Health Research Institute

Health reform: The Patient Protection and Affordable Care Act and Reconciliation

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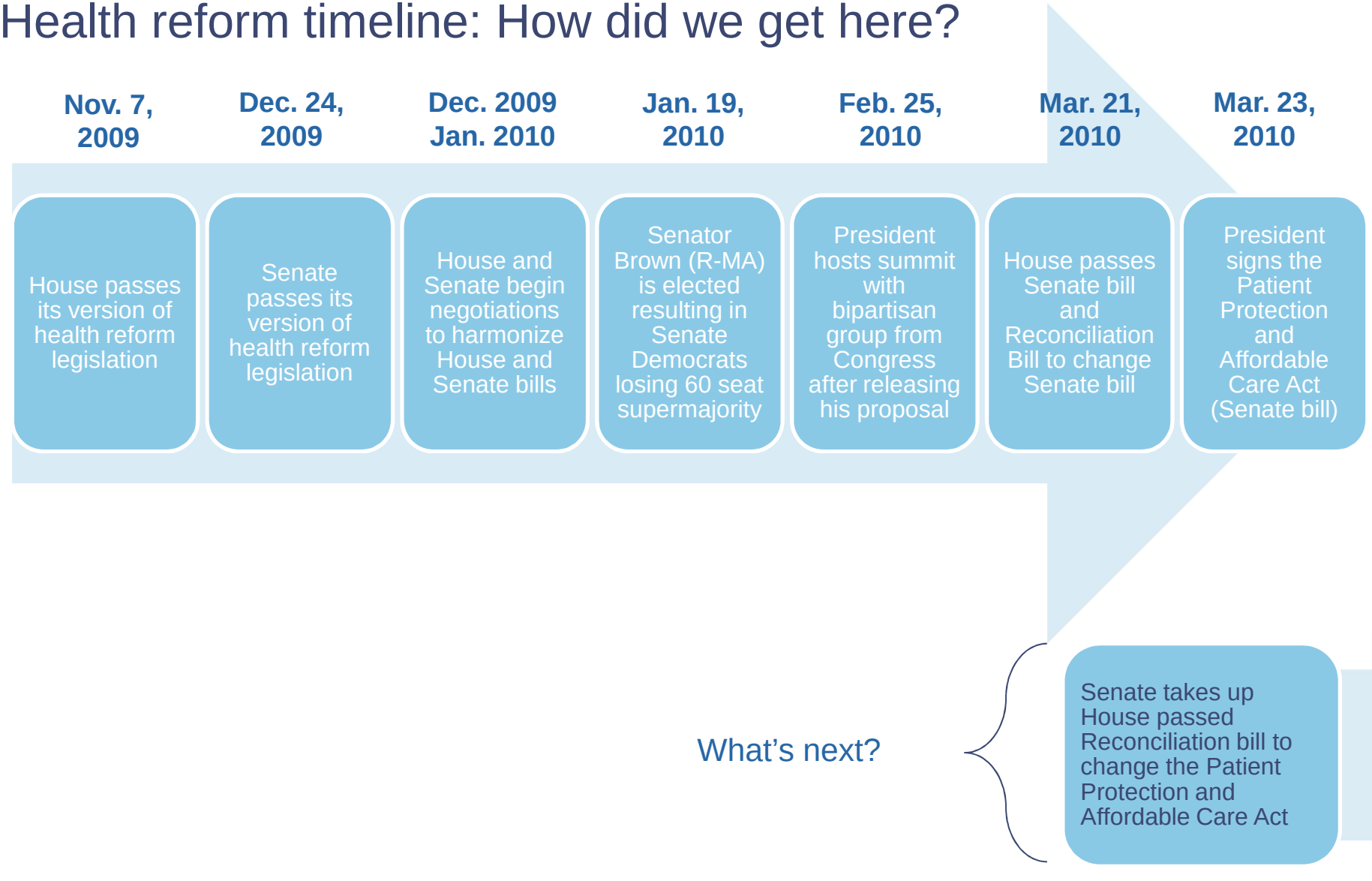
Health reform key issues

- President Obama signed the Patient Protection and Affordable Care Act (bill originally passed by Senate on Dec. 24, 2009) into law on March 23, 2010. Now the reconciliation bill, which makes changes to the law, is making its way through the process.

- This is the most substantial change to the health system since the passage of Medicare. Including the changes currently in the reconciliation bill, the Congressional Budget Office estimates that approximately 32 million people will gain coverage at a cost of $940B over 10 years while the deficit will be reduced by $138B over the same period.

