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Healthcare Reform

New business risks and opportunities

Captive Insurance Council

District of Columbia

June 22, 2010

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (PL 111-148). On March 30, 2010, he signed the *Health Care and Education Affordability Reconciliation Act of 2010* (PL 111-152)

- 2,400 page bill and 150 page reconciliation bill
- Various effective dates; some immediate, others to 2019 and beyond
- $1 trillion in new contracts, grants, entitlements and other spending
- Changes source of health insurance for 40 million Americans
- Directly impacts 20 percent of the economy
- 30,000 new IRS employees
- 30,000 new HHS employees
- 50,000 pages of new regulations . . .

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"The war to make healthcare reform an enduring success has just begun. . ." *

"Making the legislation a success requires not only that it survive but also that it be effectively implemented. Although the bill runs to more than 2000 pages, much remains to be decided. The legislation tasks federal or state officials with writing regulations, making appointments, and giving precise meaning to many terms."

HJ Aaron, RD Reischauer. The war isn't over. *N Eng J Med*. See www.healthcarereform.nejm.org

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Today's agenda

- How did we get here?
- What's going on now?
- Key provision highlights
- Stakeholders' perspectives
  - Payers, providers, manufacturers, patients
- Business hurdles and opportunities
- Where do we go from here?

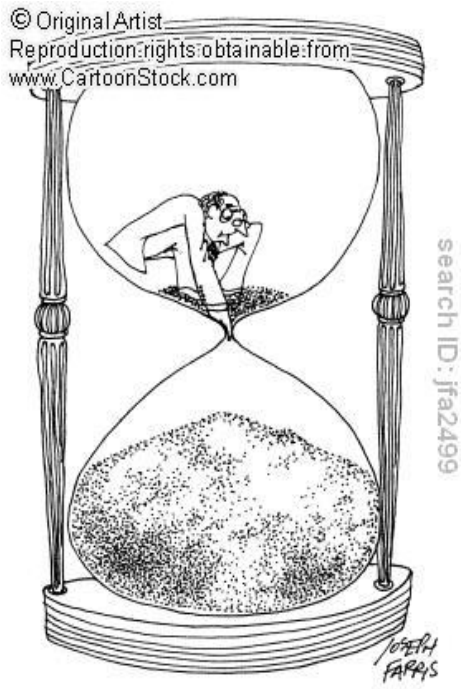
"Businesses that adjust rapidly and well to the new rules stand to gain a significant competitive advantage. . ." *

- HCR makes fundamental changes to the US healthcare system
  - Businesses and products will be created and driven out of the economy
- Careful self-assessment will inform steps forward for each stakeholder/group
  - Compliance with new requirements
  - Opportunities to influence regulation development
  - Help form, participate in demonstrations, pilots, new quality initiatives
- Timing is critical!

TA Brennan, DM Studdert. How will health insurers respond to new rules under health reform? *Health Affairs* 29, 6(2010):1147-1151

Healthcare reform legislation took more than a year to complete

- **Stimulus** (Feb 2009) . . . "'Universal coverage' or 'Government Option'" (Mar – Jul 2009)
- **Town Hall's back in the district…** (Aug 2009)
- **House:** *Affordable Health Care for America Act* (HR 3962) (Nov 7, 2009)
- **Senate:** *Patient Protection and Affordable Care Act* (S 3590) (Dec 24, 2009)
- **Conference or "Deeming"**
  - *Patient Protection and Affordable Care Act* (PL 111-148) (March 21, 2010)
  - Healthcare and Education Reconciliation Act (HR 4872) (Mar 25, 2010)
- **Next steps…**
  - Legal challenges by 19 states' attorneys general
  - Regulations, rule making, etc.
  - HHS and DOL coordination
  - Technical corrections, "healthcare fatigue", compliance requirements



