

PwC Health Research Institute

Health Reform on the Fast Track: Understanding the Impact of the Stimulus and Proposed Budget on Health Industries



*connectedthinking

PRICEWATERHOUSECOOPERS 

Agenda

Universal coverage

Modernize the health system to reduce costs

Promote prevention

Health reform implications

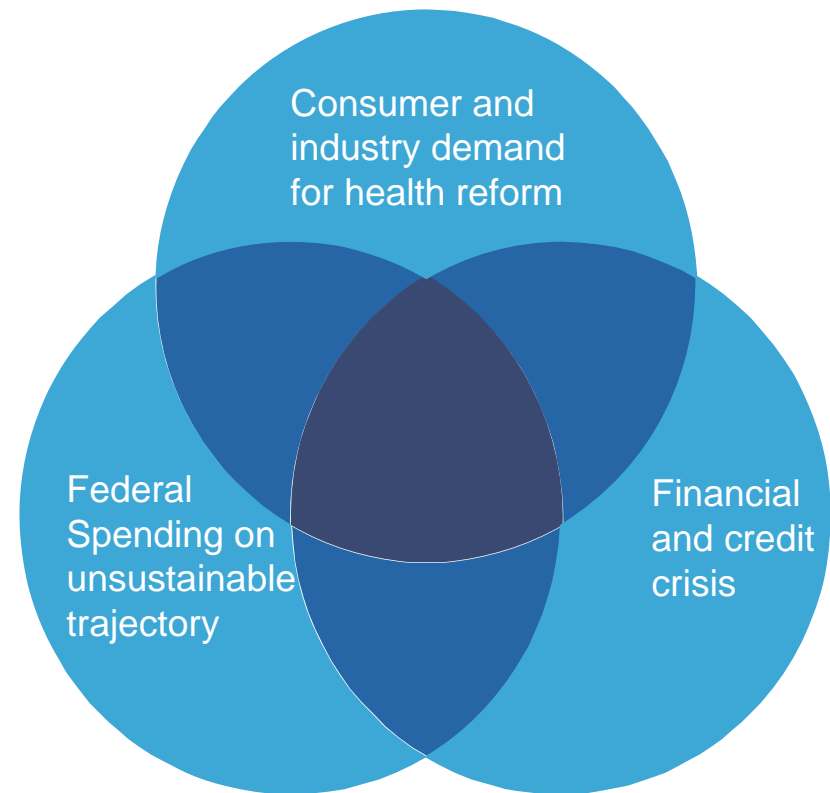
Questions and answers

President Obama came into office facing a trio of interrelated crises that he used to address a trio of health reform promises

