



# The Affordable Care Act & BMT: Updates and Program Impacts

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Tandem BMT Administrators' Meeting

2/27/2014

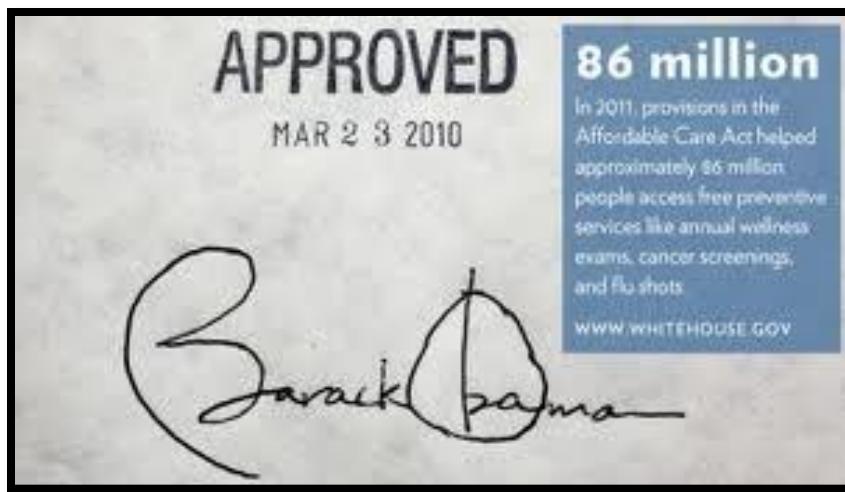
# Overview of Presentation

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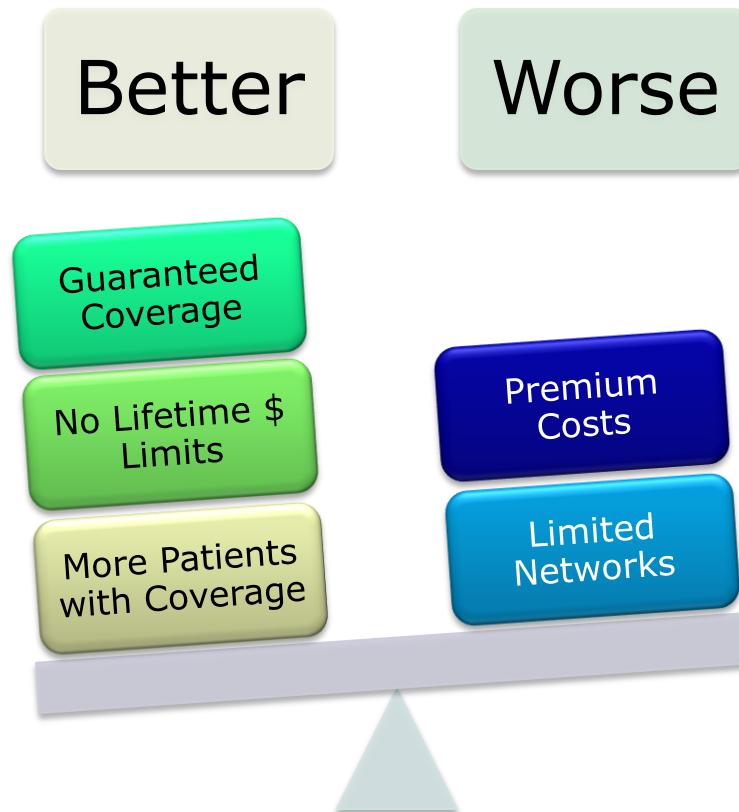
- Introduction to the ACA
- Key provisions & Emerging Issues
- Defensive Driving for Transplant Centers
- Q&A

# Introduction to the ACA

- The Patient Protection and Affordable Care Act became law in March 2010. PPACA became the ACA.
- Designed with phased implementation for preparation
- Health insurance exchanges and most benefit provision changes went into effect on January 1, 2014
- 3 Major Tenets:
  - Increase access
  - Improve quality
  - Control costs



