# What Lies Ahead for the Health Care Industry: A Glimpse into the Post-Reform Health Care System

Health Care Practice Group

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# Agenda

- Current State of Play
- Fast Forward to 2015
  - Coverage
  - Health Insurance Market
  - Reformed Delivery System
    - Quality
    - Integration and Coordination
    - Reimbursement
  - Compliance and Integrity
- Preparing for 2015 and Beyond: What You Should Consider

## Current State of Play/Immediate Future

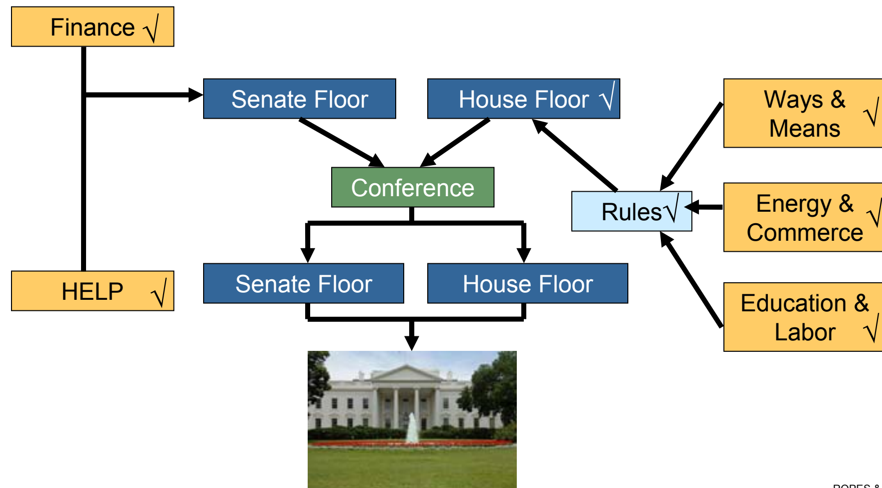
- House passed Affordable Health Care for America Act on November 7
- Senate began debate on Patient Protection and Affordable Care Act on Monday
  - Narrowly passed motion to proceed with debate 60-39
  - Expect numerous amendments and weeks of debate
  - Senate passage by year-end?
- Final passage anticipated in early 2010



## Outlook for Senate Debate

*Kaiser Health News,* "Herding Cats" by David Fitzsimmons, Dec. 1, 2009.

# Remaining Process






# Controversial Issues Still Ahead

- Public plan
- Employer mandate
- Financing mechanisms
- Subsidy levels
- Abortion coverage in Exchange plans
- Immigrants' ability to purchase plans through Exchange
- Medicaid coverage levels & federal funding
- Extension of ARRA enhanced FMAP
- Value-based purchasing
- Medicare Commission vs. IOM approach
- Selling insurance across states lines

## Fast-forward to 2015…
## Overview of Major Reforms

- Coverage
  - Individual and Employer Mandate
  - Exchange(s) and Subsidies
  - Medicaid Expansion
- Insurance Reforms
- Delivery System Redesign
  - Quality, coordination
  - Compliance and transparency
- New financing mechanisms



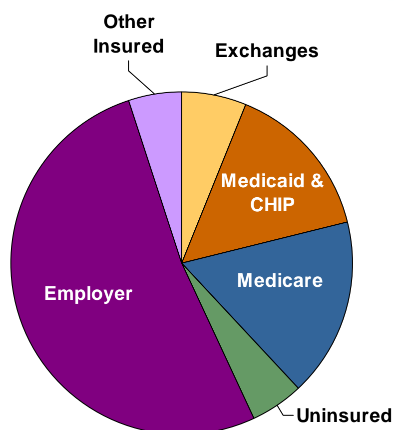
# COVERAGE

## Gradual Implementation

- Reforms phased in beginning upon date of enactment
- Coverage expansions and Exchanges do not begin until 2013/2014
- Financing, delivery system and workforce reforms beginning earlier
- Some stop-gap measures to serve as bridge to coverage expansions
- See Appendix for detailed timeline



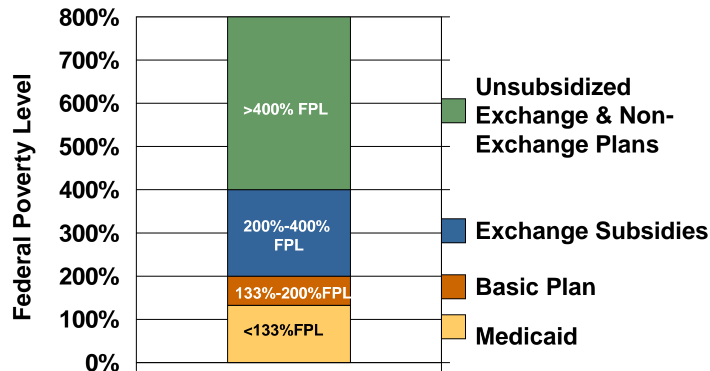
## What Coverage Looks Like in 2015




- By 2015, 92% (Senate) to 94% (House) of population insured
  - 94% (Senate) to 96% (House) excluding unauthorized immigrants