Universal coverage

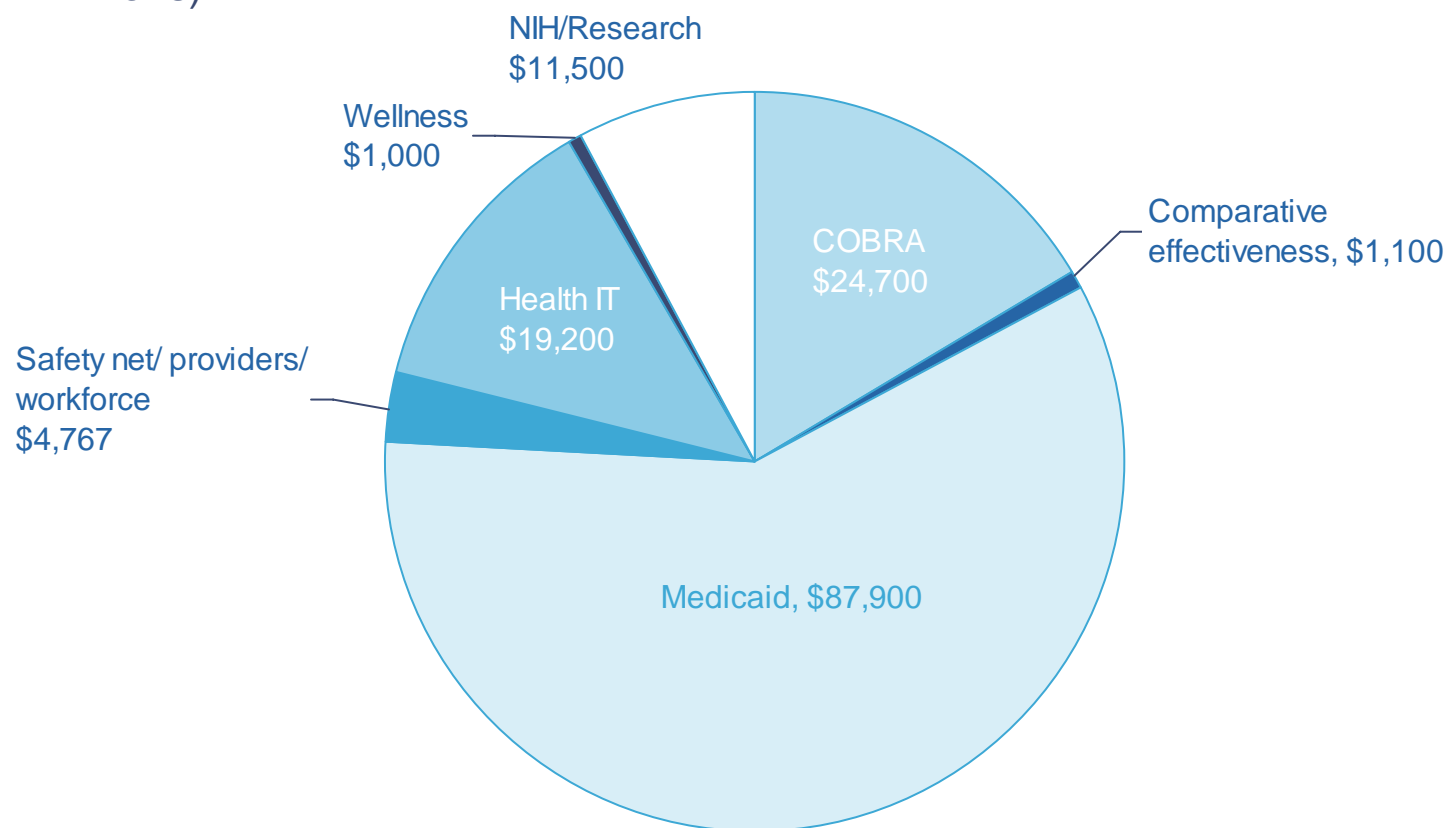
Modernize the system to reduce costs

Promote wellness, prevention



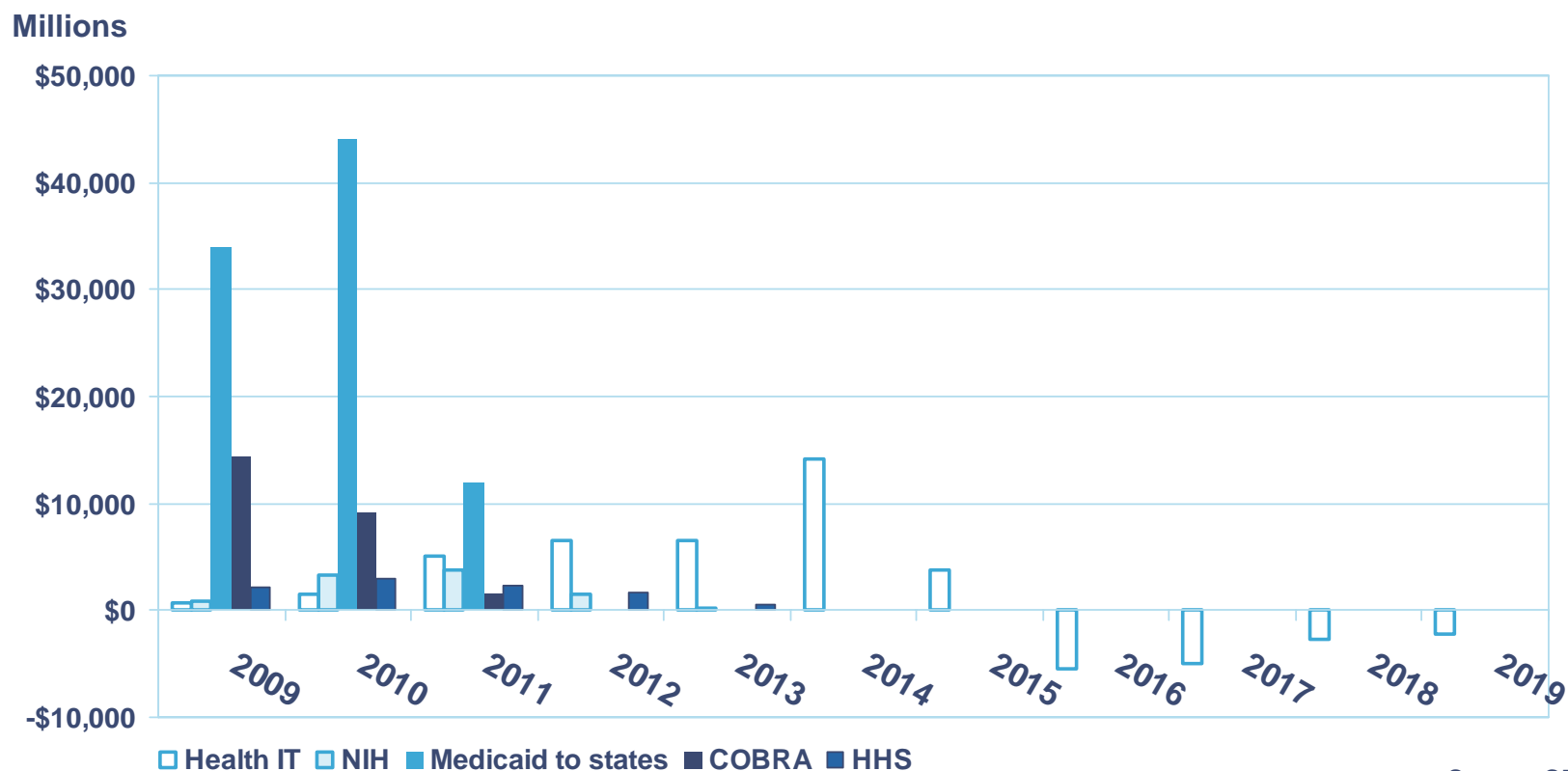
The Stimulus: Most healthcare funding temporarily stabilizes insurance coverage—providers, health IT, NIH are big winners

\$150.1 billion in healthcare spending in the stimulus package
(numbers in millions)