# What does this mean for BMT?



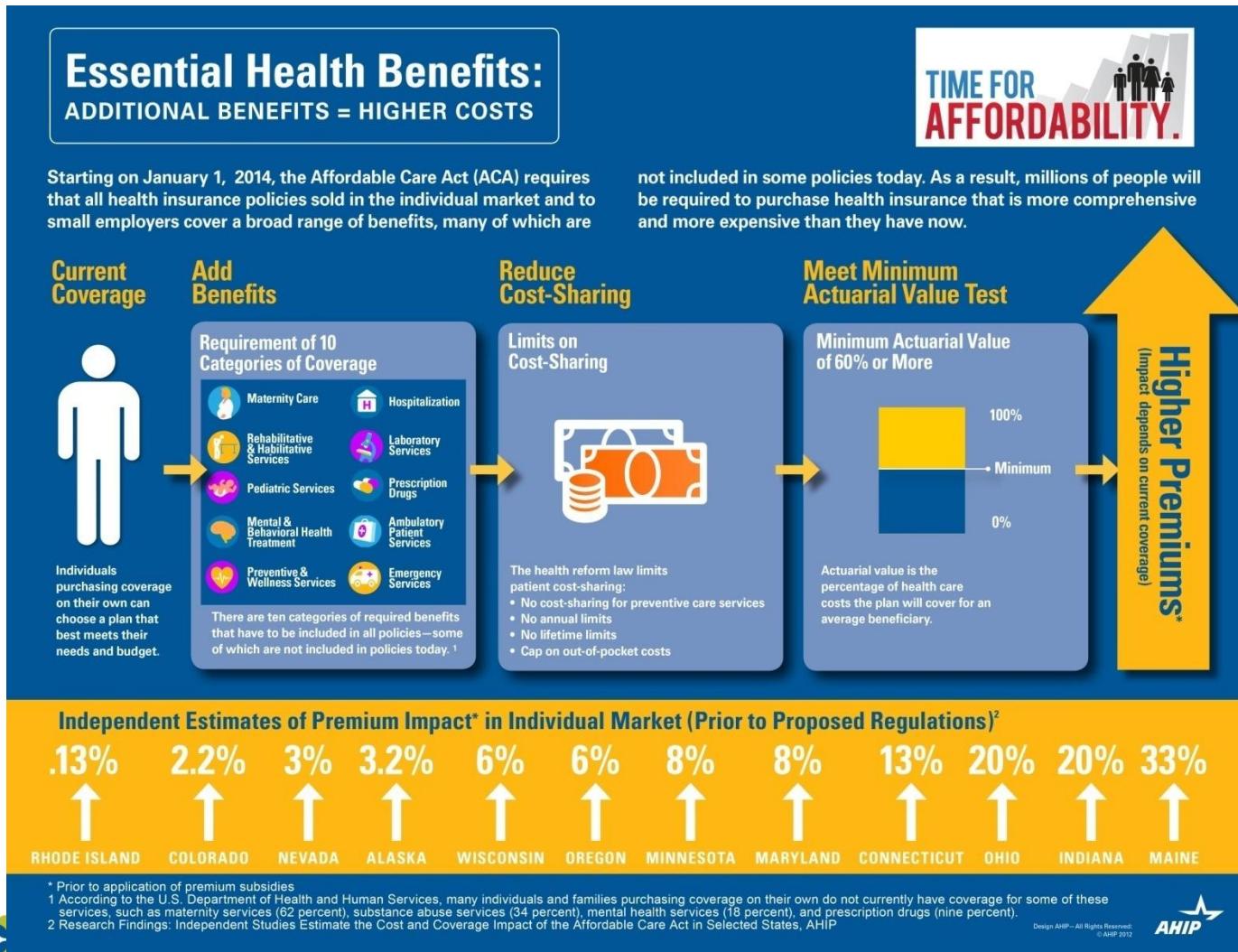
**On the whole, should be a positive change for our BMT patients.**

# The Biggest Win: Increased Access to Transplant

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- Affording transplant is almost impossible without health insurance coverage
- Increased access through:
  - Expansion of Medicaid eligibility
  - Health Insurance Exchanges
  - Subsidies to help with premium costs
- 2014 = More transplant eligible people should have coverage at the time of diagnosis

