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INTRODUCTORY REMARKS

September 8 HCR Webinar

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

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.
- 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.

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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.

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Practice Administration

So, here we go with Session #3 devoted to how the Affordable Care Act will affect Practice Administration.

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

In 2010: Tax Credits for Employer Health Insurance Contribution

In 2013: Uniform Standards for Electronic Transactions

In 2014: Electronic health records and the Employer Mandate

And then we'll look at the Big Picture, using an article written by Nancy-Ann DeParle, Director of the White House Office of Health Reform, and other Administration officials, published in the August 23rd issue of Annals of Internal Medicine. You can find a link to the article in our Health Reform Center on ACOG's homepage.

Let's begin by looking at how your practices may be affected this year.

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2010 Practice Administration

A major goal of health reform is to make sure every individual in America has health care coverage through the private market. The employer and individual insurance mandates go into effect in 2014.

Today, 31% of the working uninsured are employed in small businesses with fewer than 25 employees. The cost of health insurance benefits can be a huge burden to small employers. So this year, small businesses will be eligible for tax credits for employer health insurance contributions.

Lucia, please tell us how this works.

These tax credits are available to small businesses with fewer than 25 full time equivalent employees and average wages of less than \$50,000 per employee.

The tax credit will be up to 35% of the employers' premium contribution, 25% in the case of tax-exempt small employers.

Now, we're not in the business of giving tax advice, so none offered here. But if your practice qualifies as a small business, this tax credit might be very valuable to you. You might want to talk to your tax advisor or accountant.

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2013 Practice Administration

As you'll see when we talk about the Big Picture, a second major goal of health reform is to improve the functioning of our health care system, and theoretically make it more efficient.

A major emphasis is on bringing our health care system into the information technology age. Health IT is expected to help eliminate medical errors, improve care coordination, save staff time, and speed payments.

But it's well acknowledged that this integration can't happen until there are uniform standards in the IT industry.

Lucia, please explain these standards.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) led to standards for the electronic transition of some routine administrative and financial health records, but implementation of these standards varies significantly, making it challenging, costly, and inefficient for many physicians to conduct electronic transactions.

Health reform requires greater uniformity of these standards, mandates the creation of specific operating rules, and accelerates their adoption. It also establishes a process to update these standards and operating rules at least every three years, and requires health plans to comply or face financial penalties.

Under these new standards:

- all data elements must be described unambiguously,
- the number and complexity of forms must be kept to a minimum,
- standards and operating rules should make it possible to determine an individual's eligibility and financial responsibility for specialty health care services in real time,

- data elements should be comprehensive needing no paper or other backup clarification,
- and the claims process must include timely acknowledgement, response and status reporting.

So in 2013, the Administration will issue uniform standards for electronic health transmissions, including standard eligibility verification and health claim status, in consultation with providers, stakeholders and consensus organizations.

All health plans will have to comply with these standards, or pay \$1 per person covered by the plan per day for which the plan's data systems are not in compliance.

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2014 EHR

In 2014, more electronic health records standards will be implemented.
What are these new standards?

By January 2014, operating rules for electronic funds transfers and health care payment and remittance advice must allow for automated reconciliation of payment and remittance.

And after January 2014, all Medicare Part A (hospital) and Part B (physician) claim payments will be made by electronic funds transfers. So all Medicare participating doctors will have to use HIT by then.

In 2016, all HIT systems must adopt uniform standards for health claims, enrollment and disenrollment, premium payments, and referrals, and uniform rules for health claims attachments.

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2014 EHR

The idea behind all of this is to kick start health information technology: to make sure electronic systems are capable, affordable, and interoperable, and make it possible to increase patient safety and reduce paperwork costs.

As with so many parts of health reform, we'll see if these goals are met, but they certainly are good goals.

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2014: Employer Mandate

In the next three slides, we'll examine the employer mandate in detail. While the majority of today's ob-gyn practices are small, health reform may lead to increased integration of physician practices into larger groups.

The employer mandate is intended to create a shared responsibility for health care coverage. Individuals have to have insurance, state and federal governments have to offer safety net coverage, and employers have to do their part. This approach to health reform builds on our current system of reliance on job based coverage.

The employer mandate goes into effect in 2014, when the state insurance exchanges begin, and applies to employers with more than 50 full time employees.

The average ob-gyn practice today employs about 35 individuals, including physicians, and 75% of ob-gyn practices have fewer than 50 full time employees.

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Employer Mandate

Beginning in 2014, large employers have to offer coverage or pay a penalty, called an assessment payment. Tell us about this payment.

The payment will apply to large employers who don't offer their full time employees **the opportunity** to enroll in an employer-sponsored plan that includes minimum essential coverage in any month, **and** who have an employee in that month who gets coverage with a tax credit or premium reduction through an Exchange.

The assessment is \$2,000 per month per employee on the total number of full time employees minus 30.

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Employer Mandate Example

Lucia, give us an example of how the payment assessment would work:

In 2014, XYZ Ob-Gyn Practice does not offer minimum essential coverage and has 90 FT employees. 10 receive a premium tax credit for the year for enrolling in a state Exchange plan.

XYZ Ob-Gyn Practice owes a monthly \$2,000 assessment on each of 60 employees (90 – 30), \$120,000 a month.

XYZ Ob-Gyn Practice could avoid the assessment by offering coverage each month. It's the offer that counts, not whether or not all employees take it.

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White House Big Picture

Last month, the White House Director of the Office of Health Reform published an article in the Annals of Internal Medicine which spells out what physicians will need to do to be successful in health reform.

You can read the full article on ACOG's Health Reform Center at acog.org. Note the bullet points here.

While this article raises controversial points, as you'll see, there's emphasis on care coordination, preventive care, non physician providers, and HIT. This shouldn't surprise us. It was clear from the beginning of the health reform debate that Congress and health policy experts wanted to fundamentally change the way medicine is practiced in America.

We talked last month, for example, about how 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.

The list on this slide gives you other specifics.

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White House Big Picture

In her article, Director DeParle and colleagues describe 4 aspects of our health care system in the future. Lucia, please review these for us.

1. In her view, the health care system will evolve into 1 of 2 forms: organized around hospitals or organized around physician groups.
2. As physicians organize themselves into increasingly larger groups—i.e. patient-centered medical home practices and accountable care organizations—they will invest in IT and acquire management skills needed to efficiently organize.
3. We'll see accelerated physician employment by hospitals.
4. And increased vertical integration.

Today, 24% of ob-gyn practices are solo, 27% single specialty groups. And the average ob-gyn practice has 35 employees. So DeParle's view would signal a significant shift in what physician practices look like.

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Slide 13 is a very busy slide, with a table from the White House article that shows you how the objectives and provisions of health reform relate to physician practice. Lucia, what might this mean to those of us who provide patient care?

In order to meet increased demand for care, physicians may find it advantageous to work as a team with nonphysician providers and develop ways to monitor patients outside of the office.

Achieving quality and payment reform requirements will mean preventive care, outcomes research, and increased patient involvement.

And capturing value, ie reducing costs, means physicians will use HIT and other tools to reduce administrative costs.

Let me be clear. I'm bringing this article to your attention not because I or ACOG support it, but because it lays out so clearly the intention behind health reform. And let's remember that, even with all the good elements of health reform, ACOG opposed the final bill because we determined that it wasn't good for YOU, America's practicing ob-gyns.

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Questions

Thank you again for your attention and interest. I hope this has been informative.

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 4 on Compliance on Wednesday October 20th at Noon ET. Thank you for being with us today.

