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Health care reform: Evolution or revolution?

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Evaluating the impact of health care reform

In March 2010, Congress passed and President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation (HCER) bill. These major legislative health care reform initiatives, along with the American Recovery and Reinvestment Act of 2009, clearly strengthen the federal government's role as the major market influence on health care policy, coverage, delivery, and reimbursement. Over the next four years, PPACA will expand Medicaid significantly, subsidize insurance premiums, and provide incentives for businesses to provide health care insurance.

PPACA, the most comprehensive federal legislation since Medicare and Medicaid entitlement programs were enacted, has already established an implementation timetable that will drastically change the health care segment of the United States economy.

Government as an active change agent and purchaser of health care

As the major purchaser of health care products and services, the federal government currently covers one out of three Americans and pays over 50% of the nation's health care costs. With the most significant federal involvement since enactment of Medicare (Title-18) and Medicaid (Title-19), health care reform legislation seeks to accomplish the following:

- Increase "universal" health care coverage and access to services
- Begin to control the nation's increasing costs for providing health care coverage and services
- Transform the nation's health care system from market emphasis on quantity (fee for service) to a quality driven outcome model (pay for performance reimbursement, payment "bundling" for key medical service, etc.)
- Through proactive legislation and market leveraging, require the health care industry to implement new information technology applications and reporting requirements

The nations' legislated health care reform objectives are worthy, yet face numerous marketplace and fiscal implementation challenges.

Supply and demand

Health care reform legislation intends to expand coverage for over thirty million uninsured Americans, which will result in increased utilization and changes in the payer mix for health services. The United States is already facing increasing health care utilization due to an aging population and servicing challenges resulting from critical labor shortages within the industry.

Costs

National health care reform is being implemented during a period of economic uncertainty. The Senate Bill (HR 3690) resulted in states assuming greater reform responsibilities with accompanying rules and regulations. PPACA expectations will further complicate states' abilities to deliver new health care policies, given their own fiscal budget and economic challenges.

Employers, large and small, will face minimum standards for providing health coverage that will require cost analysis and work force planning.

By 2014, health insurance purchasing exchanges administered by the states will become a market option.

It can be expected that payers and providers of health care will need to reduce costs, in order to respond to anticipated federal mandates, taxes, and reimbursement changes.

President Obama's administration has increased its health care fraud and abuse budget by 50%, in order to identify and prosecute corporations and individuals bilking both Medicare and Medicaid entitlement programs.

The federal government, through President Obama's Deficit Reduction Commission, has begun work on developing major recommendations for economic recovery. The Commission's goal is to help identify ways to reduce the nation's annual debt from 10% of gross domestic product (GDP) to 3%, within the next decade. Recommendations are to be provided to the President by December 1, 2010. New taxes and spending cuts can be expected, with particular emphasis being placed on Medicare, Medicaid, and Social Security entitlement programs.

Reimbursement and revenues

It is inevitable that there will be "winners and losers" in the new health care market environment, as payer mix and utilization patterns change.

Tax credits (sanctions), stimulus dollars, demonstration/waiver projects, and research funding will be used in various ways to help the nation adopt new health care reform legislation objectives.

Public health, community health centers, medical research, medical home delivery, accountable care organizations, and work and retail clinic sites will benefit from the new health care reform legislation and spending.

Federal and state governments will begin to change reimbursement practices from the current "fee for service" (quantity) model to a model emphasizing "pay for performance." Reimbursement incentives for quality-based clinical outcomes are being developed for select medical conditions and procedures.

The role of pharmaceuticals and life sciences will evolve from manufacturer and supplier to one of health delivery partner, in emphasizing wellness and clinical outcomes.

Information technology

Providers and payers will seek to capture federal stimulus dollars, in order to implement electronic billing and medical record technologies. The American Recovery and Reinvestment Act of 2009 will continue to incentivize IT modernization and alternate health care delivery models outside of traditional physician offices and hospitals.

