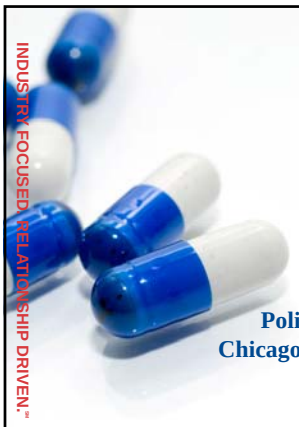

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INDUSTRY FOCUSED. RELATIONSHIP DRIVEN.™

Health Care Reform
An Overview of Politics, Law and Regulation
Chicago Estate Planning Council

September 28, 2010

Presentation Overview

I. Setting the Stage
II. Private Sector Insurance Changes
III. Medicaid/CHIP
IV. Medicare
V. Quality, Clinical Effectiveness and Delivery System Innovation
VI. Trauma Care, Workforce, Public Health and Other Potential Opportunities
VII. Charitable Hospital Requirements
VIII. Integrity/Transparency/Sunshine Act
IX. What is Happening Now and Trends to Watch

Setting the Stage--How Did We Get Here?

- Health reform has been a Democratic priority for years.
- A Democratic House and Senate, along with a committed Democratic President, created the "perfect storm" for passage of the legislation.
- Two bills were signed into law in late March:
  - H.R. 3590 – *The Patient Protection and Affordable Care Act*
  - H.R. 4872 – *The Health Care and Education Reconciliation Act of 2010.*
- Together these bills are "Health Reform".

Setting the Stage--Politics of Health Reform

- There was no Republican support for either bill.
- The Democrats are thus politically responsible for the success or failure of the program.
- Support in the Democratic House and Senate caucus was not uniform and Democratic candidates are now spending more money on campaign ads against health reform than in support of it.
- Public opinion has been very divided over the new law.

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Setting the Stage--Who is Affected by Health Reform?

- All public and private employers
- All public and private employees
- Health insurance companies
- All health care providers
- Individuals who are uninsured or underinsured
- Manufacturers of drugs, medical devices and supplies

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Setting the Stage—What's the Significance?

- Overall, will cover 35 million Americans.
- Adds 20 million to Medicaid.
- Creates State health benefit exchanges that will insure 30 million.
- New federal regulation of health insurance.
- Substantial Medicare payment cuts, revamps Medicare Advantage, makes Part D more generous, implements Independent Payment Advisory Board.
- Expansion of quality, innovation and efficiency efforts.
- Emphasis on primary care, community health, public health, wellness and prevention.
- Extensive new "fraud, waste, abuse & transparency" provisions.
- $1 Trillion in costs and offsetting payment cuts and tax increases from 2010-2020.

Numbers based on 2019 projections by CMS actuary

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Setting the Stage--What It Doesn't Do

- Does not insure every "person in the country"
  - 23 million will remain uninsured: undocumented, those cycling on/off coverage, those exempt from or willing to pay individual penalties.
- Does not create a single payer system
  - Medicaid, Medicare, employer-provided insurance, Medigap, and State exchange-based insurance will coexist.
- Does not fundamentally reform Medicaid.
- Does not fundamentally change the large group health insurance market.
- Does not reform medical malpractice law.
- Does not fix Medicare doctor payment problems.
- Does not restructure the delivery of health care, but sets in motion potentially significant changes.

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Setting the Stage--Challenges

- Massive Implementation Issues –
  - private insurance regulation and re-regulation
  - setting up the health benefits exchanges
  - implementing Medicare provider cuts and reforms
  - Expanding Medicaid
  - Launching new quality and innovation projects
  - new taxes and tax credits.
- How to serve 35 million newly insured--
  - workforce programs created but not funded.
- Balancing benefit generosity against cost.
- Managing tensions between government, providers, employers and insurers.

