Patient Protection and Affordable Care Act: Update

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Disclosures

- No conflicts to disclose
- Today’s discussion does not reflect the views of RMD, NIH, or HHS
Objective-Update

- To determine the impact of the Patient Protection & Affordable Care Act (ACA) on PM & R
  - Outline major components likely to affect care delivery
  - Current state of implementation of the law
  - Rollout issues
  - Assess the reality of ACA given fiscal and political environment
    - Popularity waning?
    - What if it fails?
Overview of the ACA

- Signed into law March 23, 2010
  - Aims: expand coverage, improve quality, and reduce costs
  - Phased over several years, with most major changes taking effect by end of 2014-5
    - Mandates individual and employer coverage
    - New regulations on insurance providers
    - Changes Medicare
    - Expands Medicaid
Constitutionality of the ACA

26 States challenged ACA

**January 31, 2011**
- *Florida v. US Department of HHS* struck down the entire law

**August 12, 2011**
- Court of Appeals for the 11th Circuit upheld an “unconstitutional” ruling of the individual mandate

**March 2012**
- Supreme Court hearing National Federation of Independent Business v. Sebelius
In a 5-4 decision announced June 28, 2012, the Supreme Court ruled:

1. The Individual Mandate
   The Court upheld the individual mandate under the taxing authority given to Congress by the Constitution.

2. Medicaid Expansion
   The requirement of states to participate in Medicaid expansion programs or have their Medicaid funds withheld was declared unconstitutional. The states may voluntarily participate in this funding.

Election of 2012

- Obama
- Strengthened Democratic Majority
- Health care reform likely to move forward for another 4 years
- Many popular changes may become entrenched before opponents regroup
Waning Popularity Overall...

ACA Support, All Adults
April 2010 – December 2013

Survey Question: “Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?”

Obamacare rollout

- Where the rubber meet the road
- Website issues
  - Federal site enrollment problems
  - States doing better
- Individuals “losing” health insurance
  - Obama promise
  - How many?
  - Do they have other options?
…But Recent Uptick in Democrats

ACA Support, Democrats
April 2010 – December 2013

Survey Question: “Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?"

Coverage expansion
Insurance Coverage in the United States
(314 million)

- Employer (49%)
- Medicare (13%)
- Medicaid (18%)
- Individual (5%)
- Uninsured (18%, 49 million)

Data from Kaiser Family Foundation & Robert Wood Johnson Foundation
Uninsured Rates Among Nonelderly by State, 2010-2011

National Average = 18.2%

- <14% Uninsured (13 states & DC)
- 14 to 18% Uninsured (20 states)
- >18% Uninsured (17 states)

SOURCE: KCMU/Urban Institute analysis of 2011 and 2012 ASEC Supplement to the CPS (two-year pooled data).
Coverage Expansion

- Estimate 25+ million previously uninsured Americans will gain coverage
  - Expands Medicaid eligibility
  - Creates Mandates
    - Individual
    - Employer
  - Creates Health Exchanges
    - outlaws lifetime caps
    - preexisting conditions
    - children to remain on their parent’s plan through age 26 (3 million)
  - Subsidizes coverage on a sliding scale up to 400% ($92K) poverty level (exchanges or employer)

## Mandates

### Individual
- In 2014, must have insurance or pay IRS the higher of
  - 1 percent of annual income
  - $95 per person ($47.50 per child)
- Exemptions include:
  - Financial
  - Hardship
  - Tribal or recognized religious affiliation

### Employer
- In 2015, if employ >50 workers and at least one employee qualifies for premium assistance:
  - Businesses that don’t offer insurance: $2k/employee (after first 30)
  - Businesses that offer unaffordable insurance: $3K/employee who qualifies for premium assistance
Coverage Expansion

EXPANSION OF MEDICAID
Expansion of Medicaid

- State expansion mandate was struck down by Supreme Court
  - States now have option to participate
- ACA expanded eligibility to 138% of Federal Poverty Level
  - ($15k:1/$30k:4 )
- Goal: 2019
  - Enrollment to increase by 10 million
  - Spending to increase by 13.2%

StateHealthFacts.org, a project of the Kaiser Family Foundation. http://statehealthfacts.kff.org/comparereport.jsp?rep=68&cat=17
Medicaid projected enrollment changes by 2019

StateHealthFacts.org, a project of the Kaiser Family Foundation.