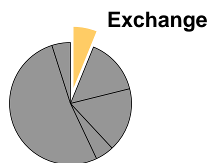
Data from CBO Letter to Hon. Harry Reid estimating spending and revenue effects of the Patient Protection and Affordable Care Act (Nov. 18, 2009) and from CMS 2008 Medicare Trustees Report

## Coverage by Income Level (Senate)



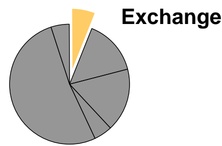


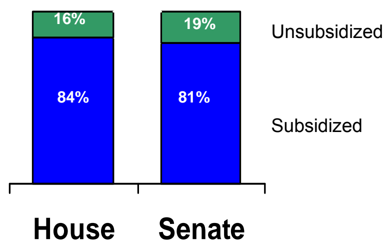

## Exchange(s)




- Exchanges functioning for individuals and small employers
  - May see further expansion to larger employers
- 16-19 million people in 2015
  - Individuals, including former CHIP (House)
  - Workers with unaffordable employer coverage
  - Members of Congress (Senate)
  - Catastrophic coverage – offered to individuals under 30 or exempt from mandates (Senate)
  - Undocumented Immigrants—House permits participation but without subsidies
  - Public plan enrollees: 3-4 million (Senate), 6 million (House)

# Exchange(s)

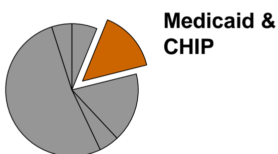



- Majority qualify for subsidies
- Sliding scale premium subsidies
  - House:133-400% FPL, Limit spending to 1.5%-12% of income
  - Senate:100-400% FPL, Limit spending to 2% to 9.8% of income
- Cost-sharing credits
  - House: 133-400% FPL, Covers 97-70% of benefit costs of plan
  - Senate: 100-400% FPL, Covers 90-70% of benefit costs of plan

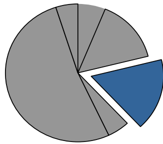


# Medicaid




- Expanded to 133% (Senate) or 150% (House) of FPL
- States newly sharing burden of newly-eligible (House) or anticipating in 2017 (Senate)
- States may have reduced eligibility for optional populations
  - Different MOE in House and Senate
  - Financial challenges after ARRA enhanced FMAP ended
- 44-47 million covered by Medicaid/CHIP (10-13 million new beneficiaries)

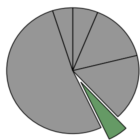
# Medicare




- No changes in eligibility
- Fewer individuals in Medicare Advantage
  - House: Aligns MA plan payments with Medicare FFS rates
  - Senate: Competitive benchmark for MA plan rates
  - CMS predicts MA enrollment drop of 64% (13.2 million projected under current law to 4.7 million) by 2014 under House provisions

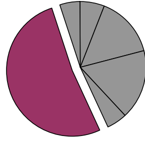


# Uninsured




- 17 million (House) to 28 million (Senate) remaining in 2015
- Reduced by 34 million (House) or 23 million (Senate)
- Includes:
  - Undocumented immigrants (1/3 of remaining uninsured under Senate)
  - Individuals exempt from penalties
  - Individuals accepting penalties

## Employer-Based



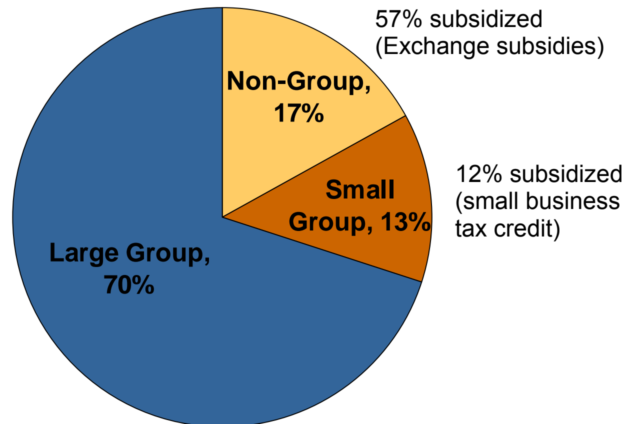
Employer

- 5/6th of commercial insurance is employer-based
- Small group vs. large group
  - Small groups may participate in the Exchange
  - Small groups eligible for tax credit
- Current coverage grandfathered
- Tax on high cost plans (Senate)
  - 19% of employment-based plans impacted
  - May result in reduced value of plans



