


Health Care Reform: The Uncertain Journey Forward

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“We’ve always seen this as being a marathon. This is a process that’s going to take years, and this is the start of the race.”

**Tom Quaadman
Senior Executive
U.S. Chamber of Commerce
New York Times, 12/9/10**





Presentation Overview

The Long Journey of Health Care Reform Legislation:

- **Chapter One: Health Insurance/Benefits Regulation**
 - *To be or not to be - a grandfathered plan?*
- **Chapter Two: Coverage Expansion**
 - *To play or pay?*
- **Chapter Three: Health System Reform**
 - *Can the triple aim of better health, better care, and lower costs, community by community, be realized in our lifetime?*

National Business Coalition on Health

- **Identity:** National, non-profit membership association of **52** business and health coalitions. Network of **7,000** employers and **25 million** covered lives
- **Mission:** To help member coalitions lead in improving health and the value of health care in their communities





The Banner NBCH Waves

Value Based Purchasing:

1. Performance Measurement
2. Transparency and Public Reporting
3. Provider Payment Reform
4. Consumer Choice/Engagement/Incentives

Measure, Report and Reward Value!



***The Long Journey
of Health Care Reform
Legislation and Implementation***



Policy *and* Politics

- New political landscape with mid-term elections:
 - Republicans control House not Senate
 - Repeal/significant changes unlikely
 - Likely piecemeal changes (e.g. 1099), oversight hearings, purse string tug-of-war
- Ongoing litigation over constitutionality of individual mandate – Supreme Court ruling likely
- 2012 Presidential Election potentially a referendum on health reform legislation



***Chapter One:
Health Insurance and
Benefits Regulation,
2010-2013***



Chapter One Overview

- Host of near-term regulations that apply to health benefit coverage
 - application of these regs depend on “grandfathered status”
- No overall change to tax treatment of employer provided coverage (40% excise tax in 2018) but with tax and tax reporting changes
- And with some employer “candy”:
 - subsidies for small business
 - subsidies for early retiree coverage



Grandfathered Plan Option

- Grandfathered plans (i.e. those in existence on March 23, 2010) are provided transition relief (until 2014) from certain insurance regs
- May add new enrollees but following actions will result in loss of status:
 - reduction in benefits
 - increase in coinsurance, copays, deductibles more than 15%
 - decreasing employer contributions by 5% or more
 - changing annual benefit limitations



Near Term Regulatory Changes

- Effective dates vary but many are effective as early as September 23, 2010 or January 1, 2011
- Grandfathered and non-grandfathered plans:
 - adult child requirement to age 26;
 - no lifetime limits
 - restricted annual limits
 - prohibition on pre-existing conditions
 - prohibition on rescission of coverage
- Non-grandfathered plans only:
 - first dollar coverage for preventive services
 - enhanced internal claims and appeals rules and new mandated external review process
 - new non-discrimination rules for insured plans
 - limitations on deductibles and out-of-pocket maximums



Tax Reporting and Tax Changes

- Effective 2011 tax year, new Form W-2 reporting requirements:
 - employers required to report the dollar value of health coverage for employee's W-2
- Effective 2012, new Form 1099 reporting requirements:
 - 1099 must be issued to any vendor receiving \$600+
 - bi-partisan support for repeal
- Effective for 2013, employee salary reduction contributions under cafeteria plan to a health FSA will be limited to \$2,500

Employer Candy

Early Retiree Reinsurance Program:

- \$5 billion in subsidies to employers who provide retiree health coverage for ages 55-65
- Subject to 5 billion being spent
- Subsidy equal to 80% of claims between \$15,000 and \$90,000
- Eligibility rules established by DHHS and applicants being accepted
- Terminates December 31, 2013 or ***when funds are expended***



Chapter One Summary

- Key decision point for employers: should I stay grandfathered?
- Or does the imperative to stay innovative in benefit design trump regulatory avoidance?
- Generally, new insurance regulations, tax reporting & tax changes will translate into short term increases in employer health care costs and compliance costs
- Obama Administration has shown flexibility in waiving some requirements to ease disruption in transition to 2014 (e.g. McDonald's mini-med benefits)
- And always accept candy (e.g. EERP) if offered



Chapter Two: Coverage Expansion 2014



Coverage Expansion Overview

- Goal to expand coverage to 33 of the 50 million uninsured Americans
- Two principal strategies to get there:
 - Medicaid expansion
 - Creation of state health insurance exchanges for individuals and small employers
- With individual and employer mandates
- And significant subsidies for individuals



Medicaid Expansion

- Effective 2014, Federal eligibility floor raised to 133% of poverty for all states
- States can go higher
- 100% of additional Medicaid expenditures to be picked up by feds - initially
- But represents long term unfunded mandate on states

