Health Care Reform

Strategic Implications for Hospitals and Health Systems

An ASHHRA Sponsored Webcast

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Health Care Reform — Strategic Implications for Hospitals and Health Systems

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Current Status

- After more than a year of political debate and legislative jousting, Congress has passed a comprehensive health reform package
  - Patient Protection and Affordable Care Act (HR 3590 signed March 23, 2010)
  - Health Care and Education Reconciliation Act of 2010 (HR 4872 signed March 30, 2010)
- President Obama signed both health care reform ("HCR") bills — they are now law
- State Attorney General challenges exist

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Health Reform — Overview

- Individuals must have health coverage or pay an income tax penalty. Coverage can be from an employer, government plan (Medicare, Medicaid) or a state-based health benefit exchange (Effective 2014)
- No employer mandate per se, but employers with 50+ employees face penalties if employees are not covered (Effective 2014)
- Plans in existence at the time of enactment are “grandfathered” and won’t have to comply with some of the benefit mandates
- Expand Medicaid eligibility to 133% of Federal Poverty Level (FPL) (Effective 2014)
- State-based American Health Benefit Exchanges for individual and small group health insurance purchases. Federal subsidies apply to low income individuals; tax credits apply to small employers (Effective 2014)
- New health insurance regulations (varying effective dates)

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Be Patient — Substantial Guidance is Coming

- Warning: Substantial new guidance is necessary on many issues that impact the implementation of Health Care Reform
  - Effective dates of many HCR provisions are after the issuance of guidance
  - Lots of answers need to be provided — it is likely that many questions you have today can't be answered
  - At least five different agencies are involved in this guidance (DOL, IRS, HHS, CMS and NAIC)

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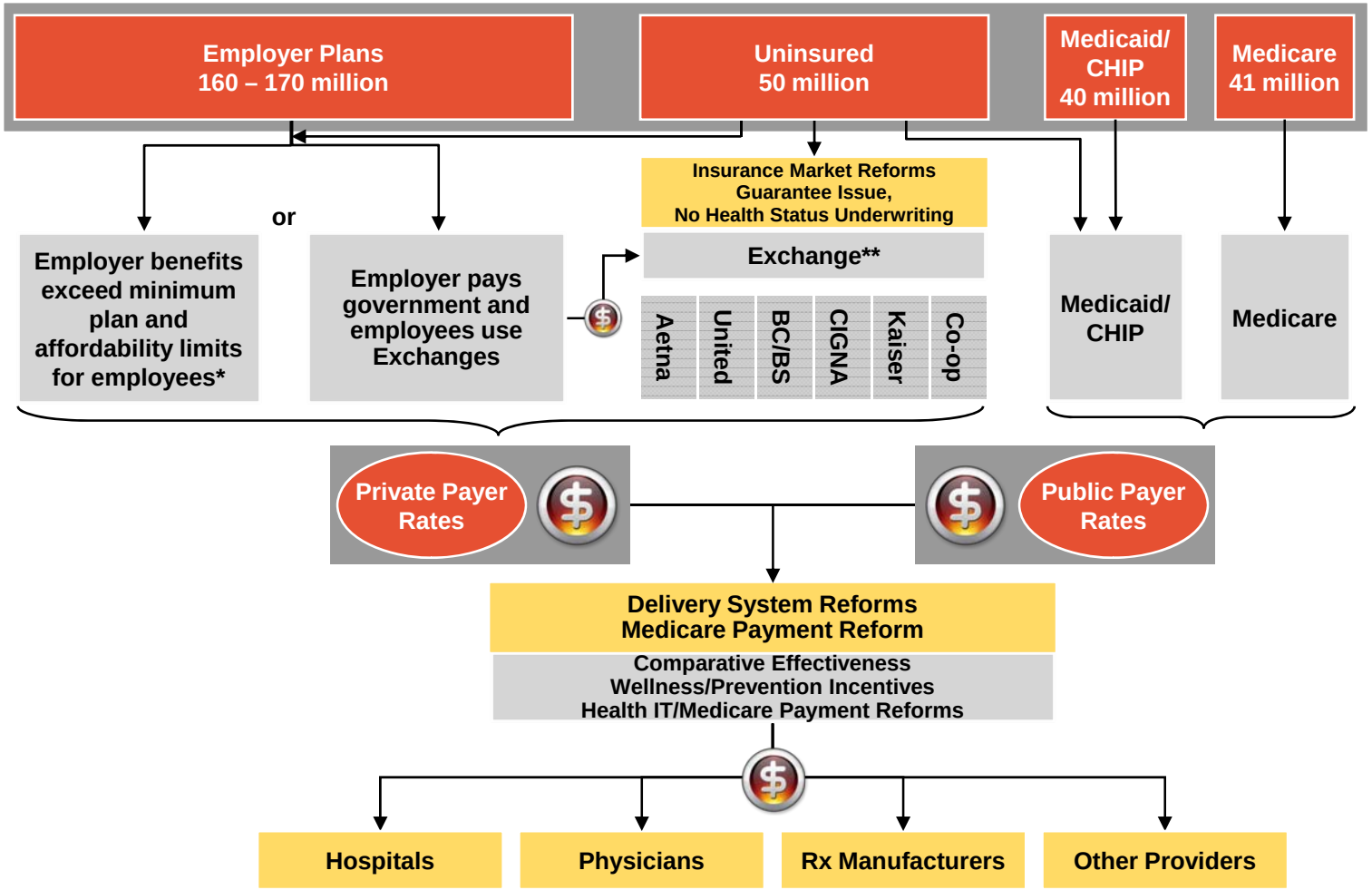
The Transformation of the Health Care Industry

