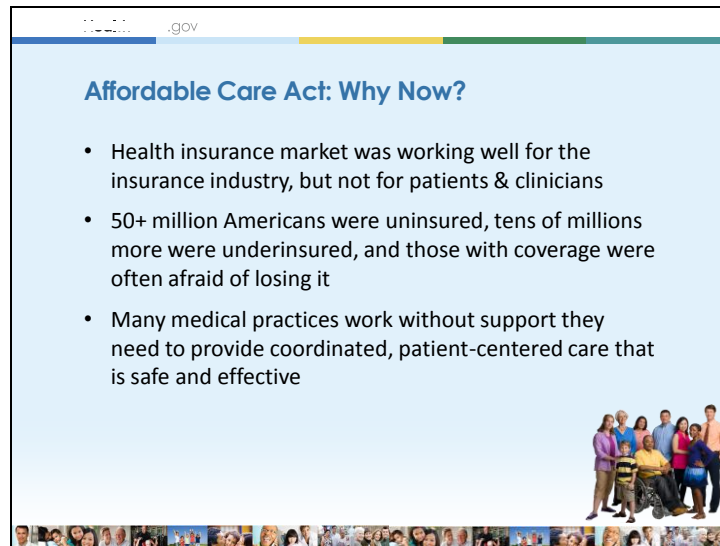




Hello, my name is XXX. And I'm glad to be with you today to talk about the health care law, the Affordable Care Act – and what it means for you, your patients, and your practice.



Slide 2



11:51 AM .gov

### Affordable Care Act: Why Now?

- Health insurance market was working well for the insurance industry, but not for patients & clinicians
- 50+ million Americans were uninsured, tens of millions more were underinsured, and those with coverage were often afraid of losing it
- Many medical practices work without support they need to provide coordinated, patient-centered care that is safe and effective

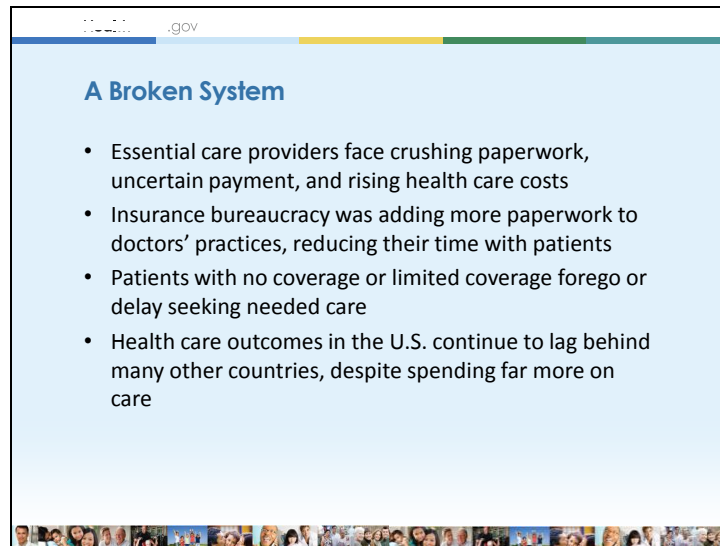


The Affordable Care Act (ACA) was signed into law in March 2010. You may have concerns about how ACA will affect you and your practice – your reimbursement, your independence, and the welfare of your patients.

The first question is: why did we need the health care law? The answer is that we had a health insurance market that worked very well for big insurance companies, but not so well for patients and providers. Insurers premiums were skyrocketing even as insurers made record profits. Fifty million Americans were uninsured and tens of millions more had coverage that didn't cover critical treatments and preventive care.

Our health care system is full of barriers, roadblocks, and red-tape—ranging from the way we pay for health care services to a lack of usable, reliable information for patients and clinicians alike—that often keep health care professionals from practicing medicine in a collegial, evidence-based, and patient-centered manner.

Slide 3



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### A Broken System

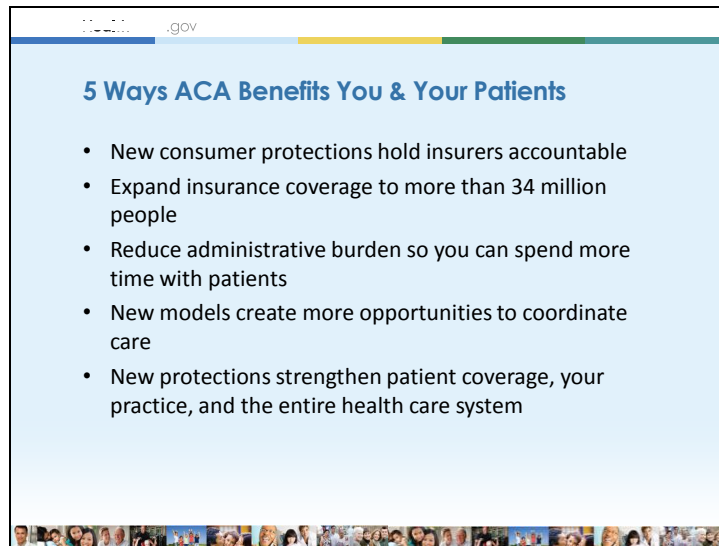
- Essential care providers face crushing paperwork, uncertain payment, and rising health care costs
- Insurance bureaucracy was adding more paperwork to doctors' practices, reducing their time with patients
- Patients with no coverage or limited coverage forego or delay seeking needed care
- Health care outcomes in the U.S. continue to lag behind many other countries, despite spending far more on care

Despite having the world's best trained doctors and nurses, the most advanced medical technology, and the finest hospitals, Americans continue to live sicker and die sooner than our peers around the world.