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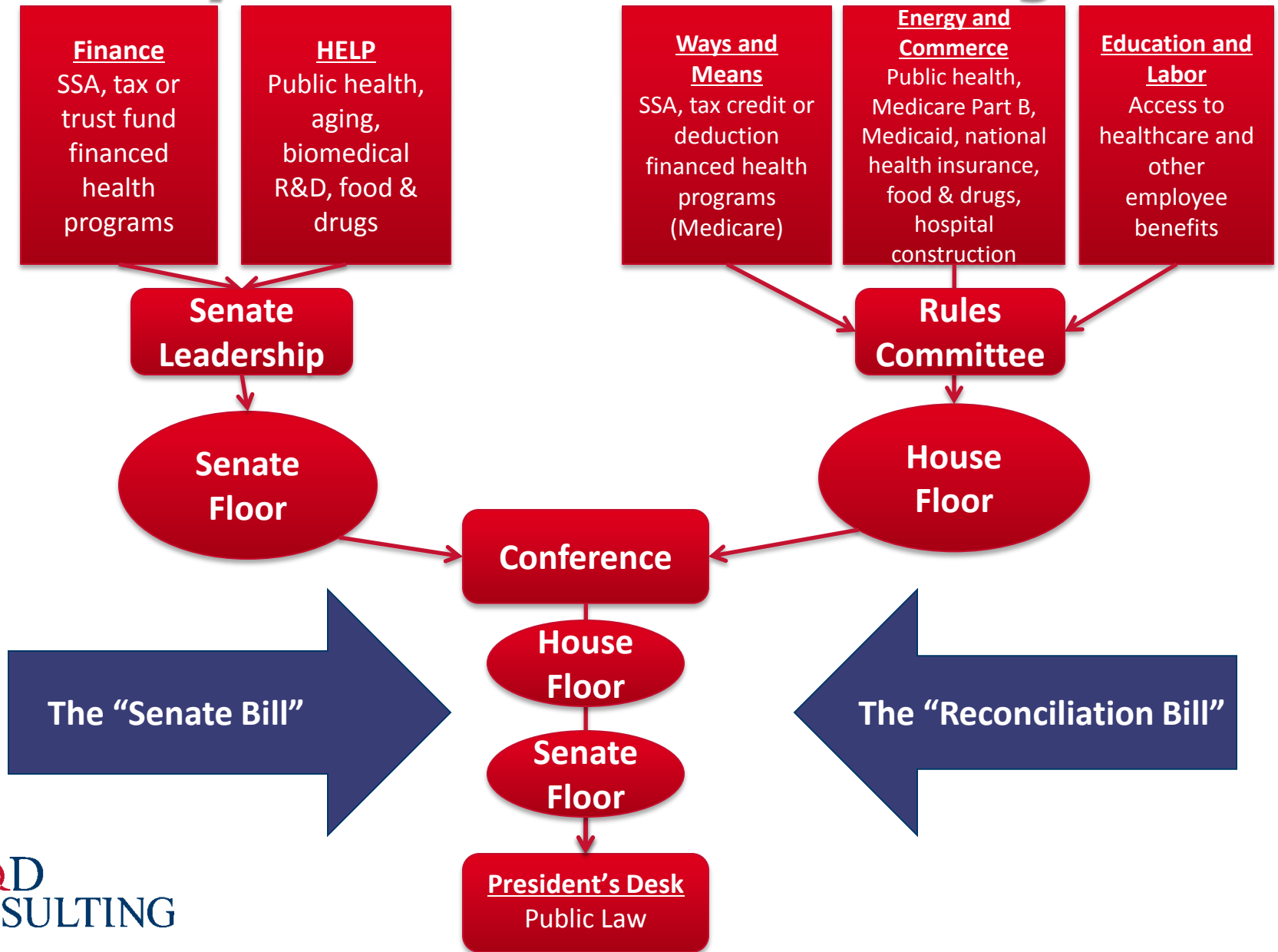
Pathway to healthcare reform legislation