The Employer and Provider Implications of Health Reform

The Health Reform House

Employer Building Blocks	Provider Building Blocks
Individual mandate	Expanded coverage
Individual and small group market reform	
Subsidies to low- and middle-income individuals	Reduced reimbursement
Health insurance Exchanges	Pay for performance
Employer pay or play mandate	
Excise tax on “high-cost” employer health coverage	Shift to primary care and underserved

The New Health Care Insurance Market



*Employees may decline employer's plan in favor of Exchange-based coverage, but they may obtain federal premium subsidies for Exchange-based coverage only if employer coverage does not meet minimum requirements or is "unaffordable."

**Low- and middle-income premium and out-of-pocket cost subsidies available up to 400% of federal poverty level.

Source: U.S. Census Bureau. Does not depict 15 million now with individual insurance expected to move to Exchange or other sources.

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The EMPLOYER Building Blocks of the Health Care Reform Law

Key Element	Congressional Direction
Individual mandate	• All individuals required to enroll in basic health coverage, with limited exemptions
Individual and small group market reform	• Insurers required to offer guaranteed issue coverage, no health status underwriting, four standard plan designs • Limits on maximum premium differentials; permitted only for certain factors (e.g., tobacco use, age, residence, family size)
Subsidies to low- and middle-income individuals	• Federal premium subsidies provided to individuals earning up to 400% of the federal poverty level (FPL) unless they have access to affordable employer coverage • Federal premium subsidies only for health coverage obtained through insurance Exchanges, not through employer-sponsored plans
Health insurance Exchanges	• State-based insurance Exchanges established to structure a market for individual and small group health insurance
Employer pay or play mandate	• Employer required to offer health plan that meets minimum requirements to those employed on average 30 or more hours per week, or pay a per-employee assessment to the government
Excise tax on “high-cost” employer health coverage	• Excise tax on carriers (insured plan) or administrators/employers (self-insured) plan when employer-offered health coverage exceeds specified value per year (e.g., $10,200 single coverage/$27,500 family coverage)

- The Public Option was not included in the Senate bill or in the budget reconciliation bill

The PROVIDER Building Blocks of the Health Care Reform Law

Key Element	Congressional Direction
Expanded Coverage	• Individual coverage mandate • Individual and small group reform • State Insurance Exchanges • Expanded eligibility under Medicaid
Reduced Reimbursement	• Medicare cuts
Pay For Performance	• Independent Payment Advisory Board with authority for Medicare to reduce cost • Bundling pilots • Readmission penalties • Value-based payments • Hospital acquired condition penalties
Shift to Primary Care and Underserved	• Increased Medicaid reimbursement to Medicare levels for primary care • Expansion of Graduate Education Program loan forgiveness for underserved markets • Rural hospital improved access • Expansion of 340B drug program to underserved hospitals