Stimulus injects most funds in first three years; Health IT funds pay out longer and generate savings by 2016

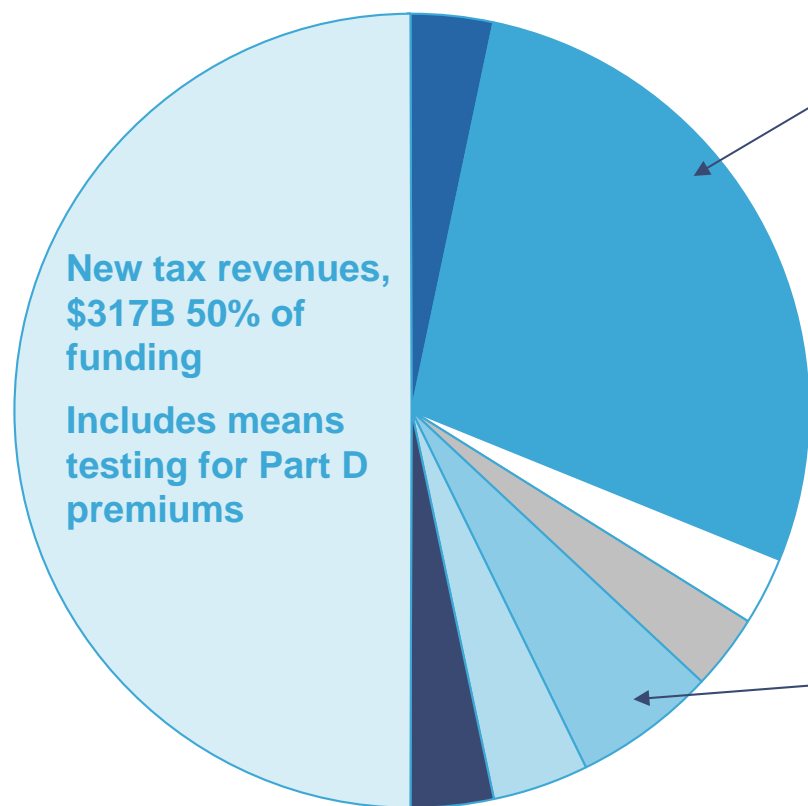
Estimated cost of spending by fiscal year



Source: CBO, February 2009

Proposed HHS budget: Includes \$630 billion over 10 years in health reserve fund to pay for expanded access