Too many patients have been harmed by a health care system that's supposed to help them get well and stay healthy. Too many doctors and nurses have seen their best intentions frustrated by a fragmented system with backward incentives.

Each year, health care costs consume a greater share of our paychecks, corporate balance sheets, and local, state, and federal budgets with no signs of slowing down.


Slide 4



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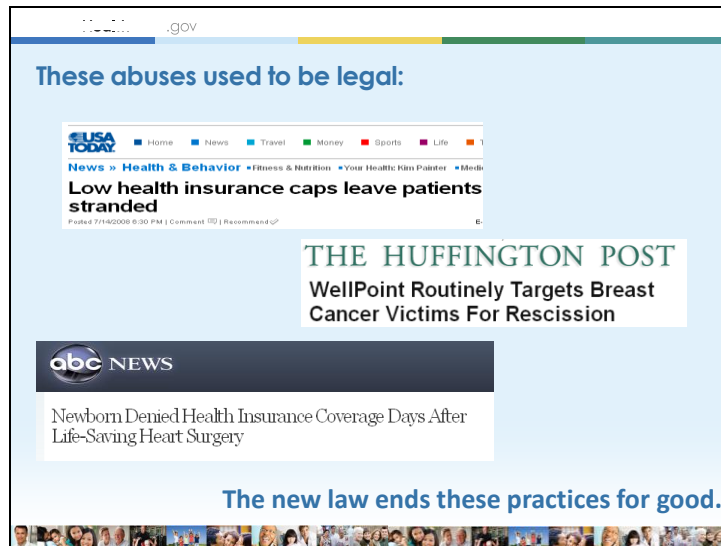
### 5 Ways ACA Benefits You & Your Patients

- New consumer protections hold insurers accountable
- Expand insurance coverage to more than 34 million people
- Reduce administrative burden so you can spend more time with patients
- New models create more opportunities to coordinate care
- New protections strengthen patient coverage, your practice, and the entire health care system



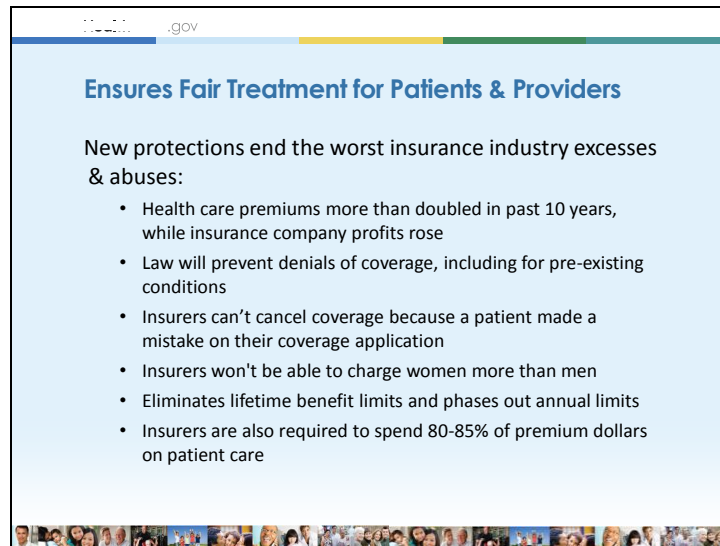
The law replaces some of the worst excesses and abuses of the health insurance industry with strong consumer protections and administrative simplification provisions, and has the potential to bring considerable financial and clinical benefits for providers across the health care spectrum.

The law enacts comprehensive reforms that will hold health insurance companies accountable, protect you and your patients, and guarantee choice and control.



I'm sure you've all heard stories like these.

Slide 6



Ensures Fair Treatment for Patients & Providers

New protections end the worst insurance industry excesses & abuses:

- Health care premiums more than doubled in past 10 years, while insurance company profits rose
- Law will prevent denials of coverage, including for pre-existing conditions
- Insurers can't cancel coverage because a patient made a mistake on their coverage application
- Insurers won't be able to charge women more than men
- Eliminates lifetime benefit limits and phases out annual limits
- Insurers are also required to spend 80-85% of premium dollars on patient care

It is now illegal for insurance companies to:

- Deny coverage to children because of a pre-existing condition like asthma and diabetes.
- Put a lifetime cap on coverage
- Cancel coverage because of paperwork mistakes

Other consumer protections in law include:

- Annual limits to coverage are being phased out and will be banned in 2014.
- Consumer access to an independent appeals process for insurance company disputes
- Insurers can't charge an extra co-pay for an out of network emergency room.
- Consumers can choose their own primary care physician in your insurers network, and can see a pediatrician or an OB-GYN without a referral.

**Holds Insurance Companies Accountable**

**BEFORE**, insurance companies spent as much as 40 cents of every premium dollar on overhead, marketing, and CEO salaries.

**TODAY**, insurance companies must spend at least 80 cents of each premium dollar on consumer health care. If they don't, they must repay the money.

