

# Health Research Institute

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



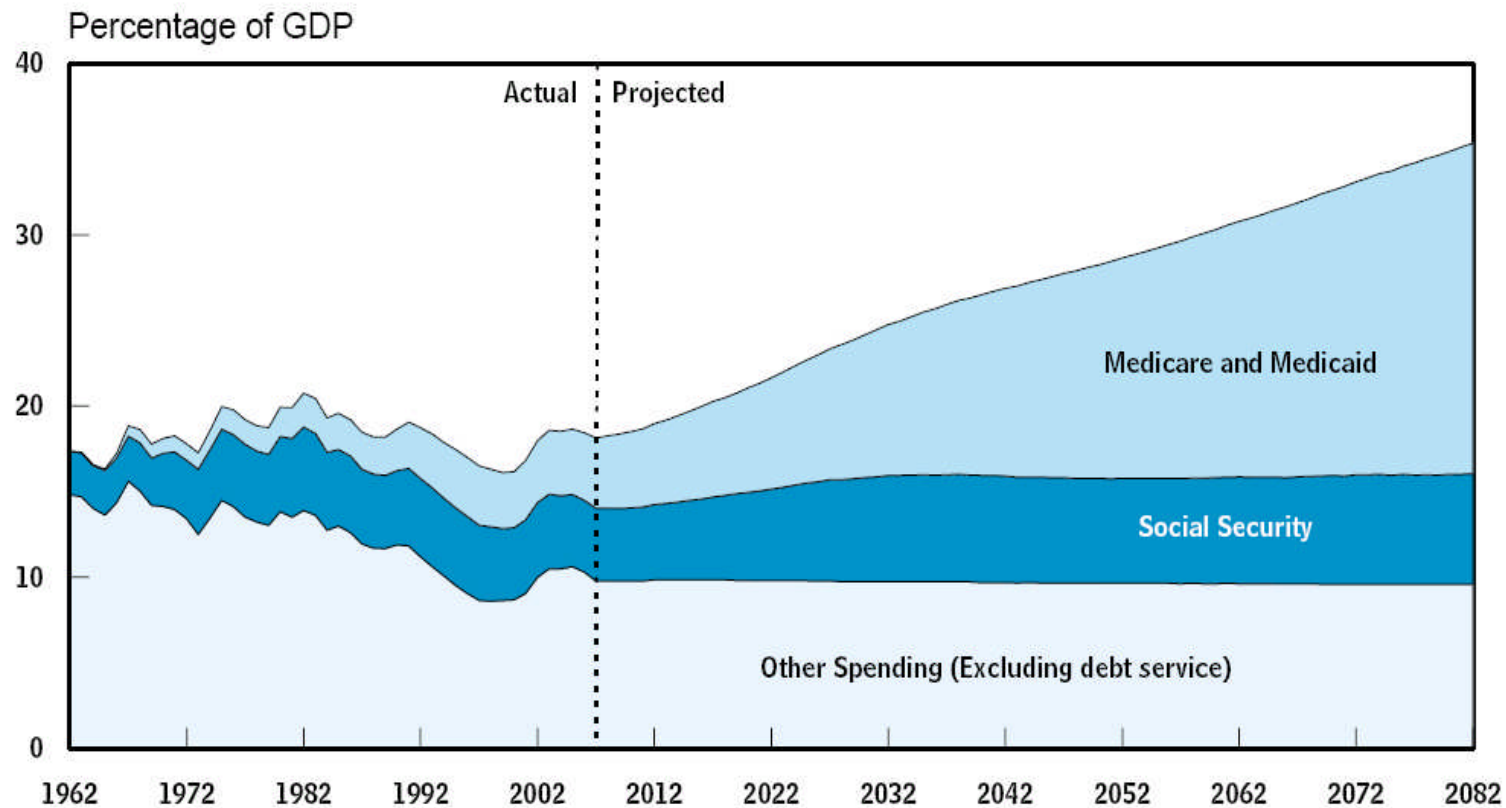