Percent Change in Enrollment, 2019

- 2.0% - 21.7%
- 25.2% - 32.4%
- 32.9% - 40.0%
- 40.4% - 61.7%
Expansion of Medicaid

- LA - enrollment up by 32.4%,
- state spending up 1.7% and federal spending for Utah up 21.6%
- OR - the largest increase in enrollment - 60%
- MA - lowest increase in enrollment - 2%
- States rejecting Medicaid are those with the largest increases in coverage
  - Largest strain on state budgets
  - Federal Funds for two year then a decrease

StateHealthFacts.org, a project of the Kaiser Family Foundation. http://statehealthfacts.kff.org/comparereport.jsp?rep=68&cat=17
Who’s in and who’s out?

- States that have ELECTED Medicaid expansion:
  - AR, AZ, CA, CO, CT, DE, DC, HI, IA, IL, KY, MD, MA, MI*, MN, ND, NJ, NM, NV, NY, OH, OR, RI, VT, WA,

- States that have DECLINED Medicaid expansion:
  - AK, AL, FL, GA, ID, IN**, KS, LA, ME, MO, MS, MT, NC, NE, NH, OK, PA**, SC, SD, TN, TX, UT, VA, WI, WY

*Michigan will expand coverage as of April 1.

**According to the Kaiser Family Foundation, Indiana and Pennsylvania have waivers pending that would expand Medicaid coverage after 2014.
Who’s in and who’s out?

NOTES: *AR and IA have approved Section 1115 waivers for Medicaid expansion; MI has a pending waiver for expansion and plans to implement in April 2014; IN and PA have pending waivers for Medicaid expansion plans that would be implemented post-2014; WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

Unanticipated consequences

- Since election, states re-examining participation
  - AZ, NM, NV, FL
- Very complex equation- hidden benefits and costs?
  - Federal support is time limited, long term impact on state budgets to be determined
- Adverse selection by state
- After costs shift to states- benefit/reimbursement cuts?
Expanding Coverage

HEALTH INSURANCE EXCHANGES
Insurance Coverage in the United States
(314 million)

- Employer (49%)
- Medicare (13%)
- Medicaid (18%)
- Individual (5%)
- Uninsured (18% uninsured 49 million)

Data from Kaiser Family Foundation & Robert Wood Johnson Foundation
25+ million still uninsured after 2019

- Individual Mandate (16%)
- Medicaid Expansion eligible (36%)
- Tax Subsidy 138-399% FPL (7.5%)
- Undocumented Aliens
- Exempt (16%)

Remain uninsured
Health Insurance Exchange (HIX)

- Individual Mandate and not eligible for Medicaid (over 138% FPL)
- May receive tax subsidies (under 138-400% FPL)
  - $94K for a family of 4
- Employers may buy in as well
- Establishes insurance “exchanges”
- Insurance companies agreed to reform only if universal mandates were put in place (expanding the market)
Health Insurance Exchange (HIX)

- Exchanges increase competition, driving down costs
  - Streamlines delivery of subsidies
  - Disperses costs across larger pool
  - States define or default to federal plan
  - HIXs are NOT insurers - they do not assume risk - they regulate - monitor compliance
Regulations of HIX insurers

- Guaranteed coverage
- No lifetime or annual limits
- Pre-existing limitations eliminated
- Must have minimal essential coverage (Essential Health Benefits/EHB) that cover 10 categories of care
  - Rehab is one category
  - Coverage levels will vary by state
    - Minimal rehab coverage determined by state benchmark
    - 29 States include specific numbers of rehab services in their definition of EHB
    - 21 States have yet to define
* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

New Legal Challenge?

- Tax credits and subsidies are available to people whose plans "were enrolled in through an exchange established by the State"
  - Slip of the pen or intent of Congress?
  - Would put the entire program in disarray
  - May not be able to provide premium subsidies in at least 36 states
  - Likely headed to the Supreme Court
Premium Assistance

- Available for individuals and families making between 100% and 400% of Federal poverty line for their given family size
- Applied on a sliding scale based on income relative to Federal poverty line
- Set annual limits on total premium spending by income categories
Cost in Park City: Individual