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Setting the Stage--An Act in 9 Titles

- **Title 1**: Federal reforms of private health insurance – some in 2010 others in 2014; creates American Health Benefits Exchange; provides persons up to 400% federal poverty level (FPL) with subsidies to buy insurance and tax credits for the smallest employers; creates employer and individual penalties.
- **Title 2**: Dramatic expansion of Medicaid to cover all people (including childless adults) up to 133% of FPL; increased federal matching to cover new enrollees; other Medicaid program changes and reforms.
- **Title 3**: Significant Medicare provider payment reductions; creation of CMS Innovation Center to pilot and expand new payment models; closes Part D donut hole; significant changes to Medicare Advantage.

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Setting the Stage--Overview of Titles

- **Title 4**: Authorizes new prevention, public health, community health programs.
- **Title 5**: Authorizes new programs to bolster healthcare workforce with particular focus on primary care.
- **Title 6**: Imposes extensive transparency and disclosure, and fraud, waste and abuse requirements on providers.
- **Title 7**: Creates approval pathway for biosimilars; 340B expansion.
- **Title 8**: CLASS Act – creates new entitlement program similar to community based long term care programs.
- **Title 9**: Imposes new revenues – "Cadillac" plans, HI payroll taxes, fees on device, pharmaceutical companies and insurers; new requirements for charitable hospitals.

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Setting the Stage--Timeline

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Private insurance reforms begin									
Medicare/Medicaid Savings: Medicare provider updates, Medicaid prescription drug rebates									
Delivery System Reform: Center for Medicare and Medicaid Innovation									
	Medicare/Medicaid Savings: Imaging, lab service, DME payment reductions								
	New Revenue: Annual fee assessed to drug & biotech makers								
		Delivery System Reform: ACOs, hospital value-based purchasing							
		Medicare Savings: MA payment reductions, productivity offset to FFS updates							

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Setting the Stage--Timeline

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
			Delivery System Reform: Hospital readmissions, payment bundling						
			New Revenue: Excise tax on medical device makers						
				Coverage: Exchanges for individual, small markets					
				New Revenue: Excise tax on health insurers					
				Coverage: Individual mandate, Employer fees					
				Medicare/Medicaid Savings: DSH reductions, IPAB					
					Delivery System Reform: Physician value-based purchasing				
							Coverage: Exchange open to large employers		

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II. Private Sector Insurance Changes:

Health Insurance Regulations
The American Health Benefits Exchange

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Health Insurance Market Reforms – Early Years

- High risk pools for individuals with pre-existing conditions -- $5 billion.
- Early retiree temporary reinsurance program -- $5 billion.
- Immediate insurance reforms, effective 9/23/10
  - No lifetime limits
  - Annual limits on "essential benefits" only as allowed by HHS
  - No rescissions
  - No cost sharing for preventive services
  - Coverage of dependents up to age 26
  - No pre-existing conditions exclusions for kids under 19.
- Medical Loss Ratio (MLR) reporting -- rebates required if MLR too low (80%/85%).
- Federal review of health insurance premium increases.
- Standardized documentation, data disclosure, quality improvement reporting, coverage denial appeals rules, patient's rights.

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Health Insurance Market Reforms – 2014

- No pre-existing condition exclusions.
- Guaranteed availability/renewability.
- Health status non-discrimination.
- Provider non-discrimination.
- Can't require prior authorization or higher cost share for emergency services whether in network or not.
- Clinical trials covered.
- Group plans – no waiting periods over 90 days.
- Small/Individual market –
  - provide "essential health benefits"
  - Rating rules – can't vary premiums based on health status
    - Family/Individual; Age (3:1), Tobacco (1.5:1), Rating Areas w/in State.

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Grandfathered Plans – the Right to Retain Existing Coverage

- Don't have to terminate coverage as it existed on the date of enactment (3/23/10); employer based plan can add new enrollees; family can add new members; collective bargaining plans good until next ratification.
- Grandfathered plans must still be changed to comply with some health insurance reforms –
  - For all plans: standard benefit summary; MLR rebate requirement; limited waiting periods; no lifetime limits, no rescissions, dependent coverage
  - For group plans only: no annual limits, no pre-existing condition exclusions and adult child coverage.
- Not entirely clear when a "plan" is no longer the same "plan".