- Expanded access will be implemented and paid for through new mandates, fees, regulatory and reimbursement reform, health exchanges, and new incentives. All of these will have profound effects on health organizations.

Health reform timeline: How did we get here?



Components of the Senate Bill (as Modified by the House Reconciliation Bill)

	Reconciliation Bill: The Health Care and Education Affordability Reconciliation Act of 2010
Cost	• $940 billion over 10 years • Deficit savings $138 billion over 10 years, according to CBO
Coverage	• 32 million gain coverage • 95% of legal U.S. residents under age 65 would be covered, compared with 83% now, according to CBO. Most provisions take effect starting in 2014
Insurance Market Regulations	• Dependent coverage to age 26 beginning in 2010 • Adjusted community rating of 3:1 • Plans must meet 85% of medical loss ratio for large group market and 80% of medical loss ratio for small group market • Uninsured eligible for high risk pools • No annual or lifetime limits
Insurance Exchange	• States create their own insurance exchanges to sell insurance products which will include four tiers of benefit plan categories. Exchanges to provide enrollment information through website and phone hotline. • Two multi-state health plans on each state exchange will be offered, at least one would be a non-profit plan. • Individuals and small businesses eligible with <25 employees in 2013, <50 in 2014, <100 in 2015, 100+ after 2015 • Essential health benefits package 60% to 80% actuarial value; four tiers; catastrophic policy for young adults • Illegal immigrants cannot participate in exchanges • Grandfathered plans prohibited from bans on annual and lifetime coverage, pre-existing conditions and must offer coverage to dependents until age 26 • Requires grandfathered plans to cover proven preventive services with no cost sharing starting in 2018

Note that the Senate Bill was signed into law March 23, 2010. The House modifications have not been considered by the Senate and are subject to change.

Components of the Senate Bill (as Modified by the House Reconciliation Bill)

	Reconciliation: The Health Care and Education Affordability Reconciliation Act of 2010
Individual Mandate	• Income surtax penalty ranging from $695 (single) per year up to a maximum of $2,085 per family or 2.5% of household income, whichever is higher • Penalties will be phased in beginning in 2014
Employer Mandate	• Tax for firms >50 employees that do not offer coverage at $2,000 per employee • Firms >50 employees pay uncovered worker fee of $750 per uncovered person by 2016 , exempts companies from paying the fee for the first 30 employees • Eliminates the fee assessment for new hires in a waiting period for their insurance, but limits waiting periods to 90 days beginning in 2014
Subsidies / Tax Credits	• Provides tax credit for small employers with <25 employees with average annual income <$50,000 • Subsidy: sliding scale 2% to 9.8% of income up to 300% FPL/flat cap at 9.8% 300%-400% FPL; cost-sharing subsidies for 100%-200% FPL • Increase low income tax credits for health insurance premiums
Funding	• Extends 3.8% Medicare wage tax to investment income, such as dividends, interest and rent , for high-income households. High income defined as >$200,000 for singles, >$250,000 for married couples filing jointly • Taxpayers under age 65 could not deduct medical expenses until they reach 10% of their income, up from the current 7.5% • Increases Medicare tax on high-income households by 0.9 percentage points so workers would pay 2.35%. Industry fees, excise tax on premium plans, 10% excise tax on tanning • Government fees on pharmaceutical to total $28 billion over 10 years • Excise tax on the medical device manufacturing sector of 2.9% to raise $20 billion over 10 years • Spends $250 million to fight waste, fraud and abuse

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Components of the Senate Bill (as Modified by the House Reconciliation Bill)

	Reconciliation: The Health Care and Education Affordability Reconciliation Act of 2010
Medicaid	• Supports up to 133% FPL • Feds pay 100% of the cost for new Medicaid patients from 2014 to 2016, and then decreasing down to 90% through 2019

Medicare	• Restructures payments to Medicare Advantage plans
	• Closes the Medicare Part D prescription drug 'donut hole' gradually over the next decade. This year once $2,830 spending limit is reached a $250 rebate is issued. In 2011 Medicare recipients receive 50% discounts on brand name prescription drugs.
	• Reduces Medicare spending over the next 10 years by almost $500 billion, according to CBO including the following :
	  • Decreases market basket update for providers - $157 billion
	  • Medicare Disproportionate Share (DSH) payment and home health adjustments - $55 billion
	  • Medicare Advantage payments - $132 billion
	• Establishes Independent Medicare Advisory Board to make recommendations to reduce Medicare spending
	• Creates Center for Medicare and Medicaid Innovation to test payment and service delivery models. By 2016 the board begins to submit recommendations to curb Medicare spending, if costs are rising faster than inflation