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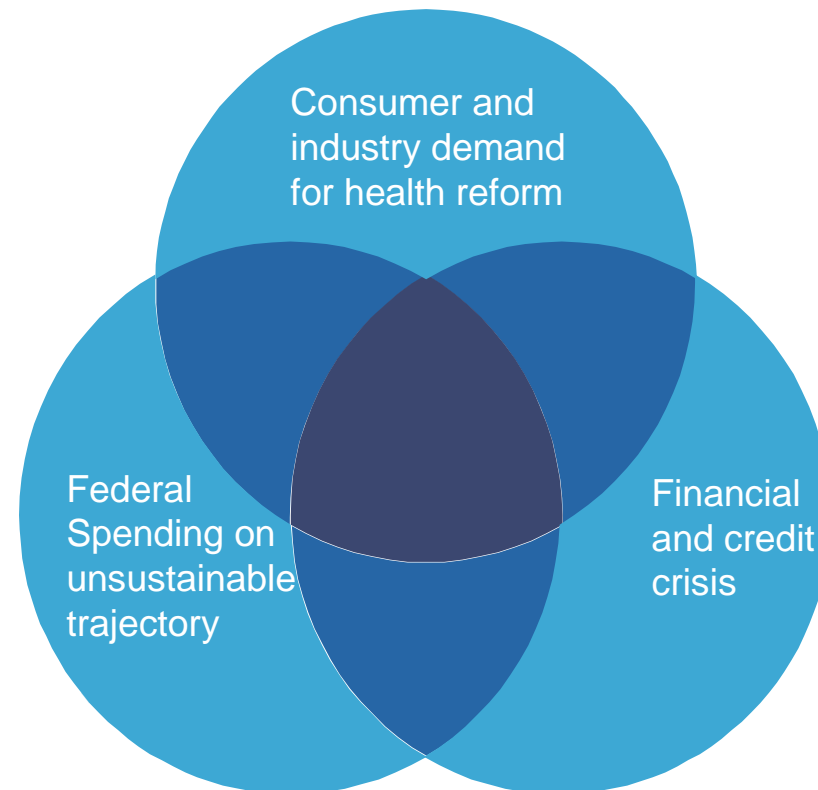
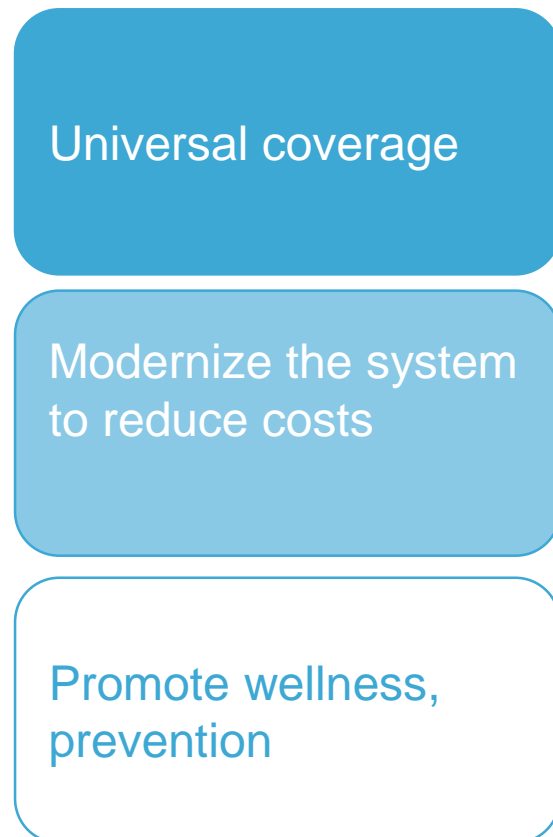
# Introduction