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The American Health Benefits Exchange

- Established via federal grants – to qualify plans and facilitate insured access to plans. A regulated marketplace.
- Generally expected to be state-based – either state or non-profit entity
  - Multi-state possible
  - If State doesn't run, federal government will.
- Operates exchange for –
  - "Qualified" plans only (except for stand-alone dental)
  - Small business health options program (SHOP)
    - Can merge the QHP and SHOP.

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Offerings and Participants

- Who is in the exchange?
  - Any individual who is not incarcerated or undocumented may choose to purchase insurance through an exchange
  - Small employers (1-100 employees) may purchase on exchange
  - 2017: large employers can enter.
- What can they purchase?
  - "Qualified" health plans offered by private insurers
  - Co-op plans (envisioned as essentially mutual non-profits)
  - Two multi-state ("national") plans administered by the federal Office of Personnel Management (who runs FEHBP).
- State may create basic health program *outside the exchange* for FPL 133-200% if covers essential benefits and affordability no more onerous than Exchange Silver plan.

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Plans Offered in the Exchange

- Certified by the State.
- Provides essential health benefits.
- Comply with cost-sharing limits
  - Deductibles -- $2k individual, $4k family
  - Total out of pocket cost capped at $5,800 individual; $11,600 family.
- Meet "actuarial value" minimum – Platinum (90% AV) to Bronze (60% AV). Must offer at least 1 silver and 1 gold.
- Catastrophic under 30 and child only option.

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Exchange – Premium Assistance Credit

- Refundable tax credit that caps the premium cost for individuals below 400% of FPL
  - Sliding scale from 133% of FPL ($14,400 for an individual) to 400% of FPL ($88,200 for a family of 4)
  - Employees whose employer-sponsored insurance covers less than 60% of allowed benefits or premium exceeds 9.5% of income are eligible for credits
  - Indexed by growth of premiums in excess of CPI.
- If eligible for premium credit, also qualify for reduced cost-sharing
  - If income is between 100-200% FPL reduce by 2/3; 200-300%: by 1/2; 300-400%: by 1/3
  - HHS pays insurer for the reduction.

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Individual Responsibility

- In 2014, individual must maintain "minimum essential coverage" or pay a penalty if without coverage for more than 3 months in a year.
- Fine equals greater of fixed amount or percentage of income over filing threshold
  - 2014: $95, or 1%; 2015: $325 or 2%; 2016: $695 or 2.5%
  - Example: Individual grossing $40,000 w/out minimum essential coverage pays penalty of $766 in 2016 ($40,000 - $9,350 x 2.5%).

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Employer Responsibility

- Employer Mandate
  - Employers with more than 50 FT employees that doesn't offer health insurance must pay a penalty if any employee receives premium assistance credits
  - $2,000 x the number of employees over 30 employees.
- Automatic enrollment
  - Employers with 200+ employees must automatically enroll employees into health insurance plans they offer. Employees may opt out of coverage.
- Free Choice Voucher
  - Employers that offer health insurance must provide a voucher to employees with incomes less than 400% of FPL who enroll in an Exchange plan
  - Voucher = cost to provide coverage to employee under employer's plan.

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The Small Business Tax Credit

- Sliding scale tax credit for employers with fewer than 25 employees and average wages of less than $50,000 where employer contributes at least 50% of premium amount (or benchmark premium)
  - Maximum credit for employers with 10 or fewer employees and average wages under $25,000
  - 2010-2014: 35% of contribution (25% for non-profits)
  - 2014: 50% for two years if purchase through exchange.

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Implications – Private Sector Health Insurance

- Will the Exchanges work?
  - Definition of Essential Health Benefits will drive cost
  - Is the premium assistance sufficient to make "affordable"?
  - Will the "young immortals" pay the penalty and stay out of the risk pool?
  - Look at Massachusetts for clues .
- Effects on insurance markets
  - Some upward cost pressure on large group market
  - Impact on small employer market unclear
    - Some small employers will force employees into exchange
    - Some may start offering health insurance through exchange
  - Will they be able to hang on to "grandfathered" plans?
  - Individual market migrates to the exchange.
- Implementation is key, the coming regulatory processes will drive much of this.

