

Slide #1

INTRODUCTORY REMARKS

August 12 HCR Webinar

Thank you for joining us for the second in our series of health reform webinars. My name is Dr. Jerry Joseph, Immediate Past President of ACOG, and joining me today, as she did last month, is Lucia DiVenere, ACOG's Director of Government Affairs.

Again, our intent in offering this series is to give you detailed practical information about the new health reform law, including changes that will affect your practices and your patients. Before we start, let me review a few "housekeeping" points:

- If you're listening in by phone, please be sure to **mute** your line for everyone's benefit.
- You can submit **questions** throughout the webcast, using the form shown on your screen. We'll answer your questions at the end, and please include your **email address** so we can get back to you if we run out of time.
- Please be sure to fill out our **exit survey** too. Your feedback will help us make this series meet your needs.
- If you experience any **technical issues** during the webcast, please use the help button shown on your screen.
- Please note that these slides are available for download at ACOG's health reform center at www.acog.org.

Slide #2

Upcoming Webinars

Before we get started on today's subject, listed here are the subjects and dates of our future webinars.

Please note that the October session will be held on October 20th, the 3rd Wednesday of the month.

Slide #3

Benefits and Insurance Reforms

So, here we go with Session #2 devoted to Insurance and Benefit Reforms in Health Care Reform.

Just like last month, I will introduce these changes by year of implementation.

In 2010:

- Insurance Reforms
- Perinatal Depression
- Maternal-Infant home visiting program
- Preventive Services
- Assistance for pregnant students
- Young Women's Breast Cancer

In 2011, look for Women's Medical Home

And, in 2014, watch for:

- Additional insurance reforms
- Incorporation of Women's Health Benefits
- Matters related to abortion coverage

Let's begin by looking at the insurance reforms that are effective this year.

Slide #4

2010 Insurance Reforms

Insurance reforms are important to us. The better the private health insurance system works for us – allowing us to provide our best possible care to our patients and making sure our patients can see us when they need our care – the less our Nation relies on the public safety net.

Beginning this year, young adults can stay on their parents' health care plan until age 26. This applies to all plans in the individual market, all new employer plans, and existing employer plans if the young adult is not eligible for employer coverage on his or her own.

It's estimated that this will help cover the one in three young adults who are uninsured.

Lucia, tell us about changes in recissions and lifetime limits.

Everyone with health insurance coverage is protected from recissions and lifetime limits. The law eliminates all lifetime limits on how much insurance companies cover if beneficiaries get sick and bans insurance companies from dropping people from coverage when they get sick. It also restricts the use of annual limits in all new plans and existing employer plans.

So, if you have private health insurance and you've faithfully paid your premiums and haven't committed fraud, your insurer cannot drop you or impose a lifetime limit on your coverage once you start to claim benefits.

This may be especially important to our patients who need the MOST care, those with cancer or other long term expensive and unpredicted diagnosis. No longer will we physicians find ourselves in the middle of a long course of treatment only to find that our patient has lost her insurance.

Slide #5

2010 Benefits: PPD

I worked closely with Senator Bob Menendez, a Democrat from New Jersey, on this provision, and consider it a solid win for ACOG and for our patients. Health reform will help bring perinatal and post-partum depression out of the shadows by providing Federal funds for research, patient education, and clinical treatment.

Lucia, how will HHS get involved in this area?

The federal Department of Health and Human Services will conduct research into the causes of, and treatments for, postpartum conditions, create a national public awareness campaign to increase awareness and knowledge of postpartum depression and psychosis, provide grants to study the benefits of screening for postpartum depression and postpartum psychosis, and establish grants to deliver or enhance outpatient, inpatient and home-based health and support services, including case management and comprehensive treatment services for individuals with or at risk for postpartum conditions.

The National Institute of Mental Health is encouraged (but not required) to conduct a 10 year longitudinal study on the effect of pregnancy on a woman's mental health, both for intended and unintended pregnancies. These effects may be positive or negative and the study is intended to focus on perinatal depression.

Community Health Centers will be eligible for grants in 2011 and 2012 to the tune of \$3M for inpatient and outpatient counseling and services.

And a federal public awareness campaign will educate the public through radio and TV ads. You should take the time now to familiarize yourself with PPD, because your patients may become much more aware and come to you for answers.

Slide #6

2010 Benefits: Maternal Visiting Program

Congress established a new Maternal, Infant, and Early Childhood Visitation program, to improve maternal and fetal health in underserved areas of our country.

This program will fund States, tribes, and territories to develop and implement evidence-based home visitation models to **reduce infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health**, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

Lucia, how is this being implemented?

These programs will have to show effectiveness and outcome improvements. HHS recently issued regulations asking for suggestions on how to demonstrate the effectiveness of home visiting program models for pregnant women, expectant fathers, and caregivers of children, birth through kindergarten entry.

The law appropriates \$100 million to this program in 2010, \$250 million in 2011, \$350 million in 2012, and \$400 million in both 2013 and 2014.