State Insurance Exchanges

- Effective 2014, states must establish insurance exchanges or delegate to feds
 - TN will, most likely, establish its own exchange
- States can join with others in regional exchanges
- Goal to spread risk across large insurance pool and give individuals and small employers (under 50 employees) greater plan choice and affordability
- Most states in active planning stages – even states that oppose health reform legislation
 - <http://www.tn.gov/nationalhealthreform/exchange.html>

MBGH is participating in TN Health Insurance Exchange planning





Individual Mandate

- Effective 2014, US citizens must have “minimum essential coverage” otherwise must pay penalty
- The penalty is equal to greater of: \$695 per individual to max of \$2,085 per family, or 2.5% of household income
- Phase in of penalty – only \$95 and 1% in 2014

***Leading to Key Question:
Will individuals pay or play?***



Individual Subsidies

- Eligibility: For lower-paid individuals with “unaffordable” employer-provided coverage
- Unaffordable – Gross income at or below 400% of the federal poverty level **and** required to contribute more than 9.5% of income
 - 53% of U.S. born, FT workers in TN have incomes at or below 400% of federal poverty level
- Subsidy amount adjusted by income level
- Subsidy can only be used to help purchase coverage through an exchange



“Play or Pay” Employer Mandate

- Effective 2014, an employer with 50+ employees must provide “minimum essential benefits” (**Play**)
- Must provide coverage to all FTEs defined as 30+ hours per week
- Penalty for non-compliance equal to \$2,000 per FTE who enrolls in exchange (**Pay**)



Affordability Employer Mandate

- Effective 2014, employers must make qualifying coverage “affordable” for each employee
- Affordable = employee contribution less than 9.5% of income
- If unaffordable, employer must pay \$3,000 penalty for each FTE or \$750 per all FTEs, if less



Access to Exchange (Voucher) Employer Mandate

- An employer must provide access to exchanges for employees with near-unaffordable coverage (defined as contributing 8 – 9.8% of an employee's income to coverage)
- Employer payment to exchange on behalf of employee must equal employer's contribution if employee was covered
- Any excess payment (i.e. employer voucher is greater than cost of exchange coverage) retained by employee as taxable income



Minimum Essential Coverage

- Definition to be determined
- Feds to set minimum floor with states having option to expand definition
 - TN will NOT expand the definition due to funding requirements
- If self-insured, may be able to avoid certain benefits and still qualify as MEC
- IOM to make recommendations to DHHS Secretary

Chapter Two Summary

- Key employer decision point: should I play or pay?
- Economic calculus must be balanced with corporate culture and need to compete for talented workforce
- Also whether exchanges prove effective or not
- At minimum:
 - understand potential impact on your company, including excise tax implications in 2018
 - consider all potential options
 - track and become involved in policy/regulatory debates in DC and in the states (e.g. essential minimum coverage, how exchanges will be organized and governed)
 - use MBGH health reform resources to stay up to date:
 - Healthcare Reform Resource Center
 - MBGH Blog
 - MBGH health reform-based meetings



***Chapter Three:
Health System Reform
2010 – to Eternity!
(And My Personal Favorite)***



Chapter Three Overview

- Under the radar of politics and media attention with hope that this could be one arena for bipartisan consensus
- Triple aim of better health, better care, lower costs
- Achieved through long journey of health care delivery reform (National Quality Strategy) and population health improvement (National Prevention Strategy)
- With attention to need for (at least on paper) public-private partnerships and community-based reforms



Health Care Delivery Reform

- 2010, Health Information Technology and “Meaningful Use” (Stimulus Bill)
- 2010, Rebuilding Primary Care Workforce
- 2011, Community Care Transitions Program to Avoid Readmissions
- 2012, Accountable Care Organizations with Shared Savings
 - ACO development has started in Memphis



Value Based Purchasing

- 2010, Comparative Effectiveness Research
- 2011, Measures Application Partnership
- 2011, Center for Medicaid/Medicare Innovation (actually launched on November 16, 2010)
- October 2011, Independent Payment Advisory Board
- October 2012, Medicare hospital pay for performance (starting with heart attacks, heart failure, pneumonia, surgical care, health care associated infections, patient experience survey)
- January 1, 2013, bundled payments for care episodes
- January 1, 2015, physician pay for performance

Memphis community-wide payment reform project in 2011



Population Health

- Cabinet Level National Prevention, Health Promotion and Public Health Council
- 2011, \$15 billion Prevention and Public Health Fund
- Employee wellness incentives
- Small business wellness grants

Chapter Three Summary

- Health system reform was not forgotten in legislation and has potential to bridge political chasm over reform
- Biggest concern: Medicare acts in silo with negative consequences for private sector; critical that delivery reform and VBP strategies be harmonized across sectors
- Biggest disappointment: lack of attention to consumer choice/engagement/incentives
- Employer/Coalition decision points: participate in policy/regulatory debate; take advantage of community-based reform opportunities
- MBGH is:
 - Tracking Memphis ACO development
 - Representing employers in Memphis community-wide payment reform project
 - Evaluating employer-sponsored payment reform pilot opportunities



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