# Medicare Begins to Consume All Available Resources after Baby Boomers Retire

## Long-Term Fiscal Outlook

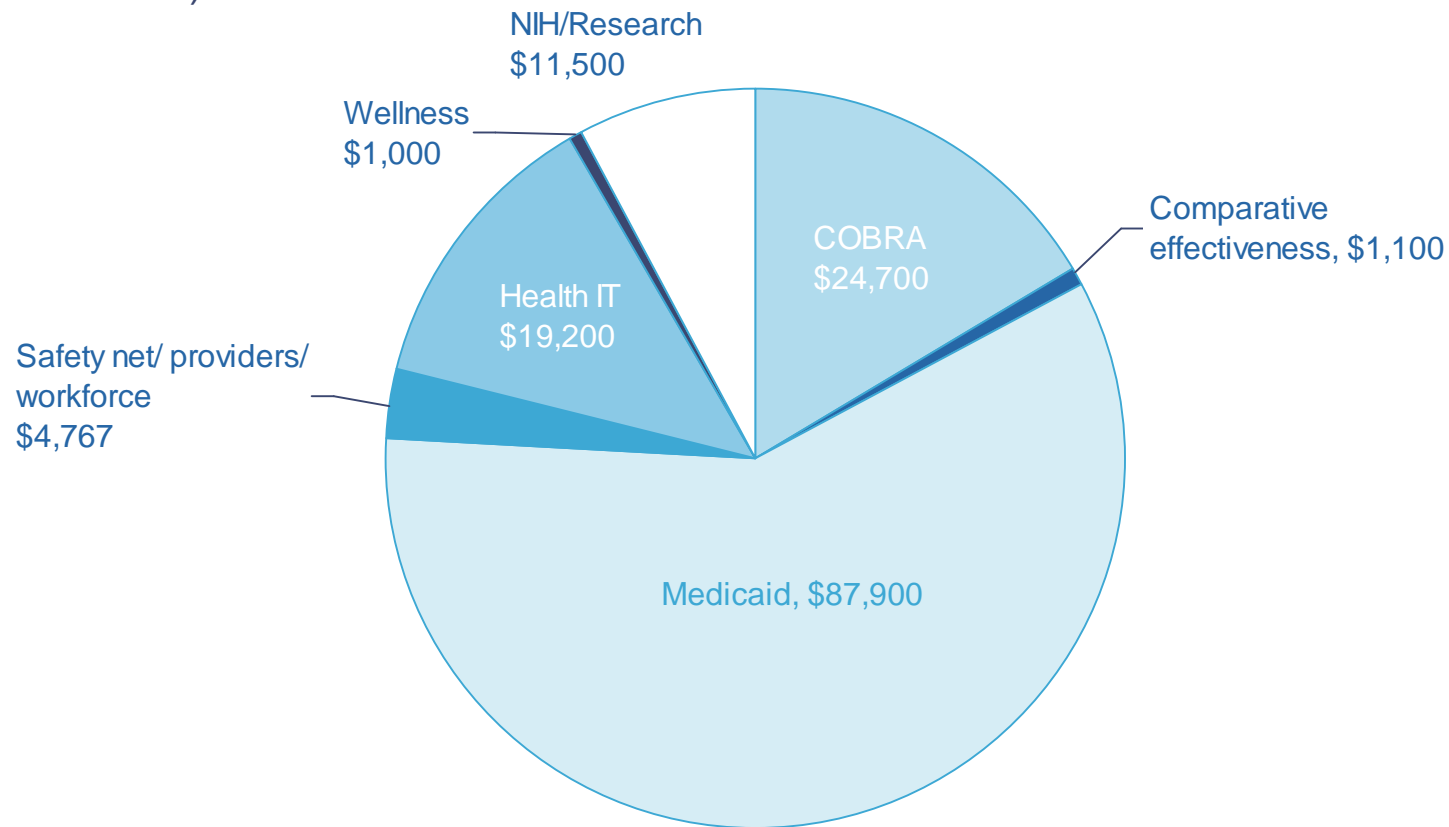


President Obama came into office facing a trio of interrelated crises that he used to address a trio of health reform promises