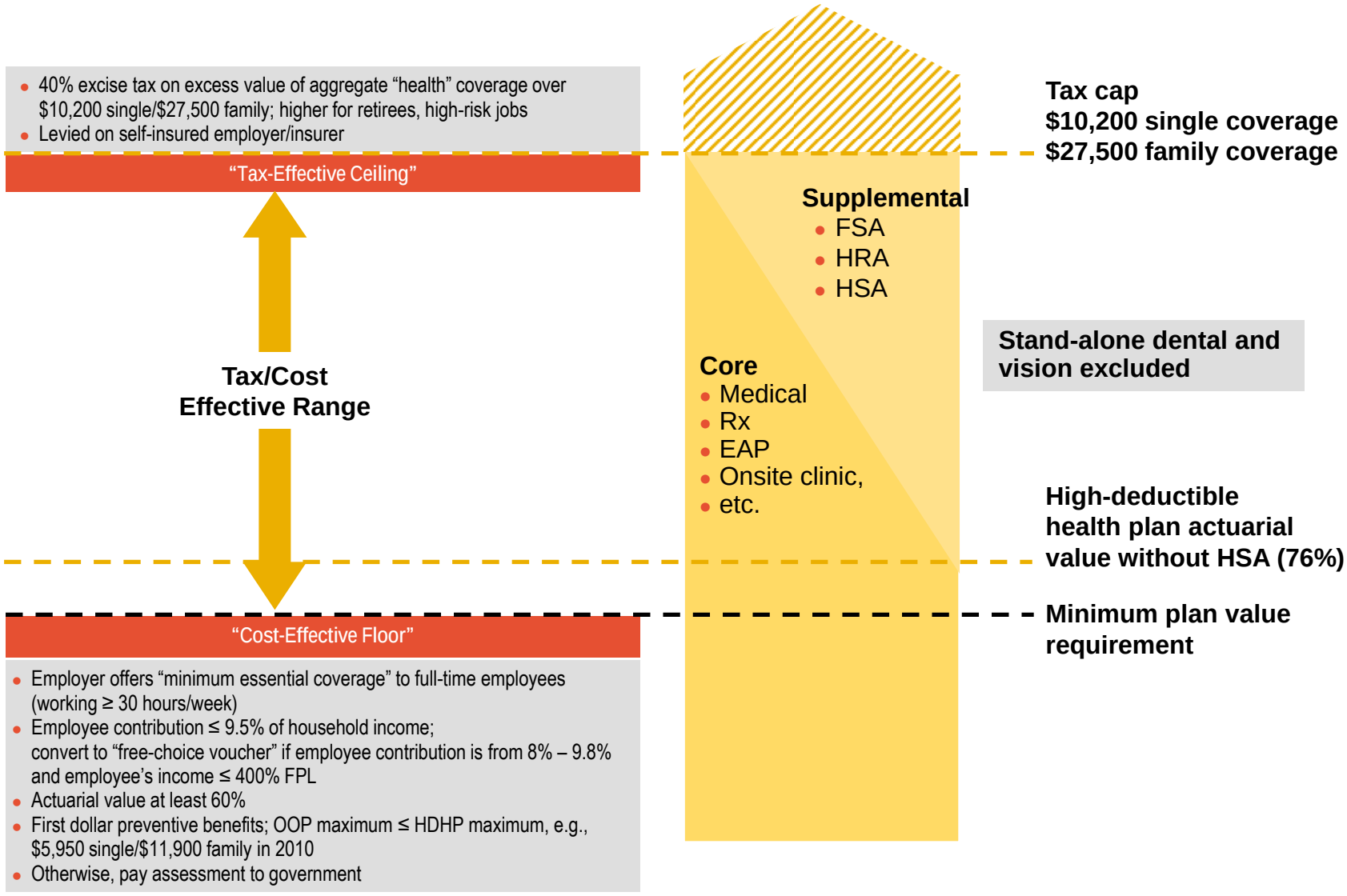
The Public Option was not included in the Senate bill or in the budget reconciliation bill.