# The Biggest Concern: Affordability





# Key Provisions & Emerging Issues

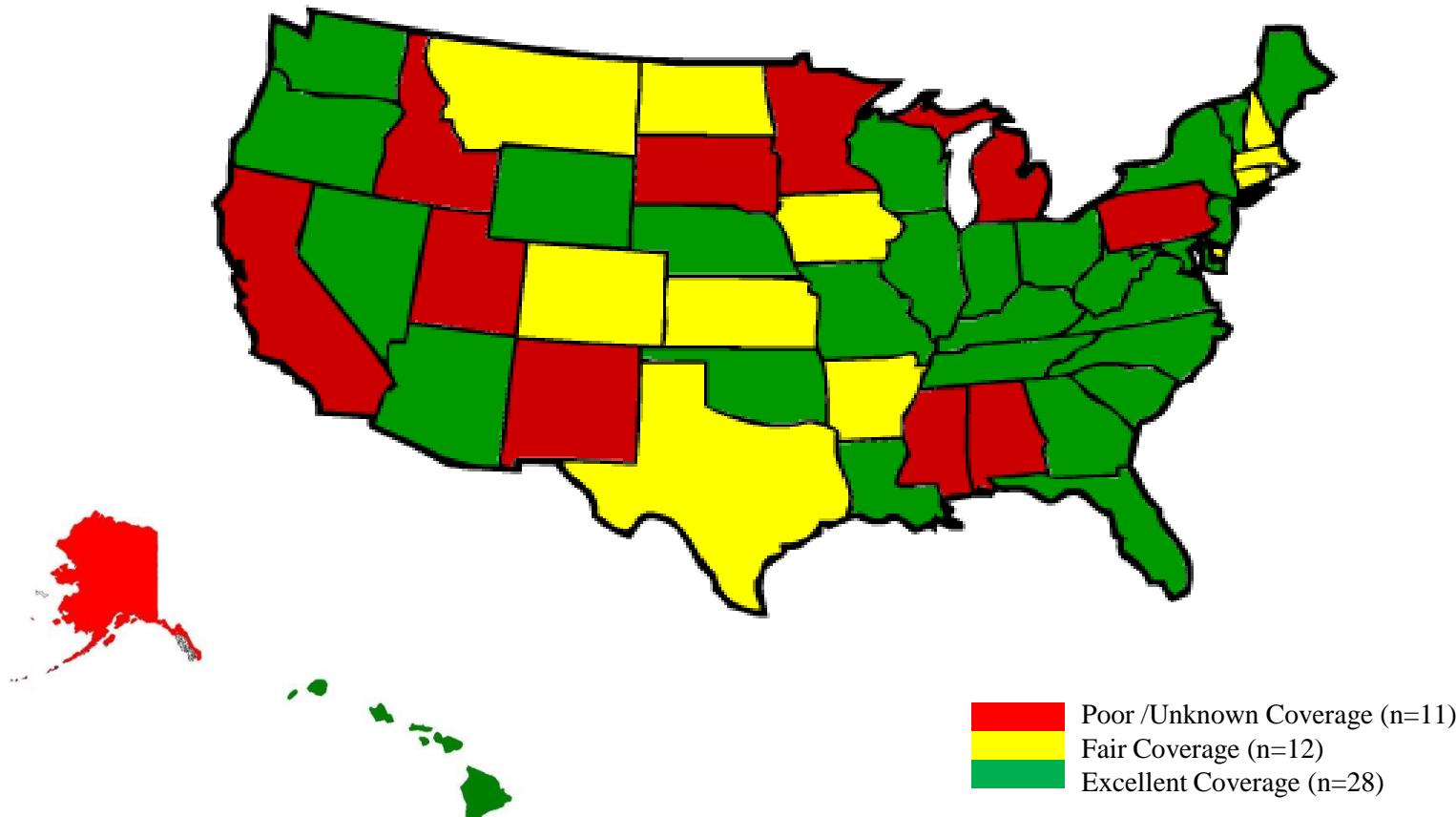


# Essential Health Benefit Set

- Requires coverage of several high-level care categories
- BMT and other transplant types not specifically defined
- Components of BMT are covered in the categories



# Mention of Transplant in State EHB Benchmark Plans



40 states have a detailed mention of BMT in their EHB benchmark plans

# No Lifetime and Annual Limits

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- **Applies to dollar value for EHBs**
  - Annual Limits can be applied to non EHB benefits
- Grandfathered plans can maintain **annual** limits
- No one can maintain **lifetime** total dollar limits
  - Exception: Hold-over individual plans for 2014
- Emerging Issue: Transplant benefits with \$ limit
  - EHBs are not supposed to be subject to \$ limits
  - May be grandfathered plans with old benefit language
  - This benefit type may challenge the vague EHB language

# Children and Dependents

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- Elimination of pre-existing condition clauses for children (up to age 19)
- Coverage of dependents up to age 26
- Both will be very helpful for adolescent and young adult (AYA) BMT patients – in the past, faced issues trying to secure coverage once 18 or when moving off of parental plan

# Removal of Pre-Existing Conditions Exclusion and Waiting Period

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- Removal of Pre-Existing Condition Exclusion
  - Beneficial for former transplant recipients
  - Beneficial for donors, too - faced issues when purchasing individual policies in the past
- Emerging Issue: Waiting Periods
  - Oregon: attempted to put 24 month wait on transplants
  - Washington State: 90 wait period being challenged
  - Up to 90 days allowed by law when patients have not had prior insurance
  - Cannot start patient evaluation during waiting period

# Clinical Trials

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- Coverage of all routine costs associated with clinical trials
  - Labs, Imaging, Drugs, Professional Fees
    - Federally “approved or sponsored” trials
    - “For the treatment of cancer and other life-threatening diseases or conditions”
- Does not apply to the **actual device, treatment or drug** that would normally be given to the patient free of charge by the clinical trial sponsor
- Emerging Issue: For new indications, is the infusion (and associated costs) considered the investigational treatment?

# External Review of Denied Service

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- If a claim or authorization is denied, insurer must tell you:
  1. Process for additional internal review
  2. Right to an external review and how to request it
  3. Information on your state's Consumer Assistance Program (if applicable)
- TBD: impact on the administrative process or authorization timelines
- Emerging Issue: Qualifications of external reviewers
  - Contracted organizations of medical directors
  - May not have hematology or transplant experience
  - Request a review by Hem/Onc or BMT physician

# Benefit Confusion

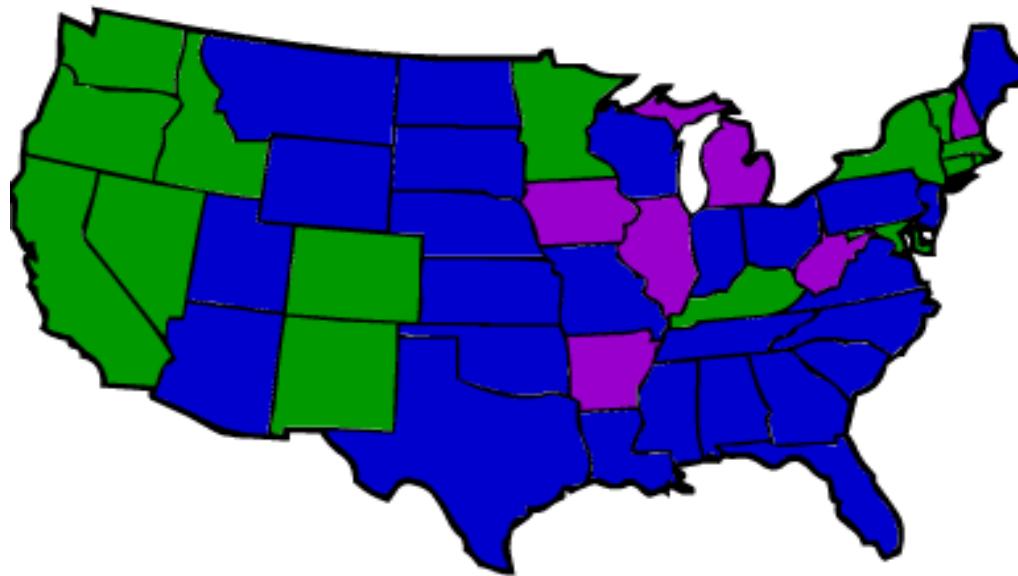
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- Different requirements and applicability of benefits based on the type of health insurance:
  - Grandfathered vs. non-Grandfathered
  - Individual (i.e. those available on the Exchanges)
  - Small Group Fully Insured (less than 50 lives)
  - Large Group Fully Insured
  - Self Insured
  - **Individual hold-over plans**
- Don't make assumptions on patient benefits



# Health Care Marketplace: The Exchanges

# Health Insurance Exchanges (HIX)



State Run Exchange (n=17)  
Federally Facilitated Exchange (n=27)  
Partnership Exchange (n=7)