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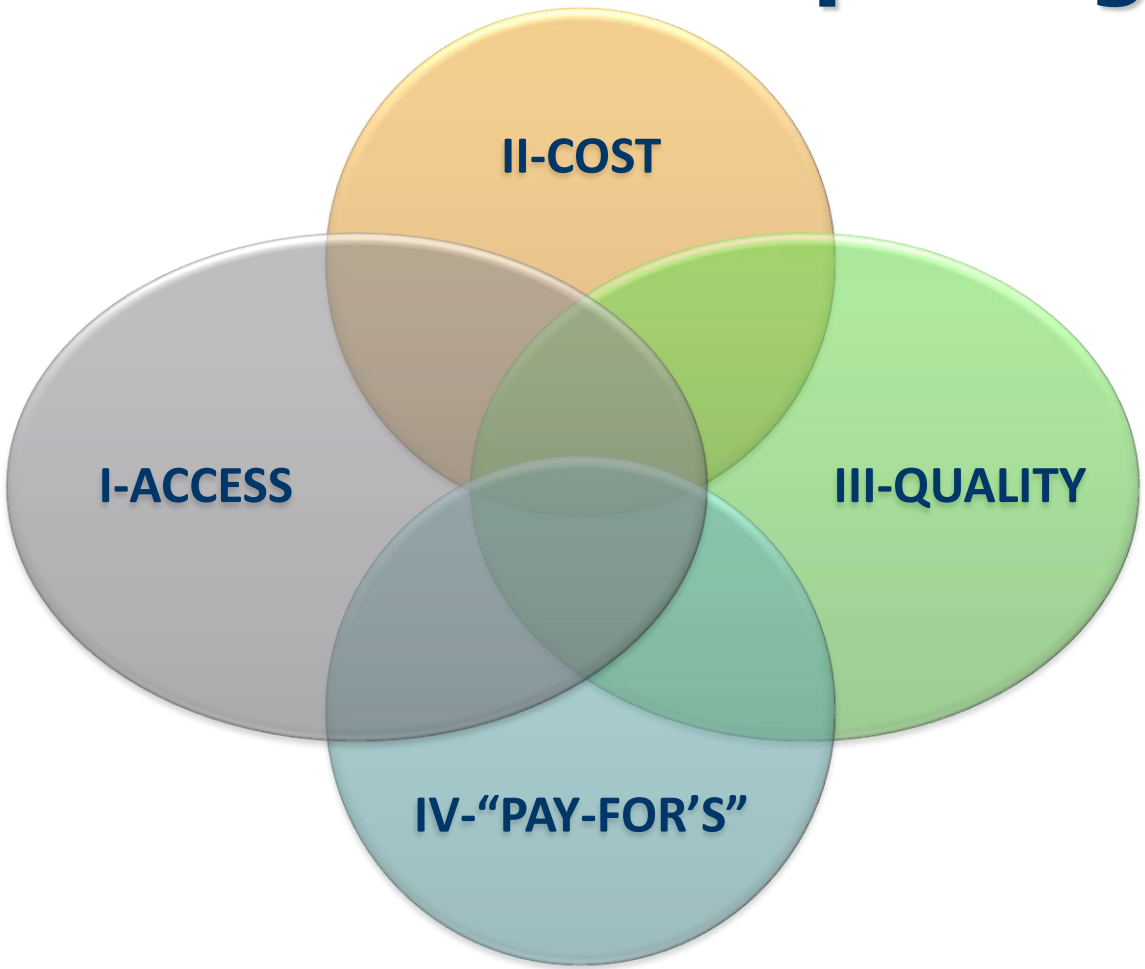
Core components of the healthcare reform package