Accountable Care Organizations	• Beginning in 2012, accountable care organizations of physicians and hospitals will participate in shared savings programs • ACO's are designed to meet quality-of-care targets and reduce costs relative to a predetermined benchmark • ACO's will be rewarded on their Medicare savings based on that benchmark
Bundled Payments	• Sets up a pilot program by 2013 to test more efficient ways of paying hospitals, doctors, nursing homes and other providers who care for Medicare patients from admission through discharge. Successful experiments would be widely adopted

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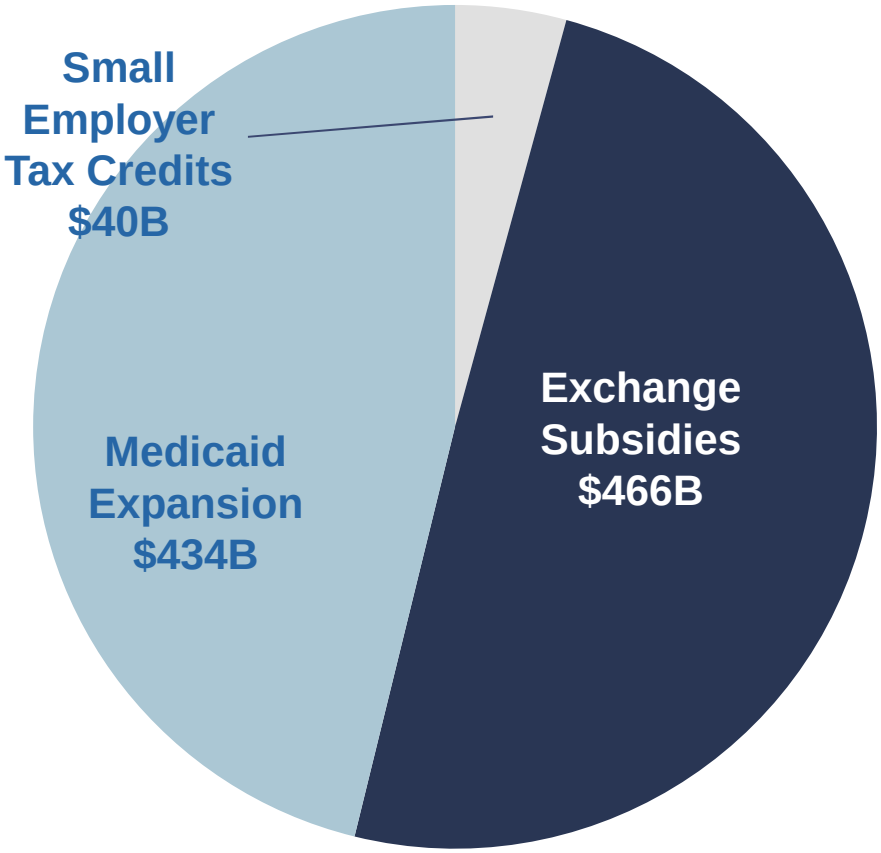
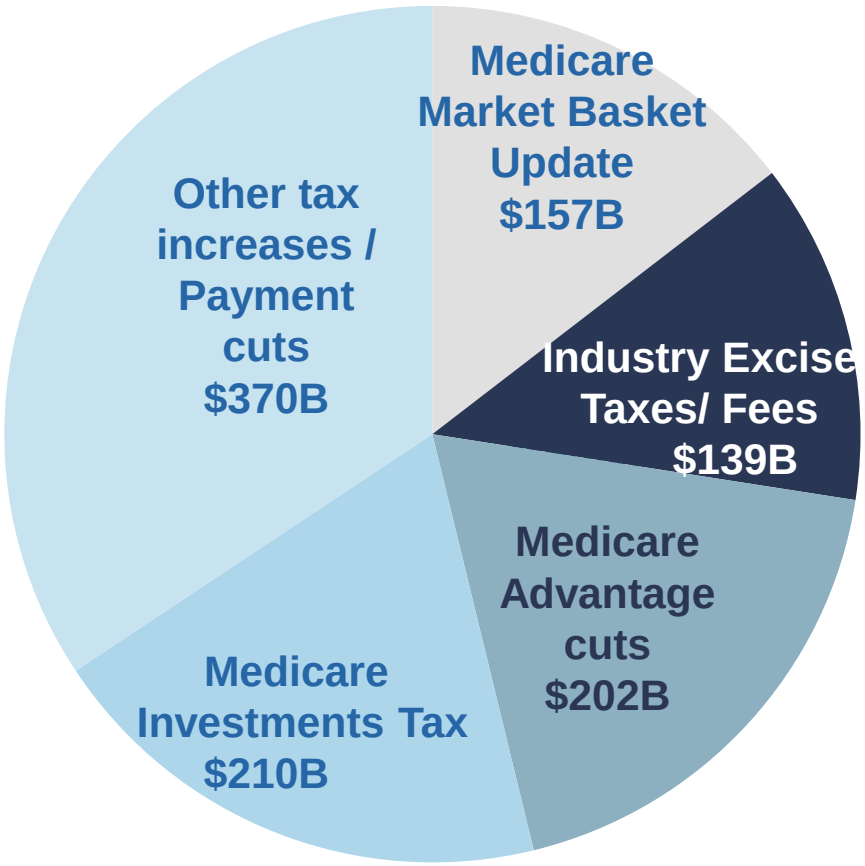
Net Flows under Senate Bill as Modified by the House Reconciliation Bill

