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An Internist's Practical Guide to Understanding Health System Reform

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How to use this guide:

This document is intended to serve as a practical resource guide for internists on health system reform legislation, the Patient Protection and Affordable Care Act (ACA), as enacted in March 2010. For easy viewing, the Guide is organized on-line by the year in which a policy issue is to be implemented, making it easily apparent which new policies may be impacting physicians/patients immediately. Simply click on the policy provision of interest, in any given year, and one will find a summary of that provision of law, in an easy "frequently-asked-questions" format. Additional resources and information on each topic are also included in each summary.

Summary of Key Health System Reforms Affecting Patients

The following summary of key provisions under the Patient Protection and Affordable Care Act (ACA) affecting patients is written in language that is intended to be understandable by much of the general public. Physician users of this guide have the option of printing out only this one-page summary and making it available to their patients.

Became Effective 2010:

- If you get sick or hurt, your insurer can no longer drop your coverage.
- Your children can remain on your health insurance plan until they turn 26.
- If you have not been able to get health insurance because of an on-going medical condition, you can join a "pool" where you can get insurance. You can also receive added financial help. You can join this "pool" until 2014. At that time, no one can be turned down for insurance because of an on-going medical condition.
- Your children up to age 19 with on-going medical conditions cannot be turned down for health insurance.
- If you are sick for a long time, your insurance company cannot limit the dollar value of your benefits over the course of your life.
- If you have Medicare prescription drug coverage, you could have received $250 from Medicare in 2010 to help with the cost of your drugs. To receive the $250, you must have been in the "donut hole." The "donut hole" is a gap in coverage where you must pay the total cost of your prescription drugs.
- Insurers writing new policies must pay for recommended preventive care for adults, infants, children and teenagers, including recommended shots to fight off diseases; and additional services for women, such as mammograms.
- If you have health insurance and have stopped working before age 65, you may be protected by a program that provides financial help to employers who have many health care claims from early retirees.
- If you have health insurance, your insurance company must tell you how much of your premium goes toward medical care and how much goes toward administrative and marketing costs.
- If you are a small company with no more than 25 employees, you may be able to get tax credits to help buy insurance for your employees. Average annual wages must be less than $50,000.

Became Effective 2011:

- If you have Medicare prescription drug coverage and are in the "donut hole," brand-name drugs cost 50 percent less and generic drugs cost 7 percent less.
- If you have Medicare coverage, you can have a physician or other qualified health professional evaluate your health each year, paid for by Medicare.
- Your health plan is required to give you money back if they do not direct 85 percent of premium costs to medical care. For small insurers and individual plans, it is 80 percent.

Effective 2014:

- If you live in the U.S. legally, you cannot be turned down for health insurance for any reason.
- No one can be turned down for health insurance because of an existing medical condition.
- If you live in the U.S. legally, you may be able to get tax credits from the federal government to help with the cost of health insurance.
- If you live in the U.S. legally, you have to buy health insurance or pay a small penalty. The federal government will not send you to jail if you do not buy insurance.
- If you do not have health insurance through your job, you will be able to shop for reasonable coverage in a new market-place called a "health exchange."
- If you work for a large company that does not provide you with health insurance, the company may have to pay a penalty. Small companies – those with fewer than 50 employees – would not have to pay the penalty.
- All children, parents, and adults with no children below certain income levels will have access to health insurance under Medicaid. You cannot have Medicare coverage at the same time.

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Summary of Key Provisions of Health System Reform Affecting Internists