NMDP Poster with additional detail:  
Health Care Reform & Access to Hematopoietic Cell Transplantation  
Thursday 9:00-5:00pm Longhorn Hall E

# Technological Barriers Slowed Enrollment

The screenshot shows the main landing page of HealthCare.gov. At the top, there's a navigation bar with links for "Learn", "Get Insurance", "Log in", and "Español". Below the navigation is a search bar with a "SEARCH" button. The main content area features a large blue banner with the text "WELCOME TO THE MARKETPLACE: Find health coverage that meets your needs and budget" and "Enroll by February 15 for coverage starting March 1". It also mentions "Open enrollment ends March 31". Below the banner are three circular icons: a blue one for "SEE PLANS BEFORE I APPLY" with a person icon, an orange one for "APPLY NOW FOR HEALTH COVERAGE" with a calendar icon, and a teal one for "USE YOUR NEW COVERAGE" with a document icon. At the bottom, there's a dark footer bar with five links: "See if you can get lower costs", "1-page guide to getting coverage", "Find local help", "Call 1-800-318-2596 for information", and "Verify enrollment & pay premiums".

# Marketplace Enrollment

	<b>Eligible for marketplace plans <i>HHS Report (12/28)</i></b>	<b>Selected a marketplace plan* <i>HHS Report (12/28)</i></b>		<b>Eligible for Medicaid/CHIP <i>HHS Report (12/28)</i></b>
<b>State-run marketplaces</b>	1,794,708	956,991		833,389
<b>Federally facilitated marketplaces</b>	3,345,090	1,196,430		751,120
<b>Total in all marketplaces</b>	<b>5,139,798</b>	<b>2,153,421</b>		<b>1,584,509</b>
<b>CBO 2014 enrollment projection</b>	<b>7,000,000</b>	<b>7,000,000</b>		<b>9,000,000</b>
<b>Percent of CBO 2014 enrollment projection</b>	<b>73.4%</b>	<b>30.8%</b>		<b>17.6%</b>

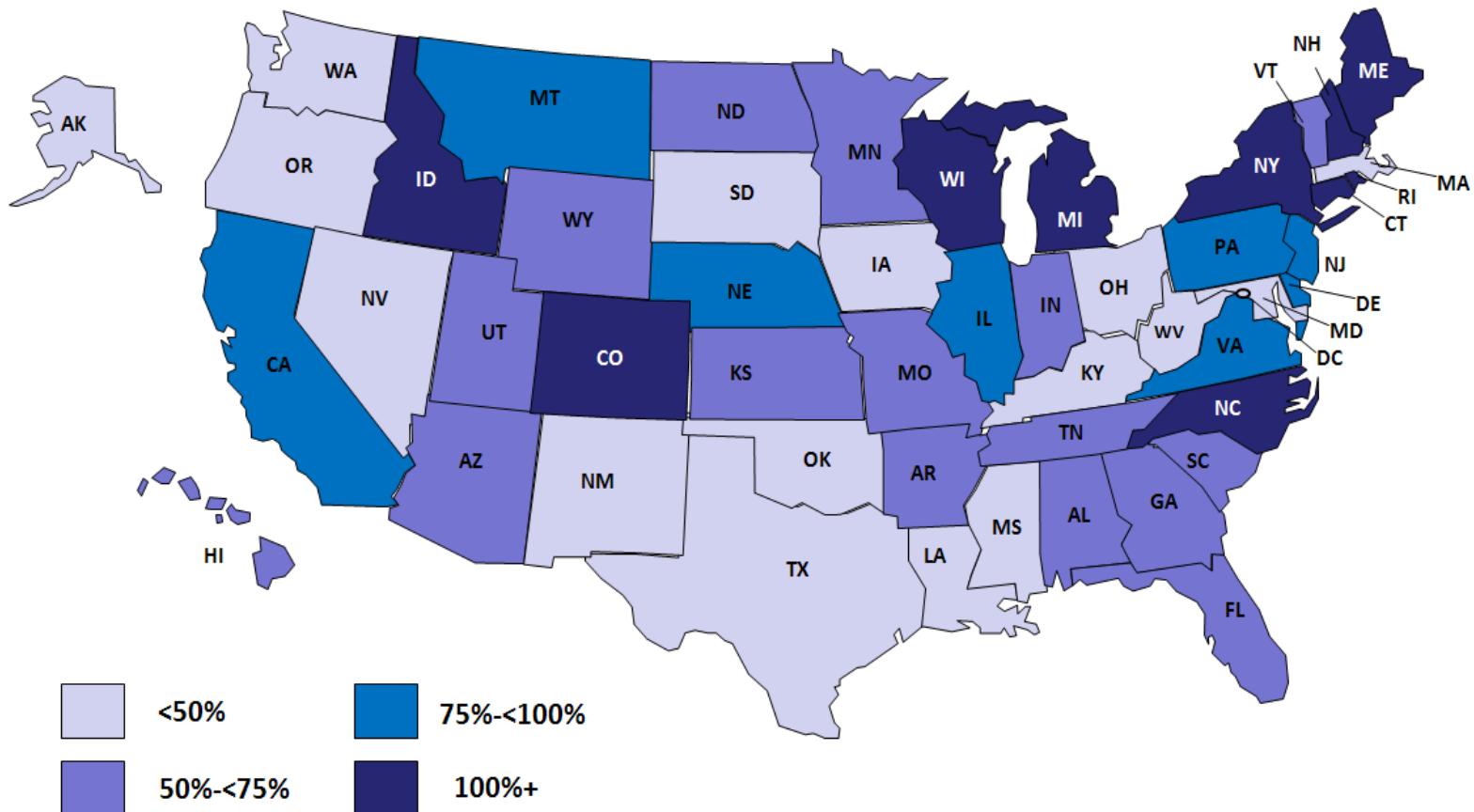
\*People who have selected a marketplace plan may or may not have paid their premiums, and thus finalized their enrollment.