Spending on health reform - $940B

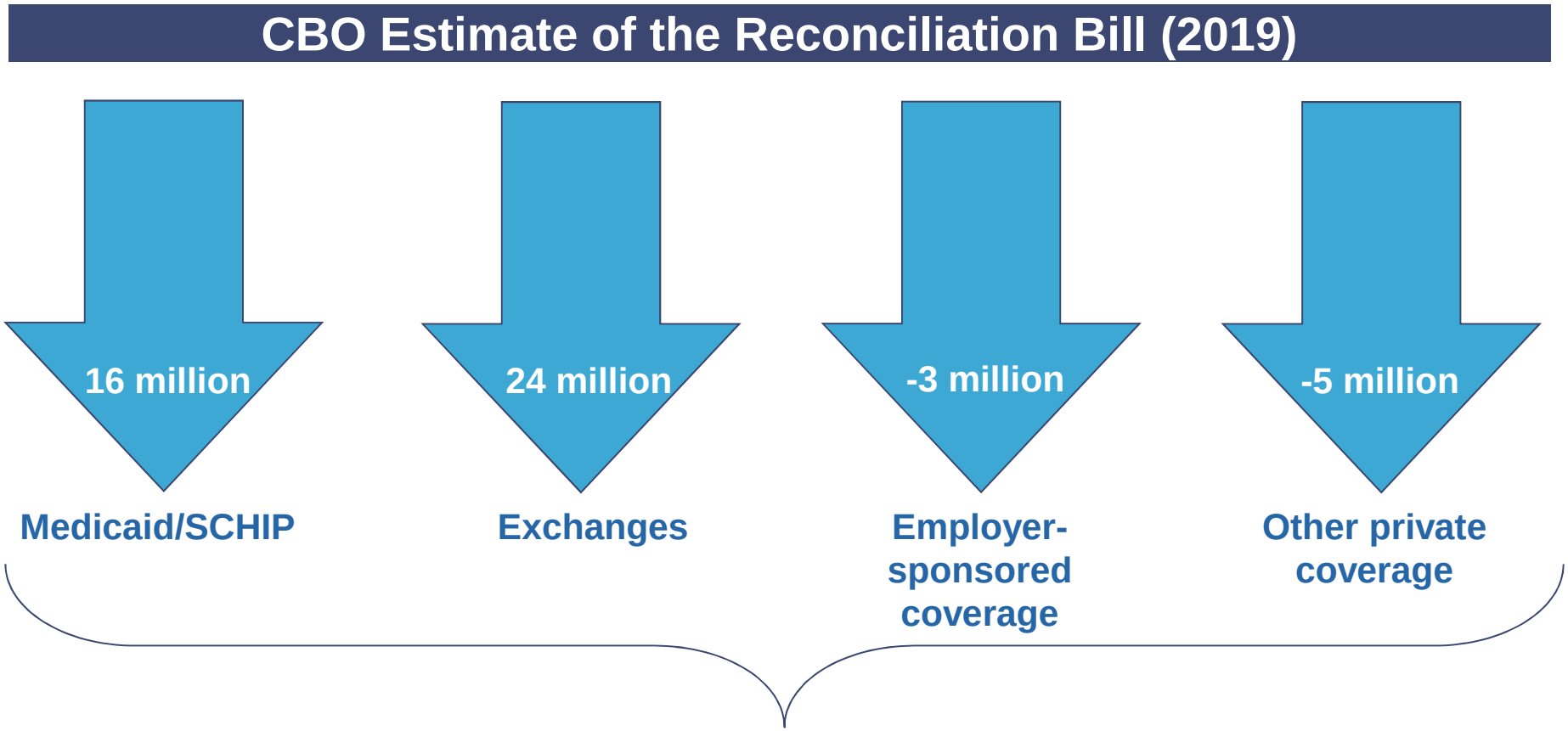


Paying for health reform - $1078B



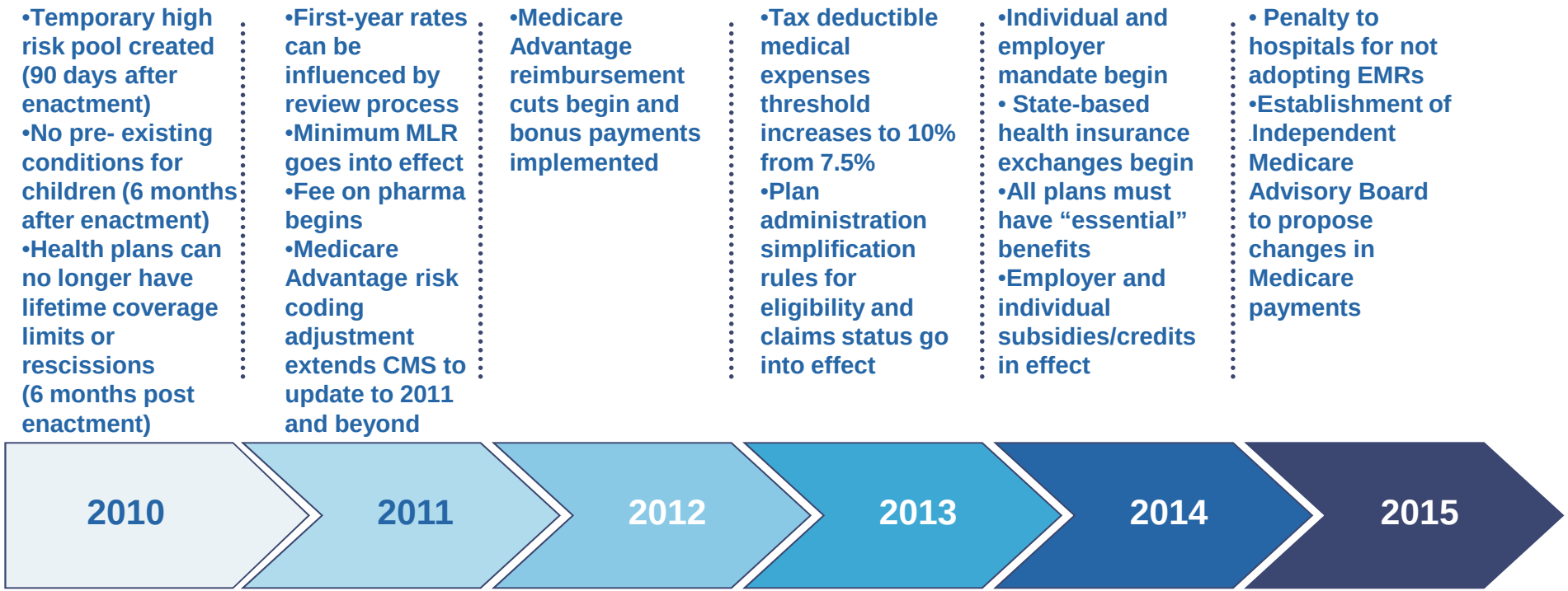
Sources: CBO Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

Health reform expansions could lead to a 32 million drop in the uninsured at a cost of nearly $1 trillion in the first 10 years



Source: CBO Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate.

