will affect about 5.5 million *insured* women.**
- **Insurance companies are not allowed to deny coverage for preexisting conditions, which will help *insure* about 100,000 women.**

State Exchange Choices



*18 states and D.C.

Source: "Where the States Stand on Insurance Exchanges," The Advisory Board Company, Dec. 14, 2012. 4

State-Run Exchanges Face Participation Challenges

Coverage-Resistant Group	Obstacle to Participation
Young people	May feel that they are healthy and don't need coverage
People employed in farming, fishing, or forestry	May be more resistant to coverage because they work in high-uninsured industries
People living in rural areas	May have less access to health care providers and may be more difficult to reach when advertising coverage
People in certain minority groups	May be wary of government involvement

Exchanges cannot work to cover uninsured state residents unless most residents participate

States must spend big to publicize exchanges to coverage-resistant groups

- Washington State hired GMMB as part of a $9.3M advertising plan, Nevada hired KPS3 Marketing for $6M, and Hawaii hired Millici Valenti Ng Pack for $1.2M, all in hopes of increasing insurance participation

Source: "States Struggle With How to Sell Their Exchanges," Paige Winfield Cunningham, Politico, Jan. 2013.

7

Women's Health in Exchanges

- **Maternity care is an Essential Health Benefit**
- **Preventive care: All new plans, in and not in EX, must cover preventive services and immunizations without patient copays or deductibles.**

Contraceptive Accommodation

- **Exempts the health plans of religious employers**.
- **Accommodates other non-profit religious** orgs (including universities). Not required to contract, arrange, pay or refer for contraceptive coverage to which they object on religious grounds.
- Women covered through these orgs will have **contraceptive coverage without cost sharing provided through separate individual health insurance policies.**

22 Covered Prevention Svcs for Women

Red = FREE, No Copays or Deductibles

1. **Anemia screening** on a routine basis for pregnant women
2. Bacteriuria **urinary tract** or other infection screening for pregnant women
3. **BRCA counseling** about genetic testing for women at higher risk
4. Breast cancer **mammography** screenings every 1 to 2 years for women over 40
5. **Breast cancer chemoprevention** counseling for women at higher risk
6. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women

22 Covered Prevention Svcs for Women

7. **Cervical cancer screening** for sexually active women
8. **Chlamydia Infection screening** for younger women and other women at higher risk
9. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
10. **Domestic and interpersonal violence** screening and counseling for all women

22 Covered Prevention Svcs for Women

11. **Folic Acid** supplements for women who may become pregnant
12. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. **Gonorrhea screening** for all women at higher risk
14. **Hepatitis B screening** for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus **(HIV) screening** and counseling for sexually active women
16. Human Papillomavirus **(HPV) DNA Test**: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older

22 Covered Prevention Svcs for Women

17. **Osteoporosis screening** for women over age 60 depending on risk factors
18. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
19. **Tobacco Use screening** and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (**STI) counseling** for sexually active women
21. **Syphilis screening** for all pregnant women or other women at increased risk
22. **Well-woman visits** to obtain recommended preventive services

Standard Benefit Packages

Bronze 60% Actuarial Value
- $4,000 Medical Deductible
- $6,250 Out Of Pocket Maximum Contribution

Silver 70% AV
- $2,500 Med Ded
- $6,250 OOP Max

Gold 80% AV
- $500 Med Ded
- $5,000 OOP Max

Platinum 90% AV
- $0 Med Ded
- $5,000 OOP Max

III. Medicaid Expansion

- **MExp + other ACA = 48% Drop in Uninsured**
- **41% Increase in Medicaid Eligibles**
- **Big Change for Women: No pregnancy requirement for coverage under the expansion**

ACA:

1. **Beginning in 2014, everyone under 138% FPL is covered by M'aid.**
2. **Fed pays 100% for 2014 – 2016, no state cost for new eligibles.**
3. **Fed share phases down to 90% by 2020 and beyond.**
4. **States must expand their programs to cover this group**
5. **Or Lost ALL their Federal Medicaid funding**

SCOTUS Ruling: Overruled 4 and 5. State Option w No Penalty

Medicaid Expansion

1. **Which States will expand?**

2. **What happens to DSH cuts?**
   - **$18B 2014 – 2020.**
   - **Hospitals have less uncompensated care after M expansion.**

State Participation in Medicaid Expansion

Source: "Where Each State Stands on Medicaid Expansion," The Advisory Board Company, March 13, 2013.