Source: Health Insurance Marketplace: January Enrollment Report, For the Period: October 1, 2013 – December 28, 2013, ASPE Issue Brief, U.S. Department of Health and Human Services, January 13, 2014,

[http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib\\_2014jan\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf); and state websites.

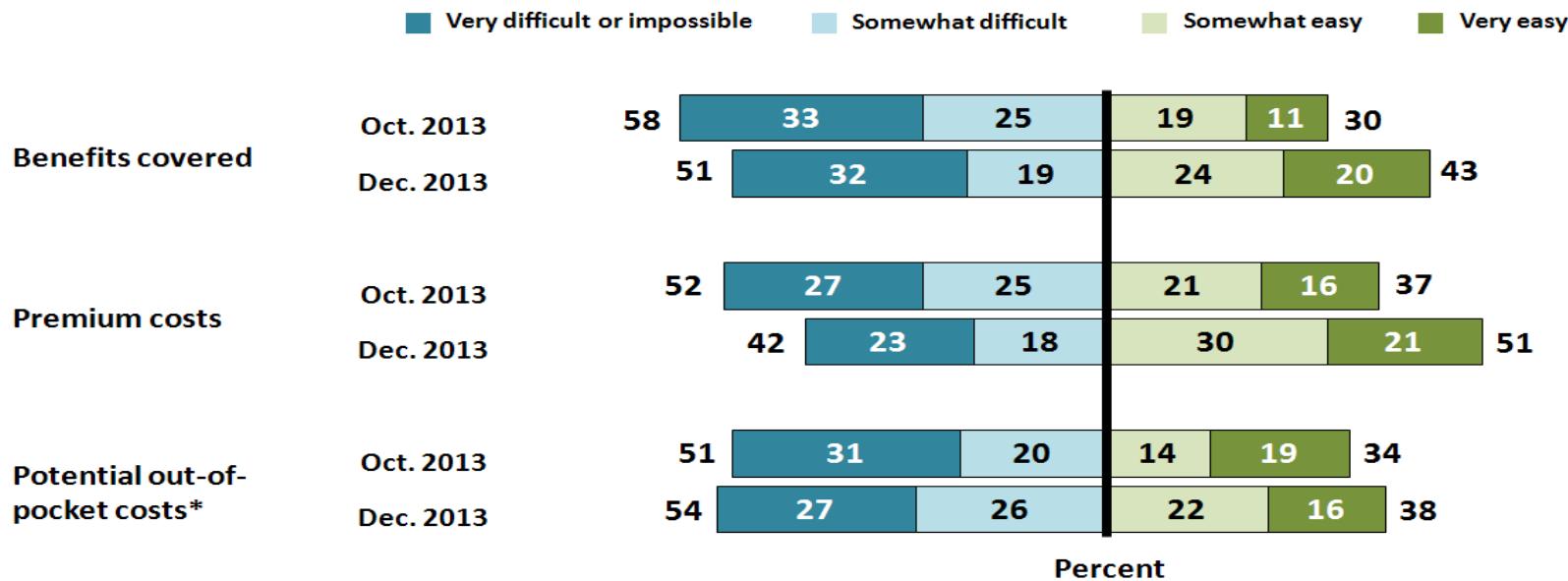
# Marketplace Enrollment

## Percent of three month enrollment target reached by 12/28/2013



# Marketplace Experience: Difficult to navigate options

How easy or difficult was it to compare the ... of different insurance plans?



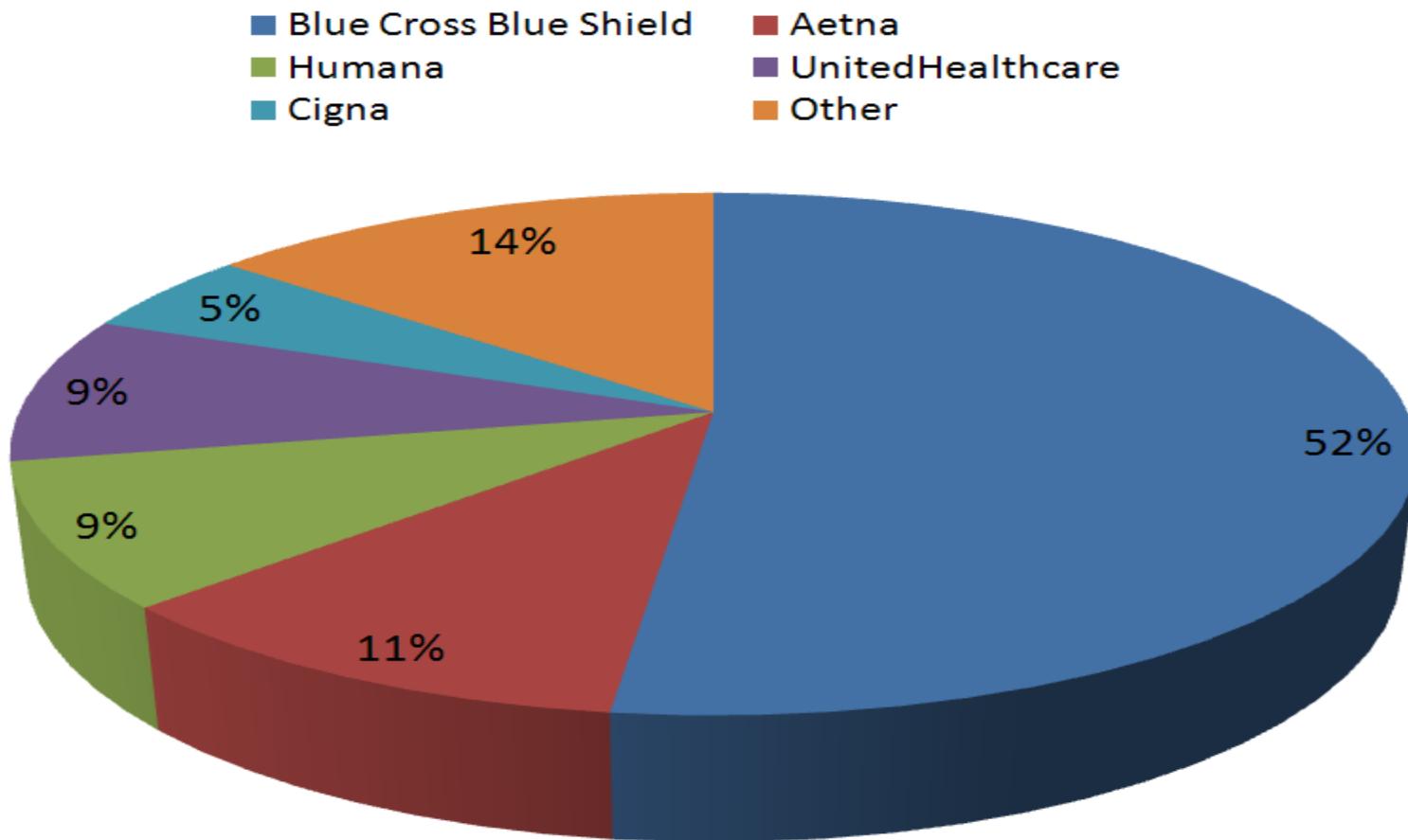
Adults ages 19–64 who are uninsured or have individual coverage and went to marketplace