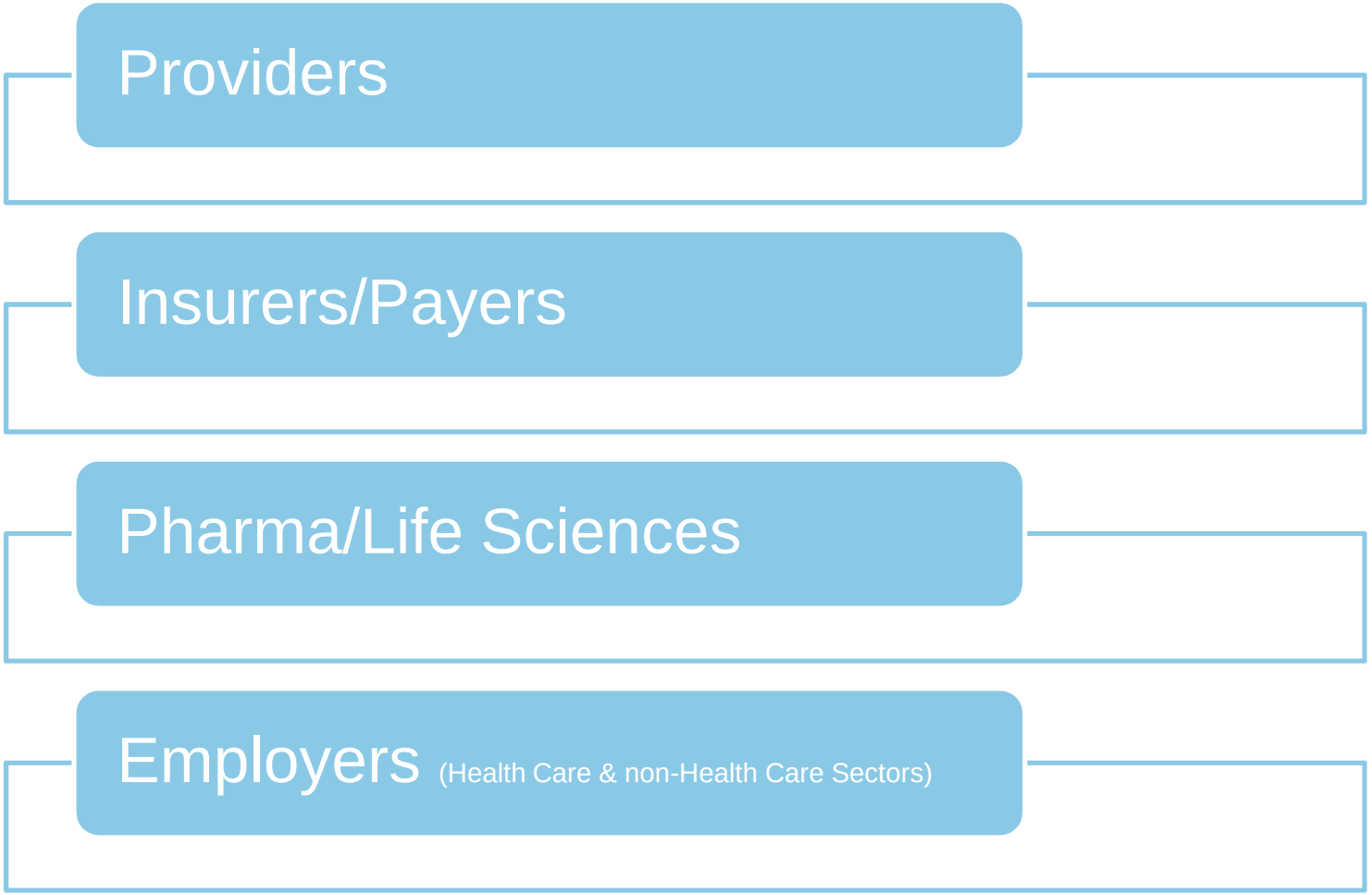
Health reform implementation timeline if Reconciliation passes



Some elements of health reform are already in motion from previous work

SCHIP	• Expands coverage, establishes new federal agency (MAC PAC) to oversee child health, sets framework for universal coverage for kids
Medicare Adv	• CMS approved a 4% drop in Medicare Advantage (MA) payments for 2010
ARRA	• Provides grants for major reform priorities such as EHR incentives and penalties; comparative effectiveness research grants to NIH, AHRQ, and HHS; $1 billion for wellness and prevention grants; and COBRA extension
Pilots	• CMS and private organizations conduct and sponsor a number of innovative demonstration projects to innovate, test, and measure healthcare reimbursement and delivery changes
Fraud & Abuse	• OIG has placed increase focus on fraud and abuse and CMS is conducting RAC audits to recoup overpayments
Reform	• Comprehensive health reform expands coverage, regulates insurance and creates exchanges, makes changes to the reimbursement system, and creates new taxes, fees and subsidies.

Sector implications



Impact to Provider Sector

Overall – more patients with insurance; some reimbursement cuts; beginning to move payment from volume to outcomes

- Reduction in annual market basket updates (cost controls) and Disproportionate Share Hospital payments at both a Federal and State level.

- Expansion of Medicaid with increase in Federal funding share, impacts on State budgets a concern for the future.

- Increases federal funding for insurance coverage through increased tax credits.

- Establishes an independent Medicare payment advisory board, that has the ability to make changes to Medicare payments unless US Congress acts to stop a particular change.