*Doctors need to be in charge, not the administrators. This is about health, not money. No more million dollar salaries to CEOs of insurance companies and pharmaceutical companies.*  
- Pediatrician

60% / 40%

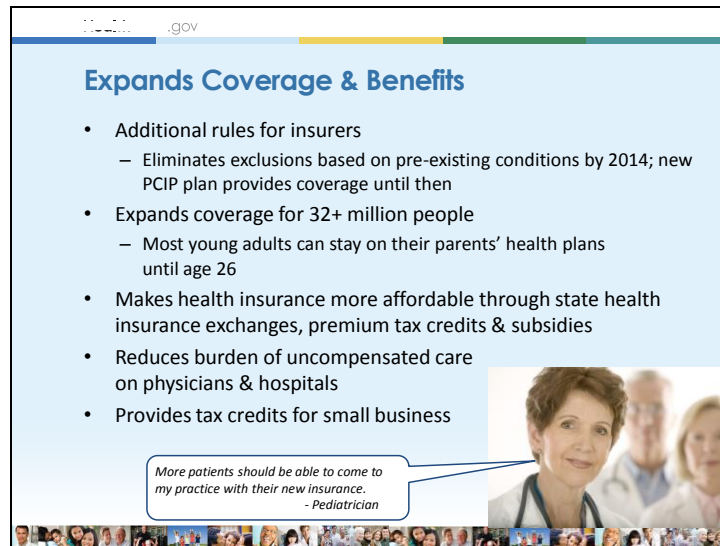
80% / 20%

The slide features a light blue background with a horizontal bar at the top in blue, yellow, and green. It includes two images of US dollar bills: a purple \$10 bill and a green \$20 bill. A small photo of a female pediatrician is on the left, with a speech bubble containing a quote. The bottom of the slide has a thin strip of many small photos of diverse people.

The law brings down health care costs and makes sure health care dollars are spent wisely. Before, some private insurance companies spent almost half of premiums on overhead, leaving only 60 cents of every premium dollar to spend on care.

The health care law mandates that insurers must now spend at least 80 percent of premiums on health care services or improving care, or they must repay the money.

The law also has new rules that require insurance companies to publicly justify any rate increase of 10 percent or more. And it gives states new resources to review and block these premium hikes.



Expands Coverage & Benefits

- Additional rules for insurers
  - Eliminates exclusions based on pre-existing conditions by 2014; new PCIP plan provides coverage until then
- Expands coverage for 32+ million people
  - Most young adults can stay on their parents' health plans until age 26
- Makes health insurance more affordable through state health insurance exchanges, premium tax credits & subsidies
- Reduces burden of uncompensated care on physicians & hospitals
- Provides tax credits for small business

More patients should be able to come to my practice with their new insurance.  
- Pediatrician

Each of these improvements helps fill gaps in the health care system. But these changes are just the beginning. In 2014, a new marketplace called an Affordable Insurance Exchange will be created in every state for families and small business owners who buy their own health insurance.

These marketplaces will function like Expedia or Orbitz for health coverage. Consumers will be able to go to a website and easily compare coverage options. And the law includes a few important rules set up to protect consumers. No turning people away because of pre-existing conditions. No charging women more just because they're women. There are significant tax credits on a sliding scale for middle class families. There will be better access to Medicaid. And Members of Congress have to get their coverage in the exact same marketplace your patients do.

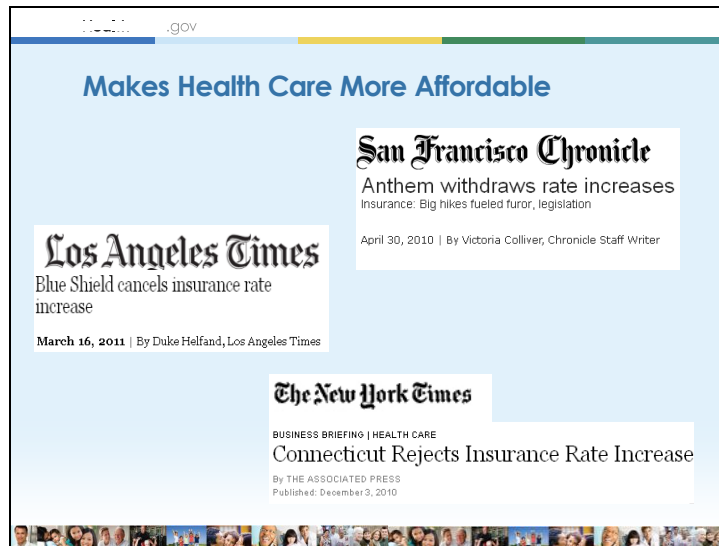
[FOR THE SPEAKER'S REFERENCE:

*Medicaid is expanded up to 133% of the federal poverty level – about \$15,000 for an individual or \$30,000 for a family of 4.*

*Tax credits are available for those under 400% of the federal poverty level who are not eligible for other affordable coverage – about \$45,000 for an individual or \$90,000 for a family of 4.]*



Slide 9



And we're already seeing these rules pay off across the country.

*[FOR THE SPEAKER'S REFERENCE:*

*Additional rate review success stories include:*

- Connecticut's Insurance Department rejected a proposed 20% rate hike by one of the state's major insurers.
- In August 2010, a major insurer in Massachusetts agreed to a significant reduction of proposed increases – less than 13% instead of the nearly 23% they initially requested.
- In 2010, Oregon disapproved health insurance premium requests of 10%, 18%, and 20% in the individual market.
- Rhode Island's Insurance Commissioner used his rate review authority to reduce a proposed rate increase by a major insurer in that state from 7.9% to 1.9%.
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7% cut to 14% following a public outcry.
- In 2010, Californians were saved from rate increases totaling as high as 87% after a California insurer withdrew its proposed increase after scrutiny by the State Insurance Commissioner.