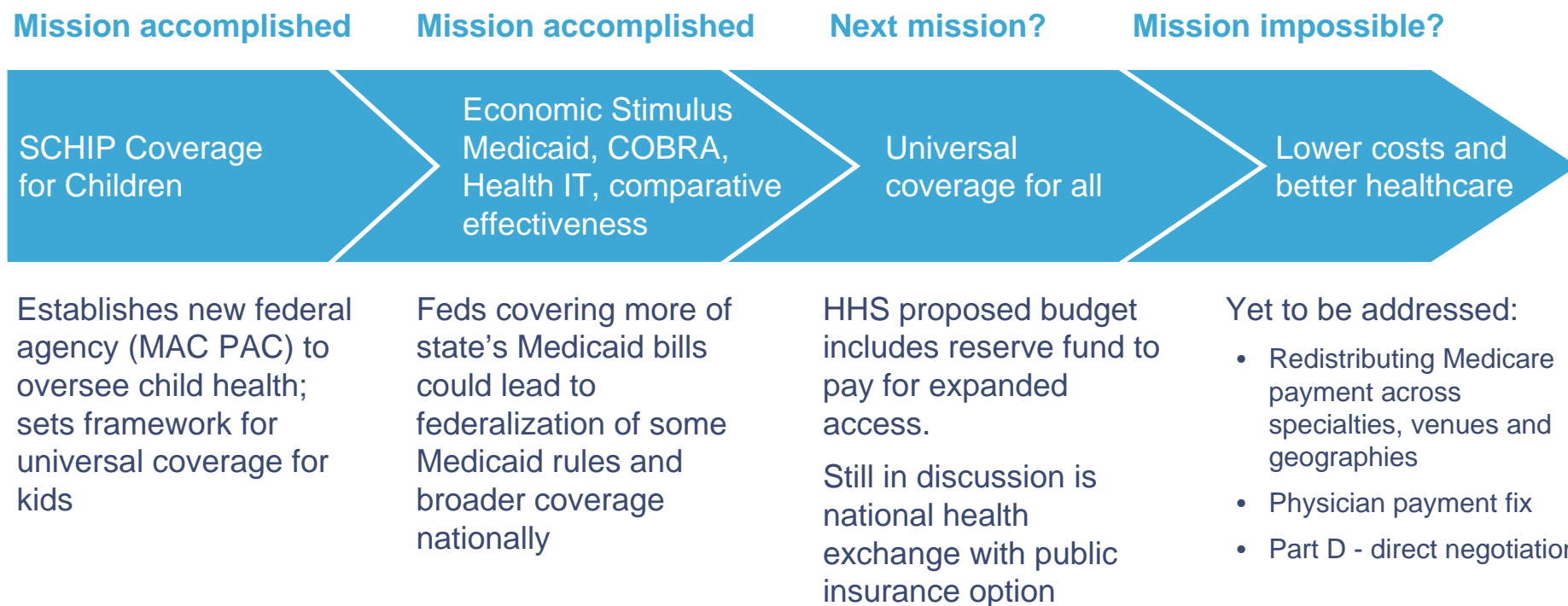
Half from increased taxes



Half in reduced spending by Medicare/Medicaid

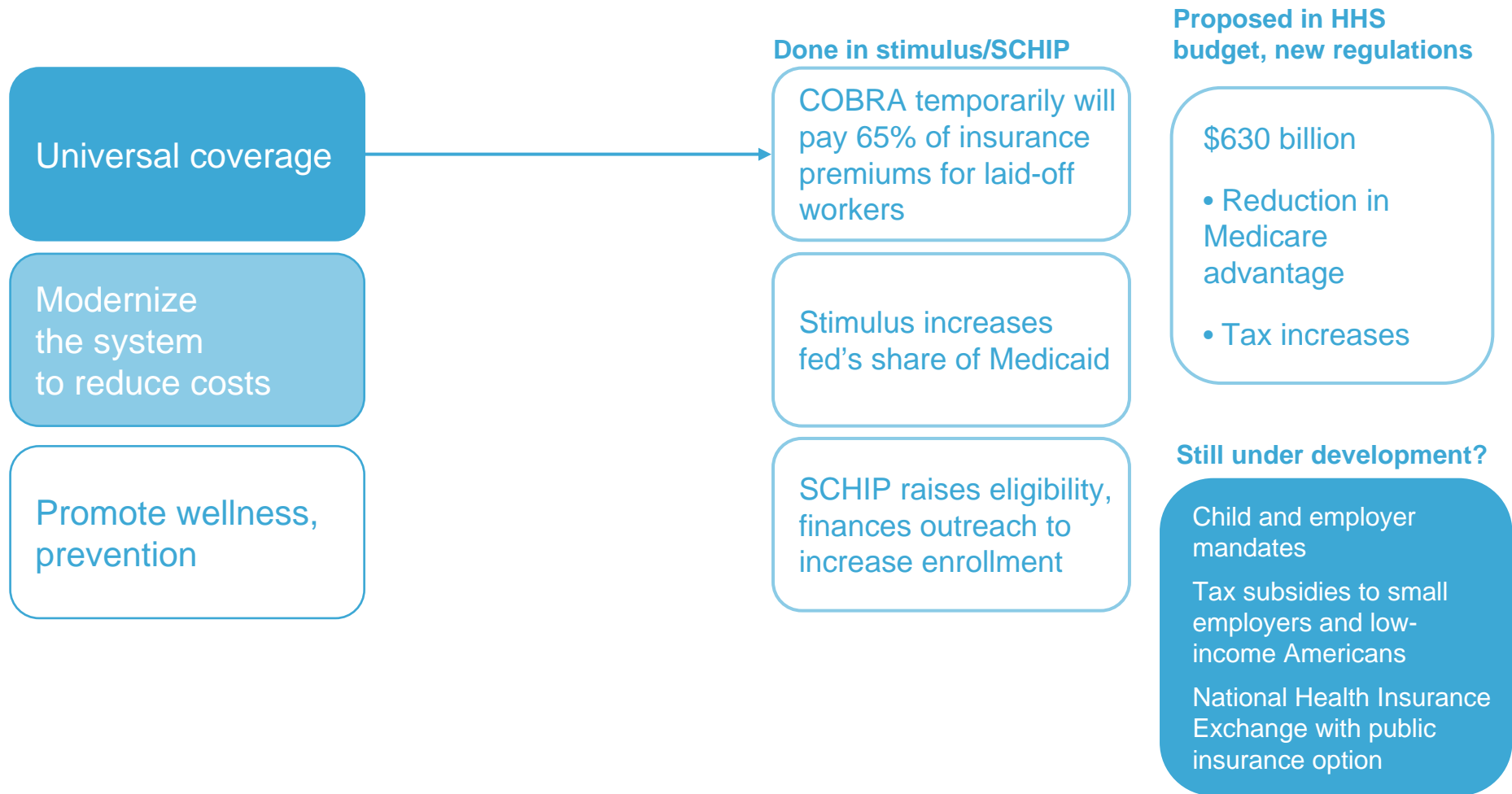
- \$176.6 billion, 28%, in Medicare Advantage reductions
- \$20.5 billion, 4%, reduce payments to hospitals with high readmission rates, low quality scores
- 17.8 billion, 3%, bundling acute and post-acute Medicare payments
- \$23.9 billion, or 4%, to reallocate resources toward fraud
- \$19.6 billion, or 3%, extending Medicaid rebates
- \$20.3 billion, or 3%, in other Medicare, Medicaid savings, including establishing pathway for generic biologics and reducing imaging spending
- \$37 billion, 6%, in reduced Medicare home health payments

Economic recovery put Obama's health reform on fast track



Universal coverage

From proposal to implementation: universal coverage



Stimulus + SCHIP stabilize, expand coverage

Stimulus is short-term fix for adults:

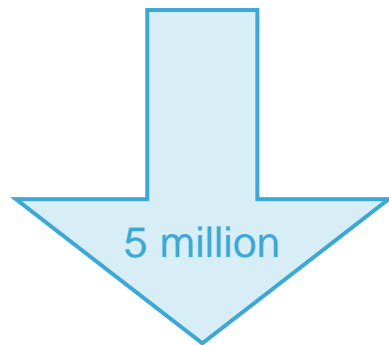
- Feds covering states' shortfalls for Medicaid
- COBRA changes mean feds will provide tax offset to employers for 65% of premium for laid-off workers
- Estimated to protect health benefits for 20 million
- Increase is temporary change in the FMAP (matching rate) - will return to baseline in 2012. Each state's matching rate is different.
- Another \$1.3 billion for Transitional Medical Assistance (TMA) payments - Medicaid payments to certain low-income families.
- Reserve fund would extend access for adults, but details of coverage are unclear

SCHIP is long-term fix for kids:

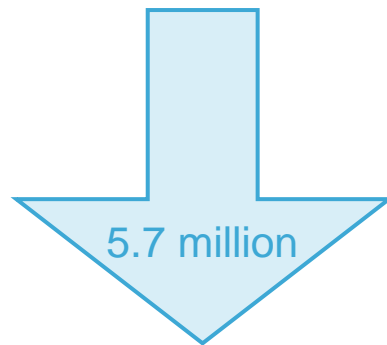
- Expands coverage to 4 million additional uninsured children at cost of \$32 billion over 4 ½ years
- Removes the five-year ban on covering legal immigrant children
- Provides \$3.2 billion in performance bonuses to encourage states to enroll more children by reducing barriers

Universal coverage

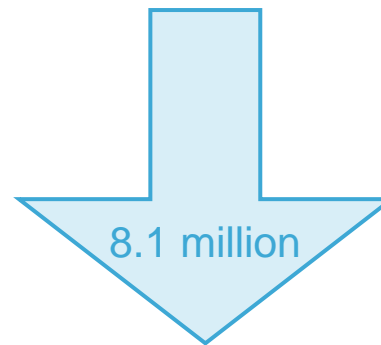
PwC's estimates are that expansions would eliminate 2/3s of uninsured at about \$75 billion a year, \$1 trillion in 10 years



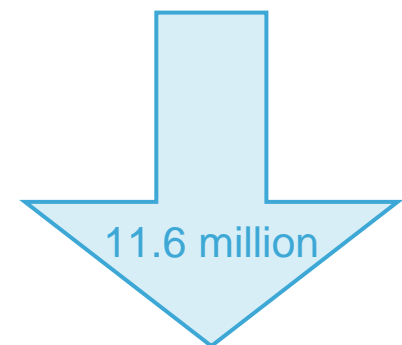
Medicaid/SCHIP



Individual market
(non-subsidized)



Individual market
(subsidized)



Employer-sponsored

Universal coverage

Massachusetts reform, which has lowered uninsured rate to 2.3%, is very similar to Obama's proposals

Ways in which Obama's plan is similar

- Expand Medicaid
- Large employers must pay-or-play
- Subsidies for low-income to buy individual private coverage
- New health insurance exchange may be like Massachusetts Connector
- Mandate on individual coverage - for children

Ways in which Obama's plan is different

- Government fall-back plan (none in Massachusetts)
- Individual coverage mandate is on children, not adults
- Subsidies for small businesses (none in Massachusetts)
- Funding can't directly come from a discrete indigent care fund as in Massachusetts

