Introduction

The purpose of this online update is to keep users of Understanding Healthcare Financial Management informed about the progress of healthcare reform, a generic term used to describe the actions taken by Congress in 2009 and 2010 to “reform” the healthcare system. Of special interest is the impact of healthcare reform on the practice of healthcare financial management. The messy legislative process was completed in early 2010 when President Obama signed the Patient Protection and Affordable Care Act on March 23. Because of the difficulties in passing legislation that was acceptable to both the House and the Senate, a second law was required. This legislation, the Health Care and Education Reconciliation Act of 2010, was signed into law on March 30, 2010. In this update, the consequences of both acts will be referred to as the reform law, or just the law.

The law includes a large number of provisions that will, if not changed, take effect over the next several years with the primary goal of helping an additional 32 million Americans obtain health insurance. The provisions include expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage based on preexisting conditions, establishing health insurance exchanges, and providing financial support for medical research. For the most part, the law focuses on the insurance side of the healthcare sector as opposed to the provider side. Thus, many people believe that the legislation should be called “insurance reform” rather than “healthcare reform.”

In addition to the provisions affecting the insurance side, other provisions are designed to offset the costs of reform by instituting a variety of taxes, fees, and cost-saving measures. Examples of such measures include new Medicare taxes for high-income earners, taxes on indoor tanning services, cuts to the Medicare Advantage (HMO) program, fees on medical devices and pharmaceutical companies, and tax penalties on citizens who do not obtain health insurance.

Finally, there are other provisions that provide funding for pilot programs to test various changes to provider systems and reimbursement methodologies (primarily Medicare and Medicaid) designed to increase quality and decrease costs. For example, the law calls for pilot programs to explore the feasibility of accountable care organizations (ACOs), the effectiveness of payment bundling, and the quality gain potential of the medical home model.

The reform law contains some provisions that went into effect more or less immediately, but most provisions will be phased in over time until 2018, when the last provisions are slated to take effect. However, it is important to note that enacting legislation typically is written without a great deal of detail. Detailed guidance is provided by the government departments that are responsible for implementation of the legislation, primarily Health and Human Services (HHS).
Thus, we will not know most of the details until the implementing regulations are promulgated, and as you know, the devil is in the details. In the November 2010 elections, the Republicans took control of the House (but not the Senate), and there are rumblings that there will be an attempt to repeal or make major changes to the law. Thus, much of the information contained in this primer has to be regarded as tentative until verified by the passage of time.

References

This primer provides only the essential details of the most important elements of the law. For more information, see the following websites:

Kaiser Family Foundation:

   www.kff.org (Click on “Health Reform” along the left side of the page.)

Robert Wood Johnson Foundation/George Washington University:

   www.healthreformgps.org

National Conference of State Legislatures (NCSL):

   www.ncsl.org (Click on “Issues & Research” on the top bar, then “Health” from the pull-down menu, and finally “Health Reform.”)

Key Provisions of the Law

Here are the key provisions of the law in order of date of mandatory implementation. Note that insurance companies and providers can implement these provisions prior to the mandatory implementation date if desired. For example, many insurers included dependent children up to age 26 in parents’ health plans before the September 23, 2010, mandatory date.

Effective at Enactment

- The Food and Drug Administration (FDA) is authorized to approve generic versions of biologic drugs (drugs synthesized from living organisms or their byproducts) and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Up to this point, there were strict regulations regarding the path for generic traditional [chemical] drugs, but none for biologic drugs.)

- The Medicaid drug rebate for brand-name drugs has increased from 11 percent to 23.1 percent (with some exceptions). Furthermore, the rebate is extended to Medicaid managed care plans. The Medicaid rebate is a system that reduces the cost of drugs to Medicaid programs by requiring participating pharmaceutical companies to offer discounts.

- Comparative effectiveness research (CER) is encouraged by the establishment of a nonprofit Patient-Centered Outcomes Research Institute. CER involves the direct comparison of existing healthcare interventions to determine which work best for which patients and which pose the greatest benefits and harm.
• A task force on Preventive Services and Community Preventive Services has been created to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.