11-2011 .gov



### Increases Access to Affordable Care: Pre-Existing Condition Insurance Plans

There are PCIP plans in every state for people who've been locked out of the insurance market because of a pre-existing condition like cancer or heart disease.

*"When I was diagnosed, they told me I had a 60 percent chance of being cured. That's pretty good odds, but I was also terribly worried about finances. Now I don't feel like we can't afford the treatment."*

--Gail O. in New Hampshire

For more, visit [www.PCIP.gov](http://www.PCIP.gov).

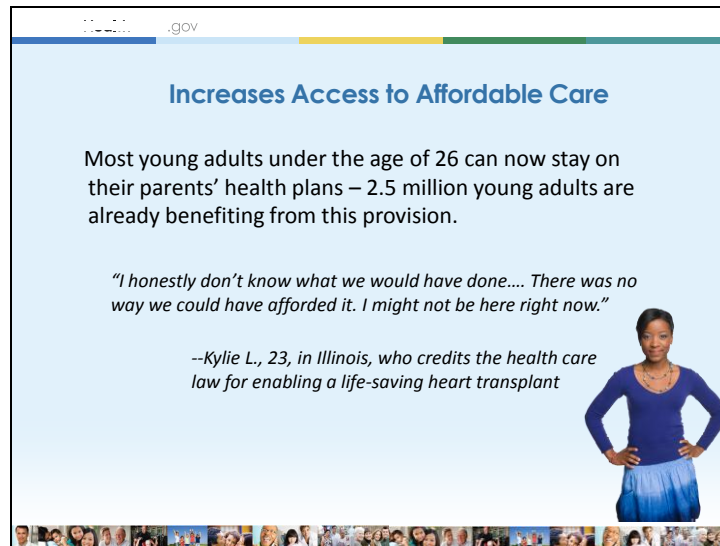


Under the old system, no one got a worse deal than the 129 million Americans with pre-existing conditions. When buying coverage on their own, insurance companies could hike their rates, carve out needed benefits, and, in many cases, lock them out of the insurance market altogether. For people with potentially fatal conditions like cancer, this often meant they couldn't afford the treatments that could save their lives.

The health care law has given Americans who've been locked out of the market for their pre-existing conditions a new coverage option. As a result, tens of thousands of Americans with serious health conditions across the country are now getting the health insurance they need.

You may already know this, as doctors have been a top source of referrals for people eligible for PCIP.

Slide 11



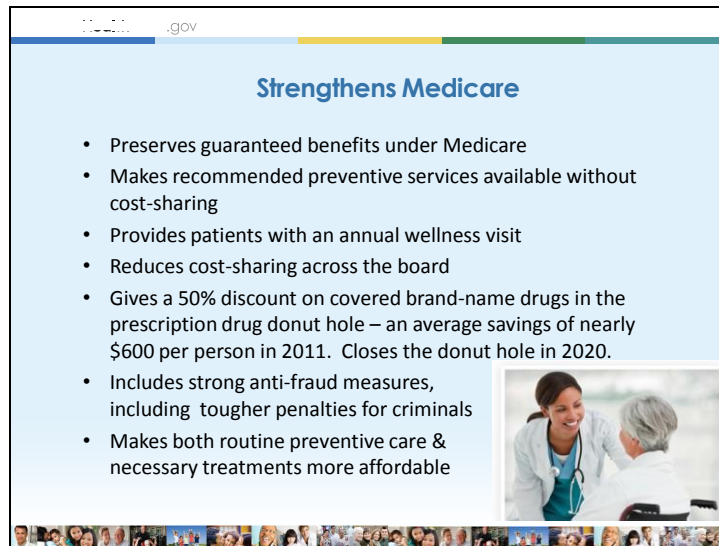
The slide features a light blue background with a dark blue header bar at the top containing the text ".gov". The main title is "Increases Access to Affordable Care" in bold blue font. Below the title, the text reads: "Most young adults under the age of 26 can now stay on their parents' health plans – 2.5 million young adults are already benefiting from this provision." A quote follows: "*I honestly don't know what we would have done.... There was no way we could have afforded it. I might not be here right now.*" Below the quote is the attribution: "--Kylie L., 23, in Illinois, who credits the health care law for enabling a life-saving heart transplant". To the right of the text is a photograph of a woman in a blue long-sleeved top and a blue skirt. At the bottom of the slide is a horizontal strip of small, diverse human faces.

The third key part of the law is a set of improvements that increases access to affordable care. For years, young adults have had some of the highest rates of being uninsured.

Most young people lost their family coverage when they graduated high school or college and it was often a few years before they got a job that offered good health coverage. Even then, they could lose their coverage if they lost their job. That meant that if they had a car accident or an unexpected diagnosis during this period, they could go broke or their families could go broke – or worse, they might not be able to afford the care they needed.

Now, under the law, young adults who don't get coverage through their jobs can stay on their parents' plans until age 26 – a change that has already allowed 2.5 million young adults to get health coverage and given their families peace of mind.

Slide 12



The slide features a light blue background with a title 'Strengthens Medicare' in bold blue text. Below the title is a list of seven bullet points. To the right of the list is a small photograph of a female doctor in a white coat and stethoscope talking to an elderly male patient. At the bottom of the slide is a horizontal strip of many small, diverse human faces.