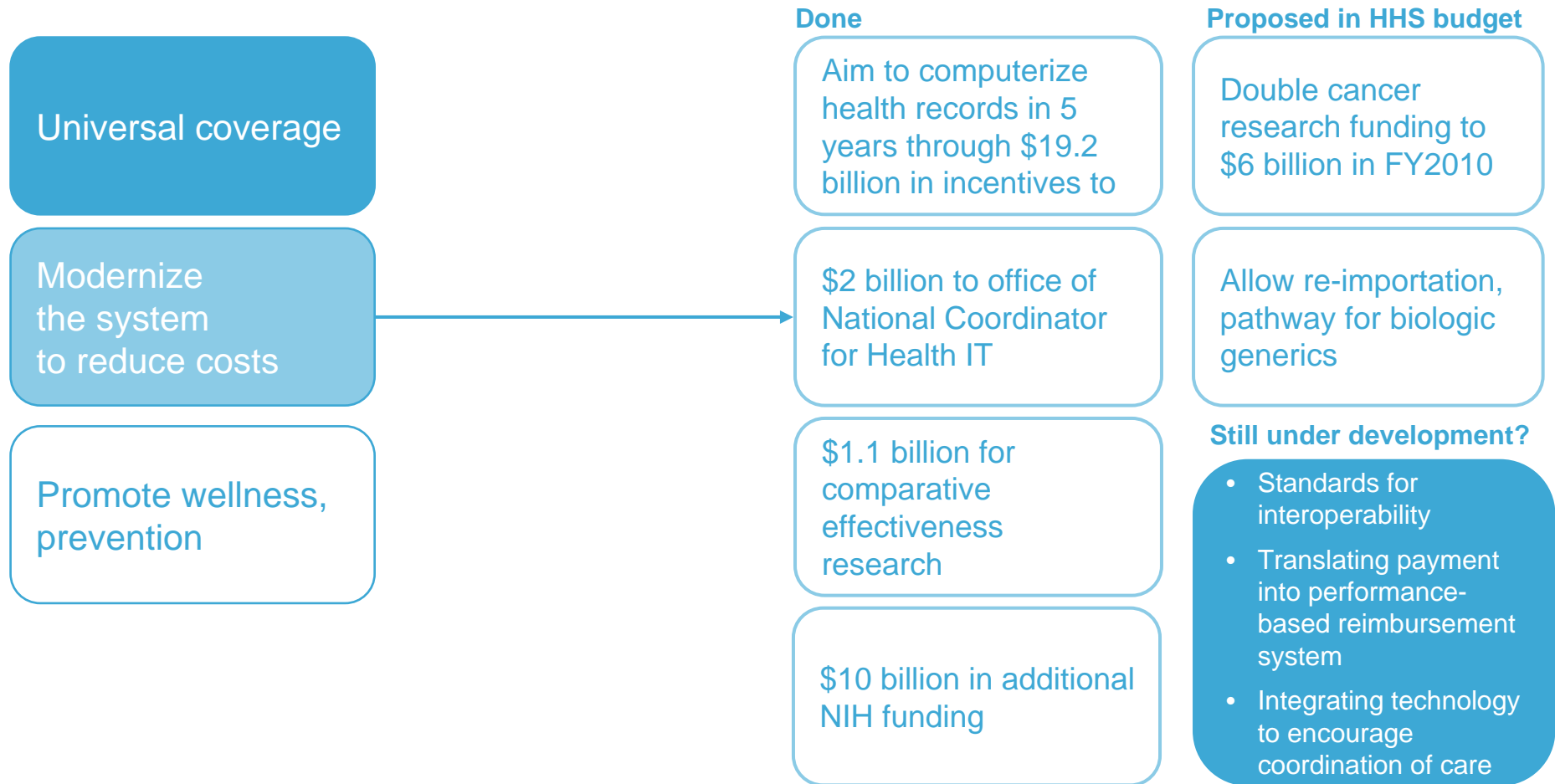
Universal coverage

Details of universal coverage are yet to be addressed

Proposed reform	Details
Child mandate	<ul style="list-style-type: none">• While not a mandate, SCHIP law broadens coverage and requires better coordination of private and public coverage
Individual and employer exemptions	<ul style="list-style-type: none">• While not a mandate, businesses with group health plans will be required to inform workers about CHIP
Increased access and further primary care physician shortages	<ul style="list-style-type: none">• More funding for National Health Service Corps and FQHCs
Individual coverage mandate	<ul style="list-style-type: none">• Not yet enacted, but still actively discussed
State coverage mandates	<ul style="list-style-type: none">• No clear indication yet
Minimum coverage levels	<ul style="list-style-type: none">• Nothing determined yet
National Health Insurance Exchange	<ul style="list-style-type: none">• Still in the works
Decreasing healthcare costs	<ul style="list-style-type: none">• Rates flattened for Medicare Advantage plans

Modernize system to reduce costs

From proposal to implementation: modernize the system



Funding expected to lead to digital records in five years, kick-start for research funding

- \$19.2 billion in incentives for hospitals and providers - entire health IT sector estimated to be between \$20 billion and \$50 billion
- \$2 billion for Office of National Coordinator of Health Information Technology (last year's budget was \$66 million) for infrastructure grants, loans and demo projects - more responsibility for overseeing interoperability
- Designed to spur interoperability, coordination of care, and provide additional privacy protections
- Most funds will be distributed between 2011 and 2016

Incentives are skewed to reward EHR early adopters

Hospitals at least \$3 million each

Physicians up to \$44K each

Government starts to pay bonuses in 2011

- Incentives are for “adoption and meaningful use of certified EHR technology”.
- Payment is \$2 million times a discharge formula that includes Medicare admissions, charges, charity care data
- Those adopting between 2011 and 2013 will get four years of payments; in 2014 get three years, in 2015, two years of payments.
- Critical Access Hospital receive up to 120% of Medicare’s portion of EHR’s cost for up to 4 years.
- \$3,000 bonus if they implement by 2012. First-year payments drop to \$15,000 in 2013 and \$12,000 in 2014. Late adopters - after 2014 - get no incentive.
- Incentive payments increase by 10% if provider predominately serves Medicare beneficiaries in a health professional shortage area.
- No incentive payment for hospital-based physicians.

Penalties begin in 2015

- Those not adopting would be penalized through Medicare’s annual update.
 - Medicare payment to physicians who have not adopted EHRs would receive 99% in 2015, 98% in 2016, and 97% in 2017
 - If there is less than 75% adoption rate the Secretary can reduce the rate by 1% per year starting in 2018 with a limit of 95%.
-

Modernize system to reduce costs

Other IT funding that could improve health systems, delivery

- \$2.5 billion for Agriculture Dept.'s Distance Learning, Telemedicine, Broadband program
- \$85 million telehealth through Indian Health Services
- \$500 million for Social Security Administration
- \$50 million for Veterans Health Administration IT system
- \$4.7 billion for broadband, some of which could go towards healthcare

New penalties, standard setters around health IT, privacy

New rules:

- Organizations must notify individuals when their personal health information has been breached, even if it was a temporary breach
- Organizations cannot receive any payment for exchange of personal health information (exemptions for research, public health and treatment)

New penalties and improved enforcement:

- Extends scope of who can be prosecuted for selling health information
- Establishes different penalties depending on whether patient information was released due to “willful neglect” or not.

New standards-setting groups and advisers to the Office of the National Coordinator:

- Establishes a new HIT Policy Committee to make recommendations to the national coordinator to establish a national health IT infrastructure
- Establishes an HIT Standards Committee to recommend standards, certification criteria
- New Health IT Technology Research Center (HITRC) to develop best practices, technical assistance to local and regional health information exchanges.