BECAME EFFECTIVE 2010
Coverage
Provides sliding scale tax credits to help businesses (2010-2013) purchase health insurance for their employees. In order to be eligible for tax credits, businesses must employ no more than 25 people and average annual wages must be less than $50,000. Small employers have to contribute at least 50 percent of the cost of employees' health insurance to receive tax credits.
Requires all health plans to provide affordable and non-discriminatory coverage to children up to age 19 with pre-existing conditions.
A temporary national high risk pool has been created to provide coverage for individuals/adults with pre-existing medical conditions starting in June 2010 until Jan 1, 2014, when the universal ban on pre-existing exclusions will go into effect.
Requires all new health plans to provide evidence-based preventive services with no cost-sharing, with the ability to compete by offering more benefits; existing individual and employer-sponsored insurance plans are exempt, but they are required to: extend dependent coverage to individuals up to age 26, eliminate lifetime limits on coverage, restrict use of annual limits on essential coverage, cannot rescind coverage, and must eliminate waiting periods greater than 90 days.
Workforce
Increases funds for the National Health Service Corps (NHSC), which includes a guaranteed funding stream for a portion of those funds. The law includes an increase in full-time awards for the NHSC from $35,000 to $50,000 per individual and a new part-time award program.
Allows up to 50 percent of the time spent teaching by an NHSC member to be counted towards his or her service obligation. The provision does not necessarily apply to individuals who are fulfilling their NHSC service requirement through work in private practice.
Increases funding for Health Professions programs under Title VII. Specifically, the new law increases the award amounts for the Faculty Loan Repayment Program from $20,000 to $30,000. The program is designed to assist health professionals from disadvantaged backgrounds in pursuing academic careers.
Increases funding for the Scholarship for Disadvantaged Students Program, also under Title VII, which provides scholarships to full-time, financially needy students who are from disadvantaged backgrounds and are enrolled in health professions and nursing programs.
Creates a national workforce commission in 2010 to determine whether the demand for health care workers is being met; to identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address such barriers; and to encourage innovations to address population needs, constant changes in technology, and other environmental factors. The Commission is to analyze and make recommendations for eliminating barriers to entering and staying in careers in primary care, including physician compensation. The Commission is not yet operational due to lack of funding.
Provides grants and Graduate Medical Education funding for Teaching Health Centers to train primary care physicians in community based settings, beginning in 2010.
Creates the Primary Care Extension Program that helps to educate and provide technical assistance to primary care physicians and other health professionals including general internists currently in practice about evidence-based therapies, preventive medicine, health promotion, chronic disease management and mental health and in developing the capabilities to become Patient-Centered Medical Homes.
Authorizes student loan repayment tax relief by including state funded loan repayment programs as eligible for exemption from federal income taxation.
Payment and Delivery System Reforms
Creates a new public-private partnership to fund and coordinate research on comparative effectiveness to inform clinical decision-making.
Creates a new Medicare and Medicaid Center on Innovation to accelerate pilot-testing of innovative payment and delivery system reforms, including Patient-Centered Medical Homes. The Center has funds to launch a variety of pilots, and the law requires that they put priority on models to reform primary care payment systems, with consideration given to the medical home as one of the models tested in the Center.
Provides a grant program to establish community-based interdisciplinary, inter-professional teams to support primary care practices. The health team must establish contractual agreements with primary care clinicians to provide support services and support patient-centered medical homes. A clinician who contracts with a care team shall provide a care plan to the care team for each patient participant; provide access to participant health records; and meet regularly with the care team to ensure integration of care.

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BECAME EFFECTIVE 2010 (continued)
Provides direction to the Secretary of Health and Human Services (HHS), largely carried out through CMS, for identifying and correcting mis-valued services; and requiring the Secretary of HHS to establish a process to validate relative value units for physician fee schedule services.
Increases the discount that applies to the technical component payment for advance imaging services on consecutive body parts during a single session from the current 25 percent rate set by CMS in 2006 to 50 percent beginning July 1, 2010.
Medical Liability Reform
Extends medical liability protections under the Federal Tort Claims Act to officers, governing board members, employees and contractors of free clinics.