Implementation Begins Right Away — And Will Take Years

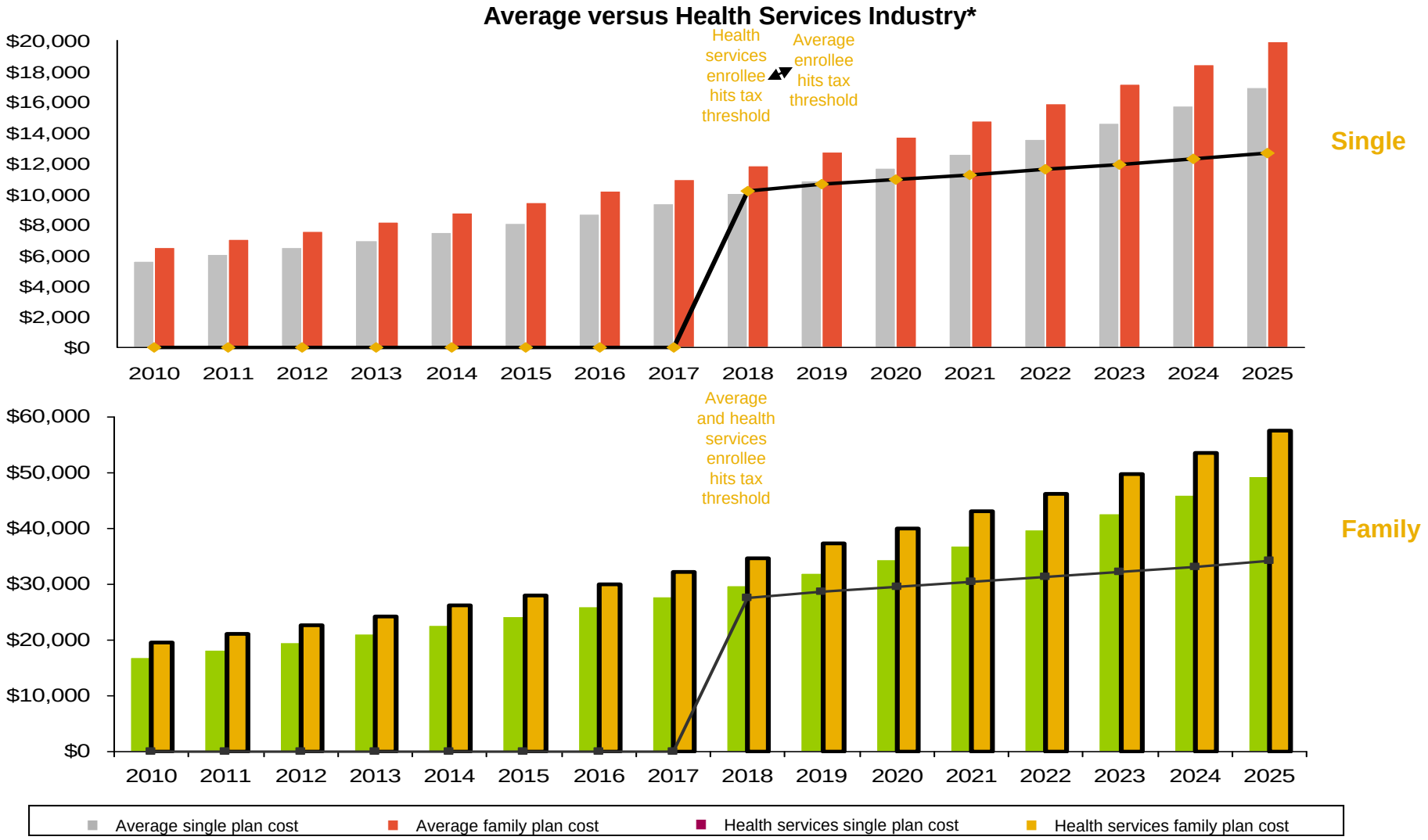
2010	• President signed PPACA and HCERA into law* • Reinsurance program for early retiree medical coverage • Accounting recognition of change in taxability of RDS payments • $250 rebate for seniors who hit Medicare Part D coverage gap • Some immediate coverage and consumer protection requirements (non-calendar year plans)
2011	• W-2 reporting of aggregate value of employees' health coverage • Extended dependent coverage, no lifetime dollar limits, restricted annual dollar limits, no preexisting condition exclusions for those under age 19, other immediate consumer protections (calendar year plans) • HSA withdrawal penalty increased • No reimbursement of over-the-counter (OTC) medicines from account-based health plans • CLASS** Act long-term care benefit enrollment
2012	• Presidential election
2013	• Medicare payroll tax increased for high-wage employees and new tax on unearned income • Cap on salary-reduction contributions to health FSAs • Change employer tax treatment for Medicare Part D retiree drug subsidy (RDS)
2014	• Individual health coverage mandate • Employer mandates: play-or-pay, automatic enrollment, free-choice vouchers • Health Benefit Exchanges operational • Premium and cost-sharing subsidies for low- and middle-income individuals • Medicaid eligibility expanded in all states to 133% of FPL • Additional consumer protection standards, such as prohibition on excessive waiting periods
2016	• Sales of health insurance across state borders permitted
2018	• 40% nondeductible excise tax on high-cost group health plans

*PPACA — Patient Protection and Affordable Care Act; HCERA — Health Care and Education Reconciliation Act.
**CLASS: Community Living Assistance Services and Support Act.

“New Normal” for Employers Effective 2018



Excise tax on high-cost plans – play scenario



*Data from the 2010 HCCS. Medical trend = 8%, FSA trend = 3%, FSA contribution single = $550, FSA contribution family = $2,200

Health Care Reform Will Put Even Greater Pressure On Health Care Employers…

Business Planning

- Lower reimbursements
- Increased demand for services
  - Routine care
  - ER
  - Specialty
  - Pharmaceutical
- Greater tax obligations

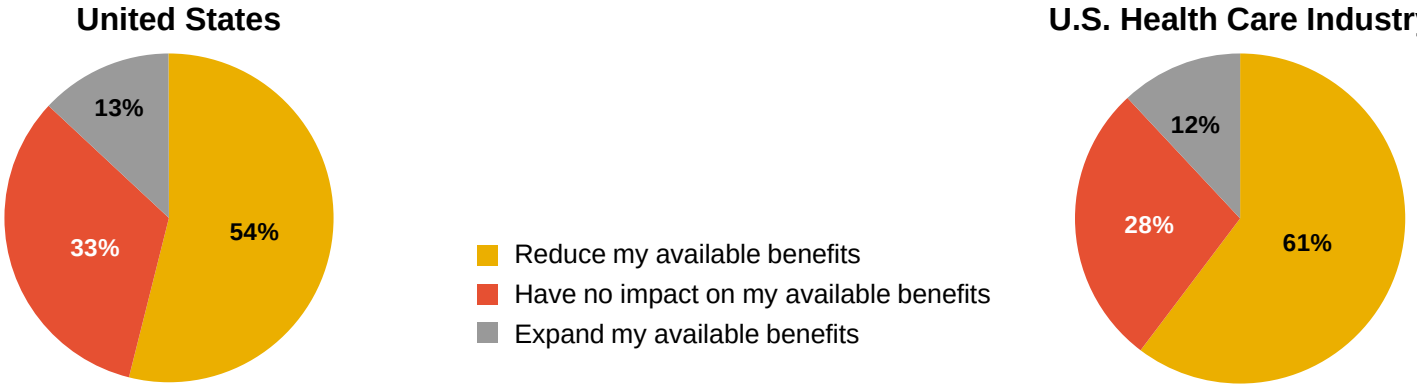
Workforce Planning

- Attract and retain scarce clinical, professional and technical talent in an age of increasing cost pressures on rewards
- Re-engage a workforce that may have become disillusioned by the recession