- Preserves guaranteed benefits under Medicare
- Makes recommended preventive services available without cost-sharing
- Provides patients with an annual wellness visit
- Reduces cost-sharing across the board
- Gives a 50% discount on covered brand-name drugs in the prescription drug donut hole – an average savings of nearly \$600 per person in 2011. Closes the donut hole in 2020.
- Includes strong anti-fraud measures, including tougher penalties for criminals
- Makes both routine preventive care & necessary treatments more affordable

You got into the health care profession to serve patients — ACA protections are designed to help you keep serving them.

Nearly 50 million older Americans and Americans with disabilities rely on Medicare each year. First, the law makes key preventive services free so no senior ever has to skip a potentially life-saving cancer screenings because they can't afford it.

Second, it gives beneficiaries in the donut hole a 50 percent discount on their covered brand-name medications. In the past, as many as one in four seniors went without a prescription every year because they couldn't afford it. Now, the seniors with the highest out-of-pocket prescription drug costs are getting an average of nearly \$600 in relief, and the law will close the donut hole by 2020.

Third, the law provides a historic boost to efforts to crack down on Medicare fraud. In 2010, those efforts returned a record \$4 billion, and the law gives law enforcement even more tools to go after those who steal from Medicare.

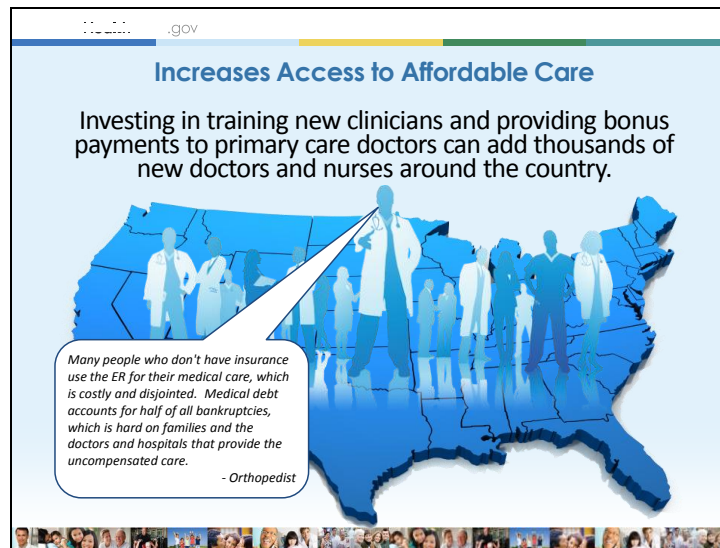
Fourth, the law contains changes that will make it easier for you to deliver the care that works best for patients. We know that a person with Medicare who has multiple chronic conditions may see as many as 14 doctors in a year. The law will help you spend more time with patients, focus on prevention, and work closely with your colleagues to coordinate care.

And since the law passed, Medicare costs have actually been going down. This year [2012], average premiums for the Part D standard benefit and Medicare Advantage plans will be lower than they were in 2011. And Part B premiums will go up far less than was predicted.

What this means for seniors overall is a stronger Medicare program that better meets their needs.

<http://www.hhs.gov/intergovernmental/acaresources/>

Slide 13



But we all know that health insurance wasn't the only obstacle to care.

That's why the health care law also invests in training and placing thousands of new doctors and nurses, and it provides bonus payments to primary care doctors. The law is also creating and expanding health centers across the country.

As a provider, this will help you see and spend more time with your patients.

Helps Reduce Administrative Burdens

- Creates new rules that standardize and simplify claims & payment processes
  - Fewer phone calls to patients & plans
  - Reduced postage & paperwork costs
- Supports your use of Electronic Health Records
- Invests in programs designed to help you transition to electronic payment & record systems

We want you to be able to spend more time in the exam room, and less on administration.

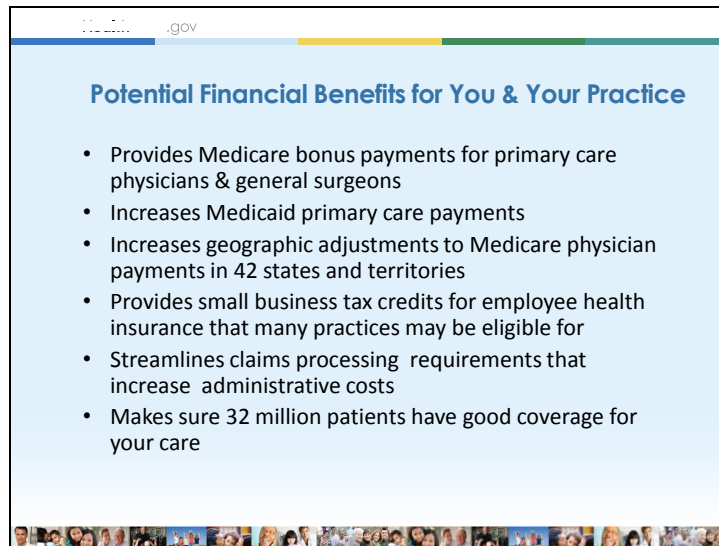
**We are taking new steps to simplify paperwork , eliminate red tape and support use of electronic health records.**

New rules make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health plan.

The new rules save an estimated \$12 billion for physicians, other health care providers, and health plans by reducing transaction costs in the form of fewer phone calls between physicians and health plans, lower postage and paperwork costs, fewer denied claims for physicians, and a greater ability to automate health care administrative processes.

Patients benefit from more accurate information about their out-of-pocket costs at the time of service, and expanded access to care as clinicians will have more time to spend treating patients by spending less time calling health plans.