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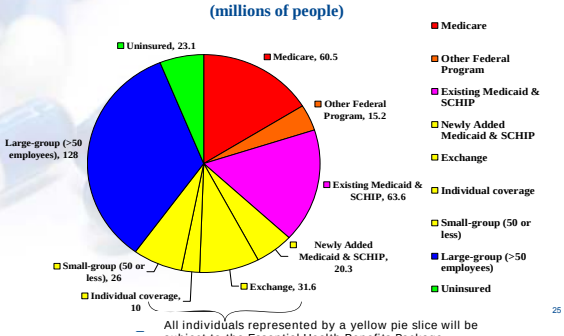
Estimated Insurance Coverage in 2019

(millions of people)



All individuals represented by a yellow pie slice will be subject to the Essential Health Benefits Package.

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III. Medicaid/CHIP

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Medicaid Eligibility Expansion

- April 2010 – State option to expand Medicaid coverage to childless adults not entitled to Medicare.
- Jan 2014 – Mandatory Medicaid eligibility category for all newly eligible individuals under 133% FPL
  - Federal matching for newly eligible set at 100% in 2014-2016, phases down to 90% in 2020 and beyond.

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Medicaid Eligibility Expansion, cont'd

- Maintenance of income eligibility (MOE)
  - States must maintain same income eligibility for adults until 2014
  - MOE requirement extended through Sept. 2019 for all kids currently in Medicaid or CHIP
  - 2011-2014: MOE exemption for optional population if State budget deficit.
- Expanded Medicaid benefits for preventive services.

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CHIP

- Reauthorizes CHIP through 2015.
- 2014-2019: states receive 23% increase in CHIP match rate, subject to cap at 100%.
- CHIP eligible kids who can't enroll due to Federal allotment caps are eligible for tax credits in Exchange.
- Increases outreach/enrollment grants.

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Medicaid Payment Changes – Hospitals

- Medicaid DSH reductions
  - Medicaid DSH payment reduction of $14.1 billion
  - Reductions phased-in, FY 2014 – FY 2020
  - Directs Secretary to develop methodology for reducing DSH allotments to all states to achieve mandated reductions.

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Medicaid Payment Changes – Physicians

- Medicaid payment rates to primary care physicians for primary care no less than 100% Medicare in 2013-2014. Provides 100% additional costs to states for meeting this requirement.
- Clarifies items to be reviewed by Medicaid and CHIP Payment and Access Commission including Federal Medicaid/CHIP regulations, reports and assessment of adult services in Medicaid.

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Medicaid – Prescription Drugs

- Prescription drug rebates:
  - Brand – increase Medicaid drug rebate % for brand from 15.1 to 23.1%, except for rebate for clotting factors and pediatric exclusive drugs to 17.1%
  - Generic – rebate increase from 11 to 13%
  - Rebates required for MCO beneficiaries
  - Total rebate liability to 100% AMP
  - All benefits of rebate % increase accrue to Federal government.

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340B Drug Discount Program

- Adds new covered entities to 340B drug purchasing program
  - Rural referral centers, sole community hospitals, critical access hospitals, freestanding children's hospitals
  - Exempts orphan drugs.

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Implications for Medicaid/CHIP

- Medicaid
  - Lots of eligibility expansion, simplifies eligibility to some degree
  - Limited payment increases (just primary care, not hospital inpatient)
  - Federal support at 90% for newly eligible (mandatory) 2020 and beyond, so….
    - Unfunded mandate on states and huge impact/pressure on federal funding
  - Coverage does not equal access
  - Trending toward Medicare requirements (e.g. transparency/integrity).
- CHIP
  - Uncertain future beyond expiration of authorization.

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IV. Medicare

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Medicare Payment Changes – Hospitals

- Incorporates productivity adjustments into market basket (MB)
  - 2014 MB = -0.3%
  - 2015-2016 MB = -0.2%
  - 2017-2019 MB = -0.75%.

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Medicare Payment Changes – Hospitals

- Medicare DSH payments reduced by 75% starting in 2014 ($22 billion over 10 years)
  - Largely replacing with additional payments based on formula that incorporates reduction in DSH funds, % change in uninsured under -65 population, and relative share of uncompensated care provided by the hospital.
- $400m for hospitals in lowest quartile of counties as ranked by risk adjusted spending per Medicare enrollee.