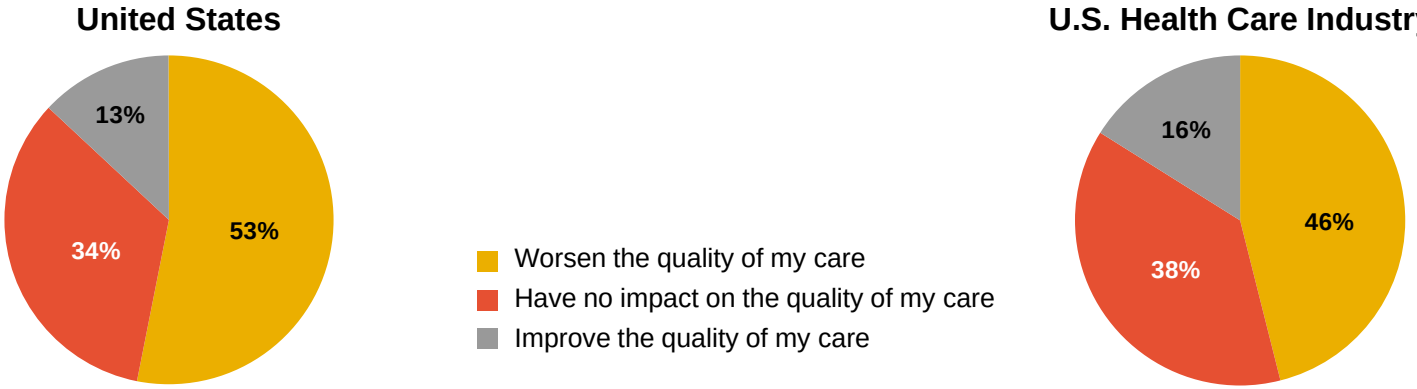
Is your workforce ready to help you move forward?

Health Care Workers Are Already Anticipating How Reform Will Impact Their Own Health Care

Availability of Benefits



Quality of Health Care



Source: Towers Watson 2010 Global Workforce Study — U.S.
Towers Watson 2010 Global Workforce Study — U.S. Health Care Industry.

While Employees Are Still Attracted By The Basics, Career Advancement Has Become More Important To Health Care Workers…

Attraction Drivers	2010	2007
Competitive base pay	**1**	**1**
Vacation/paid time off	**2**	**3**
Career advancement opportunities	**3**	6
Competitive health care benefits	**4**	**2**
Convenient work location	**5**	**5**
Flexible schedule	6	**4**
Learning and development opportunities	7	10
Challenging work	8	—
Competitive benefits	9	—
Competitive retirement benefits	10	—
Caliber of coworkers	—	7
Reputation of organization as a good employer	—	8
Reasonable workload	—	9

Source: Towers Watson 2010 Global Workforce Study — U.S. Health Care Industry.
Towers Watson 2007 Global Workforce Study — U.S. Health Care Industry.

What To Do? Understand That The Deal Has Changed For Your Business And Your Employees

Employment Deal: Your Value Proposition

Values

Leadership

Co-Workers

Culture

Total Rewards Strategy

Structure of Work

Processes and Tools

Job Responsibilities

Product Strength

Customer Focus

Attract	Retain	Engage

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How Should An Employer Look At Health Care Reform Today?

Practical Strategies For An Employer

Treat health plan as "grandfathered" plan

No grandfathered plan — Comply with HCR provisions as they become applicable (between now and 2018)

No longer offer health care to its employees — pay "no coverage" *penalty*

Note: These strategies are generally applicable for employers with more than 50 full-time employees. There are other special rules applicable to employees with 50 or less employers. There is also a special grandfather rule for collectively bargained plans, and retiree-only plays may not be subject to HCR law.