Additional rules to be implemented between 2012 and 2016 will be adopted for electronic funds transfers, payment and remittance advice, claims, health plan premium payments, referral and certification, and enrollment and disenrollment. Physicians should benefit from the changes, which will make it easier to track claims and, in many cases, should improve physician revenue cycles and reduce overhead costs.



...gov

### Potential Financial Benefits for You & Your Practice

- Provides Medicare bonus payments for primary care physicians & general surgeons
- Increases Medicaid primary care payments
- Increases geographic adjustments to Medicare physician payments in 42 states and territories
- Provides small business tax credits for employee health insurance that many practices may be eligible for
- Streamlines claims processing requirements that increase administrative costs
- Makes sure 32 million patients have good coverage for your care

The Affordable Care Act also has the potential to bring considerable financial benefits for providers across the health care spectrum.

#### **Medicare Payment Changes**

- 10 percent incentive payments for primary care services furnished by primary care physicians.
- 10 percent incentive payments for general surgeons performing major surgery in health professional shortage areas.
- 5 percent incentive payment for mental health services.
- Increased geographic payment adjustments.
- New funding for doctors in primarily rural and low-cost payment areas
- Extended Medicare quality reporting incentive payments.

#### **Medicaid Payment Changes**

- Raises Medicaid payments to family medicine physicians, general internists and pediatricians for evaluation and management services and immunizations to at least Medicare rates in 2013 and 2014.
- Provides 100 percent federal funding for the incremental costs to states of meeting this requirement.



**Opportunities & Incentives for Improved Care**

- Builds on best practices of physicians & medical groups across the country
- Developing and implementing important payment and delivery system reforms, focused on:
  - Expanding team-based care coordination
  - Rewarding clinicians for care outside of traditional face-to-face visits
  - Focusing on aggressive management of chronically ill patients
  - Expanding access to home-based care
  - Ensuring clinicians have seamless, secure ways to share patients' medical records

The slide features a light blue background with a white border. At the top left, there is a small logo and the text ".gov". Below the title, there is a list of bullet points. To the right of the text, there is a photograph of three healthcare providers: a woman, a man, and another woman, all wearing white coats and stethoscopes. At the bottom of the slide, there is a horizontal strip of many small, diverse human faces.

### **NEW PAYMENT AND DELIVERY REFORM MODELS**

The Affordable Care Act also created a new Innovation Center in the Centers for Medicare and Medicaid Services—specifically designed to identify and test new care and payment models to deliver greater value for our health system and then to rapidly spread what works. Thanks to input from hundreds of outside innovators we've developed a menu of initiatives that engage different types of providers and payers. Each initiative holds the promise of reducing health care costs, improving quality, and improving health care.

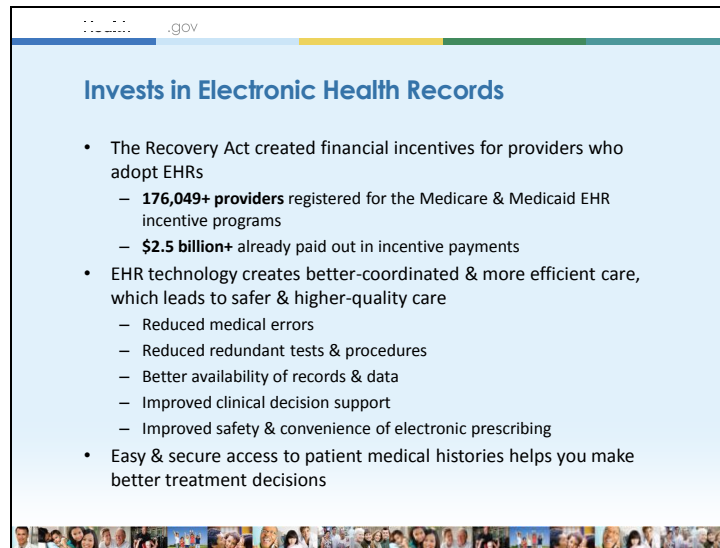
The law includes several demonstration programs to test and evaluate a variety of new voluntary payments models.

### **Looking Forward**

The Innovation Center is not only testing new models of care delivery and payment, it's also changing the way we partner with providers and conduct demonstration projects. The Innovation Center is committed to providing participants with more timely and useful data to improve and coordinate care, rapid-cycle evaluations on their performance, and new opportunities to learn from each other -- so that success is not just a report—but tangible to providers and patients across the country.

Providers will have tools and resources available to them to help spread best practices, lessons learned, and improved care strategies so that innovation is not limited to a demonstration site or only one particular community.





**Invests in Electronic Health Records**

- The Recovery Act created financial incentives for providers who adopt EHRs
  - **176,049+ providers** registered for the Medicare & Medicaid EHR incentive programs
  - **\$2.5 billion+** already paid out in incentive payments
- EHR technology creates better-coordinated & more efficient care, which leads to safer & higher-quality care
  - Reduced medical errors
  - Reduced redundant tests & procedures
  - Better availability of records & data
  - Improved clinical decision support
  - Improved safety & convenience of electronic prescribing
- Easy & secure access to patient medical histories helps you make better treatment decisions