- 28 years old, no tobacco use, annual adjusted gross income of $25,000, coverage for one adult
  - Percent of Federal poverty line: 218%
  - Maximum percent of income toward premium: 6.92%
  - Estimated cost, benchmark plan: $2,579
  - Total personal contribution to premium: $1,729
  - Potential tax credit: $850 per year

**Personal Cost by Plan Type**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Cost Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRONZE</td>
<td>$92.42 per month</td>
</tr>
<tr>
<td>SILVER</td>
<td>$144.08 per month</td>
</tr>
<tr>
<td>CATASTROPIC</td>
<td>$6,350 annual Limit on cost sharing</td>
</tr>
</tbody>
</table>

Two 37 year old adults, two children, no tobacco use, annual adjusted gross income of $75,000

- Percent of Federal poverty line: 318%
- Maximum percent of income toward premium: 9.5%
- Estimated cost, benchmark plan: $8,152
- Total personal contribution to premium: $7,125
- Potential tax credit: $1,027 per year

**Personal Cost by Plan Type**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Cost per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>$430.58</td>
</tr>
<tr>
<td>Silver</td>
<td>$593.75</td>
</tr>
</tbody>
</table>

Many issues to be worked out

- How will the IRS enforcement process work?
  - What type of documentation will they require?
  - How will they evaluate the documentation?
  - Do they have the necessary resources (financial and human) to evaluate documentation?
- Is the penalty enough?
- Will patients wait to get sick before enrolling?
- How will the employer shared responsibility payment affect hiring practices, both before and after 2015?
- Will the business penalties be delayed again?
<table>
<thead>
<tr>
<th>Income (% FPL)</th>
<th>Cap on Premium Spending (% of income)</th>
<th>Rough Premium Cost *</th>
<th>Subsidy</th>
<th>Out of Pocket Cost</th>
<th>ACA Penalties Initial/Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,282 (133%)</td>
<td>$458.46 (3.0%)</td>
<td>$2,877</td>
<td>$2,419</td>
<td>$458</td>
<td>$152/$382</td>
</tr>
<tr>
<td>$17,235 (150%)</td>
<td>$689.40 (4.0%)</td>
<td>$2,877</td>
<td>$2,188</td>
<td>$689</td>
<td>$172/$431</td>
</tr>
<tr>
<td>$22,980 (200%)</td>
<td>$1,447.74 (6.3%)</td>
<td>$2,877</td>
<td>$1,430</td>
<td>$1,448</td>
<td>$229/$575</td>
</tr>
<tr>
<td>$28,725 (250%)</td>
<td>$2,312.36 (8.05%)</td>
<td>$2,877</td>
<td>$565</td>
<td>$2,312</td>
<td>$287/$718</td>
</tr>
<tr>
<td>$34,470 (300%)</td>
<td>$3,274.65 (9.5%)</td>
<td>$2,877</td>
<td>$0</td>
<td>$2,877</td>
<td>$344/$862</td>
</tr>
<tr>
<td>$45,960 (400%)</td>
<td>$4,366.20 (9.5%)</td>
<td>$2,877</td>
<td>$0</td>
<td>$2,877</td>
<td>$459/$1149</td>
</tr>
</tbody>
</table>

Source: “Health Insurance Premium Tax Credits; Final Regulation,” 77 Federal Register 100 (23 May 2012), pp. 30377 – 30400; Kaiser Family Foundation “Subsidy Calculator,” available at: http://kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=dollars&income=34%2C470+&employer-coverage=0&people=1&alternate-plan-family=individual&adult-count=1&adults%5B0%5D%5Bage%5D=30&adults%5B0%5D%5Btobacco%5D=0&child-count=0&child-tobacco=0, accessed January 29, 2014.
Open enrollment through March 31, 2014
- Coverage begins on the first day of the following month for individuals enrolling between the 1st and 15th days of a month
- Those enrolling between the 16th and the last day of the month are covered on the first day of the second following month.

2015 open season proposed to be 11/14 through 1/15

Medicaid and CHIP have no open enrollment periods or waiting periods; individuals can apply at any time and coverage begins immediate

Enrollment outside of open season for qualifying life events
Benchmark Plans

On November 20, 2012 the Department of Health and Human Services (HHS) released proposed rules on essential health benefits.