By December 2010, the CMS office of e-health standards and services will publish its proposed definition of "meaningful use" for implementation of Electronic Medical Records and eligibility for health IT stimulus funding.

Technology and telecommunication companies will significantly increase their role within the health care industry.

By 2013, the health care industry must convert to the ICD-10 medical classification code system from the current ICD-9 platform. The United States is the only free world country not on this universal ICD-10 standard.

Transforming one-sixth of the nation's economy

The federal government's Department of Health and Human Services (HHS) will be the key agency in implementing health care reform legislation. HHS will assume the lead role in coordinating reform implementation with the Center for Disease Control (CDC), National Institutes of Health (NIH), Federal Drug Administration (FDA), Internal Revenue Service (IRS), and state agencies responsible for complying with PPACA.

Market implications

The market implications of the recently passed Patient Protection and Affordable Care Act are sweeping. The health care reform legislation, with many regulations still unwritten, will require careful monitoring of federal and state developments.

Government entities, employers, insurers, providers, and individual consumers will need to interpret regulations governing financing, delivery, and purchasing options for expanded health care coverage.

- **States:** States across the nation will need to evaluate the sales costs and timing of implementing consumer operated and oriented plans (co-ops), insurance exchanges, and state run high risk pools.
- **Employers:** From small businesses to large corporations, employers will need to evaluate the cost benefit implications of recently passed federal health care reform legislation.
- **Insurers:** Insurers will need to re-engineer marketing strategies regarding product lines and provider delivery networks.
- **Individual consumers:** Consumers should gain over time, with more market coverage options.
- **Providers:** Health care reform legislation will significantly impact utilization and payor trends. Emphasis on improving internal cost structures and revenue enhancements will be critical areas for management focus.

What next?

The Patient Protection and Affordable Care Act is now law and implementation is underway. As previously indicated, the most comprehensive federal legislation since Medicare and Medicaid entitlement programs were enacted, PPACA has already established an implementation timetable that will drastically change the health care segment of the United States' economy. Federal and state governments will proactively lead health care market changes through legislation, regulation, tax laws, and reimbursement incentives.

PPACA will be amended as market circumstances dictate and over 1,000 legislated items must be interpreted and crafted into regulations. However, there is no turning back as the nation transforms health care policy, coverage, delivery, and reimbursement.

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Government, business, and industry leaders need to identify and understand those aspects of the health care reform legislation that will have immediate, short, and long term impact on their organizations.

Baker Tilly can help

Baker Tilly has assembled a very capable and experienced health care consulting team. Our consultants average more than fifteen years of successful hands-on executive experience within the provider and payor segments of the health care industry. In addition, Baker Tilly's financial and human resource consultants are prepared to assist employers with new federal mandates.

Over the next four years, the Patient Protection and Affordable Care Act (PPACA) will greatly impact the health care industry. Government, business, and industry leaders need to identify and understand those aspects of the health care reform legislation that will have immediate, short, and long term impact on their organizations. Baker Tilly consultants have read the entire 2,074 page Patient Protection and Affordable Care Act, in order to anticipate more than 1,000 legislated items that will result in new regulations.

Baker Tilly is prepared to assist with:

- Federal and state regulatory interpretation and compliance
- Business decision modeling on key requirements governing the delivery and expansion of health coverage
- IT system readiness evaluation
- Determine revenue enhancement opportunities
- Regulatory reporting requirements
- Cost analysis of mandated federal legislation impacting payers, providers, and insurers

In addition, our international network can help research other nations' experiences in providing universal health care. For example, France, Britain, Australia, Germany, Canada, and the Netherlands have initiated unique programs to deal with providing access to health care services, while addressing fiscal constraints.

For more information or any questions you might have on this topic, please connect with us at bakertilly.com or 800 362 7301.