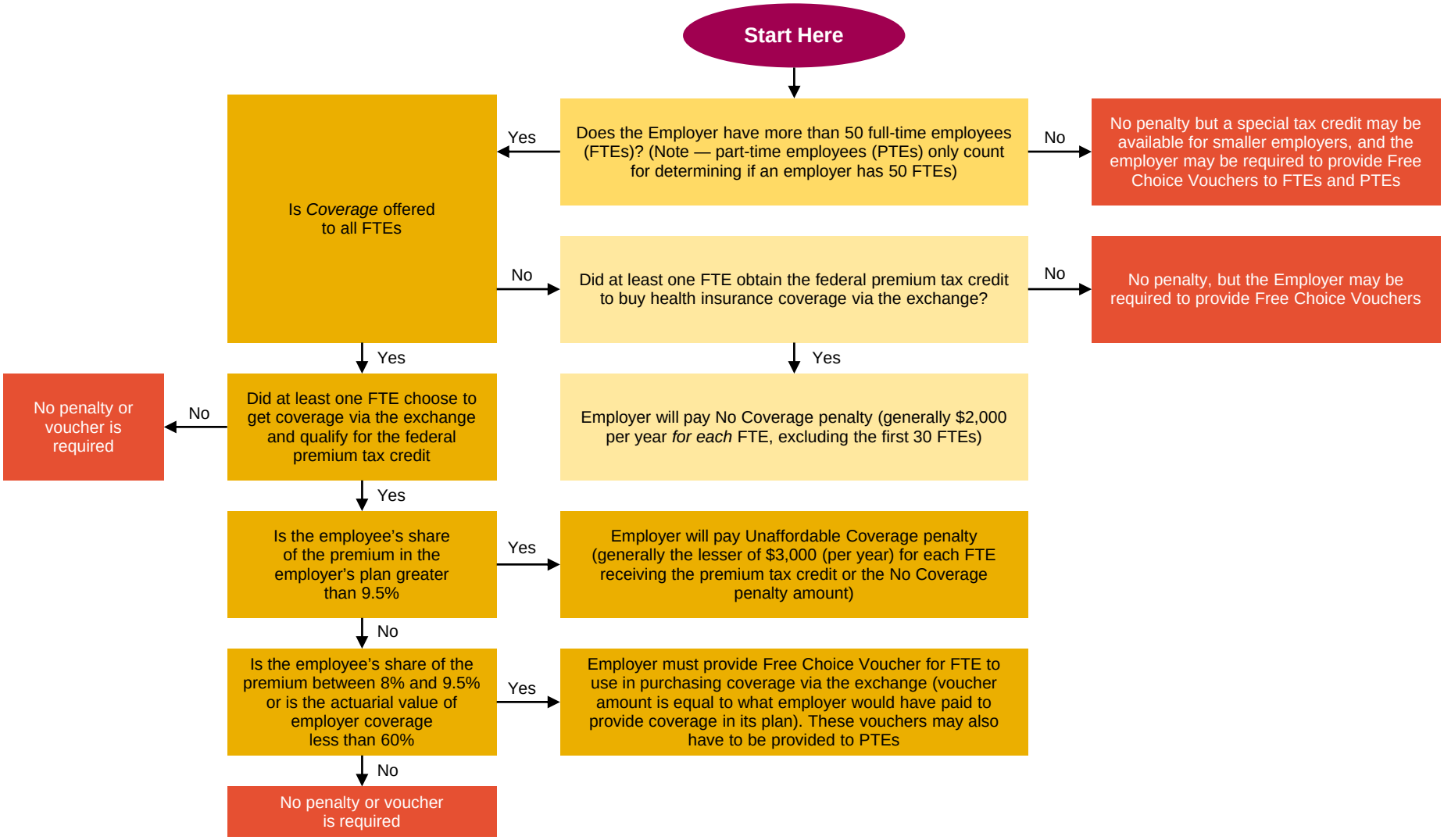
Grandfathered Plan (GF Plans)

- How does a plan become grandfathered?
- Will future changes jeopardize grandfather status?
- Changes applicable to GF Plans in next few years
- Changes applicable to GF Plans for plan years beginning 1/1/12 or later
- What happens if plan isn't a GF Plan?
- What provisions are GF plans exempt from?

Employer Mandates In 2014 Plan Year

- Penalty if employer provides “no coverage”
- Penalty if employer provides “unaffordable coverage”
- Free-choice vouchers may need to be provided

Overview Of Employer Penalty Rules (Effective In 2014)



Implications Of Health Care Reform For Health Care Providers, Especially Human Resources

- The law directs the Secretary HHS to establish a national quality improvement strategy
- Threefold objective to improve:
  - Delivery of health care services
  - Patient health outcomes
  - Population health
- Process would be transparent and collaborative and include a multi-stakeholder group including in part
  - Providers…nurses...consumer representatives...labor organizations
- Recommendations would be made by the multi-stakeholder group to the Secretary
- The Secretary would update the national strategy and report to Congress, with the first report December 31, 2010

Quality Measures Anticipated Via Organized Labor Participation As Stakeholder In Development Of National Strategy

- Mandated Staffing Ratios
  - Health Services Research Study — April 2010 (California mandated ratios results in lower patient mortality)
  - Nursing Care and Quality Improvement Act (SB224, HB 5033)
- Unions uniformly oppose state Staffing Acuity laws (e.g. Illinois, Ohio)
- Provide whistleblower protections to protect caregivers and nurses who advocate for patient safety and who report violations of staffing requirements
- Provide new regulations for creation of standards for lifting and prevention of on-the-job injuries and safe working conditions
- Oppose Health Information Technology; deny providers power over RN scope of professional practice and patient care standards via data driven and electronic technology
- Enhanced protections of Scope of RN Practice; protecting the right of every nurse to maintain professional practice and patient decision-making functions