Slide #7

2010 Benefits: Assistance for Pregnant Students

Senator Bob Casey, from Pennsylvania, added this section to the health reform law. His interest was to help teens who become pregnant and who choose to bring their pregnancies to term or keep their babies, to stay in school.

Lucia, tell us about this new program.

This new Pregnancy Assistance fund, \$25 million annually for ten years (FY2010-FY2019), requires the HHS Secretary (in collaboration with the Secretary of Education) to establish a state grant program to help pregnant and parenting teens and young women.

Grants will go to institutions of higher education, high schools and community service centers, states' attorneys general, and public awareness and education programs.

Institutions that receive grant funds must work with providers to meet specific practical needs – including housing, childcare, parenting education, post-partum counseling -- of pregnant or parenting students. These programs will also help students find and access services, and make referrals for prenatal care and delivery, infant or foster care, or adoption.

Attorney general funds will be used to combat domestic violence among pregnant teens.

ACOG has met with the White House on implementation of this program, to ensure the inclusion of prenatal maternity and postpartum care.

Slide #8

2010 Benefits: Young Women's Breast Cancer

This new program is intended to help educate young women about the importance of breast health and screening, in two ways.

First, the National Institutes of Health NIH will conduct research to develop and test screening measures for prevention and early detection of breast cancer in women ages 15 to 44.

And second, HHS will create a national awareness campaign, with \$9 million in funding each year from 2010 to 2014, to encourage young women to talk with their doctors about breast cancer and early detection.

This is where we come in. We should expect to get more questions from young women and from moms about their daughters' breast health. Prepare yourselves with good information for these important conversations.

Be ready to discuss breast self-awareness, family history that may suggest a genetic predisposition, and screening beginning at age 40 unless a family history suggests earlier.

Slide #9

2010 Benefits: Preventive Services

Coverage of preventive services is another real win for ACOG and certainly for our patients. Beginning September 1, 2010 new health plans that begin on or after September 23 must provide specified preventive services and immunizations with no copays, deductibles, or other out-of-pocket costs to its members. “Grandfathered plans,” plans already in existence, are exempt.

The law specifies that these services must include women’s preventive care and screenings included in comprehensive guidelines supported by Health Resources and Services Administration, a part of HHS, even if beyond those recommended by CDC and US Preventive Services Task Force.

Breast cancer screening, mammography, and prevention services are specifically covered as if the USPSTF November 2009 recommendations that suggested limited mammography screening for women between the ages of 40 – 49 did not exist.

ACOG feels this is very good news for our patients indeed. HHS estimates that Americans use preventive services at only about half of the recommended rate and that, in 2011, about 31 million people will be enrolled in a group health plan subject to these prevention provisions. By 2013, as many as 73 million people will be covered.

So this leaves the question of what will be included in the comprehensive guidelines supported by HRSA. HRSA has contracted with the Institute of Medicine IOM to develop these guidelines. ACOG President Rich Waldman met with the White House last month to be sure that HRSA and IOM rely heavily on ACOG’s guidelines as it develops this new set. I expect we’ll see good things in this area. That ends the 2010 benefits. Let’s see what happens in 2011.

Slide 10

2011 Insurance Reforms

Another important insurance reform is worth noting here.

The insurance practice of charging women more than men for equivalent policies will end on January 1, 2011. This should make insurance more affordable for our patients.

Lucia, tell us how this effects patients in different insurance markets.

The law will allow insurers in the individual and the small group markets to vary premiums **only** for age, geographic location, family size, and tobacco use. Not by gender.

This part of health reform applies only to insurance policies in the individual and small group markets, because plans offered by large employers, government agencies, and labor unions are already prohibited from gender rating. Women insured in these markets have had this protection since 1978, when the Pregnancy Discrimination Act was added to the 1964 Civil Rights Act, prohibiting employment discrimination on the basis of pregnancy.

The health reform law extended this protection to all women, regardless of their employment.

Slide #11

2011 Benefits: Women's Medical Home

Congress wanted to develop and test different delivery systems that would improve outcomes and efficiency and reduce costs, as part of its effort to extend better care to more individuals with the same amount of money we now spend on health care in America.

One of these options is the medical home. ACOG worked to ensure ob-gyns could participate as principle care physicians for women's medical homes. We wanted to make sure that family practice medical homes didn't capture our patients, leaving us with only segments of women's health care.

The law points the way for medical homes for women in the Medicare and Medicaid programs. Lucia, tell us about the new Innovation Center.

The bill creates an Innovation Center within the Centers of Medicare and Medicaid Services with broad authority to test, evaluate, and adopt systems that foster patient-centered care, improve quality, and contain costs in Medicare, Medicaid, and CHIP.

Models that can be tested may include:

- Patient centered medical homes, including ones that address women's unique health needs, and may also include
- Encouraging physicians to transition from fee-for-service to salary-based payment,
- State all payer payment systems, and
- Chronic care management and care coordination models.

Within Medicaid, states can require beneficiaries with two or more chronic conditions, or with one chronic condition and at risk for a second one, to designate a qualified provider as their medical home.