BECAME EFFECTIVE 2011
Coverage
Requires, among other things, that drug manufacturers provide a 50 percent discount on brand name prescriptions while the beneficiary is in the Medicare coverage gap known as the "donut hole."
If an insurer directs less than 80 percent of an individual insurance or small group plan's premium or 85 percent of a large group plan's premium to clinical and quality care improvement costs, the insurer is required to refund the difference to the enrollee.
Workforce
Redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots for primary care and general surgery. Sixty-five percent of the slots must be redistributed to primary care and general surgery.
Payment and Delivery System Reforms
Provides a 10 percent Medicare bonus payment on top of the fee schedule payment for designated primary care services—office, nursing home, and custodial care visits—furnished by primary care physicians beginning Jan. 1, 2011-2015. The law defines primary care physicians as those practicing in the following specialties: general internal medicine; family practice; geriatrics; and pediatrics. The law does not include hospital visits in the bonus. Also, in order to qualify, 60 percent of a primary care physician's total Medicare allowable charges must be for office, nursing home, home and custodial care visits. This means that some primary care internists may not qualify if more than 40 percent of their total Medicare allowed charges are for services other than the designated primary care services.
Establishes a Medicaid state plan option, called Health Homes, to address specifically the needs of beneficiaries with chronic conditions beginning in January, 2011.
Beginning on January 1, 2011, establishes a new benefit through which beneficiaries are eligible to receive an annual wellness visit that focuses on establishing a personalized prevention plan. Also effective on January 1, eliminates co-payments, co-insurance and deductibles for most Medicare-covered preventive services, meaning that Medicare pays the full allowable payment amount for such services.
Creates grants to eligible entities to support community-based collaborative care networks for low-income populations. The grant funds can assist low-income individuals to access and appropriately use health services, enroll in health coverage programs, and obtain a regular primary care clinician or a medical home.
Medical Liability Reform
Authorizes $50 million in demonstration grants (2011-2015) for state innovations in medical liability reform.

BECAME EFFECTIVE 2012
Coverage
Develops reporting requirements for health plans in order to improve health outcomes through the implementation of activities such as: quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model for treatment or services under the plan or coverage (to occur no later than two years after enactment of law).
Workforce
No significant new reforms but many of the reforms begun in 2010 and 2011 continue.
Payment and Delivery System Reforms
Instructs the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2012, a voluntary shared savings (accountable care) program that promotes accountability for services delivered to a defined Medicare fee-for-service (FFS) patient population.
Promotes simplification of the administrative burden endured by physicians by requiring a study to identify administrative transactions for which establishing standard processes would reduce physician practice burden, among other things.

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BECAME EFFECTIVE 2012 (continued)
Medical Liability Reform
No significant new reforms but reforms begun in early years will continue.

EFFECTIVE 2013
Coverage
No significant new reforms, although 2013 will be the year that most states will need to develop implementation plans to support the coverage expansions that take effect in 2014.
Workforce
No significant new reforms but many of the reforms begun in earlier years will continue.
Payment and Delivery System Reforms
Raises Medicaid payments (2013-2014) for evaluation and management services and immunizations provided by internists, family physicians, pediatricians, geriatricians and internal medicine and pediatric subspecialists, and to no less than the applicable Medicare rates, fully paid for by the federal government.
Instructs the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2013, a voluntary national pilot program focused on payment bundling that aligns incentives to promote integrated care and joint responsibility among providers across the continuum during an episode of hospitalization under fee-for-service Medicare for a defined set of conditions.
Beginning in 2013, additional federal subsidies to Medicare Part D beneficiaries will be gradually phased-in for brand-name drugs in the Part D coverage gap reducing the beneficiary co-insurance rate in the gap from 100 percent to 25 percent by 2020 – in addition to the 50 percent manufacturer brand discount that began in 2011.
Promotes simplification of the administrative burden endured by physicians by standardizing the process through which practices verify patient insurance eligibility and check on the status of claims submitted to receive payment for services rendered, among other things.
Medical Liability Reform
No significant new reforms but reforms begun in earlier years will continue.