- Increasing the Medicaid pay rates for primary care doctors to equal Medicare reimbursement rates.

- Requires community needs assessment, a publicized financial assistance policy, and tax exempt status review

- Bill does not address the Medicare sustainable growth rate related to Medicare payments to physicians.

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What should Providers be doing now?

Recommendation	Driver
Implement more quality initiatives and embrace quality improvements.	Medicare eliminated payment for never events beginning September 1, 2008. The National Quality Forum list of never events is currently at 28 and continues to grow. Private payers are also no longer paying for never events and selectively hospital acquired conditions. Health reform legislation has tighter restrictions on payment of readmissions. In the Inpatient Prospective Payment System FY2009 Final Rule, CMS included 10 categories of conditions that were selected for the Hospital Acquired Conditions payment reduction provision.
Seek creative ways to provide care outside of the traditional settings.	A variety of demonstrations are already in effect for providing care outside of traditional settings. Health reform legislation expand s these demonstrations nationwide.
Determine impact of Medicare level payments.	Sustainable growth rate reimbursement continues to decline. Congress is looking for a permanent fix to this increasingly burdensome problem. Increasing portion of the population covered under governmental program will accelerate under reform. Hospitals will be compared more against each other to set payment rates.
Collaborate and creatively find ways to reduce the cost of care.	Demonstrations are already in effect for physician and hospital partnerships. Health reform legislation expands these demonstrations nationwide.

Impact to Payer Sector

Overall – more new customers; new market opportunities through exchanges; new regulation and oversight; no public option and taxes have been delayed

- Several immediate changes beginning six months after enactment: prohibition on pre-existing conditions for children, prohibition on lifetime limits, rescissions, limits on waiting periods that are longer than 90 days and the requirement that all health plans have to cover non-dependent children up to age 26.

- Cadillac tax health insurer fee begins in 2018 allowing higher costing health insurance plans to stay in business longer.

- Provides stronger individual mandates and larger subsidies, implying more business and less adverse selection problems than Senate bill.

- For large group plans, by 2014, the medical loss ratio must be at least 85 percent. Current ratios are often lower, implying insurers spend more on administration, profits and marketing, and less on claim payments.

- Medicare Advantage plans would see their payments frozen in 2011. Medicare Advantage reimbursement cuts begin and bonus payments implemented in 2012.

- Government payments to Medicare Advantage cut $132 billion over 10 years. This provision should encourage insurers to find more efficient hospitals and doctors in high-cost areas. Some high-cost areas would be paid 5 percent below traditional Medicare, while some lower-cost areas would be paid 15 percent more than traditional Medicare.

- Delays effective date for fee imposed on health insurance providers until 2014 with $58.8 billion in fees over the period from 2014 to 2018; levies adjusted for premium growth afterward.

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What should Insurers/Payers be doing now?

Recommendation	Driver
Reduce administrative/overhead costs.	Restrictions on medical loss ratio in health reform legislation. Focus on premium increases.
Research the benefits of entering into a co-operative.	Co-operatives have begun to emerge and will be encouraged through a variety of incentives in health reform legislation. This may be especially useful for new market entrants.
Prepare for guaranteed issue and rating restrictions.	Regulatory changes will require new underwriting and marketing strategies.
Prepare for the potential emergence of insurance exchanges.	Provisions in health reform legislation include essential health benefits requirements . This may lead to greater federal oversight of insurance plans and result in the need to compete more on price and service. With greater standardization, payers should find ways to creatively market themselves to patients, such as through a variety of service offerings
Develop a more nimble product development and implementation process.	Nimbleness is needed to take advantage of new product opportunities, particularly in the individual and small group markets. Also, increasing demand for payers to cut costs while remaining competitive in the market.

Impact to Pharma Sector

Overall – new business with more insured and closing of the Medicare Part D donut; new taxes

- Increases the graduated fee on pharma to $28 billion over 10 years and includes a delay until 2011. Starts with $2.5 billion to be paid in 2011, $3 billion from 2012 to 2016, $3.5 billion in 2017, $4.2 billion in 2018, and $2.8 billion in 2019 and thereafter.

- By extending insurance coverage to millions of now-uninsured Americans, the proposal would offer pharma millions of new customers.

- 12 year patent protection for biotech drugs.

- Closing Medicare Part D ‘donut hole’ would increase pharma volume from seniors.

- Lawmakers rejected the President’s plan to end "pay-for-delay" settlements with brand-name drug makers.

- Rather than an overall industry fee on medical device manufacturers, the bill now contains a 2.9 % excise sales tax on certain devices beginning in 2013.