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Medicare Payment Changes – Other Part A

- HHS study on need for add-ons for urban Medicare-dependent hospitals.
- Negotiated rulemaking for new comprehensive methodology for health professions shortage areas and medically underserved populations.
- Delays SNF payment system changes until Oct 1, 2011.
- Authorizes PAs to order post-hospital SNF services in 2011.
- Extension of payment rules for LTC hospital services and moratorium on establishment of hospitals/ facilities.

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Medicare Payment Changes – Physicians

- Does not address the sustainable growth rate issue (SGR).
- In 2011 Medicare will pay
  - 10% bonus for 5 years for E&M services provided by primary care physicians
  - 10% bonus for 5 years for general surgeons in health professions shortage areas.
- Extends the floor on the Medicare work geographic adjustment through 2011 and requires HHS to improve the accuracy of payments for practice expenses 2012 onward.
- Strengthens HHS authority to adjust misvalued or inaccurate payment rates, particularly for high growth services.

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Medicare Payment Changes – Part B

- Extends the exception process for therapy caps to December 31, 2010, retroactive to January 1, 2010.
- Incorporates productivity adjustments into payment updates for ambulance services, ASCs, DME in 2011, and for dialysis centers in 2012.
- Reductions in payment scheduled for:
  - Home Health
  - Hospice
  - Imaging
  - Laboratories.

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Medicare Advantage – Part C

- Freezes MA payments in 2011 and reduces payments to bring more in line with traditional fee-for-service providers.
- Establishes bonus payments in 2012 for quality and enrollee satisfaction.
- MA plans must spend 85% revenue on medical costs in 2014.
- Prohibits MA plans from beneficiary cost sharing greater than FFS.
- Extends plans for special needs individuals through 2013 and makes the senior housing facility demo permanent.

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Medicare – Part D

- Reduces the donut hole
  - $250 rebate to all donut hole enrollees in 2010
  - 50% discount on prescriptions for beneficiaries in donut hole beginning in 2013
  - By 2020, phase down the coinsurance for the donut hole from 100% to 25%.
- Starting in 2011, phase in a federal subsidy of 75% by 2020, of generic drug costs for prescriptions filled while beneficiary is in donut hole.
- Reduces premium subsidies for high-income beneficiaries.

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Medicare – Independent Payment Advisory Board

- Independent, 15-member board whose purpose is to reduce per capita rate of growth in Medicare spending.
- IPAB proposals take effect unless Congress passes alternative to achieve same level of savings.
- Mandatory non-binding recommendations in years in which Medicare growth below target.
- IPAB can't ration care, raise taxes or Part B premiums or change benefit, eligibility or cost-sharing standards or recommend reduced premium support for low-income Medicare beneficiaries.

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Medicare – IPAB, cont'd

- If projected growth exceeds target growth, IPAB issues proposal to reduce per capita spending to achieve saving requirement.
- Target growth rate =
  - Through 2017=average of projected increase in CPI-U and CPI-U medical 2018 and beyond – GDP + 1%.
- If projected per capita growth rate exceeds target growth rate, must set savings requirement = lesser of
  - Projected growth rate X applicable %
    - 2015 = 0.5%
    - 2016 = 1.0%
    - 2017 = 1.25%
    - 2018 and beyond = 1.5%
  - Or projected excess.

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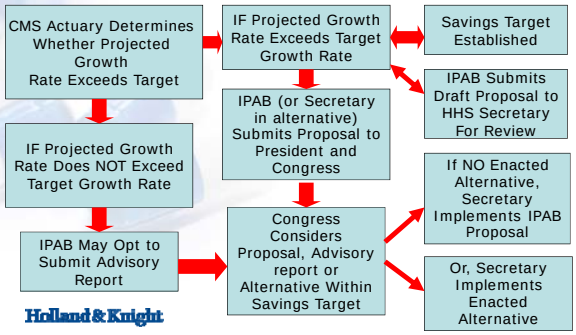
IPAB Process