- Every state must select a benchmark plan from one of the following 4 options:

  - One of the three largest small group plans in the state by enrollment
  - One of the three largest state employee health plans by enrollment
  - One of the three largest federal employee health plans by enrollment
  - The largest non-Medicaid HMO plan in the state’s commercial market by enrollment

Federal default if state does not choose a benchmark plan option.
Rehab in EHB Examples

- **Utah**-
  - Outpatient rehab (PT, OT, Speech) covered at 20 visits per plan year
  - Chiropractic not covered
  - Podiatrist visits are fully covered

- **California**-
  - Outpatient Rehab - no visit limit/fully covered
  - Only medically necessary foot care (Podiatry) is covered

Examples

- **New York**
  - Short term rehabilitation therapy - limited to 60 visits/condition/per lifetime

- **Maryland**
  - Outpatient Rehabilitation/Physical Therapy covered for 50 visits per year
  - Vocational Rehabilitation not covered
Examples

- **Florida**-
  - Outpatient Rehabilitative services covered, (35 visits per year)
  - Chiropractic services covered at 26 annually, deducted from 35 limit for Rehab services

- **Texas**-
  - Outpatient rehabilitative services covered for 35 visits per year
  - Chiropractic services is included in this count
Coverage Conclusions

- ACA may expand coverage to 32 million
- Expanded coverage may have dramatic impact on the practice of PM&R
- Many new Medicaid patients
  - Reimbursement levels?
- The definition of what constitutes rehab in EHB will vary by state
- Will HIX shape existing Medicaid benefits?
Who is not covered?

- Undocumented aliens (~12 million)
- Those who live in states without expanded Medicaid (est ~2 million). More if additional states decline expansion
  - Individual mandate still applies
- Eligible but not enrolled (up to 12 million)
- These group will have an impact because they will still need to be treated
Numbers of new enrollees

- 9 million to date
  - 6 million Medicaid
  - 3 million signed up through exchanges or are now covered under parent’s plan
Costs of ACA

- Initial estimates were a $20 billion savings/year over ten years
- $1.4 trillion in Medicaid and private insurance support
- Revenue- $350 billion from penalties and higher taxes
- $100 billion new premium payments by patients
- Savings - $1.2 trillion in payment reform
Restructuring the Delivery System

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)
Accountable Care Organizations

- ACOs are vertically integrated group (HMOs)
  - Medicare only
  - 5k Medicare benes
  - primary care physicians
  - A legal structure to receive and allocate payments
  - A management structure that includes physicians

ACO- shift to quality + capitation

- ACO vs. HMO
  - HMO incentives: limit utilization
  - ACO- FFS, DRGs, Bundled Post-acute care
  - Advanced Payment ACO program- start-up $

- 45% of the US in areas served by at least one ACO
  - 25-31M already receive care through ACOs
  - In past 2 years, ACOs have captured 10% of US
ACOs

- Growth is centered in large population centers
- Hospital Systems are primary backers
- Physician groups are now sponsoring
- 259 ACOs established in 45 states
  - DE, WV, ID, RI, SD only states without (6/2012)
ACO incentive payments

- Medicare Shared Savings Program (MSSP)
  - CMS reward ACOs for reducing total cost
  - Began with 27 ACOs covering 18 states and 375k beneficiaries
- 200+ ACO’s enrolled in the program
  - 4 million Medicare beneficiaries
- More than 500 organizations have applied for the third round, began Jan 2013
Outlook for ACOs

- Many establishing ACOs
  - Hopes of winning federal contracts
  - Few have worked out details
- Transformative effect only with widespread utilization
Payment for Performance- ACOs

- Beginning in 2013- $850 million to hospitals meeting a series of quality measures
- Funding will come from expected decrease in FFS, and is anticipated to grow over time
- Metrics used will be quality of patient care
  - Pressure Ulcers and UTIs
- 3 year commitment- year one baseline, followed by two years of assessment
ACO quality measures

- 33 metrics (half of originally sought)
- Includes metrics in 5 general domains:
  - patient/caregiver experience;
  - care coordination and patient safety;
  - preventive health; and
  - caring for at-risk populations
  - patient function
ACO conclusions

- Substantial gaps exist in how an ACO will be structured
- HMO lite?
- Will inpatient rehab be included?
- Will there be a shift to SNFs?
- Impact of ongoing bundling?
What Next?
What happens if it fails?

- Successful legal challenge?
- Insurance exchanges fold due to adverse selection?
- Federal Medicaid support dries up?
- Unable to reduce payments to providers?

