The Affordable Care Act & BMT: Updates and Program Impacts

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Tandem BMT Administrators’ Meeting
2/27/2014

Overview of Presentation

• 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?

Better
- Guaranteed Coverage
- No Lifetime $ Limits
- More Patients with Coverage

Worse
- Premium Costs
- Limited Networks

On the whole, should be a positive change for our BMT patients.
The Biggest Win: Increased Access to Transplant

• 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
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

- 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

- 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

- 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

• 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

• 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

- 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)

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
### Marketplace Enrollment

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<tr>
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<tbody>
<tr>
<td>State-run marketplaces</td>
<td>1,794,706</td>
<td>956,591</td>
<td>833,389</td>
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<tr>
<td>Federally facilitated marketplaces</td>
<td>3,346,090</td>
<td>1,196,436</td>
<td>751,120</td>
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<tr>
<td>Total in all marketplaces</td>
<td>5,140,796</td>
<td>2,153,021</td>
<td>1,584,509</td>
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<tr>
<td>CBO 2014 enrollment projection</td>
<td>7,000,000</td>
<td>7,000,000</td>
<td>9,000,000</td>
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<tr>
<td>Percent of CBO 2014 enrollment projection</td>
<td>73.4%</td>
<td>100.0%</td>
<td>17.6%</td>
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*People who have selected a marketplace plan may or may not have paid their premiums, and thus finalized their enrollment.

Marketplace Enrollment

People who have selected an exchange plan, as of Feb. 1

Source: U.S. Department of Health and Human Services

Marketplace Experience: Difficult to navigate options

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

<table>
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<tr>
<th>Benefits covered</th>
<th>Oct. 2013</th>
<th>50</th>
<th>33</th>
<th>25</th>
<th>19</th>
<th>11</th>
<th>30</th>
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<tr>
<td></td>
<td>Dec. 2013</td>
<td>51</td>
<td>32</td>
<td>19</td>
<td>24</td>
<td>20</td>
<td>43</td>
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<table>
<thead>
<tr>
<th>Premium costs</th>
<th>Oct. 2013</th>
<th>52</th>
<th>27</th>
<th>25</th>
<th>21</th>
<th>18</th>
<th>37</th>
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<tbody>
<tr>
<td></td>
<td>Dec. 2013</td>
<td>51</td>
<td>23</td>
<td>18</td>
<td>30</td>
<td>21</td>
<td>51</td>
</tr>
</tbody>
</table>

| Potential out-of-pocket costs* | Oct. 2013 | 51 | 31 | 20 | 14 | 19 | 34 |
|                               | Dec. 2013 | 54 | 27 | 26 | 22 | 16 | 38 |

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

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

Marketplace Plan Selection

- Blue Cross Blue Shield: 52%
- Aetna: 14%
- Humana: 9%
- UnitedHealthcare: 9%
- Cigna: 5%
- Other: 11%

Importance of FEHBP in the Exchanges

- 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

- 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?

- 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?

- 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 28th. Plagued by technical problems - looking to move to federal operations if the situation does not improve

### Medicaid Expansion
Medicaid Expansion Decisions

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

Gap in Coverage in Non-Expansion States

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

- **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

Medicare Focus on Quality

• 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

- 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

- 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

- 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

- 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

- 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

- 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

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?

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

NMDPpayorpolicy@nmdp.org
www.network.bethematchclinical.org/reimbursement