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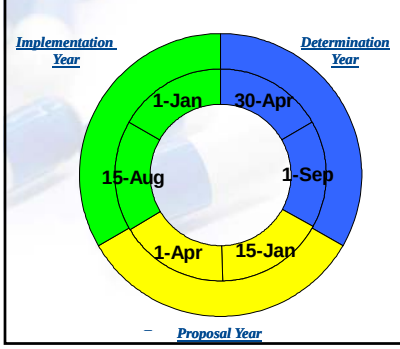
Lifecycle of IPAB Proposal



- April 30:CMS Actuary projects whether growth exceeds target
- Sept 1: IPAB submits draft proposal to Secretary for review
- Jan 15: IPAB submits proposal to President and Congress
- April 1: Congressional committees report legislation to either enact or alter proposal
- Aug 15: Unless alternative proposal enacted, Secretary prepares to implement IPAB proposal
- Implementation of proposal in next fiscal year

Who is Subject to IPAB 2014-2020

Exempt From Rate Cuts Before 2020
- Inpatient Acute Care Hospitals
- Long-term Care Hospitals
- Inpatient Rehabilitation Facilities
- Psychiatric Hospitals
- Outpatient Hospitals

BUT…..Hospitals/IRF only exempt from rate cut, so potentially subject to other proposals such as related to utilization

Subject to Rate Cuts Before 2020
- Physicians
- Skilled Nursing Facilities
- Home Health Agencies
- Ambulance Services
- Ambulatory Surgical Centers
- Laboratory Services (beginning 2016)
- Durable Medical Equipment
- Prosthetic Devices, Orthotics and Prosthetics
- Medicare Parts C and D

Unclear Prior to 2020
Hospice
Dialysis

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Geographic Variation

- Wage Index
  - Hospital wage index reclassifications extended through 2010
  - HHS to report on reform to Medicare wage index by Dec. 31, 2011. 2011 – restores thresholds to %s used in 2009 until report submitted to Congress
  - Oct. 2010 – application of budget neutrality associated with effect of imputed rural and rural floor to application on national (non-State specific) basis through uniform national adjustment to area wage index.
- Medicare Spending Per Enrollee
  - $400 million for hospitals in lowest quartile
  - Sebelius letter to establish IOM study
    - Fall Summit on geographic variation
    - Implementing IOM study
    - Will implement further changes within statutory authority.

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V. Quality, Clinical Effectiveness & Delivery System Innovation

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Quality – Big Picture

- HHS to develop national quality strategy.
- Significant increase in funding for research in quality improvement and comparative effectiveness.
- Continued quality measure development.
- Expansion of quality measure reporting by all provider groups.
- Value-Based Purchasing – linking quality performance to payment.

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Value-Based Purchasing -Hospitals

- Incentive payments for performance of quality measures (10/2012).
- Increase in DRG payment/program budget neutral.
- Initially high cost conditions/procedures
  - Acute myocardial infarction
  - Heart failure
  - Pneumonia
  - Surgeries
  - Healthcare-Associated Conditions.
- Hospital performance publically available.

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Quality Focused Initiatives - Hospitals

- Readmissions – heart attacks, heart failure, pneumonia (2012).
- Hospital-Acquired Conditions (2014).
- Shared Savings Program/Accountable Care Organizations (2012)
  - Coordinate services under Part A and B and encourage investment in high quality services
  - Additional payment if ACO per capita fee is below fee-for-service-based benchmark and quality standards are met
  - Integration of hospital, physician, and allied health services
  - Primary care services included.

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Quality Initiatives – Physicians & Other Providers

- Physicians
  - PQRI bonus payments extended; penalties for non-reporting in 2014
  - Value-based modifier under MD fee schedule (2015)
  - "Physician Compare" website.
- LTC hospitals, inpatient rehab, PPS-exempt cancer hospitals and hospice
  - Quality measure reporting
  - Reduction in payment update (2013)
  - Secretary can test value-based purchasing programs.
- SNF, Home Health, ASC
  - Secretary to develop plan for value-based purchasing programs (9/2012).