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Health Care Reform Timetable

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Key provisions of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation (HCER) bill

2010 key provisions

- Increased Medicaid drug rebates and expanded rebate opportunities to Medicaid managed care plans
- Federal funding support for comparative effectiveness research through establishment of a non-profit (Patient-Centered Outcomes Research Institute)
- Support for public health initiatives through creation of task forces
- Coverage for adults with pre-existing conditions eligible for state-run high risk insurance pools to be replaced by health insurance purchasing exchanges
- Dependant children allowed to remain on parents' insurance plans until their 26th birthday
- Insurers are prohibited from discriminating against individuals under age 19 due to pre-existing medical conditions
- Insurers "new" insurance plans cannot change co-pays or deductibles for preventative care and medical screening
- Insurance practice of annual spending caps restrained and completely eliminated by 2014
- Insurers cannot drop policy holders when confronted by illness
- Health insurance companies must provide detailed information about administrative and executive expenditures
- Increased support for identifying and prosecuting within the industry
- Companies providing early retiree benefits for individuals age 55 to 64 are eligible to participate in a limited program that reduces premium costs
- Non-profit Blue Cross Blue Shield insurance plans are eligible for IRS tax benefits if medical loss ratios are > 85%
- Tax credit incentives for development of new initiatives targeting disease prevention and for treatment

Over the next four years, PPACA will expand Medicaid significantly, subsidize insurance premiums, and provide incentives for businesses to provide health care insurance.

2011 key provisions

- Health insurers required to spend 85% of large group and 80% of small group insurance premiums or return dollar difference in form of rebates
- Federal "stimulus" dollars offered to encourage implementation of electronic medical records and billing
- Health insurers must annually report on share of premium dollars spent on medical costs
- Insurers required to create voluntary options for long-term care insurance
- Employers required to disclose value of health insurance coverage on employees W-2 form
- New Simple Cafeteria Plan created to enable small businesses to provide tax-free benefits for health coverage to their employees

2012 key provisions

- Incentives for creating integrated health systems (i.e., accountable care organizations)

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2013 key provisions

- Industry-wide adoption of ICD-10 medical coding standard
- Adoption of payment bundling for select medical conditions and procedures
- Health insurers required to implement uniform standards for electronic exchange of health information to reduce paperwork and administration costs

2014 key provisions

- Insurers are prohibited from discriminating against or charging higher rates for any individuals based on pre-existing medical conditions
- Insurers are prohibited from establishing annual spending caps
- Expand Medicaid eligibility; individuals with income up to 133% of the poverty line qualify for coverage, including adults without dependent children
- Offer tax credits to small businesses who have fewer than 25 employees and provide health care benefits for them
- Impose a $2,000 per employee tax penalty on employers with over 50 employees who do not offer health insurance to their full-time workers (as amended by the reconciliation bill*)
  *In 2008, over 95% of employers with at least 50 employees offered health insurance
- Impose an annual penalty of $95, or up to 1% of income, whichever is greater, on individuals who do not secure insurance: this will rise to $695, or 2.5% of income by 2016; this is an individual limit, families have a limit of $2,085; exemptions to the fine in cases of financial hardship or religious beliefs are permitted
- Under CLASS Act provision, creates a new voluntary long-term care insurance program; enrollees who have paid premiums into the program and become eligible (due to disability or chronic illness) would receive benefits that help pay for assistance in the home or in a facility
- Employed individuals who pay more than 9.5% of their income on health insurance premiums will be permitted to purchase insurance policies from a state-controlled health insurance option
- Pay for new spending, in part, through spending and coverage cuts in Medicare Advantage, slowing the growth of Medicare provider payments, reducing Medicare and Medicaid drug reimbursement rate, cutting other Medicare and Medicaid spending
- Revenue increases from a new $2,500 limit on tax-free contribution to flexible spending accounts (FSAs), which allow for payment of health costs
- Chain restaurants and food vendors with 20 or more locations are required to display the caloric content of their food on menus, drive-through menus, and vending machines; additional information, such as saturated fat, carbohydrate, and sodium content, must also be made available upon request
- Establish health insurance exchanges, and subsidization of insurance premiums for individuals with income up to 400% of the poverty line, as well as single adults
- Creation of national health insurance exchanges to provide individual and small group markets comparison shopping of health care coverage options

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