Implementation of the Affordable Care Act: Opportunities for Collaboration and Partnership

Herb K. Schultz

2011 Annual Tribal Leaders' Annual Consultation Conference
"Putting Health Care First"
March 17, 2011

Priorities of HHS Secretary Kathleen Sebelius

Strategic Initiatives

- Transform Health Care
- Implement Affordable Care Act
- Implement the Recovery Act
- Promote Early Childhood Health and Development
- Help Americans Achieve and Maintain Healthy Weight
- Prevent and Reduce Tobacco Use
- Protect the Health and Safety of Americans in Public Health Emergencies

Priorities of
HHS Secretary Kathleen Sebelius

Strategic Initiatives

- Accelerate the Process of Scientific Discovery to Improve Patient Care
- Implement a 21st Century Food Safety Program
- Ensure Program Integrity and Responsible Stewardship

Inter-Agency Collaboration & Transparency

- **Web Portal – www.healthcare.gov/www.cuidadodesalud.gov**
  Comprehensive one-stop: Updated with valuable information on an ongoing basis.
- **Community Health Data Initiative (CHDI)**

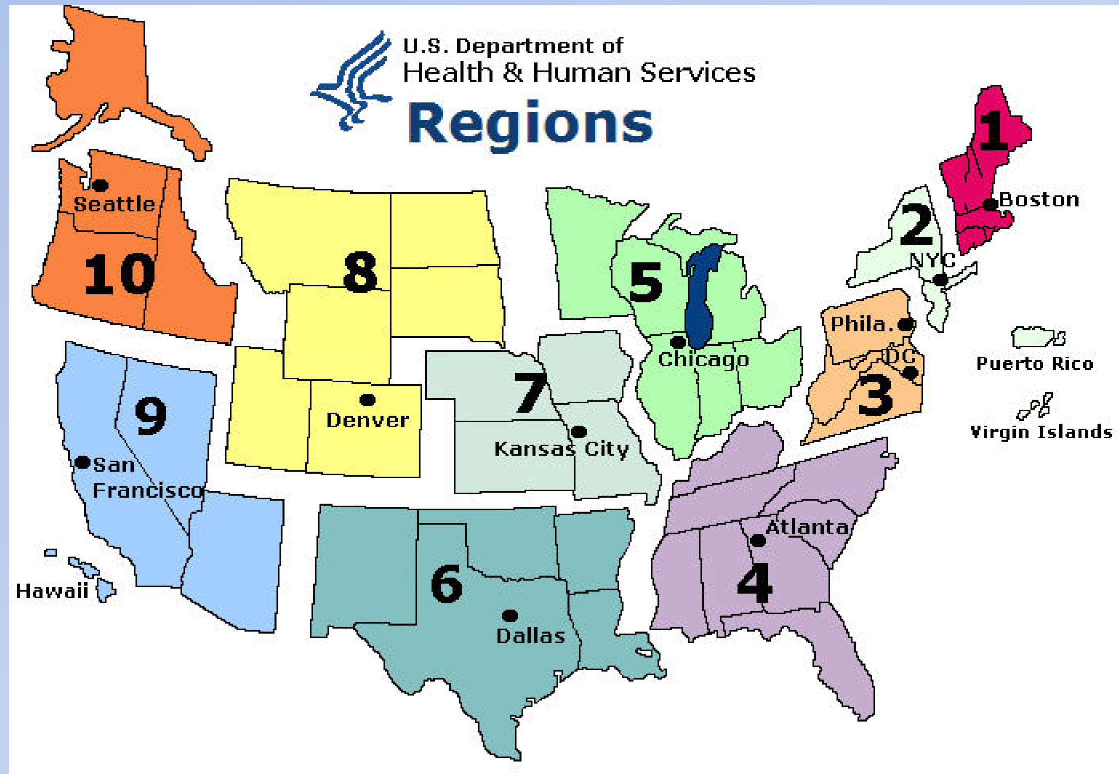
  Putting Data and Innovation to Work to help Communities and Consumers Improve Health. Massive collections of data will be made available in accessible formats that allow and encourage the fullest use of data, ensuring greater transparency of programs and greater accountability for results.

