

Health Care Reform in 2011: What It Means for Today, Tomorrow

AN INTERVIEW WITH DEAN A. ROSEN, JD

Along with the economy, health care reform is currently top on the minds of many in the United States. Since the sweeping health care bill, the Patient Protection and Affordable Care Act (PPACA), was signed into law in mid-March 2010, there has been much debate and questioning regarding its overall effects. Retina Today recently spoke with health-policy expert Dean A. Rosen, JD, a Partner with Mehlman Vogel Castagnetti in Washington, DC, to sort through some of these issues for our readers.

Retina Today: Insurance reform is the first step in the overall health care reform timeline. What should physicians know in terms of the impact for private insurance patients as well as those on Medicare or Medicaid?

Dean A. Rosen, JD: The Patient Protection and Affordable Care Act has two main timelines for implementation. One set of reforms, which includes no more lifetime financial limits on insurance coverage, restrictions on annual insurance financial limits, no pre-existing condition limits for children, and coverage for adult children up to age 26 on their parents' health plans, has already begun to be put into place. Additionally, this set of reforms includes some protections for patients and, therefore, doctors, in terms of appeal rights. For example, patients have the right to appeal if they feel they have been wrongly denied certain benefits by their plan.

The second wave of more comprehensive insurance reforms will go into effect in 2014. At this time, the state insurance exchanges for small businesses and individuals and restrictions on how much insurers can charge individuals based on factors such as age, gender, and health status become effective. Also included in the private insurance sector is a whole set of subsidies that will help individuals be better able to afford their coverage.

There are also big changes ahead for Medicaid coverage. It is estimated that 32 million Americans will gain

insurance coverage as a result of the new law; half of those will be covered under Medicaid.

RT: What are the key prescription drug provisions of which retina physicians should be aware?

Rosen: Retina-related drugs, such as bevacizumab (Avastin, Genentech) and other injectables that are physician-administered, are covered under Medicare Part B, so there will be few changes for those doctors who see Medicare patients and provide in-office treatments under the law. For Medicare Part D, however, there will be some changes with respect to access to what is covered—affordability is addressed under an agreement between key members of Congress, the Administration, and the pharmaceutical industry. There will be a subsidy of approximately 50% for those who hit the so-called donut hole in Medicare. Currently, these patients are covered under the standard Medicare prescription benefit up to a certain amount, approximately \$2,000. From there until roughly \$4,000, when Medicare kicks in with catastrophic coverage and covers 95% of drug costs, patients are on their own, except for very-low-income seniors. The new provisions, however, will include a relatively generous subsidy within that donut hole, so instead of paying 100%, patients will pay about half the amount they would normally owe. This should make a substantial difference in terms of seniors being able to better afford their prescription drugs.

In the private sector, patients who previously did not have insurance will have insurance and drug benefits as part of the standard benefits defined by the law. For patients who currently have private insurance, there will not be dramatic changes outside of terms of coverage.

Under this new health care law, approximately 32 million previously uninsured people will gain medical insurance. Half of those will receive insurance through Medicaid. As physicians are aware, the reimbursement for services to doctors through Medicaid is relatively low, and on top of that, many

states have restrictive prescription drug lists and formularies with which both patients and doctors will have to contend.

The other part of the law that is not directly aimed at prescription drugs but that will most likely have an effect is the provision for the formation of a group known as the Patient Centered Outcomes Research Institute (PCORI). This group is composed of individuals from the private sector and will be responsible for reviewing the comparative clinical effect of prescription drugs. The implication is that this will bring more scrutiny from the US Food and Drug Administration (FDA) and the Centers for Medicare and Medicaid Services (CMS) in regard to newer, more costly drugs.

RT: Will there be an effect on the ability of physicians to prescribe branded drugs to patients when generics are available?

Rosen: There could be. Generics are already on the preferred tier of most private insurance plans. You might have drugs that are older and are generic, and then a company does research for years and invests millions, if not billions, of dollars to develop a new drug with additional clinical benefit. If that drug is examined in a robust, transparent matter, however, and it is determined that the additional clinical benefit does not justify the higher cost, it may not be placed in a preferred tier or be covered at all.

RT: Will PCORI make its recommendations directly to the FDA?

Rosen: They will make recommendations publicly, but not directly to the FDA. In general, PCORI will be evaluating drugs that are already FDA-approved.

RT: What are the roles that individual states are playing and will continue to play?

Rosen: Individual states have a large role in implementing the law. First, as I mentioned earlier, 50% of the 32 million people newly insured under health care reform will be covered under Medicaid. An additional 7 to 10 million are expected to gain coverage through state-based health insurance exchanges, which are essentially organized purchasing entities at the state level to help consumers compare costs and benefits of different insurance plans. So, although the tax subsidies will come from the federal government, they will flow through the states, and these must oversee and enforce the law.

Although states have substantial responsibility for expanding coverage under the law through Medicaid and these exchanges, it remains to be seen how much flexibility

they will have to make decisions that may reflect individual market conditions in their states. Some believe that the federal law is too rigid and prescriptive and does not allow the states enough flexibility to manage these programs.

RT: How will Republican control of the House in 2011 affect health care reform?

Rosen: Health care reform was, of course, a major issue in the recent 2010 midterm elections. Almost all of the new Republican House members and many of the new Republican senators campaigned on platforms of repealing the health care reform bill and replacing it with what they say are more common-sense reforms. The Democrats continue to control the Senate, however, and any votes by the House to repeal the law or portions of the law would have to pass the Senate. Further, even if a repeal did pass the Senate, it would be subject to a presidential veto. So we still have divided government, and I believe that there will be a lot of heat, but little change in direction based on these factors.

I do, however, foresee more hearings and oversight committees directed toward the Administration on this subject. The Secretary of Health and Human Services testified once before the House in the 8 or 9 months since the bill was enacted when the Democrats controlled the House in 2010. Donald M. Berwick, MD, MPP, the Administrator for CMS, never testified. Under Republican control of the House, that will change. There will be several hearings by different committees of the House, and additional forms of oversight as well, regarding what Republicans view as bad decisions that are being made by the Administration or provisions in the law that they think are wrong.

If repeal efforts fail, I believe that individual provisions that are unpopular in the health care reform bill, such as the mandate for individuals to purchase insurance, will be addressed through more targeted laws that will move through the Republican-controlled House. Even these surgical strikes may not pass the Democratic Senate. Much of these efforts at repealing and replacing the law, as well as oversight, are aimed at reminding the American public that many of the provisions of the law are unpopular, in the hopes that Republicans will win the presidency and pick up more congressional seats in the 2012 election and be able to repeal or make more substantial changes to the law at that time. ■

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