Comparative effectiveness funding big win for health research community, but lacks teeth around coverage

Stimulus details

- \$300 million for AHRQ, \$400M to NIH and \$400M to be allocated by HHS
- Congress did not say how the findings would be used, however, the bill specified that it is not to be used “to mandate coverage or reimbursement.”
- Funding is for “research to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition.”
- Establishes Federal Coordinating Council for Comparative Effectiveness Research, composed of up to 15 federal officials (at least half must be clinicians)

Cost: \$1.1 billion

Impact:

- Funding doubles AHRQ’s annual budget
- Specifies that research must include women and minorities
- Legislation notes that a “one-size-fits-all” approach to patient treatment is not the most medically appropriate solution to treating various conditions...”

National Institutes of Health funding will ease research backlog

Stimulus details

- \$1.3 billion for National Center for Research Resources to construct, renovate or repair existing facilities
- \$7.4 billion for scientific research of which \$800 million can be short-term grants that can be completed within two years.
- \$800 million for research and grants that could be completed in two years
- \$500 million to repair and renovate buildings on NIH's Bethesda campus
- \$1.5 billion to aid universities to compete for biomedical research grants

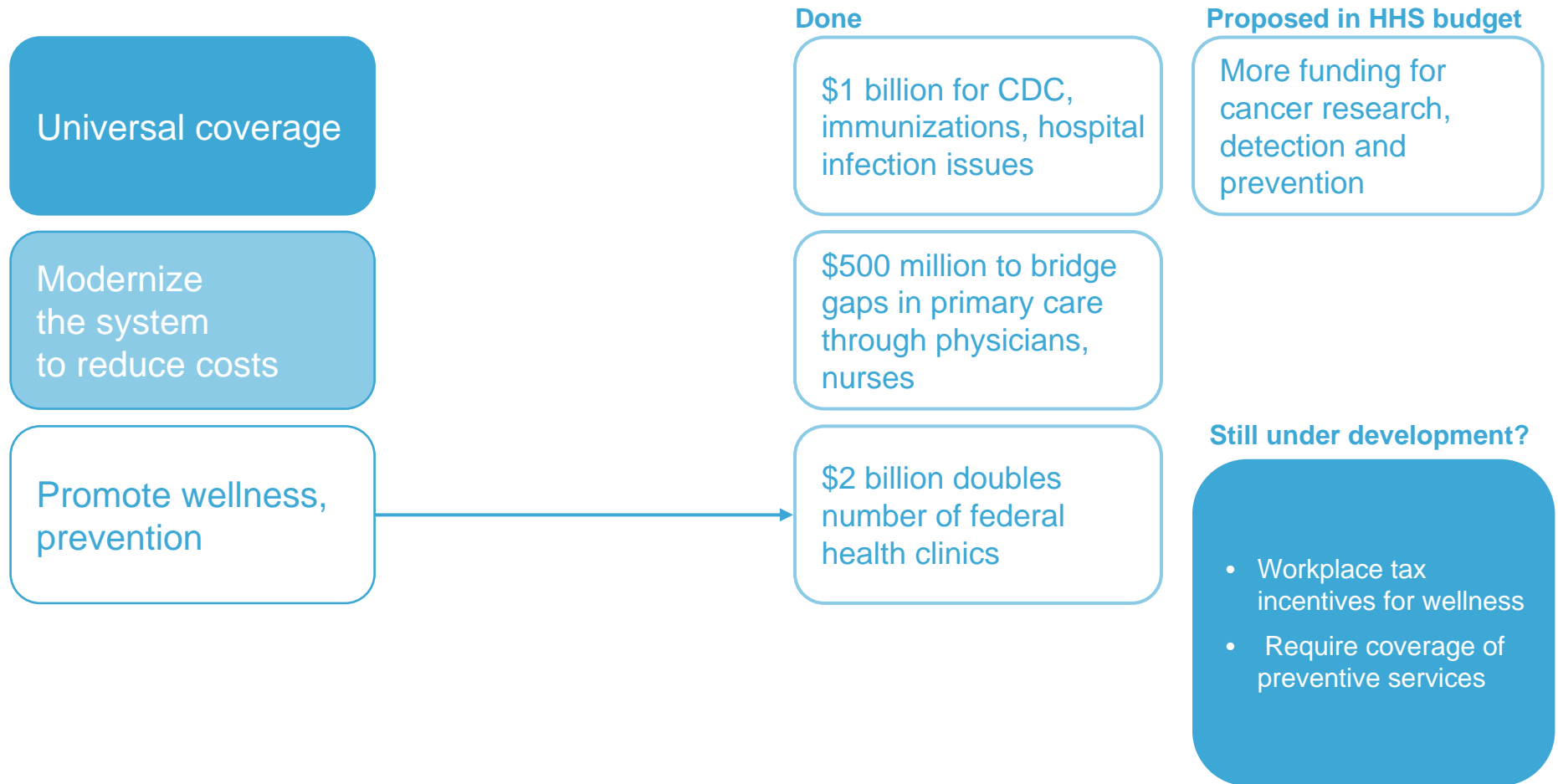
Cost: \$11.5 billion

Impact:

- Estimated to create 70,000 jobs (Research America)
- FY09 budget for NIH is \$29.3 billion - budget been flat
- Expected to end backlog of grant applications
- NIH would fund studies through 2014
- Only \$855 million is projected to be spent in FY 2009

Promote prevention

From proposal to implementation: promote prevention



Safety net providers, programs and clinicians get new burst of funding

Centers for Disease Control and Prevention (CDC)

- Immunization
- Implement healthcare-associated infections (HAI) reduction strategies.
- Evidence-based clinical and community based prevention and wellness programs that address chronic disease rates

Funding for safety net providers, clinics, physicians and nurses could overcome access problems experienced in Massachusetts

Health reform implications

What may be the next wave of health reforms?