• The Indian Health Care Improvement Act has been reauthorized and amended. This provision permanently authorizes and amends appropriations targeted for Native Americans in 1976.

**Effective June 21, 2010**

• Adults with preexisting conditions are eligible to join a temporary national high-risk pool, which will be superseded by the healthcare exchange in 2014.

• The Early Retiree Reinsurance Program, a $5 billion pool designed to help employers offer insurance coverage to early retirees (aged 55 to 64), has been established. These retirees are particularly vulnerable because they are not yet eligible for Medicare but are in an age group highly susceptible to poor health. This program ends in 2014 when other insurance options become available to early retirees.

**Effective September 23, 2010**

• Dependent children are permitted to remain on their parents’ insurance plan until their 26th birthday.

• Insurers are prohibited from discriminating against children (defined as individuals under age 19) on the basis of preexisting medical conditions. In 2014, this prohibition will also apply to adults. (A preexisting condition is any disease or condition that was diagnosed before a patient applied for a health insurance policy. In the past, patients who had been diagnosed with a condition and who then experienced an interruption in health insurance coverage, or were changing insurance carriers, could be denied coverage because of their so-called preexisting condition. In the case of applying for health insurance through an employer, the preexisting condition clause was limited to conditions that were treated within the previous six months.)

• Insurers are prohibited from charging copayments or deductibles for Level A or Level B preventive care and medical screenings on all new insurance plans. (Level A preventative services are those that have a substantial net benefit; Level B services have a moderate net benefit.)

• Individuals affected by the Medicare Part D (prescription drug) coverage gap will receive a $250 rebate, and 50 percent of the gap will be eliminated in 2011. The entire gap will be eliminated by 2020. The idea is to do away with the existing “doughnut hole,” whereby Medicare pays 75 percent of drug costs up to some amount, say, $3,000, at which point the beneficiary pays the full amount above the lower threshold. Then, above some higher threshold, say, $5,000, Medicare pays almost the entire cost of prescription drugs. In effect, the beneficiary is responsible for all costs in the “doughnut hole,” which is between $3,000 and $5,000 in this example.
• Insurers are prohibited from placing lifetime limits on health policies. In addition, annual limits, which are prohibited after 2014, must meet specified guidelines. Note that lifetime limits (caps) were first introduced in health insurance products in the 1970s and a common limit at that time was $1 million. Because of medical cost inflation, that $1 million cap translates today to $10 million, even though most health insurance plans currently have caps in the $2 million to $5 million range and some still have $1 million caps. Medicare imposes no lifetime dollar limit, although it does limit the amount of some covered services, such as inpatient psychiatric services. (It will be interesting to see how this provision shakes out. The whole idea of insurance is to protect against catastrophic losses, yet insurers argue that premiums will soar if there are no caps.)

• Insurers are prohibited from dropping policyholders when they get sick. The only valid reason for canceling coverage is fraud on the part of the beneficiary.

• Insurers are required to reveal details about administrative and executive expenditures.

• Insurers are required to implement an appeals process for coverage determination and claims on all new plans.

• Indoor tanning services are subject to a 10 percent service tax.

• Enhanced methods of Medicare and Medicaid fraud detection have been implemented.

• Not-for-profit Blue Cross insurers are required to maintain a loss ratio (money spent on procedures over money incoming) of 85 percent or higher to take advantage of existing tax benefits.

• A new HHS website provides consumer insurance information for individuals and small businesses in all states.

• A temporary credit program has been established to encourage private investment in new therapies for disease treatment and prevention.

**Effective by January 1, 2011**

• Insurers are required to spend 85 percent of large-group and 80 percent of small-group/individual plan premiums (with certain adjustments) on healthcare or to improve healthcare quality or return the difference to customers as a rebate. In 2009, most large-group plans met this threshold, but many of the small-group/individual plans did not, the average being only 74 percent. Because much of the administrative expense on these policies goes to agent sales commissions, many insurers have already begun to reduce this expense, primarily by moving from a percentage to a flat-fee basis. Conversely, some insurers are dropping small-group/individual plans because they cannot be effectively marketed without the use of agents.

