

In

What Is To Be Done!
Thriving in the Age of Obamacare
Presented to the
American Society for Automation in Pharmacy
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Outline

1. PPACA (Obamacare)
2. Other Health Reform
3. Impact on Public and Private Payers
4. Impact on Employers
5. Impact on Automated Pharmacy
6. Opportunities

Obamacare is not the last Health Reform It Is The Most Recent Health Reform

- **History Matters!**
 - **Health IT and Automation Succeeded Bricks and Mortar as Key Structural Component**
 - **Donabedian: The Definition of Quality and Approaches to its Assessment**
 - **HITECH and PPACA = Hill Burton**

- **Patient Protection and Affordable Care Act (PPACA)**

AKA Health Reform, Themes Include

- > **Access, 30 Million New Covered Lives**
- > **Insurance Market Reforms**
- > **Cost Control**

Key Health Reform Issues Include:

- 1. Transformation of Health Coverage Market**
 - a. Massive Increase in Medicaid**
 - b. Government Definition of Benefit Packages and Premiums**
 - c. Shift from Employer Based Coverage to Health Insurance Exchanges**
 - d. Employer and Individual Mandates**
- 2. Limitations on Health Plan Spending**
- 3. Minor Provider Changes such as Accountable Care Organizations and Medical Homes**
- 4. Leftover ARRA/HIPAA issues like 5010 and ICD-10 Implementation.**
- 5. Legal and Legislative Challenges.**

Medical Loss Ratio: The Battleground

- **Requires medical loss ratio reporting for health plans and rebates**
- **Report must include premium amount spent on**
 - (1) clinical services,**
 - (2) activities to improve quality,**
 - (3) all other non-claims costs.**
- **Regulations using NAIC develop definitions and standardize methodologies**
- **Large Group MLR: 85%**
- **Small Group and Individual MLR: 80%**
- **What is Automated Pharmacy? PBM? Clinical or Administrative?**

PPACA and Medical Loss Ratio Impact on

Pharmacy Management and Automation

Five categories of activities in addition to payment for Clinical Services, characterized as improving quality, and therefore Medical loss:

- 1. Activities to Improve Health outcomes**
- 2. Activities to Prevent Hospital Readmissions**
- 3. Activities to Improve Patient Safety and Reduce Medical Errors**
- 4. Wellness and Health Promotion Activities**
- 5. Health Information Technology to Improve Health Care Quality**
- 6. All HIT Investment to Implement 1 – 4.**








➤ **Qualified Health Plans**

➤ **Mandatory Benefits**

- **Each QHP must offer a core set of “essential health benefits” to be set by HHS.**
 - **Enrollees allowed to select their PCP, or pediatrician for children, from among any available participating PCP.**
 - **Prior authorization and increased cost sharing on emergency services prohibited.**
 - **Plans can’t require authorization or referral for OB/GYN services by a participating specialist in these areas.**
 - **States responsible for increased costs from higher mandatory benefits under Medicaid expansion**
- EMPLOYERS AND INDIVIDUALS PAY FOR EVERYTHING ELSE.**

Accountable Care Organizations

Group of primary care providers, specialists and/or hospital and other health professionals who manage the full continuum of care and are accountable for the *total costs and quality of care for a defined population*

-  **A minimum population eligible for membership > 5,000 members**
 -  **Full complement of medical services with the exception of transplants**
 -  **Formal legal structure to receive and distribute reimbursement**
 -  **An adequate network of ACO professionals to provide total care to the defined population**
 -  **Defined relationships with hospitals and physicians**
 -  **Deploy an IT platform supporting the capture and electronic exchange of**
clinical information across the Ambulatory, Inpatient and Ancillary (lab, imaging, eRX, etc.) settings for the high volume ACO Professionals
 -  **Electronic medical record system for improved coordination of care**
- Kaiser, Geisinger, et. seq. The only structure that has ever worked to improve quality and manage cost.**

Health Information Exchanges

A Noun, A Verb and the Future of Health Care.

> In 2014, the Market for Health Coverage.

Key: Understand Market Rules and Opportunities

> Essential to Risk Management for anyone transmitting data in the health care system

> Incentives on Employers to Dump Employees onto the Exchanges.

A Majority of States are not implementing State Based Exchanges.

PPACA does not provide subsidies from Federal Exchanges

➤ Exchanges

➤ Who can purchase through the Exchange

- Any person qualifies for individual Exchange QHP coverage if he or she lives in the State, is not incarcerated (except for those awaiting disposition of charges) and is a citizen or an alien anticipated to be lawfully in the country for the enrollment period.
- A small employer with an ERISA group health plan can participate in the Exchange if all full-time employees are eligible for coverage.
- "Small group" means an employer that in the previous year averaged 1 or more employees but not more than 100.
- Large groups may not participate in state Exchanges until 2017.
- Starting in 2017, a State may permit insurers to provide coverage for large employers through the Exchange.

Recent Guidance From HHS on Obamacare/HITECH Implementation (and other things)

Final Privacy and Security Regulations

ACOs Booming

DEA Proposed Rule on Controlled Substance Disposal

Operating Rules for Exchanges

NPRM on PPACA Insurance Regulations

Meaningful Use Stages 2 and 3.

➤ **Cost of PPACA,**

- **Or, the Myth of Budget Reduction or Neutrality**
- **Paid for by Health Plan Taxes:**
 - **In 2018, 40% excise tax on plan value that exceeds \$10,200 / \$27,500**
 - **In 2014, annual fee on plans based on an insurer's net premiums (self-insured plans are exempt)**
 - **\$2 per enrollee tax on insurance plans, including self-funded insurance plans, to fund the bill's comparative effectiveness fund (gov't plans, including Medicaid managed care plans, are exempt)**
 - **Taxes on devices, drugs, etc.**
 - **COB vs. Chief Actuary**

- **Implications for Private Payers**
 - **Structured System**
 - **Rules on Rates, Risk Pools, Guaranteed Renewability, Guaranteed Renewal**
 - **Mandated Benefits and MLR**
 - **Differentiation: Services**

- **Implications for Public Payers/States**
 - **Medicaid Expansion or Not**
 - **Destroys working state programs**
 - **The worst of all possible worlds**
and
 - **Sets up battles among competing state priorities.**

- **Implications for Automated Pharmacy**
 - **Integration with Systems Being Implemented**
 - **Integration with HUM and WCUM Systems**
 - **Integration with Employer Based and Convenient Care Clinics**
 - **Opportunity to Demonstrate Value**
 - **Future Battles or Collaboration with Traditional Pharmacy Interests**

- **Implications for Purchasers
(employers and individuals)**
 - **What will it cost?**
 - **Choices for employers and individuals?**
 - **How does Automated Pharmacy fit?**
- **Questions? Gripes? Complaints?**

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