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Innovation – CMS Innovation Center

- $5 million (2010); $10 billion (2011-2019).
- Research and test payment and delivery models that improve quality, lower costs .
- Rules waived and funding provided for un-covered benefits.
- Successful models can be expanded nationally.
- Opportunities for all providers - hospitals, physicians, LTC facilities, home health, hospice .

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Innovation – New Patient Care Models

- Pilots and Demonstrations
  - Payment bundling
  - Gainsharing
  - Patient-Centered Medical Homes
  - Tele-health.

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Comparative Effectiveness Research

- Establishes the Patient-Centered Outcomes Research Institute
  - Non-profit/independent entity
  - Identifies research priorities and conducts comparative clinical effectiveness research
  - Cannot mandate coverage or reimbursement policies.

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Comparative Effectiveness Research

- Definition: research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services and items
  - Medical treatments, services and items include:
    - Health care interventions
    - Protocols for treatment
    - Management and delivery of care
    - Medical devices, diagnostics, and drugs.
  - Considerations in setting research priorities
    - Disease incidence/burden- emphasis on chronic conditions
    - Gaps in evidence/clinical outcomes
    - Practice variation
    - *The effect on national expenditures associated with health care treatment.*

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Implications – Quality & Clinical Effectiveness

- Linkage of payment to quality performance.
- Commitment to developing quality measures for all providers.
- Significant funding for research in clinical and comparative effectiveness, model delivery systems.
- Testing of integrated systems of care such as ACOs to see what can be expanded nationally.
- Secretary can expand successful models.
- Focus on high cost/high prevalence conditions effecting the Medicare population.

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VI. Trauma Care, Workforce, Public Health & Other Funding Opportunities

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Emergency and Trauma Care

- Regionalization Pilot Program – 4+ pilots on regionalized systems of emergency care.
- Trauma center and trauma service availability grants.
- Reauthorization of EMSC.

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Workforce

- National health care workforce commission to assess manpower needs.
- Funding for training programs and loan repayment.
- Major focus on bolstering primary care.
- Grants for programs in nursing, dentistry, geriatric, mental/behavioral health, physician assistants.

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Public Health / Disease Prevention

- Establishes $15 billion Prevention and Public Health Trust Fund
  - Funding for state and local health departments as well as federal activities.
- Establishes new interagency Prevention, Health Promotion, Public Health Council.
- No cost-sharing for preventive services and immunizations – public and private insurance.
- Grants to small businesses, school-based clinics.

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Commissions & Advisory Boards

- ✓ Advisory Board for State Cooperatives
- ✓ Independent Payment Advisory Board (IPAB)
- ✓ IPAB Consumer Advisory Council
- ✓ Advisory Group on Prevention, Health Promotion, and Integrative and Public Health
- ✓ Interagency Pain Research Coordinating Committee
- ✓ National Health Care Workforce Commission
- ✓ Commission on Key National Indicators
- ✓ Patient-Centered Outcomes Research Institute (PCORI)
- ✓ PCORI Clinical Trials Advisory Panel
- ✓ PCORI Clinical Trials Advisory Panel
- ✓ PCORI Rare Disease Advisory Panel
- ✓ PCORI Standing Methodology Committee for the Institute
- ✓ Advisory Board on Elder Abuse, Neglect, and Exploitation
- ✓ CLASS Independence Advisory Council
- ✓ CLASS Personal Care Attendants Workforce Advisory Panel
- ✓ Cures Acceleration Network Review Board
- ✓ Advisory Committee for Young Women's Breast Health Awareness Education Campaign

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VII. Charitable Hospital Requirements

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Charitable Hospital Requirements

- If a hospital organization operates more than one facility, each hospital facility must meet the requirements separately..
- New requirements: In addition to existing requirements, 501(c)(3) hospitals must now:
  - Conduct a community health needs assessment
  - Meet certain financial assistance policy requirements
  - Meet certain requirements with respect to charges
  - Meet certain billing and collection requirements.
- Tri-annual review of community benefit activities by IRS.
- Effective date
  - Community health needs assessment applies to taxable years beginning 2 years after date of enactment
  - All other provisions apply to taxable years beginning after date of enactment.