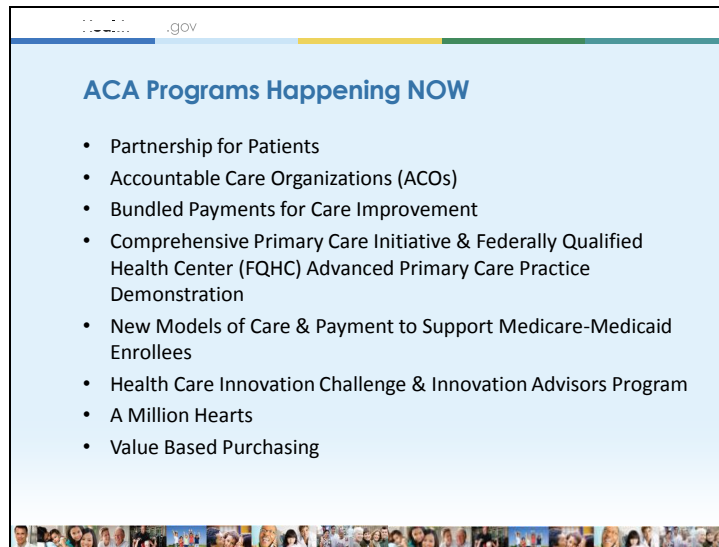
Meaningful use of EHRs leads to improvements in patient and quality care, including reduced medical errors, increased availability of records and data, improved clinical decision support, and the improved safety and convenience of electronic prescribing.

E-prescribing can improve patient safety by reducing the possibility of a medication error due to various causes, such as poor handwriting.

Laboratory tests or x-rays downloaded and stored in the patient's EHR make it easier to track and share results.

Automatic alerts built into EHR systems direct attention to possible drug interactions or warning signs of serious health conditions.

E-prescribing also lets providers send prescriptions electronically to the pharmacy, so medications can be ready and waiting for the patient.

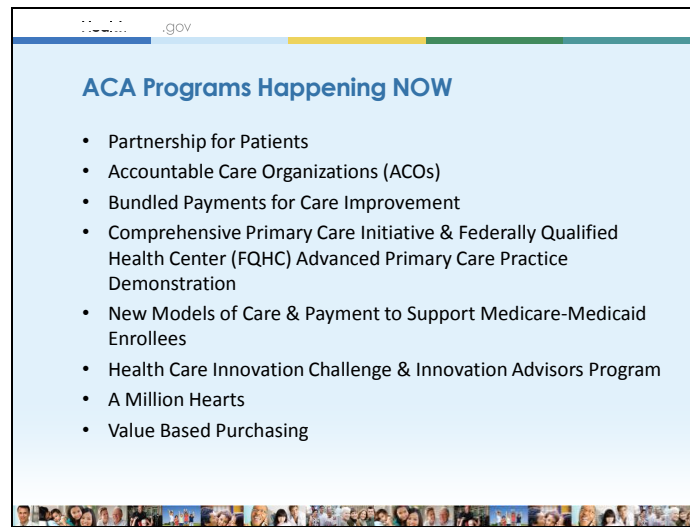


**These are just some of the initiatives launched to date as a result of the Affordable Care Act:**

**Partnership for Patients:** The Partnership for Patients initiative is a public-private partnership with hospitals, physicians, nurses, other clinicians, consumer groups, and employers to reduce hospital-acquired conditions and preventable hospital readmissions. The Partnership's two goals: **to reduce preventable harm in hospitals by 40% and readmissions to hospitals within 30 days of discharge by 20% in the next 3 years.** Over 7,100 organizations participating as of January 2012, including more than 3,200 hospitals. The Partnership is investing up to \$500 million in public private engagement networks that will help hospitals adopt proven strategies to reduce hospital-acquired conditions in their own facilities and systems. The Community-based Transitions Program, is a \$500 million initiative to reward hospitals, physicians, and others who partner together to keep patients out of the hospital after discharge. Taken together, the Partnership has the potential to save 60,000 lives, reduce millions of preventable injuries and complications in patient care and, by meeting its goals, save our health care system as much as \$50 billion over 10 years, according to the CMS Office of the Actuary.

**Accountable Care Organizations (ACO):** The **Pioneer ACO Model** tests the rapid transition to a new payment model where experienced organizations are paid according to their ability to improve the health of their patient population, rather than for each specific service they provide. 32 organizations are participating in the Pioneer ACO Model to test what can be achieved through highly coordinated care for more than 850,000 Medicare fee-for-service beneficiaries. According to the independent CMS Office of the Actuary, this model is projected to save Medicare up to \$1.1 billion over 5 years. The **Advanced Payment ACO Model** will test whether pre-paying a portion of future shared savings will allow more physician-based and rural ACOs to participate in the **Medicare Shared Savings Program**. In the Shared Savings Program, groups of providers come together as accountable care organizations and can share in savings they generate for Medicare if they meet certain quality improvement metrics. The Innovation Center is still accepting applications for Advanced Payment ACOs, which will start in April and July of this year in concert with the first two enrollment periods for the Shared Savings Program.

**Bundled Payments for Care Improvement:** Patients experience care in episodes, often visiting multiple doctors' offices, hospitals, and laboratories as they seek treatment and recovery. The **Bundled Payments for Care Improvement initiative** builds on episode-based payment models pioneered in the private sector by redesigning payment to match the patient experience. It offers providers 4 patient-centered episode of care models to choose from, allowing providers the flexibility to choose the conditions they believe make sense to bundle, decide how best to work together to deliver high-quality, coordinated episodes-of-care, and determine participating providers' share of payment. Health care organizations will give Medicare a discount off the current cost of care for the episodes covered under the initiative, thereby ensuring Medicare Trust Fund savings.