# HEALTH INSURANCE MARKET

## Snapshot of Reformed Insurance Market




Based on CBO Letter to Hon. Harry Reid estimating spending and revenue effects of the *Patient Protection and Affordable Care Act* (Nov. 18, 2009)



## Exchanges Enter the Market

- National (House) or state/regional (Senate) exchanges
  - Administered by National Commissioner (House) or government or non-profit entity (Senate)
  - Private plans, public option, co-ops
- Only Qualified Health Benefits Plans may participate
  - Standardized affordability, essential benefit, and consumer protection requirements
  - 4 plan types ranging from 60/70% to 90/95% actuarial value

## Essential Benefits

- Hospitalization
- Ambulatory services
- Emergency Services
- Maternity & newborn care
- Mental health/substance abuse
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care
- Durable medical equipment (House)
- Services, equipment and supplies incident to physician services (House)



## Public Plan Competing with Private Exchange Plans

- States may opt out (Senate)
- Subject to all Exchange plan requirements
- Rates negotiated with providers
  - Ceiling based on average rates paid by Exchange plans; House creates floor based on Medicare rates
- Costs financed through premium revenues
- Start-up funding recouped over 10 years
- Basic Health Plan option for 133-200% FPL (Senate)

## Changes in Premiums

| | Percentage, by Market | | |
|---|---|---|---|
| | Nongroup[a] | Small Group[b] | Large Group[c] |
| Distribution of Nonelderly Population Insured in These Markets Under Proposal | 17 | 13 | 70 |
| *Differences in Average Premiums Relative to Current Law Due to:* | | | |
| Difference in Amount of Insurance Coverage | +27 to +30 | 0 to +3 | Negligible |
| Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees | -7 to -10 | -1 to -4 | Negligible |
| Difference in Types of People with Insurance Coverage | -7 to -10 | -1 to +2 | 0 to -3 |
| Total Difference Before Accounting for Subsidies | +10 to +13 | +1 to -2 | 0 to -3 |

Based on CBO Letter to Sen. Evan Bayh analyzing impact on premiums of the *Patient Protection and Affordable Care Act* (Nov. 30, 2009)



## Impact of Public Plan Premiums

- Public plan's premiums somewhat higher than the average private plan in the exchanges
  - Lower administrative costs than private plans, but
  - Less benefit management and attract a less healthy pool of enrollees (risk adjustment imperfect)
- Public plan would reduce slightly private plan premiums
  - Competitive pressure in the exchanges in areas that are currently served by a limited number of private insurers
  - Public plan would attract the less healthy enrollees

## Insurers Living Under New Regulations

### Small group & individual market reforms:

- Guaranteed issue & renewability
- No pre-existing condition exclusions
- Community rating
- Medical loss ratio
- Annual review of premium increases by HHS/States (House)
- Essential health benefits package

### All group & individual market reforms:

- No lifetime or unreasonable annual limits
- No rescissions
- Unmarried dependent coverage
- No cost sharing for preventive services
- Extension of mental health and substance abuse parity requirements
- Quality reporting (Senate)



## Expanded Reach but New Taxes

- Sale of insurance across state lines (Senate)
  - Regional compacts
  - Nationwide plan
- New taxes
  - High cost health plans tax (Senate)
  - Annual fee on all insurers (Senate)
  - Per capita fee on insurers for comparative effectiveness (House & Senate)

# REFORMED DELIVERY SYSTEM



## Payments Based on Quality (Senate)

- Hospitals
  - In 3rd year of VBP program, facing 1.5% payment reduction to fund incentive payments
- Physicians
  - Quality reporting mandatory since 2014
  - Receiving reports on relative per capita utilization
  - First year of quality payment modifier
- Skilled Nursing Facilities & Home Health
  - HHS' VBP plan released in 2012
  - Congressional action to implement?

## Payments Based on Quality (House)

- IOM issued recommendations in 2011 for establishment of Medicare "value index"
  - GME, DSH and HIT payments excluded
- Deadline for Congressional action passed in 2012
- Value index implemented?