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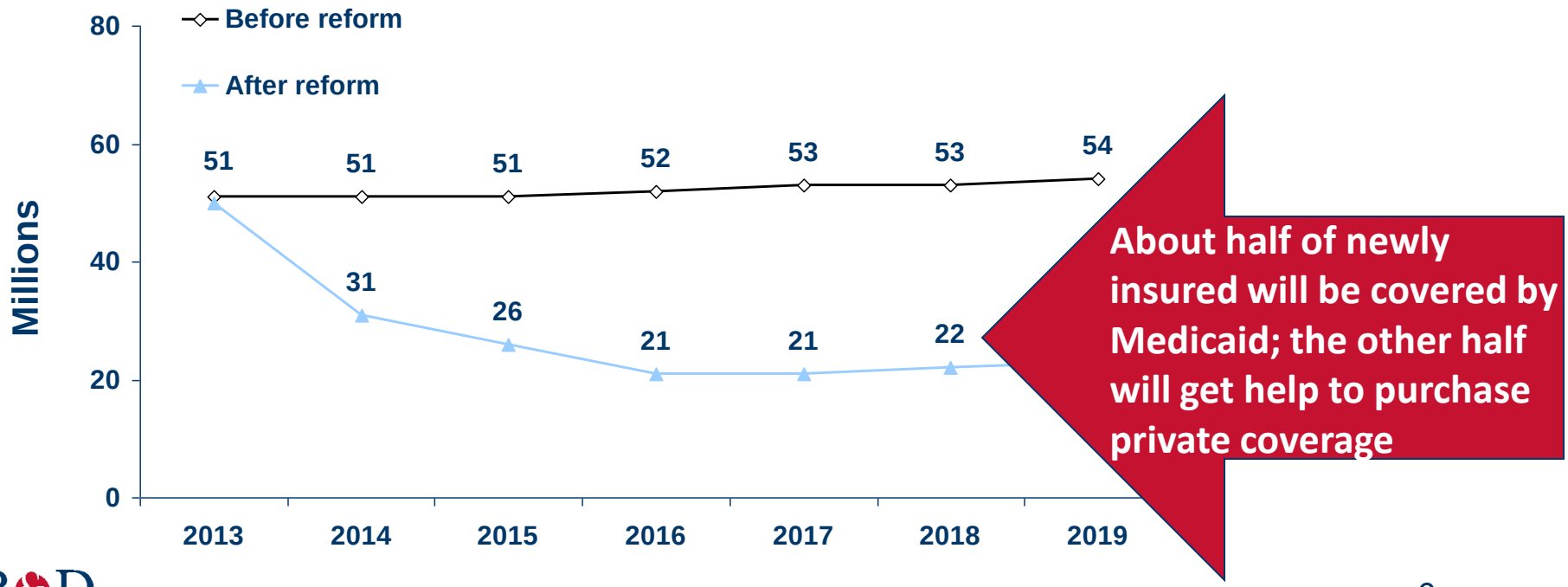
I-Healthcare reform expands access to insurance for US citizens and legal residents

- Purchase insurance or pay penalty
- Medicaid expanded to 133% FPL



Courtesy: The Commonwealth Fund

I-Expanding access forces health plans to comply with complex timelines for new regulations

- Jun 21, 2010:
  - Create high risk pools

Eligibility	Individuals who have a pre-existing medical condition and have not had creditable coverage for the previous six months.
Benefits	The Secretary of HHS will determine the minimum benefits that must be included and plans must cover at least 65% of health care costs.
Premiums and Cost-Sharing	Set premiums as if for a standard population and not for a population with a higher health risk. Allow premiums to vary by age (4:1), geographic area, and family composition. Limit out-of-pocket spending to $5,950 for individuals and $11,900 for families, excluding premiums.
Funding	$5 billion
Timeline	Effective 90 days after the bill is enacted (June 21, 2010). Terminates on January 1, 2014 when the American Health Benefit Exchanges are established.

I-Complex timelines continued…

- **Effective Oct 1, 2010:**
  - Children remain on parents' plan through age 26
  - Lifetime limits on benefits prohibited
  - Annual limits on essential benefits restricted
  - Excluding children with preexisting conditions prohibited
  - Medical loss ratio establish
  - Coverage for high cost members cannot be rescinded
- **Effective Jan 1, 2014:**
  - Guaranteed issue
  - Prohibits medical underwriting
  - Prohibits exclusion for preexisting conditions
  - Minimum "essential benefits" required
  - Eliminates lifetime annual limits on essential benefits
  - Prohibits rescinding policies, except for nonpayment

I-Employers and exchanges

- Employers offer insurance or pay a penalty ("pay or play" with exceptions for small employers)
- State-based exchanges fill in gaps for individuals and small businesses