23

Cost and Effect 2014 – 2019

Full M Expansion *Cost*

Fed Cost: $443.5B

State Cost: $ 21.1B

Full M Expansion *Effect*

27.4% drop in uninsured adults

1.4% inc in state spending

IV. *Pros* for Ob-Gyns

1. Direct Access for Ob-Gyns

- **State by State fight for 20 years. Still no DA in 9 states, limited DA in 16.**
- **National direct access law w no restrictions**
  - **Not tied to primary care designation**
  - **Not limited to # of visits**
  - **Not limited to certain services**

Pros for Ob-Gyns

2. Standardized HIT.

- Uniform standards:
  - **automatic reconciliation of EFTs and HIPAA** payment and remittance.
  - **improving the claims payment process.**
  - **consistent methods of health plan enrollment and claim edits.**
  - **simplify and improve routing of health care transactions.**
  - **electronic claims attachments.**

Pros for Ob-Gyns

3. Research into post partum depression

4. Ob-gyn participation in medical homes for women

5. Saved Ob-Gyn ultrasound from cuts

6. Defeated an effort to restrict obs to attending only high risk hospital deliveries

V. *Problems* for Ob-Gyns

1. Increased integration, hospital employment, and large practices. 24% of ob-gyn practices are solo.
2. Increased inclusion of lay midwives. In freestanding birth centers and through nondiscrimination requirements.
3. Abortion coverage.

Abortion 2014

- Applies only to plans in the State Exchanges, which begin in 2014.
- No federal subsidies or premium dollars may be used to purchase coverage for abortion.
- In every Exchange, at least 1 plan that does and 1 plan that doesn't.

Abortion, cont.

- Requirements on plans that cover ab:
  - Provide notice to enrollees and employers
  - Estimate cost of ab services per enrollee. Enrollees write 2 checks.
  - Separate accounts for funds collected and paid out
  - No plan in the Exchange can discriminate against an individual provider or facility because of its unwillingness to provide ab services.

Abortion, cont.

- **States hold ultimate trump card.**
- **Can pass legislation to prohibit any plan offering ab in the state's Exchange.**
- **Makes no changes to any existing state ab laws: parental notification, etc.**

VI. *Problems for All MDs:* Unfinished Business of the House of Medicine

Most Post 2014, when ACA turns its focus from coverage to paying for quality.

1. IPAB, the 15 person Medicare cost-cutting body. Our top repeal priority. Roe HR452

Problems for All MDs

2. Accountable Care Organizations: pro & con

- **Shared savings.**
- **Large groups, doctors and hospitals.**
- **3 year contract.**
- **Sufficient # of primary care providers to care for at least 5,000 Medicare patients.**
- ***Quality performance standards.***

Medicare ACOs

The Shared Savings program

Medicare continues to pay individual health care providers and suppliers for specific items and services as it currently does today (FFS). CMS develops a benchmark for each ACO against which its performance is measured to assess whether it qualifies to receive shared savings, or must absorb losses. It's up to the individual ACO to determine how to distribute any earned savings or losses among its providers.

The Advanced Payment ACO Model

Builds on the Shared Savings Programs , tests whether advance payments can help smaller practices and rural providers participate in the Shared Savings Program.

The Pioneer ACO Demonstration Model

Designed for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements.

In the first two performance years, the Pioneer Model tests a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program.

In year three, Pioneer ACOs that have shown savings over the first two years can move to a population-based payment model, a per-beneficiary per month payment amount intended to replace some or all of the ACO's FFS payments with a prospective monthly payment.

Problems for All MDs

3. **Value based payment modifier that will reduce payments to "low quality" physicians, and give those payment to higher quality docs.**
4. **Mandatory HIT, no more paper billing.**
5. **Public Physician Compare website.**
6. **No tort reform.**
7. **No SGR repeal.**

The FISCAL CLIFF

Sequester (AKA across the board cuts)

- **Medicare: 2% effective April 1 for MDs**

$11B Medicare (2% cut)

$5.2B SMI (MDs)

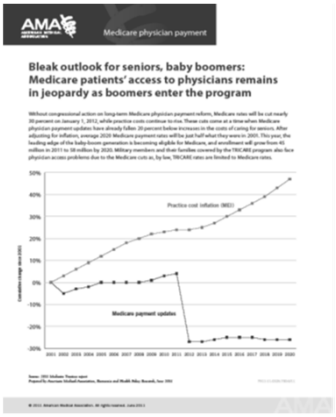
$5.8B HI

$0B Medicaid

SGR

It's BACK!
Dec. 31, 2013 deadline for action.

27% cut Jan. 1, 2014



Thank You and Questions

ldivenere@acog.org