## Payments Based on Quality

- Healthcare Acquired Conditions (HACs)
  - 2015 is first year when high HAC rates result in payment penalties
  - 1% payment penalty in 2016 based on 2015 HAC rates
  - Medicaid nonpayment began in 2010 or 2011

## Toward More Integrated & Coordinated Care

- Coordination among hospitals and post-acute providers
  - Ongoing payment bundling demo
  - Medicare payment reductions for high readmission rates
- Demonstrations underway to test new models
  - Accountable Care Organizations
  - Medical Homes/Health Homes
  - Collaborative Care Networks
  - New CMS Innovation Center evaluation of models
- HIT Payment Incentives/Penalties in Place



## Workforce Adequacy

- Primary care shortages anticipated with full implementation of coverage expansions
- Workforce Initiatives
  - Federal advisory body on workforce development
  - Numerous grant and demo programs in place
  - Medicare residency slots have been redistributed to primary care
  - Training in teaching health centers and outside of inpatient setting
  - Medicare & Medicaid primary care payment bonuses

## Provider Reimbursement Changes

- Annual Medicare productivity adjustments for most providers
  - Hospitals also subject to market basket reduction
- Medicare and Medicaid DSH
  - First states may meet trigger for Medicaid DSH cuts (Senate) or anticipating DSH report in 2016 and cuts in 2017 (House)
  - First year Medicare DSH payments cut 75% and a portion redistributed (Senate) or anticipating report in 2016 and cuts likely beginning 2017 (House)
- SGR still under annual fixes???



## Provider Reimbursement Changes (Cont.)

- Medicare fast-tracked payment reform initiatives in place
  - (Senate) Independent Medicare Board issued first report in January 2014 for 2015
  - (House) IOM recommendations on value-based index implemented, unless Congress disapproved
  - (House) Geographic adjustments to hospital & physician payments implemented; no hold harmless payments
- Medicaid Payment Adequacy Reports
  - (Senate) MedPAC and MACPAC required to study Medicaid rates

# COMPLIANCE/ INTEGRITY




## Compliance/Integrity

- False Claims Act extended to payments made "by, through or in connection with" the Exchange (Senate)
  - If payments include federal funds
  - Beyond treble damages – up to 6 times the amount
- FCA applies to public plan in House bill
- No knowledge requirement for anti-kickback liability (Senate)
- New physician self-referral disclosure protocol in place (developed 6 months after enactment)

## Compliance/Integrity

- More limited availability of the Stark law's whole-hospital exception for physician-owned hospitals
- Physician payments sunshine requirements took effect in 2011 or 2013
- No more blanket antitrust exemption for health insurers (House)



## Compliance/Integrity (Cont.)

- Medicare/Medicaid requirement to establish a compliance program by a date set by HHS
- RAC now reviewing Medicare Part D, MA, and Medicaid (Senate)
- Tax-exempt hospitals must complete community needs assessment every 3 years, and annual reporting on charity care, etc.

# FOOD FOR THOUGHT




## Preparing for 2015 and Beyond: What Providers Should Consider

- How will your **patient population** change under health reform? Do you anticipate significant new insured populations? Will your insured patients have better coverage? Will there be a significant Medicaid expansion in your state? Will you likely still treat a significant uninsured population?
- How are your **payment rates** likely to be affected by the new coverage – Medicaid rates vs. Exchange plan rates vs. public plan negotiated rates vs. current rates?
- Are you prepared to absorb **payment cuts** – Medicare productivity adjustments, Medicare & Medicaid DSH cuts, market basket reductions?
- How will your **uncompensated care** costs be impacted?

## What Providers Should Consider (Cont.)

- Are you part of an **integrated delivery system** or are your relationships with other providers organized such that patient care can be appropriately coordinated?
- Does your system include sufficient **primary care capacity**, or are you affiliated with a sufficient network of primary care providers, to meet anticipated demand? Are incentives appropriately aligned with these providers?
- Have you established programs to manage **chronic diseases**? **Prevention and wellness** programs? **Patient safety** initiatives?
- Do you have **post-acute care** systems and cooperative acute-post acute care relationships in place to prevent readmissions and manage transitions?
- Are you on track to be an early **"meaningful user" of HIT**?



## What Health Plans Should Consider

- How will your products be impacted by **new insurance regulations** (as compared to existing state law regulations)?
- How will you restructure your **Medicare Advantage** products to absorb anticipated rate cuts?
- Are your **provider networks** adequate to meet demand of anticipated increased enrollment? Do you have sufficient primary care capacity?
- Will any of your products be impacted by a **tax on high cost plans**?
- Are you positioned to compete in a more **transparent competitive environment**? What are your competitive strengths that you can market successfully and weaknesses that need to be addressed?