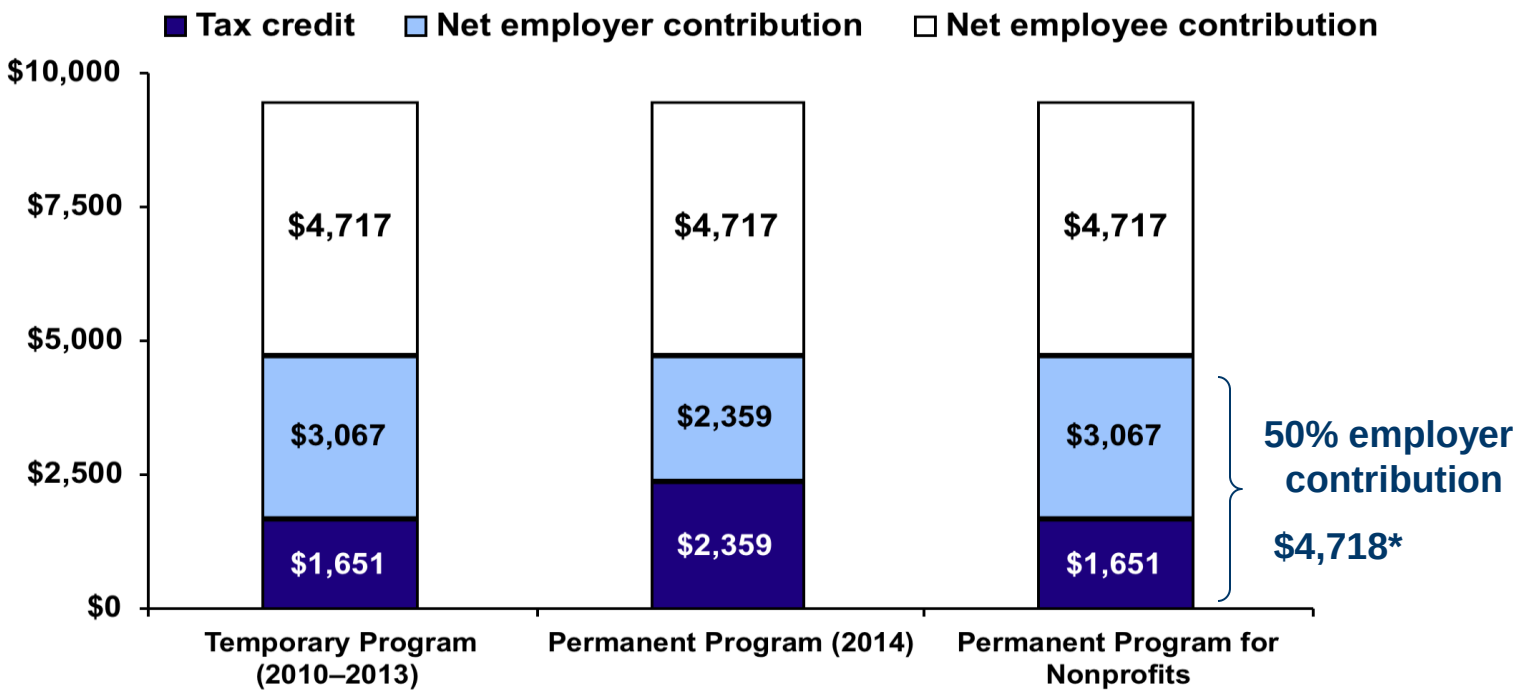
I-In 2014, small employers can elect to purchase coverage for their employees through exchanges

- Tax credit to small business
  - Offset up to 35% of employer's premium contribution for 2 yrs for low wage firms with fewer than 25 employees
    - Temporary program starts in 2010; permanent program in 2014 will provide up to 50% credit for 2 yrs
  - Assesses contribution from larger businesses whose employees receive government subsidies
  - Requires individuals to have coverage

I-Small businesses may qualify for tax credits for family premiums

$9,435—projected family premium

Credit per employee



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Courtesy: The Commonwealth Fund

I-Exchanges will help pool risk, lower administrative costs and provide choice of plans

- By 2014: limited to workers buying coverage in individual market and those in firms with 50 or fewer employees
  - States may agree to include firms with 100 or fewer employees
- After 2017, states may open exchange to firms of any size
- Essential standard benefits package
  - 2 tiers to allow families to understand OOP liability; actuarial values from 60 (bronze) to 90 percent (platinum)

II-Healthcare reform seeks to "bend the cost curve"

- Reduce DSH payments to hospitals
  - 75 percent cut in 2014, then increase based on number of uninsured
- Create Innovation Center (Jan 2011)
  - Test payment reform models
- Reduce payments for hospital readmissions (Oct 2012)
- Encourage use of biosimilars
- Reduce waste, fraud, abuse
  - Increased enforcement across healthcare delivery
  - Increased funding to OIG