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What should Pharma/Life Sciences be doing now?

Recommendation	Driver
Understand the comparative effectiveness research development process.	There is comparative effectiveness funding in the stimulus package, and it is expanded in health reform bill. Pharmaceutical companies should understand what it is, what how the process works, and how value is going to be defined.
Get ready for products to be valued based on outcomes and cost effectiveness and for the eventual shift away from direct-to-consumer marketing.	Expansion of comparative effectiveness research funding, potential cuts in reimbursement, potential elimination of “pay for delay” practices that allow companies to pay to keep generics off the market, and increased regulation on pharmaceutical marketing practices.
Promote prescription drugs related to wellness and prevention (evaluate prescription drug delivery strategy).	Provisions in health reform legislation has proposed that these drugs will be covered at no cost for Medicare beneficiaries.
Cut administrative/overhead costs to prepare for a potential industry tax and reimbursement cuts.	Industry taxes are a source of funding for health reform legislation.

Impact on Employers (all health care & non-health care sectors)

Overall - the new law (with reconciliation fixes) affects insured and self insured plans and is phased in over 9 years

- Impact on virtually all aspects of employment-based health benefits, including:
  - Eligibility
  - Benefit plan design
  - Underwriting rules
  - Regulatory compliance
  - Funding
  - Taxes
- Affects active employee and retiree benefit plans
- Creates new disability benefit fund (CLASS Act)
- Creates new State Health Insurance Exchanges – alternative to employment-based benefits
- Starting in 2014, all employers with >50 full-time employees that do not offer coverage for all full-time employees, will be required to pay a penalty. The penalty begins once a single employee receives a tax credit. The penalty is $2,000 for every employee above a 30-employee threshold.

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What should Employers be doing now?

Recommendation	Driver
Identify and address immediate changes – Phase I: effective first plan year beginning w/in 6 mos. of enactment	Provisions* require: dependent coverage to age 26, no lifetime limits, "reasonable" annual limits on benefits, no waiting periods >90 days, no pre-existing condition exclusions, HHS-Approved external review process Provisions* permit: temporary re-insurance program for early retirees, HIPAA-allowed incentives for wellness up to 30%; tax credits for small business
Identify and address immediate changes – Phase II: effective January, 2011	Provisions* affect: • Level of benefits: Out-of-Pocket (OOP) Max must be <=HSA OOP Max. • Scope of benefits: OTC drugs not qualified medical expense • Reporting: value of benefits on W-2 • Accounts: Increased penalty for non-qualified HSA distributions • Retirees: begin to fill Part D donut hole
Assess impact of changes to be phased in 2012-2018	Selected high impact provisions* phase in: • 2012: CLASS Act auto-enrollment, $65 payroll deduction w/ opt out • 2013: Auto enroll employees in a plan; RDS tax; $2,500 Maximum FSA contribution; MA payment cuts, Medicare surtaxes; CRE fee per EE • 2014: Exchanges open to small employers; "Free Rider Assessment , vouchers for exchanges; individual mandate • 2017: Exchanges open to large group market (100+ EEs) • 2018: "Cadillac Tax"
Revise health care strategy in light of changes in law that affect your company	The law necessitates plan changes, increases compliance and provides longer term alternative (exchanges) to employer-sponsored health coverage.

*this list is illustrative and not intended to be comprehensive; consult your benefits advisor for details

Client Webcast – Prospering in a post-reform world

Friday, April 23, 2010, 11:30-12:30PM EST

One of the most impactful pieces of health legislation since Medicare is now the law of the land. Within this 2,000-page law is a blueprint for a new health system. Health executives will have to work quickly to position their organizations for the post-reform world.

The well-publicized aspects of reform often refer to the challenges - new taxes, new regulations, and new administrative deadlines. Agile organizations, however, will take advantage of key opportunities available now as the rest of the industry tries to find its bearings.

In our upcoming webcast, the PricewaterhouseCoopers' Health Research Institute will brief you on meaningful details in the legislation and their ramifications for your organization. Register online today at www.meetpwc.com/healthreform .

- Learn how your organization can prosper in the post-reform world. Key research and analysis includes:
- Overview of reform, including its major components and implementation timeline
- The key implications of health reform to your organization, including opportunities (stimulus funding, new markets and insured, and demonstration projects) and challenges (new regulations, decreasing reimbursement, new taxes, and fraud and abuse enforcement).
- Specific recommendations for each of the major health sectors (payers, providers, pharmaceuticals/ life sciences), as well as for large employers.

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