## What Health Plans Should Consider (Cont.)

- Have you established **coverage or reimbursement policies** and programs to promote care coordination, chronic care management, innovative provider structures (such as ACOs and medical homes), prevention and wellness, reduction in hospital readmissions, patient safety?
- Are you positioned to offer insurance **across state lines**?
- Are you on track to have **interconnected HIT systems** that can promote high quality care at all levels?



# APPENDIX: IMPLEMENTATION TIMELINE

## FFY 2010

**House**

- Medicare IPPS productivity adjustments (10/1/2009, for discharges after 1/1/2010)
- Medicare Medical Home Pilots (enactment; funding for FY2009)
- Limited insurance reforms (1/1/2010)
- Begins to fill in Part D donut hole (1/1/2010)
- Medicaid primary care reimbursement increases (1/1/2010)
- No Medicaid coverage for hospital-acquired conditions (1/1/2010)

**Senate**

- Medicare market basket decreases (10/1/2009)
- $6.7 billion annual fee on health insurance plans (1/1/2010, retroactive to 1/1/09)
- Medicaid pediatric ACO and bundled payments demos (1/1/2010)
- Requirements for non-profit hospitals (taxable years after enactment)
- Limited insurance reforms (plan years 6 mos after enactment)
- Begins to fill in Part D donut hole (7/1/2010)



## FFY 2011

**House**

- Funds programs to increase size of workforce (generally 10/1/2010)
- Funding for Coordinated Care Networks (10/1/2010)
- Begins funding CMS Payment Innovation Center (1/1/2011)
- Medicare 5% bonus for primary care services (1/1/2011)
- No cost-sharing for Medicare preventive services (1/1/2011)
- Extends ARRA enhanced FMAP (1/1 to 6/30/2011)
- March 31, 2011, Physician Payment Sunshine

**Senate**

- Medicare payment adjustments begin (10/1/2010)
- 10% Medicare payment bonus primary care and general surgeons (1/1/2011)
- CMS Innovation Center established (by 1/1/2011)
- Residency slot redistribution (7/1/2011)
- No federal Medicaid payments for hospital-acquired condition penalty regulations (7/1/2011)

## FFY 2012

**House**

- Readmissions penalties (10/1/2011)
- Medicare Accountable Care Organization Pilot (1/1/2012)

**Senate**

- Medicare payment productivity adjustments (10/1/2012)
- Medicaid bundled payment demo (10/1/2011)
- Accountable care organization demonstrations (1/1/2012)



## FFY 2013

**House**

- Comprehensive insurance reforms
- Per capita tax on insurers comparative effectiveness fund (10/1/2012)
- Individual and employer mandates (1/1/2013)
- Exchange implemented for individuals and small employers <25 employees (1/1/2013)
- Exchange subsidies and small business tax credits available (1/1/2013)
- Public option created (1/1/2013)
- Medicaid expansion to 150% FPL (1/1/2013)

**Senate**

- Readmissions penalties (10/1/2012)
- Hospital VBP program (10/1/2012)
- Physician value-based payment program (10/1/2012)
- Per capita tax on insurers comparative effectiveness fund (10/1/2012)
- Payment bundling pilot (1/1/2013)
- High cost insurance excise tax (1/1/2013)
- Additional Medicare tax for high wage workers (1/1/2013)
- Physicians payment sunshine (3/31/2013)
- Regulations issued for insurance across state lines (7/1/2013)

## FFY 2014

**House**

- Exchange expanded to small business <50 employees, individuals with unaffordable employer insurance (1/1/2014)

**Senate**

- Enhanced CHIP match (10/1/2013)
- Comprehensive insurance reform (1/1/2014)
- Individual penalty and employer mandates (1/1/2014)
- Exchange for individuals and employers in the small group market (1/1/2014)
- Public option available (1/1/2014)
- Subsidies and small business tax credit available (1/1/2014)
- Medicaid expanded to 133% FPL (1/1/2014)
- Independent Medicare Advisory Board submits report to Congress (1/1/2014)



## FFY 2015

**House**

- Exchange expanded to small business <100 employees (1/1/2015)
- ARRA Medicare eHR penalties take effect (10/1/2014 hospitals; 1/1/2015 physicians)

**Senate**

- Medicaid and Medicare DSH cuts estimated to begin (10/1/2014)
- Independent Medicare Advisory Board recommendations implemented (10/1/2014)
- ARRA Medicare eHR penalties take effect (10/1/2014 hospitals; 1/1/2015 physicians)
- Medicare hospital-acquired conditions penalty (10/1/2014)