• Healthcare companies are required to issue Forms 1099 to any vendor from which the company purchases more than $600 per year in services and/or goods and send a copy to the Internal Revenue Service. To comply with this requirement, companies have to gather a large amount of data from most of its vendors, even individuals, such as tax
identification numbers or Social Security numbers. For example, if a healthcare business buys a used car from an individual for $1,000 or if one of its salespeople spends $750 at a restaurant, it has to issue a Form 1099 for that transaction. Experts estimate that this requirement will cause healthcare businesses to issue billions of new Forms 1099 and significantly increase the cost of accounting.

- CMS established the new Center for Medicare and Medicaid Innovation (CMI) (discussed later).

**Effective by January 1, 2012**

- Providers organized as accountable care organizations (ACOs) that voluntarily meet quality and cost reduction goals will be allowed to share in the cost savings to Medicare (discussed later).
- Bonus payments will be provided to high-quality Medicare Advantage plans.

**Effective by January 1, 2014**

- Insurers will be prohibited from discriminating against or charging higher rates for any individuals on the basis of preexisting medical conditions.
- Employers will be allowed to offer rewards to employees worth up to 50 percent of their cost of healthcare coverage for participating in wellness programs and meeting specified health benchmarks.
- Insurers will be prohibited from establishing annual spending caps.
- Medicaid eligibility will expand; individuals with income up to 133 percent of the poverty line will qualify for coverage, including adults without dependent children.
- Tax credits will be offered to small businesses that have fewer than 25 employees and provide healthcare benefits for them.
- A $2,000 per employee tax penalty will be imposed on employers with more than 50 employees that do not offer health insurance to their full-time workers. (In 2009, more than 95 percent of employers with at least 50 employees offered health insurance.)
- An annual penalty of $95, or up to 1 percent of income, whichever is greater, will be imposed on individuals who do not secure insurance; this penalty will increase to $695, or 2.5 percent of income, by 2016. This limit will be the individual limit; families will have a limit of $2,085. Exemptions to the penalty in cases of financial hardship or religious beliefs will be permitted.
- The Community Living Assistance Services and Supports (CLASS) Act provision will create a new voluntary long-term care insurance program that will be offered by employers but paid for by employees. Enrollees who have paid premiums into the program and become eligible (due to disability or chronic illnesses) will receive benefits that help pay for assistance in the home or in a facility.
Employed individuals who pay more than 9.5 percent of their income on health insurance premiums will be permitted to purchase insurance policies from a state-controlled health insurance option.

New spending will be paid for in part through spending and coverage cuts to Medicare Advantage, slowing the growth of Medicare provider payments (in part through the creation of a new Independent Payment Advisory Board), reducing the Medicare and Medicaid drug reimbursement rate, and cutting other Medicare and Medicaid spending.

There will be a new $2,500 limit on tax-free contributions to flexible spending accounts (FSAs), which allow for payment of health costs.

Members of Congress and their staff will be offered healthcare plans only through the exchange or plans otherwise established by the bill (instead of the Federal Employees Health Benefits Program they currently use).

Chain restaurants and food vendors with 20 or more locations will be required to display the caloric content of their foods on menus and vending machines. Additional nutritional information (such as saturated fat and sodium content) must be made available upon request.

Health insurance exchanges with subsidies of insurance premiums for individuals and families with income up to 400% of the federal poverty level (FPL) will be established. Subsidies will be provided as a refundable tax credit, allowing individuals and families with no tax liability to receive the credit.

Earned income of individuals that is greater than $200,000 annually or of couples that is greater than $250,000 annually will be subject to Medicaid Payroll withholding of 3.8 percent.

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A new excise tax applicable to pharmaceutical companies and based on the market share of the company will go into effect; it is expected to create $2.5 billion in annual revenue.

Most medical devices become subject to a 2.9 percent excise tax collected at the time of purchase.