EFFECTIVE 2014
Coverage
Begins to expand coverage to up to 30 million previously uninsured people—resulting in coverage for about 94 percent of all legal residents—by filling gaps in our current system. How many people will gain coverage will depend in large part on how many states accept federal dollars to expand Medicaid.
Provides sliding scale tax credits to help individuals and families buy coverage. The law provides tax credits for individuals, with incomes of 133 percent to 400 percent of the federal poverty level, to purchase health insurance. 133 percent of the federal poverty level equates to $14,856 for an individual and 30,657 for a family of four (2012 figures—will be updated by 2014), 400 percent equates to $44,680 for an individual and $92,200 for a family of four.
Provides tax credits to eligible small businesses of 50 percent of the employer's contribution (35 percent for non-profit firms) towards their employees' health insurance premium.
Beginning January 1, 2014, provides funding for states to expand Medicaid to all persons with incomes up to 133 percent of the Federal Poverty Level. Eligible persons include those individuals earning up to $14,856 or $30,657 (2012 figures—will be updated by 2014), for a family of four. The federal government will reimburse states for 100 percent of the cost of expanding Medicaid to new beneficiaries from 2014-2016, 95 percent of costs in 2017, 94 percent of costs in 2018, 93 percent of costs in 2019, and 90 percent of costs in 2020 and subsequent years. Because of a 2012 Supreme Court ruling, the decision to expand Medicaid and accept the federal dollars is completely optional for states.
Requires individuals to buy coverage or pay a penalty if they do not, with hardship exemptions.
Beginning Jan. 1, 2014, requires large employers to contribute to coverage or pay the costs associated with subsidies to their employees if they do not. Employers with more than 50 employees will be assessed a fee of $2,000 for every full time employee over 30 employees, provided they have at least one employee who receives a premium credit through a health insurance exchange. Employers who provide inadequate coverage and have at least one employee receiving Exchange-based coverage credits will also be required to pay a fee.
Creates health exchanges to offer one-stop-shopping for qualified health plans and to spread insurance risk so as to provide eligible individuals and small businesses with access to more affordable premiums offered by participating plans. The law will require each state to offer health insurance for their residents through a state-based exchange by 2014. If states have not implemented an exchange by this year, or if the Secretary determines by January 1, 2013, that a state has not made sufficient progress toward this goal, the Secretary would establish an exchange within that state.

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EFFECTIVE 2014 (continued)
Requires the Department of Health & Human Services to develop a strategy to provide health plans within the health exchanges that begin in 2014 with increased reimbursement or other incentives for implementing activities such as: quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through use of the medical home model for treatment or services under the plan or coverage.
Encourages employers to develop preventive care and wellness programs for their employees.
Workforce
Improves Income-Based Repayment (IBR) plan option for borrowers of federal student loans.
Payment and Delivery System Reforms
Increases the advanced imaging service assumed equipment use rate as a result of enactment of the American Taxpayer Relief Act of 2012 (H.R. 8) in January 2013. This will result in a reduction in how much Medicare pays physicians for advanced imaging.
Establishes an Independent Payment Advisory Board (IPAB), which must submit Medicare cost reduction proposals to Congress, beginning in 2014, for each year when Medicare costs are projected to increase faster than the 5-year average of the consumer price index (CPI).
Promotes simplification of the administrative burden endured by physicians by standardizing the process by which health plans: make electronic payment for claims, known as an electronic funds transfer; and communicate payment decision related to claims, known as remittance advice.
Medical Liability Reform
No significant new reforms but many of the reforms initiated in earlier years will continue.

EFFECTIVE 2015 AND BEYOND
Coverage
No significant new reforms but many of the reforms initiated in previous years continue.
Workforce
No significant new reforms but many of the reforms initiated in previous years continue.
Payment and Delivery System Reforms
Includes penalties on physicians who do not successfully report on evidence-based quality measures. (2015 and beyond)
Beginning in 2015, implements a value-based payment modifier to adjust Medicare physician fee schedule payments based on the quality and cost of care physicians deliver to Medicare beneficiaries. This modifier will affect some physicians (in larger groups) in 2015 but by 2017, the modifier will apply to all physicians. (2015 and beyond)
Promotes simplification of the administrative burden endured by physicians by standardizing the process by which health plans: approve referrals, certifications, and authorizations; and receive electronic submission of supporting information that is attached to a claim, known as a claim attachment. (2016)
Medical Liability Reform
No significant new reforms but many of the reforms initiated in previous years continue.

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