A New Reality

"After a year of striving, after a year of debate, after a historic vote, health care reform is no longer an unmet promise. It is the law of the land."

President Barack Obama
March 23, 2010

HHS Regional Offices



Office of the Regional Director

- Role of the Regional Director
  - Implementation of health care reform is the number one priority in Region IX (Arizona, California, Hawaii, Nevada, American Samoa, Guam, Commonwealth of the Northern Mariana Islands, Republic of the Marshall Islands, Federated States of Micronesia, and Republic of Palau).

Office of the Regional Director

- Agency Collaboration
  - Work across regional office and among all regions to:
    - **Collaborate and coordinate on issues;**
    - **Troubleshoot potential problems;**
    - **Partner on events and public affairs; and**
    - **Educate the public on the benefits of healthcare reform**
      - **Healthcare.gov**
      - **CuidadodeSalud.gov (Spanish)**
  - Represent & communicate health care policies.
    - **Work to implement reforms with State, Local, Tribal, and Territorial Officials and Non-Governmental External Stakeholders.**
  - Notification of grants and other funding opportunities.

Framework of Health Reform

- Three-legged stool:
  - Expanding Coverage and Access
  - Consumer Protections
  - Improving Quality and Lowering Costs
- 32 million more insured people by 2014 (92% of non-elderly population)
  - 16 million more Americans in Medicaid by 2014
  - 29 million Americans covered via new Exchanges

Progress-To-Date

- Providing affordable coverage to Americans without insurance due to pre-existing conditions (PCIP).
- Providing much-needed financial relief for employers so early retirees (55-64 years old) can get quality, affordable insurance
- 4 million seniors have received a $250 rebate to assist with the Medicare prescription donut hole.
- Providing small businesses (both for profit and non-profit) with under 25 employees are getting tax credits that allows them to provide coverage for workers.
- Ensuring resources to support state efforts to review premiums and guard against unreasonable premium increases.

Patients Bill of Rights
(Consumer Protections)

- Extends dependent coverage to young adults up to age 26.
- Prohibits lifetime limits and restricts annual limits on coverage.
- Protecting Insurance Premiums
  - Saving families up to $2,000 annually with their insurance premiums
- Saving our economy $230 billion over the next 10 years (Congressional Budget Office)

Patients Bill of Rights
(Consumer Protections)

- No pre-existing condition exclusions for children under age 19.
- Prohibits insurance companies from dropping coverage in absence of fraud.
- Removes insurance company barriers between you and your doctor.
- Eliminates co-pays and deductibles for preventative services (commercial or Medicare).

Individual Mandate

- Exemption for Tribes
- Other exemptions include:
  - Financial hardship;
  - Religious objections,
  - Without coverage for less than 3 months;
  - Incarcerated individuals; and
  - Cost exceeds 8% of individual’s income.

Employer Requirements

- 200+ Employees - Auto enrollment with employee opt out.
- Penalties – Two scenarios of assessments.
- Less than 50 Employees – exempt from penalties.
- Free Choice Voucher – less than 400% FPL and premium share 8+% to 9.8%.

Implementation Timeline in 2011

- Improving Quality & Lowering Costs
  - Medicare prescription drug discounts.
  - Delivery system reforms that raise quality & lower costs.
- Increasing Access to Affordable Care
  - Increases access to services at home and in the community.
  - Expands community health centers.
- Holding Insurance Companies Accountable
  - Adds transparency, strengthens State premium oversight, Medical Loss Ratio (MLR) review.

Implementation Timeline in 2012

- Improving Quality & Lowering Costs
  - Streamlining paperwork and administrative costs.
  - Connects Medicare payments to quality outcomes.
  - Establishes "Independent Payment Advisory Board."
- Increasing Access to Affordable Care
  - Establishes CLASS program, a voluntary option for long-term care insurance.

Implementation Timeline in 2013

- Improving Quality & Lowering Costs
  - Expanding Medicare authority to bundle payments.
- Increasing Access to Affordable Care
  - Increases Medicaid payments for primary care services.
  - Additional funding for the Children’s Health Insurance Program (CHIP).

