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Summary of Major Provisions Affecting Pulmonary, Critical Care and Sleep Medicine in the Affordable Care Act

Implementation Calendar

2010	<ul style="list-style-type: none"> • Elimination of Pre-existing condition exclusions for children • Extension of dependant insurance coverage to individuals up to age 26 • Elimination of lifetime insurance coverage limits • Prohibition of insurance coverage rescissions. • Set up of Medicare and Medicaid Center on Innovation • Preventive Services Coverage with no cost-sharing • Set up of Prevention and Public Health Fund • Set up of Workforce Advisory Commission (delayed due to lack of funding)
2011	<ul style="list-style-type: none"> • Creation of High-Risk Pools • Adjustment of Insurance Medical-Loss-Ratio (MLR) • Annual Wellness Visits
2012	<ul style="list-style-type: none"> • Essential Health Benefits to be defined • Creation of Accountable Care Organizations • Expanded Health plan reporting requirements
2014	<ul style="list-style-type: none"> • Employer Mandate on insurance coverage in effect • Set up of Health Insurance Exchanges • Medicaid Expansion • Set up of Independent Medicare Payment Advisory Board • Standardized electronic insurance claims and payment decisions
2015	<ul style="list-style-type: none"> • Electronic standardization of insurance processes • Provider penalties for non-reporting of quality measures

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EXPANSION OF INSURANCE COVERAGE
<p>The centerpiece of the Affordable Care Act (ACA) is the expansion of health insurance coverage to an estimated 30 million Americans. The main mechanisms for expanding coverage are through an employer mandate, setup of health insurance exchanges, subsidies for exchange consumers to buy coverage, Medicaid expansions and tax credits for small businesses.</p>
<p>Employer Mandate – 2014 Employers with more than 50 employees will be required to provide health coverage for full-time workers or pay a fine of \$2,000 per employee.</p>

<p>Health Insurance Exchanges - 2014</p> <p>The ACA requires states to offer insurance coverage for residents through a state-based exchange. In states that do not setup their own exchange, the Health and Human Services (HHS) Secretary will create one. Exchanges will serve as a competitive marketplace where individuals and small businesses will be able to choose from private health insurance plans.</p>
<p>Essential Health Benefits - 2012</p> <p>A proposed rule on the essential health benefits (EHB) that must be covered by insurance plans in health insurance exchanges will be issued before the end of 2011. Indications are that the EHB package will not specify all services but will require coverage in the following benefit areas: outpatient, hospital, emergency, maternal, newborn and children's care, prescription drugs, mental health and substance abuse treatment, rehabilitation, labs, prevention and wellness. It is expected that the EHB will resemble a mid-tier health plan.</p>
<p>Medicaid Expansion - 2014</p> <p>All persons up to 133% of the federal poverty level become eligible for Medicaid on January 1, 2014. Eligible persons are those earning up to \$14,404 or \$29,327 for a family of four (these amounts will be updated by 2014).</p>
<p>INSURANCE REFORMS</p>
<p>Elimination of Pre-existing Condition Exclusions for Children - 2010</p> <p>All health plans must provide non-discriminatory coverage to children up to age 19 with pre-existing conditions.</p>
<p>Other Insurance Reforms - 2010</p> <ul style="list-style-type: none"> • Extension of dependant insurance coverage to individuals up to age 26 - 2010 • Elimination of lifetime insurance coverage limits. • Prohibition of insurance coverage rescissions.
<p>High-Risk Pools - 2011</p> <p>A temporary national high-risk pool to provide coverage for adults with pre-existing conditions has been created. It will operate until January 1, 2014, when the ban on pre-existing condition exclusions and insurance exchanges go into effect.</p>
<p>Adjustment of Medical-Loss-Ratio (MLR) - 2011</p> <p>Individual and small group insurers must spend at least 80% and insurers in the large group market at least 85 % of premiums on beneficiary health care. On state request, the Dept. of HHS can adjust state MLR requirements to prevent destabilization of the individual market.</p>
<p>MEDICARE</p>
<p>The ACA proposes a number of changes to the Medicare system, including a new advisory board with more authority to find savings in the program and pilot programs and mechanisms designed to move the program away from fee-for-service-based payment and towards incentivized performance-based pay system.</p>
<p>Medicare and Medicaid Center on Innovation – 2010</p> <p>New center to create and test innovative payment and delivery system changes, including Patient-Centered Medical Homes.</p>
<p>Annual Wellness Visits - January 2011</p> <p>Yearly preventive visit for Medicare beneficiaries that includes development of a personalized plan of services for prevention of chronic diseases. May be conducted by any physician. The visit includes taking of medical history, family history, review of risk factors and development of screening schedule for 5 - 10 years.</p>

Accountable Care Organizations - 2012

Administered through Medicare's shared savings program, ACO's are voluntary organizations of health care providers that are accountable for the quality, cost, and coordinated care of at least 5,000 assigned Medicare beneficiaries. ACO's may choose to operate without financial risk for the initial three-year contract period but must meet quality measures focused within patient experience, care coordination and patient safety, preventive health and care for at-risk populations.

Independent Medicare Payment Advisory Board – 2014

A fifteen member panel tasked with identifying cost-reduction proposals for Medicare. The IPAB's recommendations become law unless Congress presents a plan making alternative cuts of the same savings level. A roadblock to the setup of the panel may be the Senate confirmation process for members.

ADMINISTRATIVE REFORMS

- Standardized electronic insurance claim payment and payment decisions – 2014
- Standardization of insurance referrals, authorizations and electronic submission of claim attachments - 2015

PAYMENT AND DELIVERY

- Increased reporting requirements for health plans on quality measures, chronic disease management, case coordination and other areas – 2012
- Imposition of penalties on providers for non-reporting of quality measures – 2015

PREVENTION**Preventive Services Coverage - 2010**

New health plans and Medicare must cover evidence-based preventive services with no co-pays or cost-sharing.

Prevention and Public Health Fund - 2010

A funding stream to support state/local efforts to prevent diseases including obesity, heart disease and cancer, with a strong focus on reducing tobacco use. Activities supported by the fund include tobacco cessation programs, primary care training, expanded access to immunizations and improving state public health infrastructure for the control of infectious diseases such as tuberculosis. The Fund was originally authorized at \$15 billion over ten years but has been targeted for funding cuts.

PHYSICIAN WORKFORCE**Workforce Advisory Commission - Scheduled for 2010 but Delayed by Lack of Funding**

A fifteen member panel created to develop and commission evaluations of education and training activities; identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address them; and to encourage innovations that address population needs, changing technology, and other environmental factors. Authorized funding has not been appropriated by Congress so though commission members have been named, it is not yet functioning.