Appendix: Health Care Reform Implications

For Health Care Providers

Implications For Health Care Providers In General

- **Insurance Exchange:** 2014 — about half, 16 million, of the newly insured under health care reform are expected to enroll in private plans resulting in less uncompensated care
- **Medicaid expansion**: 2014 — the other half, 16 million, of the newly insured would obtain coverage through Medicaid when uniform national eligibility is set for all up to 133% of Federal Poverty Level (FPL)
  - Medicaid reimbursement often does not cover the actual cost of providing care
- **Undocumented workers**: No coverage provided for illegal immigrants who continue to receive charity care; not permitted to buy Exchange-based insurance
- **Individual Health Coverage Mandate**: 2014 — penalties on individuals may be increased if they prove too weak for not enrolling in mandated "minimum essential coverage," especially for young and healthy individuals; penalties set at:
  - 2014 — greater of $95 or 1% of income
  - 2015 — greater of $325 or 2% of income
  - 2016 — greater of $695 or 2.5% of income
- **Administrative Simplification**: 2012 — Provides 11 specific expansions of administrative simplification provisions under HIPAA by HHS, as well as periodic reviews (every three years thereafter) of where greater uniformity would further improve operation of health care system and reduce administrative costs. The process requires input from the National Committee on Vital Health Statistics
- **Tort reform**: $50M for state tort reform demonstration projects included in the legislation
- **Indirect impact:** Workforce planning for health systems (physicians, nurses and staff) to handle the increase in number of individuals with insurance (i.e., access to care, demands on the ER, etc.)

Implications For Hospitals Specifically

- **Reduced reimbursements**: Hospitals agreed to help defray the cost of health reform by contributing $150 billion over ten years, largely by accepting lower payments under Medicare
  - Decreases Medicaid Disproportionate Share Hospital (DSH) payments by $14 billion beginning in 2014
  - Decreases Medicare DSH payments by $22.1 billion with reductions beginning in 2014
  - Reduces hospital Medicare payment updates by approximately $112.6 billion over ten years
- **Bundled Payment Pilot**: 2013 — Establishes a national, voluntary, five-year program on bundling payments to providers for ten conditions. If successful, the Secretary may expand pilots after 2015
- **Accountable Care Organizations (ACOs):** 2012 — Allows hospitals, in cooperation with physicians, to provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries and allows the Secretary to share some of the savings from the improved care management with providers
- **Value-Based Payments (VBP)**: 2013 — Establishes a VBP program for hospital payments based on hospitals' performance in 2012 on measures that are part of hospital quality reporting program. The program is budget neutral, with 1% of payments allocated to the program in FY 2013, growing to 2% in 2017 and beyond
- **Readmissions**: 2013 — Imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels based on a 30-day readmission measures for heart attack, heart failure and pneumonia that are part of the Medicare pay-for-reporting program. Excludes critical access hospitals and post-acute care providers
- **RAC expansion**: The Recovery Audit Contractor (RAC) program will be expanded to include State Medicaid programs

Implications For Physicians Specifically

- **More insured patients**: Physicians may benefit from more paying customers through a decrease in uninsured patients who obtain coverage from an employer or on a State-run insurance exchange
- **More Medicaid patients**: Physicians may also have an increase in Medicaid patients at reimbursement levels that may not cover the cost of delivering service
- **Doctor fix**: Health reform ignores need for “doctor fix” to avoid Medicare payment cuts >20%; Congress continues temporary delays on these cuts
- **Elimination of physician-owned hospitals**: Virtually eliminates the Stark Law “Whole Hospital” exception permitting physician-owned hospitals. Increases disclosure requirements
- **Increased Medicaid payments for primary care**: Primary care physicians (pediatricians, family physicians and internists) will see increased Medicaid reimbursements starting in 2013
- **Value-based payments for primary care**: Implementation of a relative value unit (RVU) modifier system to enable differential payment to physicians based on their achievement of certain quality metrics
- **Disclosure of ownership of imaging and other DSH**: Effective immediately, referring physicians must inform patients in writing at the time of a referral that the patient may obtain specified imaging services (i.e., MRI, CT and PET scans) and other DSH as designated by the HHS Secretary, from a person or entity unrelated to the referring physician. In addition, the referring physician must inform patients with a list of alternative suppliers in the area where the patient resides

Implications For Health Insurers (Some Owned By Health Systems)

- 2011 — Host of new insurance mandates (no preexisting, lifetime or annual limits, etc.) on *new* policies; existing plans grandfathered from most new mandates
- 2013 — Deduction limited to $500K compensation for any employee of health insurers; applies to deferred compensation for services performed after 2009
- 2014 — Influx of new individual/small group customers through subsidized policies sold on state exchanges
- 2014 — Exchanges bring increased regulatory oversight than insurers now typically face and may need to alter their business models drastically
- 2014 — Law places strict limits on premium bands among the people taking out the same policy, based on age, geography and tobacco use
- 2014 — Insurers concerned that young and healthy people will not enroll because new requirements will make their premiums higher to subsidize the sick people
  - The legislation requires insurers to cover people with costly preexisting conditions
- 2014 — Penalties may be too low to enforce mandated “minimum essential coverage”:
  - 2014 —Greater of $95 or 1% of income
  - 2015 — Greater of $325 or 2% of income
  - 2016 — Greater of $695 or 2.5% of income