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Charitable Hospital Requirements, cont.

Limits on Charges:

- With respect to emergency or medically necessary care, can't charge individuals eligible for financial assistance more than charging insured patients.
- 501(c)(3) hospitals are prohibited from use of gross charges.

Billing and Collection Requirements:

- Hospitals may not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the hospital's financial assistance policy.
- Required Secretarial guidance on what constitutes "reasonable efforts".

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Collection/Reporting of Charity Care Data

- **Additional Reporting Requirements:** Must disclose on Form 990
  - how addressing community health needs
  - what needs that are not being addressed (with reasoning).
- **Annual Report to Congress:** Treasury and HHS must report annually to Congress on the levels of charity care, bad debt expenses, and unreimbursed costs of government programs incurred by private tax-exempt, taxable, and governmental hospitals, as well as the cost of community benefit activities incurred by private tax-exempt hospitals.
- **Congressionally-Mandated Study:** Treasury Department and HHS must submit a study to Congress within 5 years of enactment on the trends in the information included in the annual report to Congress.

VIII. Integrity/Transparency/Sunshine Act

Protections Against Fraud, Waste & Abuse

- Three-pronged approach:
  - Up-front screening of providers
  - Reporting and compliance obligations
  - Increased sanctions.
- Screening includes the ability of HHS to categorically disallow certain providers from participating in Medicare and Medicaid.
- Consolidation of databases and input from states.
- Compliance programs are mandatory – a condition of participation in federally funded health care programs.

Protections Against Fraud, Waste & Abuse, cont'd

- Specifies liability for false statements made in application for participation in federal programs.
- Allows HHS to suspend payments to a provider while the government is investigating "credible allegations of fraud".
- Expands use of civil False Claims Act and its treble damages + penalties
  - Applies specifically to violations of anti-kickback act
  - FCA liability also arises where overpayments are not returned within 60 days of "discovery".
- Expands RAC to require states to hire RACs for Medicaid, and expands RAC to Medicare Parts C and D.

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Sunshine Act Provisions

- Requires drug, device, biological, and medical supply manufacturers to report all "payments" made to physicians and teaching hospitals that exceed $100 per year.
- "Payment" is broadly defined and includes gifts, food, entertainment, travel, honoraria, research funding, education, compensation for serving as faculty at CME programs, etc.
- Other reporting for physician ownership interests in manufacturer or group purchasing organization.

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Sunshine Act Provisions

- Reports will be publicly available and readily searchable.
- Federal reporting requirements will preempt state laws that are *less* onerous, but states can require *more* reporting.
- Penalties ranging from $1,000 to $1 million for failure to report.

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IX. Health Reform Provisions Already Implemented and Trends to Watch

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What Has Been Implemented Now?

- Small business health insurance tax credits.
- Expanded Medicaid eligibility.
- Relief for seniors who hit “donut hole” in Medicare prescription drug coverage.
- Early retiree reinsurance program.
- High risk insurance plan.

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What Has Been Implemented Now?

- Health insurance coverage for dependents to age 26.
- Eliminate copays for preventive health services.
- No rescission of health coverage except in cases of fraud.
- No lifetime caps.
- New federal regulation of annual caps.
- No denial of children's’ coverage based on pre-existing condition.

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What Has Been Implemented Now?

- New support for healthcare work force, especially primary care.
- New $15 billion preventive health fund.
- Increased support for community health centers.

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Trends to Watch

- Do employers and individuals take the coverage or pay the penalty?
- Does the Essential Health Benefits Package become the standard?
- Does market consolidation occur as predicted?
- Do higher cost providers get excluded from networks?
- Deficit Reduction Commission + IPAB = additional entitlement cuts?
- Will PPACA really bend the cost curve?
- Does uncompensated care increase, decrease or shift to certain providers?
- Is access to care impacted by the amounts of newly insured?
- Physician shortage – does the law do enough? What about specialists?
- Does emphasis on prevention work? Save money?
- How much of drug and device tax is passed onto providers?
- Will we see a blurring between the distinction of non-profit and for-profit hospitals?

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