Implementation Timeline in 2014

- New Consumer Protections
  - Eliminates discrimination due to pre-existing condition or gender.
  - Eliminates annual limits on coverage.
- Increasing Quality and Lowering Costs
  - Medicare delivery system changes and cost containment policies implemented.
  - Small business tax credit expansion.
- Increasing Access to Affordable Care
  - Work with States to establish State-based exchanges, tax credits.
  - Increasing access to Medicaid.

Planning for Exchanges

- 2010: Exchange planning grants, IT systems & federal policymaking.
- 2011: States enact legislation & federal rules issued.
- 2012: States notify HHS of intent to run exchanges and begin to qualify plans.
- 2013: Exchanges bring IT systems online and ensure operation before enrollment.
- January 1, 2014: Exchange-provided coverage is in effect, tax credits begin.

Essential Benefits in Exchanges

- Ensure appropriate balance between the services required;
- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and others;

Essential Benefits in Exchanges
(continued)

- Ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of age or expected length of life or present of predicted disability; and
- Require that plans providing essential benefits may not impose prior authorization or any limitations on coverage for emergency services; out of network emergency services shall have the same cost sharing as services in network.

Essential Benefits (Definition Process)

- DOL/“Typical” Employer - March
- DHHS/Institute of Medicine - Current
- DHHS – Notice of Proposed Rule – Fall 2011

Small Business

- Increases quality, affordable options.
- Small Business health care affordability tax credits.
- Security and stability that promotes entrepreneurship.
- Clarifies part-time worker definition.
- Increased access to workplace wellness programs.
- Simplifies cafeteria plans for small businesses.

Role of Public Programs Medicaid and CHIP

- Expands eligibility for Medicaid to include all non-elderly Americans with incomes at or below 133% of the Federal Poverty Level.
- The federal government will pay 100% of the cost of covering these newly-eligible individuals for the first three years of expansion.
- Maintains current funding levels for Children's Health Insurance Program (CHIP) through FY2015.

Role of Public Programs
Medicare

- Adds at least twelve years to the solvency of the Medicare Hospital Insurance trust fund.
- Fills the Medicare prescription donut hole and offers in 2010 a $250 rebate.
- Improves Medicare payments for primary care.
- Encourages reimbursing health care providers on the basis of value, not volume.

Tax Changes - Financing

- Limit deductibility of executive and employee compensation to $500k per individual for health insurance providers (2009).
- Tax of 10% for indoor tanning services (July, 2010).
- Annual fees on the pharmaceutical manufacturing section (2012).
- Excise tax on medical devices (2013).
- Annual fee on health insurance sector (2014).

Maternal and Child Health Services

- Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s) - sets asides 3% of funding for Indian, Tribal, and Urban Indians (I/T/Us), tribal entities are preferred.
- Creates grant programs to educate adolescents on abstinence and contraception – includes a 5% set aside (out of $65 million per year) for grants to Indian Tribes and Tribal Organizations.

Protections for American Indians

- Prohibits cost sharing for Indians below 300% of the FPL enrolled in any qualified health plan in the individual market through an Exchange.
- Indian, Tribal, and Urban Indian (I/T/U) providers are the payors of last resort for services provided to Indians by I/T/U for services provided through such programs.
- Facilities operated by the IHS and Indian, Tribal, and Urban Indian facilities, would be added to the list of agencies that could serve as an “Express Lane Agency” under sec. 1902(e)(13) of the Social Security Act.
- Makes permanent reimbursement for all Medicare Part B services furnished by Indian Health Service hospitals and clinics.

Affordable Care Act

Benefits for American Indians and Alaska Natives

- Provides more choice – to use the IHS, to purchase affordable health care coverage, and/or access coverage through other sources (Medicare, Medicaid, CHIP) if they are eligible.
- Tribes may purchase insurance for their employees or their members, and can benefit from more affordable options and reduced costs.
- Improved coverage and quality with IHS hospitals and clinics.
- Allow IHS, Indian tribe or tribal organization, and urban Indian program spending to count toward the Medicare Part D out of pocket threshold, or coverage gap.