II-Independent Medicare Payment Advisory Board

- Fifteen member Board, insulated from influence, required to impose cuts if spending growth exceeds 5 yr CPI/GDP+1
  - Bipartisan, appointed by President, confirmed by Senate
    - Medical or other expertise in healthcare policy
- Make annual recommendations to President to set payment updates across all sites of service
- Budget neutral recommendations and authority to make broader reforms to improve quality/efficiency
- President accepts/rejects recommendations within 30 days
- Congress accepts or passes joint resolution within 30 days
- CMS implements through rulemaking
- May not "ration" care, increase revenues or change benefits, eligibility

III-Improve the quality of care

- Develop national quality improvement strategy, and quality measures
  - Plans to report on quality improvement initiatives
  - Movement from "P4R" to "P4P"
- Focus on prevention and wellness
  - No co-insurance for USPSTF-approved preventive services
  - Increased focus on primary care and wellness

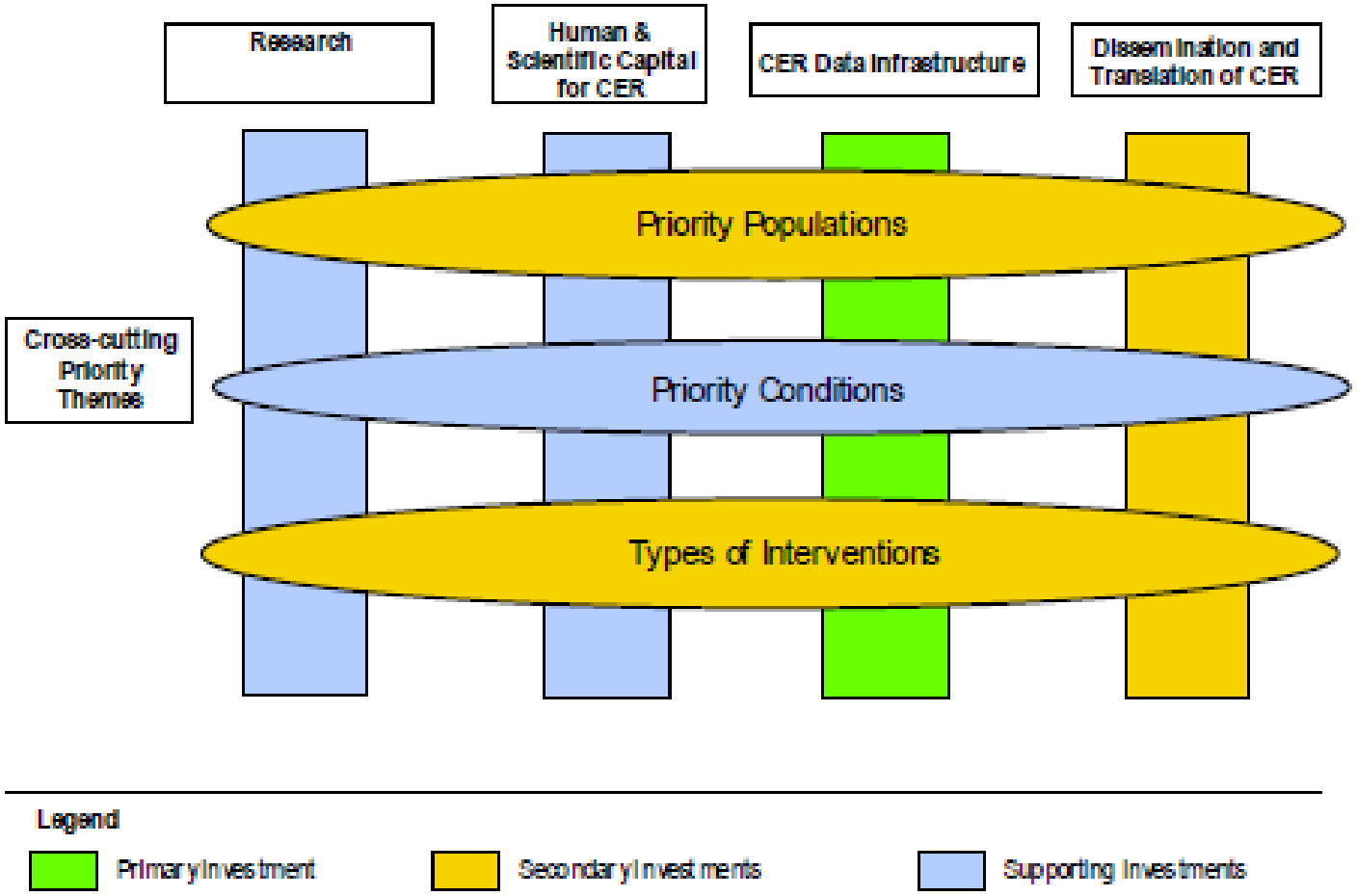
III-Reform offers new rewards for quality, not volume