**NOTES cont'd:** These are just some of the initiatives launched to date as a result of the Affordable Care Act:

**Comprehensive Primary Care Initiative & Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration:** The **Comprehensive Primary Care Initiative** is a collaboration between public and private payers and primary care practices to support patient-centered primary care in communities across the country. Primary care practices will receive new, public, and private funding for primary care functions not currently supported by fee-for-service (FFS) payments, including an opportunity to share net savings generated through this program. In return, participating practices will agree to give patients 24-hour access to care, create personalized care plans for their patients, and coordinate with other providers to ensure patients are getting healthy and staying well. The **Federally Qualified Health Center Advanced Primary Care Practice Demonstration** tests whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs. In October 2011, 500 community health centers in 44 States were selected to receive approximately \$42 million over 3 years to reorganize as Patient Centered Medical Homes and improve the coordination and quality of care they give to people with Medicare and other patients.

**New Models of Care & Payment to Support Medicare-Medicaid Enrollees:** Working with the CMS Medicare-Medicaid Coordination Office, the Innovation Center is empowering States to test new payment and service delivery models that will help improve quality of care, and reduce the costs of care, for the nearly 9 million people enrolled in both the Medicare and Medicaid programs. These people account for 21% of Medicare beneficiaries but 36% of Medicare spending, and 15% of Medicaid recipients but 39% of Medicaid cost. To date, 15 States have been awarded design contracts of up to \$1 million to develop new ways to meet the needs of this complex population. Additionally, the Innovation Center and the Coordination Office have offered States the opportunity to move beyond the design phase and test new models of payment and care coordination in their States. 38 States and the District of Columbia have expressed interest in working with CMS.

**The Innovation Advisors Program** seeks to deepen the capacity for transformation by creating a network of experts in improving the delivery system for Medicare, Medicaid, and CHIP beneficiaries. The Innovation Advisors will: use their knowledge and skills in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement; Work with other local groups to drive delivery system reform; Develop new ideas for possible testing by the Innovation Center; and build durable skill in system improvement throughout their area. In December 2011, the CMS Innovation Center selected 73 individuals out of 920 applications to participate in the initiative.

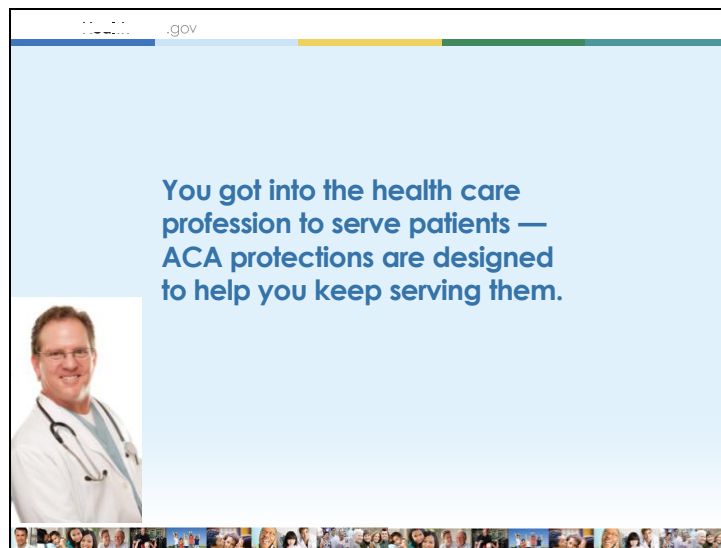
**A Million Hearts:** A national initiative to prevent 1 million heart attacks and strokes over the next five years.

**Value Based Purchasing:** Starting in October 2012, Medicare will reward hospitals that provide high quality care for their patients. This program marks the beginning of an historic change in how Medicare pays health care providers and facilities—for the first time, hospitals will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide. In FY 2013, the

<http://www.hhs.gov/intergovernmental/acaresources/>

## Health Care Law and You: Providers

Hospital Value-Based Purchasing Program will distribute an estimated \$850 million to hospitals based on their overall performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. This will be taken from what Medicare otherwise would have spent for hospital stays, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance. This redirection is intended to result in significant, additional savings to Medicare, taxpayers, and enrollees over time.



And as you think and talk about the law, you should also remember the key benefits for you and your patients:

The health care law protects people from the worst insurance company abuses. It drives down costs. It gives you support to better care for your patients. It gets your patients access to the care they need.

The image shows a screenshot of the HealthCare.gov website. At the top, there is a navigation bar with the text ".gov". Below this is a large blue banner with the text "Learn More". Underneath the banner, there are two main sections: "HealthCare.gov" and "Social Networks". The "HealthCare.gov" section features a screenshot of the website's homepage, which includes a search bar, a navigation menu, and a main content area with the heading "Your Health Care, Explained" and a sub-heading "Need help? Get consumer assistance in your state". The "Social Networks" section is titled "Stay Connected" and lists several options: "Email Updates", "twitter", "facebook", "YouTube", "View all Widgets and Badges", and "HealthCare Blog RSS". Below these sections, there are two red bullet points with placeholder text: "[Insert regional office contact information]" and "[Insert additional resources known to presenter]". At the bottom of the slide, there is a horizontal strip of small, colorful icons representing various people.

The health care law is a work in progress. But it has already made huge improvements that over time will touch every American in some way.

To learn more about the law and any of the new benefits I mentioned, please go to [healthcare.gov](http://healthcare.gov). You'll find information and plenty of resources you can share with your friends and family.

Thank you.