Note: Bars may not sum to 100 percent because of “don’t know” responses or refusal to respond; segments may not sum to subtotals because of rounding.

\* Potential out-of-pocket costs from deductibles and copayments.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, Oct. 2013 and Dec. 2013.

# Marketplace Plan Selection



# Importance of FEHBP in the Exchanges

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- Many enrollees will have access to the Federal Employee Health Benefit Plans (FEHBP)
- FEHBP:
  - Currently largest employer-sponsored benefit plan, covering 8+ million employees and dependents
  - Limited donor search benefit across most FEHBPs:
    - Siblings plus 4 potential donors
    - Siblings and “actual donor”
  - Disease indication list varies by Plan
- These plans are available in 31 states in 2014; will be rolled out to all states over next four years

# Limited Networks

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- To make exchange plans affordable, insurers may dramatically reduce network size. **In some cases, this could mean there is no Allo BMT provider.**
- Minnesota:
  - Several “one-name” plans – e.g. Fairview, Allina – limit providers to the provider/hospital group in their network
  - Of 13 plans offered, only **9** have an Allo BMT program in network
- Some centers may have opted out of networks due to very low reimbursement rates

# Unknown: How will limited network issues be handled?

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- When a patient is in a limited network plan and needs a transplant, what options will they have?
  - Single-case agreements with a local provider?
  - Will patients face out-of-network costs?
  - Will they have to go to the closest center?

# Future of Exchanges: Will the State Exchanges Succeed?

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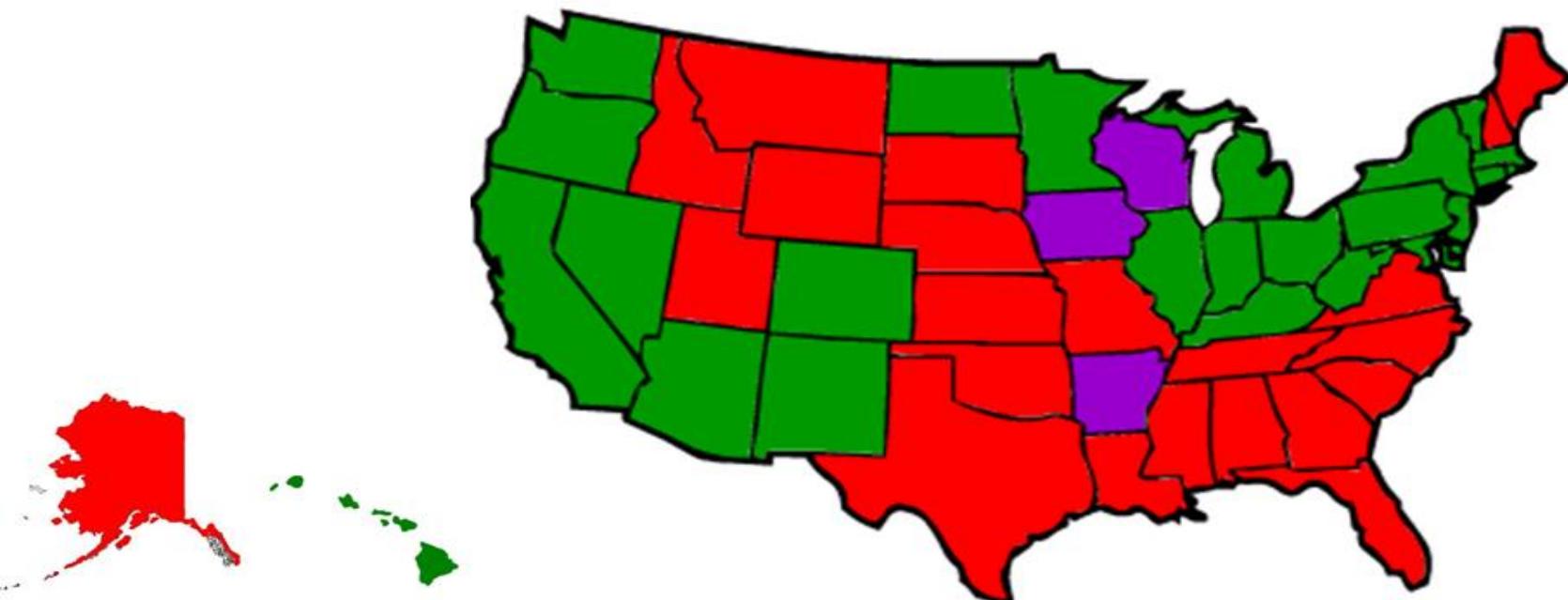
- State exchanges are funded by federal grants and fees from health plan carriers
- Grants end by 2015; Need to become self-sustaining
- Lower than expected enrollment means a funding crisis
- State Examples:
  - MNSure: received \$150 million in grants; enrollment strong enough that it will be self-sustaining in 2015
  - Oregon: ~8% of expected enrollment as of December 28<sup>th</sup>. Plagued by technical problems - looking to move to federal operations if the situation does not improve