- Improves Medicare prescription drug benefit
  - $250 rebate for those in donut hole in 2010
    - 2011, 50% discount on brands
  - Eliminates coverage gap by 2020
    - Pay 25% (not 100%) of costs

III- A new comparative effectiveness entity will be created

- Board of Governors with stakeholder reps
- Sets priorities, carries out agenda
  - Contract with Fed Agencies (e.g., AHRQ) or private sector
- Comparative clinical effectiveness
- Advisory panels as needed
  - Topics, methods, rare disease
- Transparency and public comment
- CER for coverage only if:
  - Stakeholder input
  - Subgroup analysis conducted
  - GAO report required
- Funding through Patient Centered Outcomes Research Trust

Recommended High Level OS Investment Priorities



III- Stakeholders should consider business strategy in light of CER update

- Access to decision makers and influencers
- Evolving, interoperable data systems
  - Distributed model may require least new infrastructure development
- Opportunity to reframe market space
- Impact on coverage determination process
  - Length, participants, public comment and response
- Transparency of process
  - New reporting/data collection burden
- Focus on impact of product/service within health system
- "Clinical" effectiveness language persists
  - Role of economic analysis

III-Quality initiatives in HCR are far-reaching

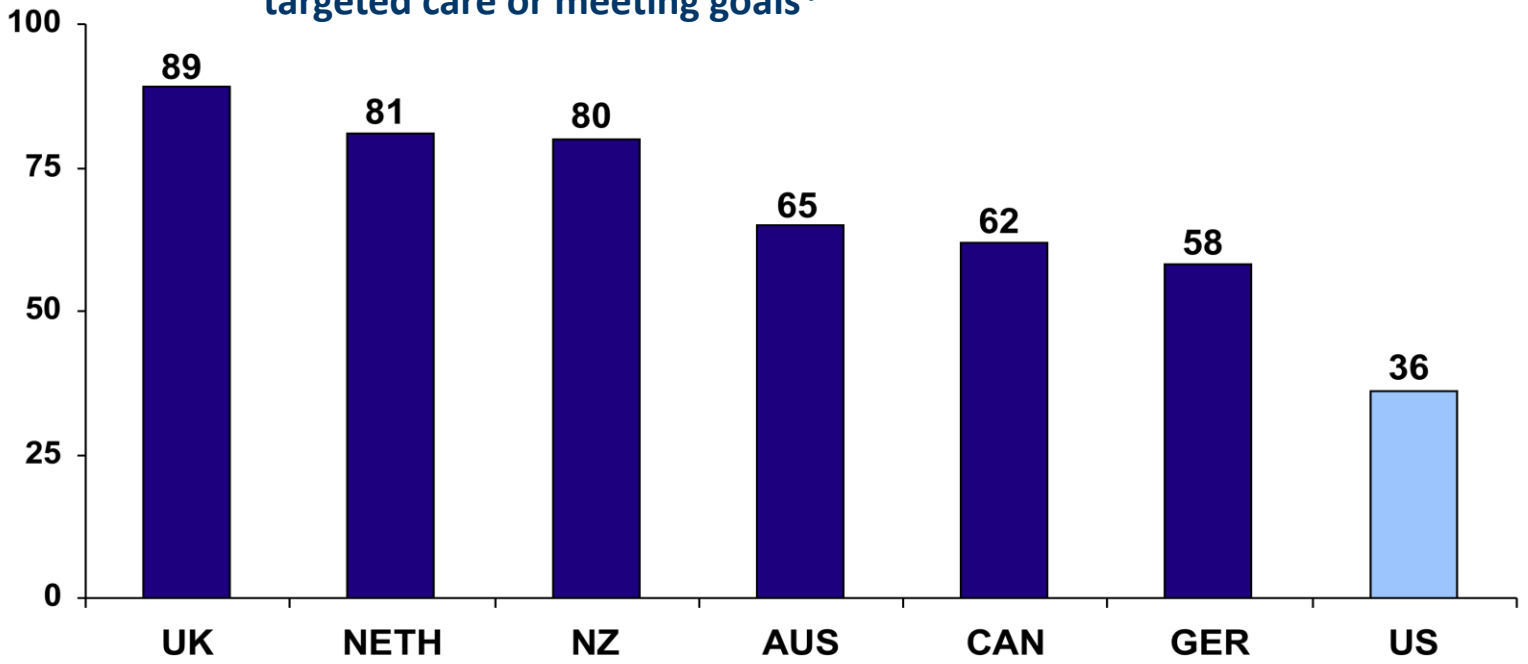
- Establish hospital value-based purchasing
- Invest in infrastructure for high performance health system
  - Public reporting of quality, cost, performance of providers and insurers
  - Use of HIT
  - National strategies on prevention, public health, quality, safety and healthcare workforce