Implications For Health Insurers (Some Owned By Health Systems)

- New taxes are imposed on health insurers, allocated based on net written premiums; half-shares for non-profits:
  - 2014 — $8 billion
  - 2015 — $11.3 billion
  - 2016 — $11.3 billion
  - 2017 — $13.9 billion
  - 2018 — $ 14.3 billion; indexed thereafter
- Higher medical cost from pass-through excise taxes on medical device manufacturers and pharmaceutical companies, and other cost increases will put more pressure on premium rates

Implications For Executive And Physician Compensation

- The precise implications of health care reform on executive and physician compensation is not all that clear; however, there are areas where some impact seems to be a natural consequence

Accountable Care Organizations (ACO)/Gainsharing	• Through executive compensation program design, the development of an ACO or the development of ROI analysis may be a measurement for incentive design
Bundled Payment Pilot Program	• This anticipated reduction in a source of revenue will seemingly affect the funding of incentive opportunities for both executives and physicians
Stark Law Disclosure Protocol	• Physician "policing" through increased reporting and HHS Secretary empowerment in relation to fine assessment and mediation may alter some practice arrangements
Expansion of Health Care Workforce	• Appears to be an attempt to steer away from the trend towards specialists only and encourage both primary care physicians (gatekeepers) and nurses (or mid-level provider arrangements)
Avoidable Errors	• While the precise measurement for success or failure against this government-imposed expected outcome financial benefit has not yet been established, successful performance will need to be evaluated from a design perspective on all levels
Value-Based Payments for Hospital Services (DRG Withhold Program)	• Is the value worth chasing? Value-based funds available through quality performance achievement
Additional Requirements for Non-Profit Hospitals	• Include increased community benefit reporting and tracking, which previously we had discussed with clients as possibly introducing into incentive compensation programs
Elimination of Physician-Owned Hospitals	• Shifting to more purchasing of physician practices by systems and hospitals will continue to challenge compensation program integration and organizational alignment opportunities
Increased Medicaid Payments for Primary Care	• Equalizing Medicaid payments with Medicare payments of "primary care physicians" may increase compensation expectation levels

Timeline

Employer Implications Of Health Reform

Effective in 2010

- Small business tax credit available
- Temporary reinsurance program for early retirees
- New full-time employees must be automatically enrolled in an employer-sponsored health plan (employee may opt out) — more guidance needed on the effective date

Effective For Plan Years Beginning Six Months After Enactment (January 1, 2011 For Calendar Year Plans)

- Prohibit lifetime limits on the dollar value of coverage
- Coverage must be available to dependent children (married or unmarried; student or not) to age 26
  - [GF Plans — delay until 2014 *if* child has access to other employer-provided coverage]
- Prohibit pre-existing condition limitations for children
- Annual limits on the dollar value of coverage must be reasonable (as defined by regulation)
- Preventive health services must be provided without cost sharing (A or B rated by the U.S. Preventive Services Task Force)
  - [Does not apply to GF plans]

Effective 2011

- Over-the-counter medications not reimbursable through an HRA or health FSA; prescribed medicines, drugs and insulin still qualify
- Non-health HSA distributions taxed at 20%
- Employers required to disclose on Form W-2 the value of health benefits

Effective 2012

- Employers must distribute a uniform summary of benefits and coverage explanation prior to enrollment or reenrollment
- Requirement to provide 60-day advance notice of benefit changes begins
- HIPAA “uniform” electronic transaction standards begin (rolled out in stages through 2016)

Effective 2013

- Medicare Part A tax increased to 2.35% for earnings over $200k (individual return) and $250k (joint return)
- Employer tax deduction for Medicare Part D retiree drug subsidy eliminated
- Health care FSA contribution limited to $2,500 annually (indexed)
- Employers required to notify employees of the 2014 existence of the health exchanges

Effective 2014

- Individual mandate applies (may increase enrollment in employer plans)
- Exchanges open
- Annual limits on the dollar value of coverage prohibited
- Waiting periods cannot exceed 90 days
- Prohibit pre-existing condition limitations for adults
- GF Plans must make coverage available to all dependent children to age 26
- Essential benefit provisions (determined annually by the Secretary of HHS) apply to new plans
  - [Does not apply to GF Plans]

Effective 2014

- Employer “mandate” and potential penalties begin
- Employers required to provide “free choice” vouchers to qualified employees
- Employers may offer rewards to employees who participate in wellness programs; limited to 30% of the cost of coverage
- Employers required to furnish an information return to employees and to the government identifying coverage periods, the portion of premium paid by employer and other information (i.e., 2014 information to be reported on return issued in January 2015)
  - [Does not apply to GF Plans]

Effective 2018

- 40% tax on high-value plans (over $10,200 for individuals and $27,500 for families)

Questions?

Thank you for participating

For any questions, please feel free to contact our speakers.

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