Ob-Gyn practices are eligible to participate and participating practices would be eligible for additional reimbursement.

Slide #12

2014 Insurance Reforms

This brings us to 2014, the key year in health reform when the health insurance exchanges become reality.

Lucia, remind us exactly what an exchange is.

Let's remember what these exchanges will be: an exchange is a marketplace where people can shop for health insurance; exchanges will operate on a state or multi-state level, and will select the insurers allowed to sell policies and set the minimum benefits those insurers must provide. The idea is to offer a choice of health insurance plans to individuals and provide insurance options that are affordable, comprehensive, and easy for consumers to compare. Low income individuals will be able to purchase private insurance in the exchanges with federal premium subsidies.

Once insurance Exchanges are up and running, there can be no coverage denials for pre-existing conditions, including pregnancy and domestic violence. In the past, pregnancy itself, could be construed as a pre-existing condition as could a history of domestic violence.

Further, coverage cannot be denied based on medical history, health status, genetic information or disability.

Finally, there can be no waiting period greater than 90 days before coverage takes effect.....No more 9 month waiting periods that would obviously exclude coverage of a current pregnancy.

Many of these insurance reforms are most beneficial to the patients we care for and again, their inclusion in the final plan represents a lot of diligence on the part of ACOG.

Slide #13

2014 Benefits: Women's Health

Effective January 1, 2014, small and individual insurance plans, except plans that existed before March 23, 2010, are required to offer at least the essential health benefits package.

You'll note that this and other requirements don't apply to plans that existed before health care reform. Many people were concerned that health reform would change their current insurance. So President Obama reiterated at every event that "If you like your plan today, you can keep it."

People can switch to new plans if they think the new plans are better than what they have today, but they don't have to.

Slide #14

2014 Essential Benefits

On this slide, the law specifies these services as **essential health benefits**: And you can see that maternity care is explicitly covered, a huge ACOG accomplishment!

Exactly what maternity care and all other essential health benefits coverage will look like – scope, frequency, duration, etc, -- will be determined through regulations. Lucia, how will this be done

Congress wanted to set a basic standard of health care coverage that would protect every person in America, regardless of where they live, who employs them, or income. The idea is that fundamental coverage can improve health, reduce the need for more expensive care, and spread the costs more evenly.

In order to set this standard coverage floor, the Secretary of the Department of Labor will survey how each of these benefits is covered in the nation's large employer plans, and will report this information to the Secretary of Health and Human Services.

The details of these benefits must be equal to the benefits of a typical large employer plan.

Slide #15

2014 Benefits: Abortion

Coverage of abortion services, as you can imagine, was very much contentious. Let's spend a minute clarifying how the law deals with abortion.

Abortion provisions in this new law apply only to insurance plans offered in the state Exchanges, which begin in 2014.

Abortion cannot be a mandated benefit as part of a minimum benefits package.

Restrictions on abortion coverage apply only to plans in the exchange and only to abortion services beyond those allowed under the 1976 Hyde amendment. Lucia, please review the Hyde amendment for us.

The Hyde amendment allows federal funds to be used to cover abortions **only** in cases of rape, incest, or to save the life of the mother.

Every exchange health plan can determine whether it will cover no abortions, only those abortions allowed under Hyde, or abortions beyond those allowed by Hyde.

No tax credit or cost-sharing credits may be used to pay for abortions beyond those permitted by Hyde.

The HHS Secretary will ensure that in each state exchange, at least one plan covers abortion and one plan either covers no abortions or only abortions allowed under Hyde.

Slide 16

Abortion continued

And what about the rules on insurers?

Insurers who offer abortion coverage beyond Hyde in the Exchanges must:

notify enrollees and employers of abortion coverage in the plan.

The plan must estimate the cost of abortion coverage per enrollee, including men, women and children.

Individuals and businesses covered in these plans are required to write two separate checks---one for basic coverage and another for abortion coverage.

The insurer must keep these funds separate; one check covers the actuarial value of the premiums and one can only be used to cover the cost of abortion coverage.

And insurers are prohibited from discriminating against providers or facilities who do not wish to participate in abortion services.

Remember that these rules apply only to insurers in the state exchanges that cover abortions beyond Hyde, rape, incest, and to save the life of the mother.

Slide #17

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Congress was clear that the ultimate decisions should be made at the state, not the federal level, and so states hold the ultimate trump card.

Any state can pass legislation that prohibits any plan from offering abortion coverage of any kind within the State's Exchange.

The federal law does not make any changes to existing state abortion laws such as a parental notification requirement.

Slide #18

Questions

Please type in any additional questions and submit them now with you e-mail address in case we do not have time to answer them before time expires.

Remember that these slides can be found on ACOG's Health Reform Center at ACOG's home page-----www.acog.org, where our webinars are archived and can be viewed at any time.

I hope you'll join us for Session 3 on Practice Administration on Wednesday, September 8th at NOON ET, and that this session has been helpful to you.

Thank you for being with us today.