- Medicare doctor payment formula still unsustainable
- MedPAC continues to recommend move to value-based reimbursement, change in primary care payment, and ways to address geographic variations in care.
- Continued discussion on how federal standards might supersede state benefit mandates
- National health exchange with public plan option could be most contentious fight
- Some incentives for small employers through SCHIP, which could broaden to cover more adults

What insurers face

- Continued commercial insurer consolidation
- Drop in number of privately insured
- Plans may trade-off guaranteed issue for individual mandate
- Reduced Medicare Advantage rates and dropped coverage in some regions

Positive implications

- More insured could mean more premium revenue, with profit margins exceeding ASO business
- New markets from the National Health Insurance Exchange creating incentive for innovative products
- National reform could pre-empt state reform, creating more uniform standards
- Health IT funding could be boon

Negative implications

- Changes possible in guaranteed issue community rating rules
- Public plan could lead to private health plan erosion
- If Medicare reimbursement rates decrease, hospitals will pressure private plans for higher rates
- Possible change to the broker relationships

What providers face

- Even with COBRA, uncompensated care may rise
- Commercial payers may lose more private customers
- Increased PCP funding at an expense to specialists and hospitals
- Reduction in investment income, access to capital

Positive implications

- Fewer uninsured and less uncompensated care during economic downturn
- More DSH funding
- Big boost in health IT investment builds needed digital infrastructure
- Workforce funding could help with physician/nursing shortages
- New FQHCs could relieve uninsured burden

Negative implications

- New policies and regulations on privacy impact employees, clinicians, business partners
- Focus on quality and bundling could reduce payment
- Shift in payer mix to more Medicaid and Medicare will lower profit margins

What employers face

- Large retiree health benefits liabilities
- Erosion of small employer health insurance market
- Large employers want to provide health benefits but global companies indicate that healthcare costs make them increasingly uncompetitive
- Health benefit costs rivalling other expenses for globally competitive employers

Positive implications

- Less cost shifting to employers and private plans
- Productivity increases from wellness and prevention programs
- Opportunities to leverage government savings from comparative effectiveness, new payment models, and prevention
- Possible lower cost health insurance through the insurance exchange
- Public health insurance options could offer exit

Negative implications

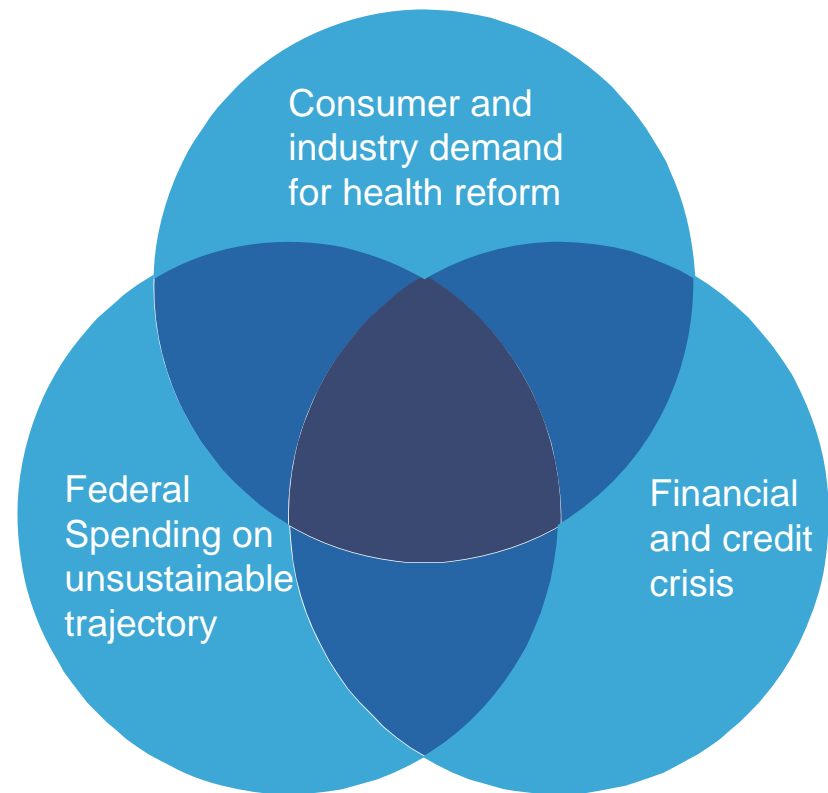
- Employer and child mandate could add compliance costs and create conflicts with ERISA
- Brokers could be squeezed out by exchange
- New administrative burdens from SCHIP and COBRA
- Cuts in Medicare Advantage may affect retiree health plans
- “Pay or play” mandate could force employers to offer more generous benefits

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to reduce costs

Promote wellness,
prevention



Questions and answers

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