Health insurance companies become subject to a new excise tax based on their market share; the rate will gradually increase between 2014 and 2018 and thereafter increases at the rate of inflation. The tax is expected to yield up to $14.3 billion in annual revenue.

The qualifying medical expenses deduction for Schedule A tax filings will increase from 7.5 percent to 10 percent of earned income.
**Effective by January 1, 2017**

- A state will be permitted to apply to the HHS Secretary for a waiver of certain provisions, provided that the state develops a detailed alternative that “will provide coverage that is at least as comprehensive” and “at least as affordable” for “at least a comparable number of its residents” as the waived provisions. The decision of whether to grant this waiver is up to the HHS Secretary (who must annually report to Congress on the waiver process) after a public comment period.

**Effective by 2018**

- All existing health insurance plans will be required to cover approved preventive care and checkups without copayment.

- A new 40 percent excise tax on high-cost (“Cadillac”) insurance plans will be introduced. The tax (as amended by the reconciliation bill) will be on the cost of coverage in excess of $27,500 (family coverage) and $10,200 (individual coverage) and $30,950 (family) and $11,850 (individual) for retirees and employees in high-risk professions. The dollar thresholds will be indexed with inflation; employers with higher costs on account of the age or gender demographics of their employees will be allowed to value their coverage using the age and gender demographics of a national risk pool.

**Impact of the Law on Providers**

The good news regarding reform and the use of *Understanding Healthcare Financial Management* is that healthcare reform does not invalidate the theory, principles, and concepts contained in the book. The primary impact of reform will be on the strategic management of healthcare providers rather than on the process of financial decision making.

**Additional Details for Providers**

Here are some additional details on measures that directly affect healthcare providers:

- The new law amends the Ethics in Patient Referrals Act, better known as the “Stark” act, by rescinding physicians’ ability to self-refer to hospitals in which they have an ownership interest if those hospitals were not operating with both physician ownership and a Medicare provider number by December 31, 2010. Also prohibited is the conversion of an ambulatory surgical center to a physician-owned hospital on or after the date of enactment. Existing hospitals meeting this basic requirement will be “grandfathered” and allowed to continue to self-refer, subject to compliance with certain conditions.

- The law requires the establishment of a Center for Medicare and Medicaid Innovation (CMI) within CMS by January 1, 2011, and allots $10 billion for this purpose. The Center is charged with developing innovative healthcare delivery systems that will improve quality and slow cost growth. It is expected to develop new pilot projects (or join ongoing projects) to determine which approaches prove to be most effective. The law lists 18 delivery and payment models to be tested initially, including patient-centered medical
homes and the use of health information technology to promote coordination of care. In selecting such models, the Secretary may give preference to models that also improve the coordination, quality, and efficiency of healthcare services furnished to beneficiaries, such as patient-centered medical homes and new continuing care hospitals that offer inpatient rehabilitation, long-term care, and home health or skilled nursing care after an inpatient stay.

- The law requires the award of state planning grants to establish Medicaid Health (Medical) Home Programs for eligible enrollees by January 1, 2011. Eligible participants must have at least two chronic conditions, such as asthma, diabetes, or mental health issues, and must select a designated provider to serve as a health home. Payment is not limited to per member per month (PMPM) and states may propose alternative methods of payment.

- Beginning January 1, 2012, groups of qualifying providers will have the opportunity to form accountable care organizations (ACOs) and share in the cost savings they achieve for the Medicare program. To qualify as an ACO, an organization will have to meet several criteria. For example, it must (1) agree to become accountable for the overall care of its Medicare fee-for-service beneficiaries, (2) agree to a minimum three-year participation in the program, (3) have a formal legal structure enabling it to receive and distribute bonuses to participating providers, (4) provide information on the physicians participating in the ACO, (5) have a management and leadership structure in place, (6) define processes to promote evidence-based medicine and patient engagement, (6) report on quality and cost measures and coordinate care, and (7) demonstrate that it meets specified patient-centeredness criteria determined by the HHS Secretary. To earn incentive payments, ACOs must meet specified quality thresholds.