  - Savings - $1.2 trillion in payment reform
    - 10-12% doc payments
    - Rx, DME, Hospitals
Opinion Divided on Next Steps

Survey Question: What would you like to see Congress do when it comes to the health care law?

Vermont

- True single payer
The Republican Alternative

**Title 1: Repeal Obamacare**
- Both the ACA and the Health Care and Education Reconciliation Act would be repealed

**Title 2: Patient-Centered Reforms**
- Consumer protections
- Pre-existing condition protections
- Individual tax credits
- Increased state tools
- Expand health savings accounts

**Title 3: Modernize Medicaid**
- Introduce capped Medicaid allotments
- Reauthorize “Health Opportunity Accounts”

**Title 4: Malpractice Reforms**
- State incentives for medical liability reforms

**Title 5: Increased Price Transparency**
- Insurance coverage and cost disclosure
- State incentives for Medicaid disclosure
- Hospital payment and charity care disclosure

**Title 6: Tax Code Changes**
- Capped tax exclusion on employer-sponsored health benefits
- Maintain business deductions for sponsored insurance
## Key Feature Comparison

<table>
<thead>
<tr>
<th>Feature</th>
<th>ACA</th>
<th>Republican Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidy eligibility</td>
<td>Up to 400% of Federal poverty line</td>
<td>Up to 300% of Federal poverty line</td>
</tr>
<tr>
<td>Medicaid expansion?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Individual mandate?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Prohibition on lifetime limits?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Age rating ratio</td>
<td>Limits insurers to 3:1 ratio of charges for older and younger individuals</td>
<td>Limits insurers to 5:1 ratio of charges for older and younger individuals</td>
</tr>
<tr>
<td>Dependent coverage up to age 26?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Protection for pre-existing conditions</td>
<td>Requires insurers to cover</td>
<td>Requires insurers to cover only if individual has been continually enrolled in a health plan</td>
</tr>
<tr>
<td>Enrollment</td>
<td>Initial open enrollment followed by annual open seasons</td>
<td>Initial open enrollment followed by annual open seasons</td>
</tr>
</tbody>
</table>
MEDICARE SUSTAINABLE GROWTH RATE (SGR)
Medicare Sustainable Growth Rate (SGR)

- Physician Fee Schedule (1997) to control Medicare payments to physicians
  - Linked MD fee schedule to changes in Medicare costs
  - Complex formula:
    - % change in fees for physicians’ services
    - % change in the average number of Medicare fee-for-service beneficiaries
    - 10-year average annual percentage change in real GDP per capita
    - % change in expenditures due to changes in law or regulations

*All numbers are estimated*
SGR Formula: Increase or Decrease Physicians’ fees

- Formula would have resulted in absolute decreases in reimbursement rates for several years
  - low inflation rates & ballooning costs
- Cuts never been enacted, but have accumulated
- Cuts have grown to >24% but are again delayed until 4/1/2014.
- Permanent repeal: $121 Billion
- 0.5% annual increases to 2018
3 month moratorium

- Repeal the SGR
- 0.5% pay increases to 2017 then flat through 2023
- Consolidate existing payment incentive programs into a single Value-Based Performance Incentive Program
- Provide a 5% bonus for physicians participating in an alternative payment models
- Require appropriate use criteria for advanced imaging
- Make payment data on providers public
- Set a deadline of 2017 for electronic health record vendors to make their EHRs interoperable
DEMONSTRATION PROJECTS
Demonstration Projects

- Post-Acute Care Bundling
- In the works
  - Patient-Centered Medical Homes
  - Continuing Care Hospital (CCH) Demonstration
  - Independence at Home Demonstration
Bundling

- Post-acute care (IRF, SNF, HH, outpatient)
  - ~15% of all Medicare dollars
  - One of the fastest growing expenditures
- Each provider has a separate Medicare prospective payment system
- Ideal target for consolidation
Bundling

- RTI International conducting the Post Acute Care Payment Reform Demonstration Project
  - Developed *Continuity Assessment Record and Evaluation (CARE)* for use in inpatient post-acute setting
  - Tool in very long…..