Affordable Care Act

Benefits for American Indians and Alaska Natives

- Participation in the Health Insurance Exchanges.
- Exempt from individual responsibility assessments.
- Value of health services/benefits from IHS-funded health programs or Tribes will be excluded from an individual's gross income so it cannot be taxed.
- Expands Medicaid coverage starting in 2014 to individuals up to 133% of poverty level (~$30,000 for a family of 4).

ACA Grant Opportunities

- Title III – Improving the Quality and Efficiency of Health Care
  - Authorizes the Secretary to award grants that will improve the quality of health care.
  - IHS and tribal health programs are eligible entities for several grant programs:
    - Collection and analysis of data for quality and resource use measures;
    - Identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services;

ACA Grant Opportunities
(continued)

- Establish community-based interdisciplinary, inter-professional teams to support primary care practices;
- Pilot projects for innovative models of regionalized & comprehensive emergency care and trauma systems;
- IHS, Tribal and Urban Indian trauma centers to assist in defraying substantial uncompensated care costs and to further the core missions of such trauma centers.

Promoting Prevention and Improving Public Health

- Invests in a national prevention and public health fund and strategy.
- **Prevention and Public Health Fund ($1.25 billion)** for 2010 and 2011 for prevention and to expand primary care workforce.
- Removes financial barriers to preventive care and encourage prevention.
- Promotes prevention and wellness for Seniors and older Americans.
- Nutrition labeling.

Promoting Prevention and Improving Public Health

- Educates individuals and communities on disease prevention and health promotion.
- Awards grants that promote individual community health.
- Promotes workplace wellness.
- Improves access to preventive services for Medicaid participants.
- Other individual incentives.

AI/AN Disease Prevention

- Assistant Secretary for Indian Affairs will be part of the National Prevention, Health Promotion and Public Health Council;
- Education and outreach campaign regarding preventative benefits, including Indian health programs;
- Requires the Secretary to ensure American Indians/Alaskan Natives are targeted in the Oral Healthcare Prevention activities; and
- Indian tribes are eligible to participate in creating healthier communities.

Investing in Our Nation's Health Care Workforce

- Invests in the National Health Service Corps.
- Reauthorizes and improves scholarship and loan repayment programs.
- Increases workforce diversity.
- Develops workforce planning and analysis.
- Incentivize primary care and practice in underserved areas.

A New Focus on Education and Worker Training

- Increasing access to providers in underserved areas.
- Focus on career training.
- Expanding tax benefits to health professionals working in underserved areas.
- Building primary care capacity through Medicare and Medicaid.
- Providing financial assistance for students.
- Making health care education more accessible.

Tribal Health Care Workforce

- Includes employees of tribal public health agency in definition of “allied health professional”;
- Increasing the supply of health care workforce in tribal health agencies;
- Award demonstration grants to address health professions workforce needs – at least 3 of the grants will be awarded to eligible entity that is Indian tribe, tribal organization or tribal college/university; and
- Authorizes appropriations for grants to FQHCs.

Let's Move! Campaign

- The Regional Offices of Health and Human Services are working with cities and towns to join the First Lady's Office to eliminate childhood obesity in a generation
- Pillars of Campaign:
  - Help Parents Make Healthy Family Choices
  - Create Healthy Schools
  - Provide Access to Healthy and Affordable Food
  - Promote Physical Activity

2011 Tribal Consultation

- Thursday, March 11 – Las Vegas
- Tribal/Federal /State Interaction
- Follow-Up Meetings – CA/AZ/NV
- CMS/HRSA/ACF/AOA

Contact Information

Herb K. Schultz

Regional Director, Region IX

U.S. Department of Health & Human Services

90 Seventh Street, Suite 5-100

San Francisco, CA 94103

(415) 437-8500 – Main Number

(415) 437-8502 – Direct Number

(415) 265-7049 – Cell Phone

Herb.Schultz@hhs.gov

HHS Website: www.hhs.gov