- Beginning in 2013, the law establishes a value-based purchasing (VBP) program to pay hospitals for their actual performance on quality measures rather than just for reporting those measures. The VBP program will apply to all acute care prospective payment system (PPS) hospitals. Certain hospitals are excluded, including those that do not have a sufficient number of patients within the related conditions. Measures will be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia, and surgical care, and measures assessing patients’ perception of care.

- Beginning in 2013, a Medicare voluntary pilot program on payment bundling will be established to improve the coordination, quality, and efficiency of healthcare services. Entities comprising groups of providers may apply to participate in the program. The pilot program may cover inpatient and outpatient hospital services, physician services (both in the inpatient and outpatient settings), post–acute care services, and other services that the HHS Secretary determines appropriate. The law requires a test of alternative payment methodologies for the pilot program, which may include bundled payments or bids from participating entities.
Also beginning in fiscal year 2013, inpatient PPS hospitals with higher-than-expected readmission rates will experience decreased Medicare payments for all Medicare discharges.

The law significantly expands efforts to establish uniform standardized transactions and administrative processes among health plans, clearinghouses, and providers. It amends the statement of purpose section of the HIPAA administrative simplification provisions to require uniform standards that achieve administrative simplification and reduce clerical burdens on patients, providers, and plans. At a more practical level, the law requires the adoption of a single set of “operating rules” for each of the HIPAA transaction standards. Operating rules are intended to reduce variations in how individual health plans and clearinghouses implement HIPAA transaction standards.

Impact on Hospitals

Success in the post-reform era will require hospitals to pursue many strategies simultaneously. Perhaps the biggest benefit of the law is the expectation that over 30 million Americans will be added to the insurance rolls, which means that roughly 65 percent of the patients who are currently at risk of being categorized as indigent or bad debt losses will now be insured. Here are some of the key actions considered to be important for success under reform:

- Hospitals must enhance efforts to improve quality, patient safety, and patient satisfaction. The law places considerable emphasis on quality and patient safety, so hospitals must ensure that systems are in place that document and ensure patient quality and safety. Major goals should be to reduce preventable readmissions and increase patient satisfaction.

- Hospitals must increase clinical and operational efficiencies. Although more patients will be insured, the law likely will place additional constraints on reimbursement; hence, hospitals must rigorously contain costs to maintain a sound financial condition.

- Hospitals must identify community partners and conduct community needs assessments. The law encourages an increased focus on community health and ultimately will tie reimbursement to health status as opposed to health treatments.

- Hospitals must assess and strengthen plans for health information technology and electronic health records. The ability to communicate within health systems will decrease overall costs, increase patient satisfaction, encourage sound treatment protocols, and reduce costs.

- Hospitals must prepare for episodic (bundled) reimbursement and explore organizational capacity to manage care across the continuum. With more emphasis on ACOs, medical homes, and bundled payments, hospitals are going to have to work more closely with physicians and other providers and develop new competencies for clinical integration. This cooperation among providers may take the form of single ownership (hospital
acquisition of medical practices) or of more loosely aligned systems (joint ventures and operational agreements).

**Impact on Physicians**

Here are some of the implications for physicians:

- The increasing demand for physician services (especially primary care services) will require increased use of physician extenders (nurse practitioners and physician assistants). In addition, the primary care workforce will be defined more broadly to include retail clinics and expanded roles for pharmacists. The medical home will be a centerpiece of care, but the model will evolve as care management technologies are fully developed and performance-based payments become standard. Because the financial investment required to create and manage ACOs and other provider systems will be substantial, many medical practices will have to merge or be acquired by hospitals to provide economies of scale and enhance financial resources.

- The movement to bundled payment methodologies will require greater cooperation among physicians and between physicians and hospitals. Best practice procedures will be emphasized, and team-based patient care management and medical home models will require specialists to collaborate with peers in shared risk arrangements.

- In summary, the law will require physicians to alter their entire approach to the practice of medicine. Instead of acting alone with more or less complete autonomy, reimbursement will be based on the evidence-based performance of teams of providers.