III-The law creates demonstration and pilot programs to test new service delivery and payment models

- Medical home pilot
- Independence at home demonstration
- Accountable care organization (ACO) pilot
- Hospital readmissions program
- Post-acute care (PAC) pilot
- Acute care episode (ACE) demo conversion
- Bundled payments for episodes of care

III-The law rewards physicians for quality

Percent of physicians reporting any financial incentive for targeted care or meeting goals*



* Financial incentives for : high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding non-physician clinicians to practice and non-face-to-face interactions with patients.

Source: C. Schoen, R. Osborn, et al, "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171–w1183.

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IV-"Pay for's" were fundamental challenge to establishing reform; will be key issue for mid-term elections

- Healthcare reform law will cost $938 billion over ten years, financed through
  - Excise tax on high-cost insurance
  - Device tax
  - Pharma discounts to close "donut hole"
  - Increased enforcement to reduce waste, fraud, abuse
- All sectors impacted; additional "pay-for's" and service reductions nearly certain

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Is healthcare reform an opportunity for captive insurance?

- Intensified insurer regulation
  - ✓ **Many regulations remain to be developed**
- End of risk selection
- FEHB becomes standard against which plans are measured
- Broadened employer responsibility
- Deficit driven pressure on reimbursement
- Value based bundled pricing

Self-insured plans may have more flexibility to build new service and payment models efficiently

How long will the opportunity to lead innovation remain before government and other influencers take the lead?

- Incentivize coordinating care across providers and sites of service
  - Short and longer-term outcomes
- Consider bundled payment and quality incentives across sites of service (e.g., ACOs)
- How valuable is member data?
  - De-identified clinical/claims data becomes critical asset
  - Resource for CER
  - Platform for enhanced product offerings

What should you and your clients be doing now?

- Assume fee for service payment system disappears
  - **New system based on performance, quality, reporting**
- Assume trend toward bundling will continue/expand
  - **New incentives, new value proposition, new role for innovation**
  - **New focus on quality and efficiency**
  - **New relationships and decision makers**
- High volume/high cost conditions with well-defined treatment pathways offer starting point for innovation
- Evidence driven process
  - **Evaluate specific cost and claims data**
  - **Identify and fill gaps in data, experience**
  - **Consider potential need to expand network**

"Businesses that adjust rapidly and well to the new rules stand to gain a significant competitive advantage. . ."

- Analyze law, implementation timeline, agency notice and rulemaking
- Identify/evaluate compliance requirements
- Set priorities
  - Where must we come into compliance?
  - What resources are needed?
  - Where can we impact regulation development?
  - Where can we partner?
- Identify and engage influencers

Thank you

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