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Bundling Pilot Program

- CMS pilot program to test bundling payments for 10 different conditions in 2013
  - Quality measures used to assess care should focus on:
    - Functional status improvement
    - Rates of discharge and readmission
    - Incidence of health care acquired infection
    - Patient satisfaction
  - Case mix adjustment to ensure bundled payments are fair and accurate
Long term goals

- Link bundling with ACO’s
  - ACO’s would be responsible for episodes of acute and post-acute care
  - Payment incentives would:
    - Drive costs down
    - Improve outcomes (pay for performance)
Consequences

- ACOs and HMOs may move toward low cost post-acute care
- IRF need to be competitive on price, or provide much better outcomes
Patient Centered Medical Homes

- Primary care providers
  - Organize teams of other professional to meet patients’ needs
- US spends majority of $ on those with:
  - Chronic health conditions
  - Individuals with disabilities
- Goals- better coordination, higher quality care

Continuing Care Hospitals (CCH)

- New delivery model and to bundle payments for its services
- IRHs could become CCHs
  - Managing more services or partnering with LTCH or hospital based SNFs to form a virtual CCH.
- Capitated payments (LOS + 30 days following discharge)
- HHS has not yet moved forward with this demonstration project.

Questions and Answers for the Continuing Care Hospital (CCH) concept. In: Association AMRP. 2009
Independence at Home Demonstration

- Began December 2011, it is an initiative to provide home health care to chronically ill patients

- Participating organizations provide home visits to 200 or more eligible patients with teams led by physicians, nurse practitioners, or physicians assistants with certain qualifications
IAH Locations

Participating Practices
- Aimed at Medicare beneficiaries with chronic conditions
  - Received acute or sub-acute rehab in last year
  - “require the assistance of two or more activities of daily living”
- Clinicians may need to adapt to providing their services in a home setting and become familiar with different aspects of home care

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)
Independent Payment Advisory Board

- Medicare payments:
  - MedPAC recommendations – Congress approval
  - IPAB sets new policy that Congress must override

- IPAB
  - 15 individuals responsible
  - Only submit cuts if health care costs > inflation +1%
  - Suggestions must be implemented, unless Congress can determine equivalent savings
  - Takes 3/5 vote of Senate to override IPAB determinations
May **NOT**
- Ration health care, raise revenues, raise premiums, share costs, limit benefits to recipients, or change eligibility
- Lower payments to hospitals or hospices before 2020 or lower payments to clinical laboratories prior to 2016

May
- Lower payments to docs, Medicare Advantage, Part-D, SNF, HH, Dialysis, DME, ASCs
Praise of IPAB

“IPAB was created for the same reason [that] BRAC was created — to remove strong interest that protects the status quo.”
- Eric Seiber, PhD, a health services management and policy professor at Ohio State University.

“IPAB is set up to provide a backstop against interest-group pressure on the Congress that makes it difficult to adopt cost-containment measures”
- Judy Feder, PhD, a professor of public policy at Georgetown University
Criticism of IPAB

- The AMA has compared the board’s purpose to Medicare’s sustainable growth rate formula, another spending control mechanism developed by Congress that threatens to impose deep cuts to doctor pay.

- Many opposed to healthcare reform for political reasons view the IPAB as an entity that will ration care.
IPAB effects on PM&R

- Medicare budget cuts home based health care and durable medical equipment
- ASCs
- Injections and Musculoskeletal Medicine
- Decrease in more expensive post-acute care
- EMGs
Dead in the water

- Obama has yet to appoint any members
- $10 million in funding was cut
15 possible changes to Medicare:

- Raise the Medicare Eligibility Age
- Raise Medicare Premiums for Higher-Income Beneficiaries
- Change Medicare to a Premium Support Plan
- Require Drug Companies to Give Rebates or Discounts to Medicare
- Increase Medicare Cost-Sharing for Home Health Care, Skilled Nursing Facility Care and Laboratory Services
- Generate New Revenue by Increasing the Payroll Tax Rate
- Increase Supplemental Plan Costs and Reduce Coverage
15 possible changes to Medicare:

- Raise Medicare Premiums for Everyone
- Strengthen the Independent Payment Advisory Board (IPAB)
- Redesign Medicare’s Copays and Deductibles
- Address the Sustainable Growth Rate (Physician Payment) Formula
- Increase Penalties for Health Care Fraud
- Allow Faster Market Access to Generic Versions of Biological Drugs
- Enroll All Beneficiaries Covered by Both Medicaid and Medicare Managed Care
- Prohibit Pay-for-Delay Agreements
THANKS!