



***Compliance in the Post-Reform World***

*Economics of Health Care Reform*

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**New Environment**

- Patient Protection and Affordable Care Act (“PPACA”) signed into law March 23, 2010
- Health Care and Education Reconciliation Act of 2010 (“HCERA”), often referred to as the Reconciliation Bill, signed March 30, 2010

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## Congressional Findings

- National health spending:
  - \$2,500,000,000,000 or 17.6% of economy in 2009
  - \$4,700,000,000 in 2019
- Private healthcare spending:
  - \$854,000,000,000 in 2009



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## Costs

- On March 20, 2010, the Congressional Budget Office estimated that PPACA and HCERA will produce a net reduction in federal deficits of \$143 billion over the 2010-2019 period
- On April 22, 2010, the HHS Office of Chief Actuary estimated that PPACA as amended will result in an increase in overall national health expenditures of \$311 billion during the 2010-2019 period

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## Controversies

- Greater utilization costs
- More costly for employers
- Employers may opt out
- Premiums increase because of new coverage
- Less cost shifting between commercial payers and government
- Fraud and abuse enforcement only goes so far to save costs
- Efficiency and quality saves
- More people paying into the system
- Early access and prevention
- Penalties for not participating
- Less cost sharing to cover the costs of the uninsured
- Taxes
- Exchanges improve competition
- Medical costs reflect care

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## Insurance Market Reform and Exchanges

- PPACA Expands access to coverage to 32 million individuals by 2019 through a combination of public program expansions and private sector health insurance reforms
  - Beginning January 1, 2014, all US citizens and legal residents have to obtain coverage or face a tax penalty (though subsidies are available)

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## Insurance Market Reform and Exchanges

- Medicaid expansion
  - Beginning in 2014, all state Medicaid programs are required to cover individuals up to 133% of the federal poverty level
  - States will receive federal funds to pay for the newly expanded populations



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## Insurance Market Reform and Exchanges

- Funding reduced
  - Medicare market basket reductions and productivity adjustments will result in approximately \$160 billion in cuts to providers over 10 years
  - Medicare and Medicaid DSH payments reduced substantially



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## Insurance Market Reform and Exchanges

- Health Insurance Exchanges
  - States are required to establish health insurance exchanges through which individuals and small businesses can purchase qualified private health insurance coverage
  - There is no government-run program



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## Insurance Market Reform and Exchanges

- Deductibles limited
- No lifetime or annual limits
- No pre-existing condition exclusions
- No waiting periods >90 days
- Coverage for preventive services
- Extension of dependent coverage to 26
- Guaranteed availability and renewability
- No discrimination: health status, medical condition, claims experience, receipt of health care, medical history, genetic info, evidence of insurability, disability, or any other status factor



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## Insurance Market Reform and Exchanges

- Individuals must maintain Minimum Essential Coverage by 1/1/2014
  - \* This is the Constitutional fight
- Penalties for not doing so
  - 2014: \$95 or 1% of income
  - 2015: \$325 or 2% of income
  - 2016 and following: \$695 or 2.5% of income indexed
- Limits based on ability to pay
  - Family limit of 300% of amount for year (\$2085 in 2016)



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## Insurance Market Reform and Exchanges

- Demonstration Projects
  - Adjust payment structure from fee-for-service to global capitated payment structure
  - Bundling payments to providers
  - Geographic variation
  - Medical liability demonstrations
  - National demonstration projects on nursing homes
  - Extension of gainsharing demonstration



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## Impact on Employers

- Employer Mandate: Pay or Play
  - >50 FTEs
  - Must provide “minimum essential coverage” if one employee obtains coverage elsewhere with premium credit or cost-sharing reduction



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## Impact on Employers

- Small Business Health Care Tax Credit
  - Fewer than 26 FTEs, average wages <\$50k
  - Up to 35% of employer-paid premiums
  - Phase out of credit for >10 FTEs or if average wages >\$25,000
  - Credit available in 2010



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## Impact on Employers

- Employers with >199 employees must automatically enroll new hires.
- Employees may opt out.
- Applies to all plans.
- Subject to forthcoming regs, but seems to be effective now.



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## Taxes

- Excise tax on high-cost health plans (2018)
  - Nondeductible 40 percent excise tax on group insurers if annual premium payments exceed \$10,200 per year for individuals, or \$27,500 for families
- Medical device tax (2013)
  - Sales of medical devices will be subject to a 2.9 percent national sales tax
- Assessment on health insurers (2014)
  - The health insurance industry will be subject to an \$8.0 billion annual excise tax, which increases to \$11.3 billion annually for 2015, 2016, and 2017, and to \$14.3 billion in 2018 (rises by inflation thereafter)
  - The tax is assessed based on a companies market share and is non-deductible for federal tax purposes
- Assessment on pharma (2011)
  - The pharmaceutical industry will be subject to a \$2.5 billion annual excise tax, which increases in subsequent years, rising to \$4.2 billion in 2018
  - The tax is assessed based on a companies market share and is non-deductible for federal tax purposes



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## Physician Integration and Acquisition

- Changes to reimbursement have increased interest in physician practice acquisition, particularly among cardiologists, orthopedists and other specialists
- Several models exist for acquiring physician practices that provide greater flexibility for both hospitals and physicians
- Each acquisition presents its own unique challenges, but many common issues exist



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## Accountable Care Organizations (ACO)

- Group of providers held jointly responsible for improving the quality and cost of health care of a certain population, with the opportunity to share in any financial benefits that result
  - Combination of one or more hospitals, primary care physicians and possibly specialists
  - Large enough to support comprehensive performance measurement
  - Provide or effectively manage the full continuum of care as a real or virtually integrated local delivery system



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## ACO- Advantages

- Most physicians already practice within real or virtual ACOs
- Effective performance measurement at the ACO level would be more readily accepted
- Measures and incentives could encompass total Medicare program payment
- ACOs would have the ability to invest in system improvement and are at the appropriate level to control cost
- Establish accountability for local decisions about capacity, and thus cost



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## ACO- Challenges/Barriers

- Difficult to reverse current market trends that disproportionately reward high technology procedures and providers who own these facilities
- Over-coming physician cultural barriers that reward a high degree of professional autonomy and individual responsibility
- Legal obstacles
- Variability in the degree to which physicians and patients are aligned with a single hospital medical staff



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## ACO- Organizational Considerations

- Incentive Payment Qualification
  - Report quality CMS-specified indicators
  - Spending baseline most recent 3 years total per beneficiary spending (Parts A and B), adjusted by CMS expected national growth rate
  - 50% savings shared



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Thank you.



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