# Medicaid Expansion

# Medicaid Expansion Decisions

State Medicaid Expansion Decisions



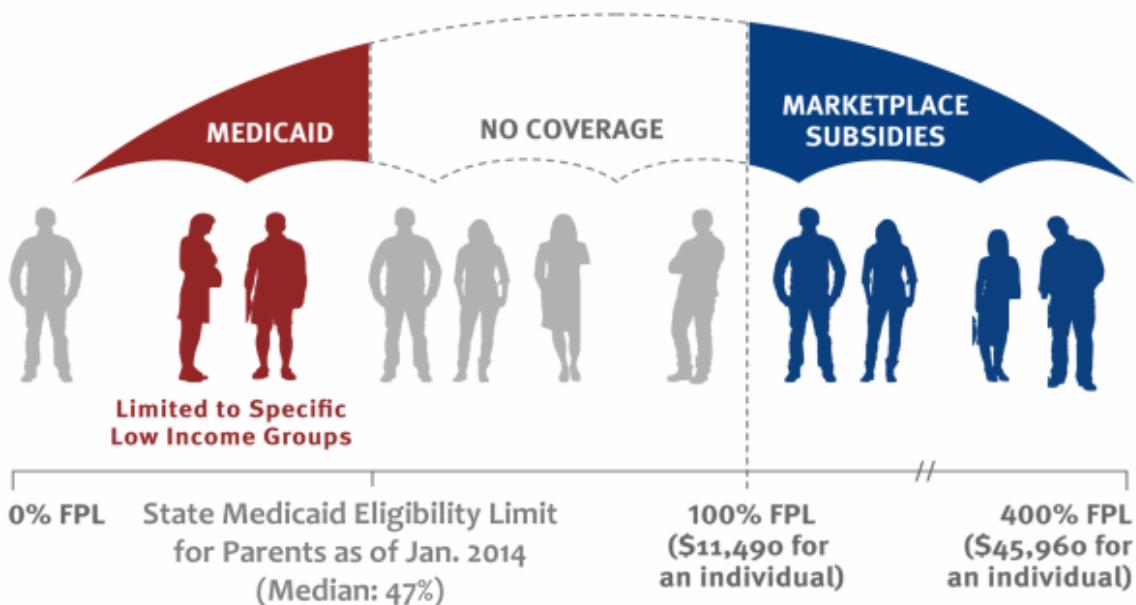
On average, 24% of each state's population will have Medicaid after the expansion.

 Expanding (n=26)  
Unique Expansion plan (n=3)  
Not Expanding (n=22)

# Gap in Coverage in Non-Expansion States

Figure 3

**In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.**



NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid.

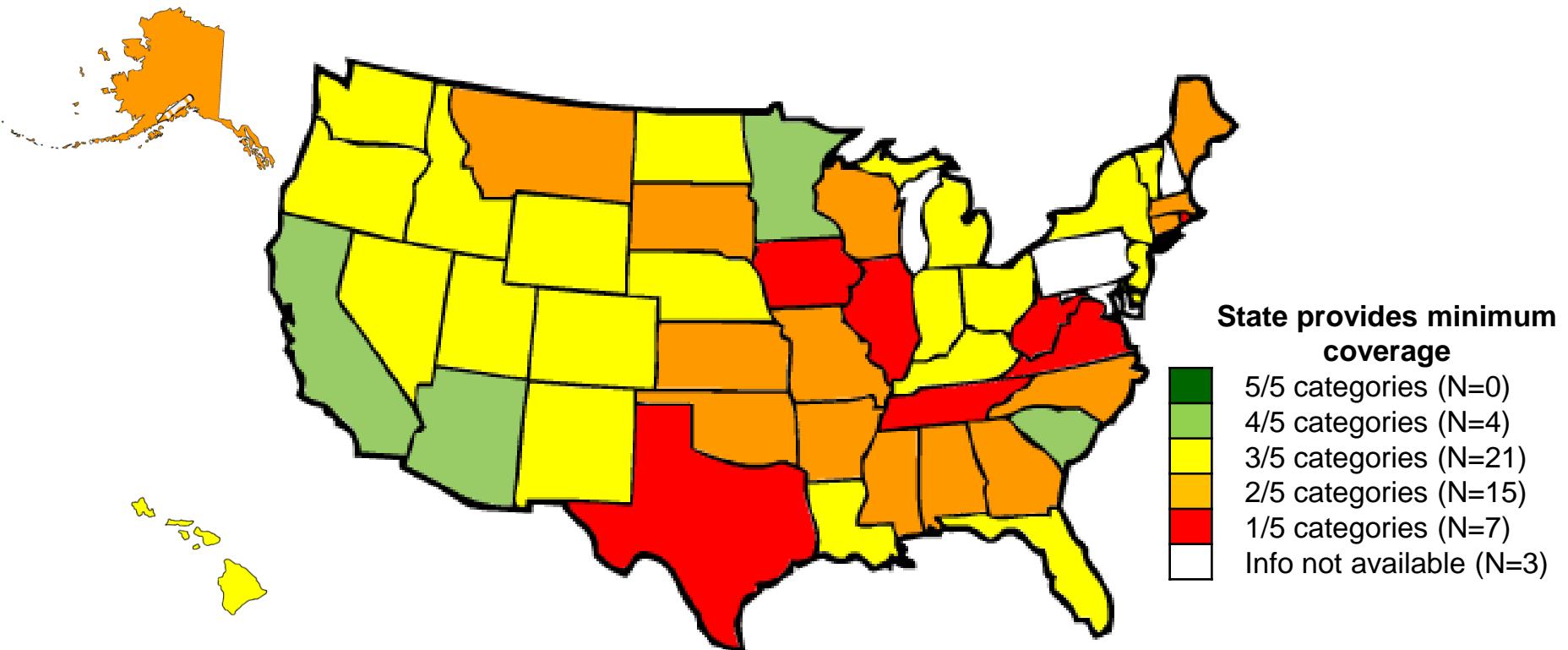


# Medicaid and BMT

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- **Bottom line = more access, less delay in eligibility**
- However, Medicaid continues to be a poor payor overall
  - Lack of donor search coverage
  - Limited coverage of certain donor options – cord blood
  - Reimbursement rates often far below cost
- Patients in a state without a TC will continue to have barriers to access
  - Other states not required to accept out-of-state Medicaid
  - Travel and lodging benefits limited or non-existent
- **Expansion does not fix the benefit issues**

# Medicaid Benefit Rating



Source: JM Pruessler, SH Farnia, EM Denzen, NS Majhail. "Variation in Medicaid Coverage for Hematopoietic Cell Transplantation". Accepted for Publication in Journal of Oncology Practice.



# Paying for Quality

# Medicare Focus on Quality

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- Medicare reforms focus value and research:
  - Required measurement of quality indicators
  - Created the Patient-Centered Outcomes Research Institute (PCORI)
  - Created the Innovation Center – will support innovation through payment bundling, etc.
    - Accountable Care Organizations
    - Patient Centered Medical Home
- Promote the adoption of electronic medical records
  - Capture patient care data
  - Feed studies on effectiveness

# Comparative Effectiveness Research

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- Due to increased focus on cost control, all areas of medicine subject to new scrutiny
- Interested in knowing:
  - What works? = Clinical Effectiveness
  - What works best? = Comparative Effectiveness
  - What has the best value? = Cost Effectiveness
- Value = Return on Investment
- **How do we demonstrate our value as a field?**
- **How do TCs demonstrate their value to a network?**

# Defensive Driving for Transplant Centers

Or - Proactive Positioning?



# Real Impact of the ACA: Tipping Point for Program Fiscal Health

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- Many trends prior to the ACA were in evidence – smaller networks, paying for quality, demonstrating efficacy and value
- Hospitals face a great amount of pressure to evaluate all service lines for their impact on the bottom line
- Transplant programs should not rely on the business office in understanding their revenue flow
- Successful TCs will need to understand and advocate internally and externally for their programs

# 1. Know Your Payors

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- Public and Private, Local and National; Understand their COE programs, client strategies and quality initiatives
- Keep track of your contacts – Medical Directors, Clinical/Administrative Program leads, Case Managers
- Build relationships outside of billing problems and appeals. Share information on clinical trials, expertise in rare indications, program strengths
- Find ways for your physicians to be involved in policy decisions, expert panels, advisory committees
- Don't forget about Medicaid – often looking for assistance in determining medical policies

## 2. Know Your Market

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- Does your state:
  - Have a State-run or Federally Facilitated Health Insurance Marketplace? Partnership?
  - Have an expanded Medicaid eligibility plan?
  - What does the state EHB benchmark plan look like? Does it explicitly mention transplant?
- What about other states near your center or that you commonly receive referrals from?
- **New** NMDP Resource: Database of key information, searchable by state. Coming Soon! Spring 2014

### 3. Know Your Networks

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- Know what networks and Exchange plans your center participates in
  - Conduct a detailed review of the BMT benefits in these plans
  - Consider having a list of networks that you participate in on hand for current or future patients when reviewing their options
  - Talk with your contracting team about how to handle limited network exclusions of your center

## 4. Know Your Colleagues

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- Get to know people in key departments:
  - Contracting
  - Coding/Billing
  - Government Affairs/Relations
- Consider having discussions with each department about the impact of the ACA changes on your team
  - Government Affairs: Ask for their help in educating local officials about any transplant benefit problems with your local EHB benchmark plan
  - Contracting: Make sure to explain your costs and special issues (donor search) for their exchange plan negotiations

## 5. Know Your Numbers

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Understand:

- Your program's clinical outcomes and how they compare to others in the area and nationally
- Your program's balance sheet and how it compares to other service lines
- Your hospital's overall financial health and how they're planning to prioritize funding
- Your Medicare reimbursement, the rate-setting process, and your center's reporting behaviors
- Your center's typical donor search pattern, average cost and if there are ways to search more cost-effectively

# Questions?

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Payor Policy staff will be at the NMDP Booth  
tomorrow (Friday) from 12:30-1:30PM

[NMDPpayorpolicy@nmdp.org](mailto:NMDPpayorpolicy@nmdp.org)

[www.network.bethematchclinical.org/reimbursement](http://www.network.bethematchclinical.org/reimbursement)