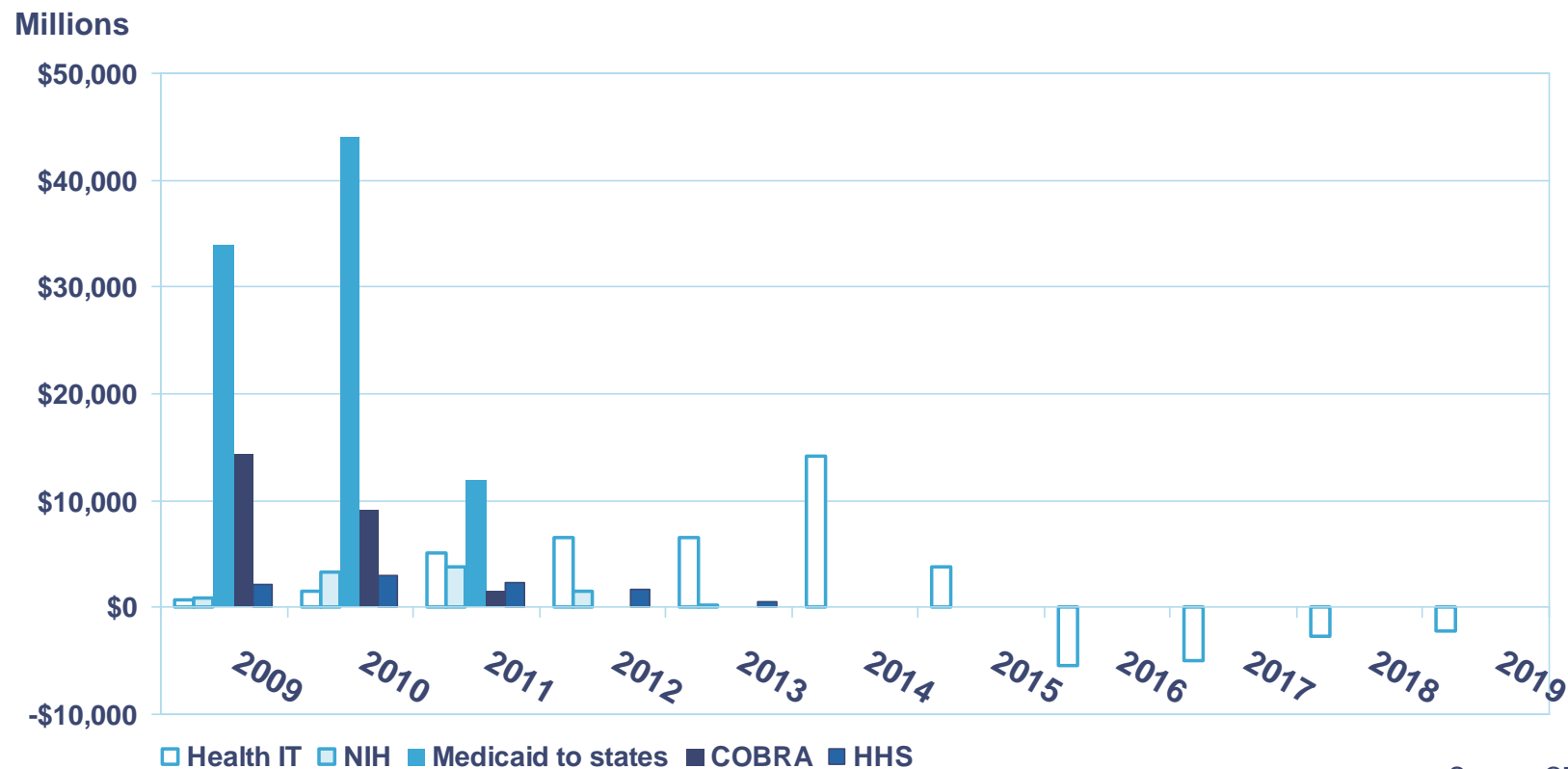
# The Stimulus: Most healthcare funding temporarily stabilizes insurance coverage—providers, health IT, NIH are big winners

\$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

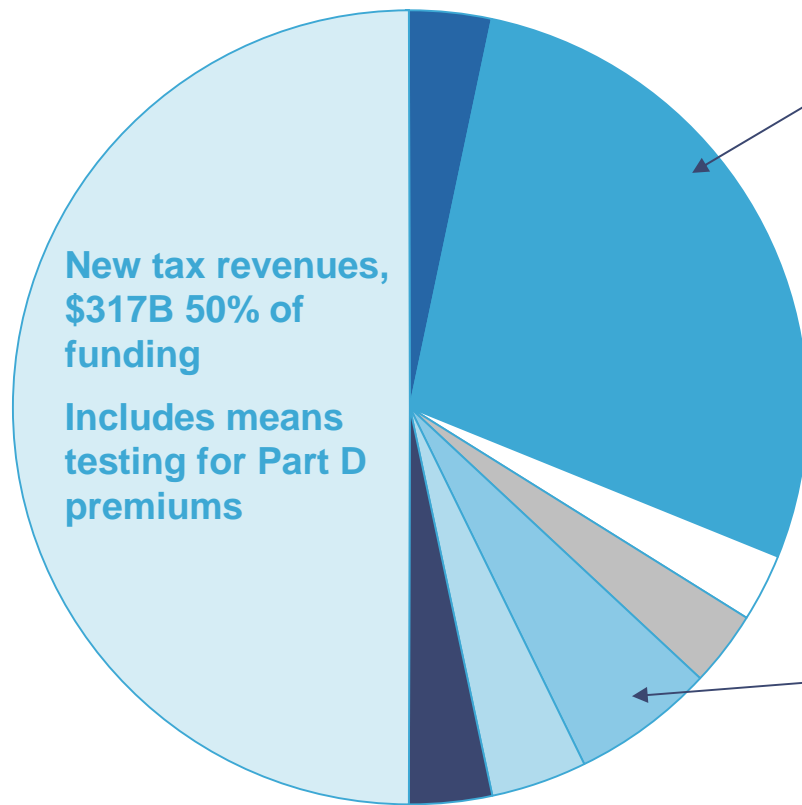
Estimated cost of spending by fiscal year



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

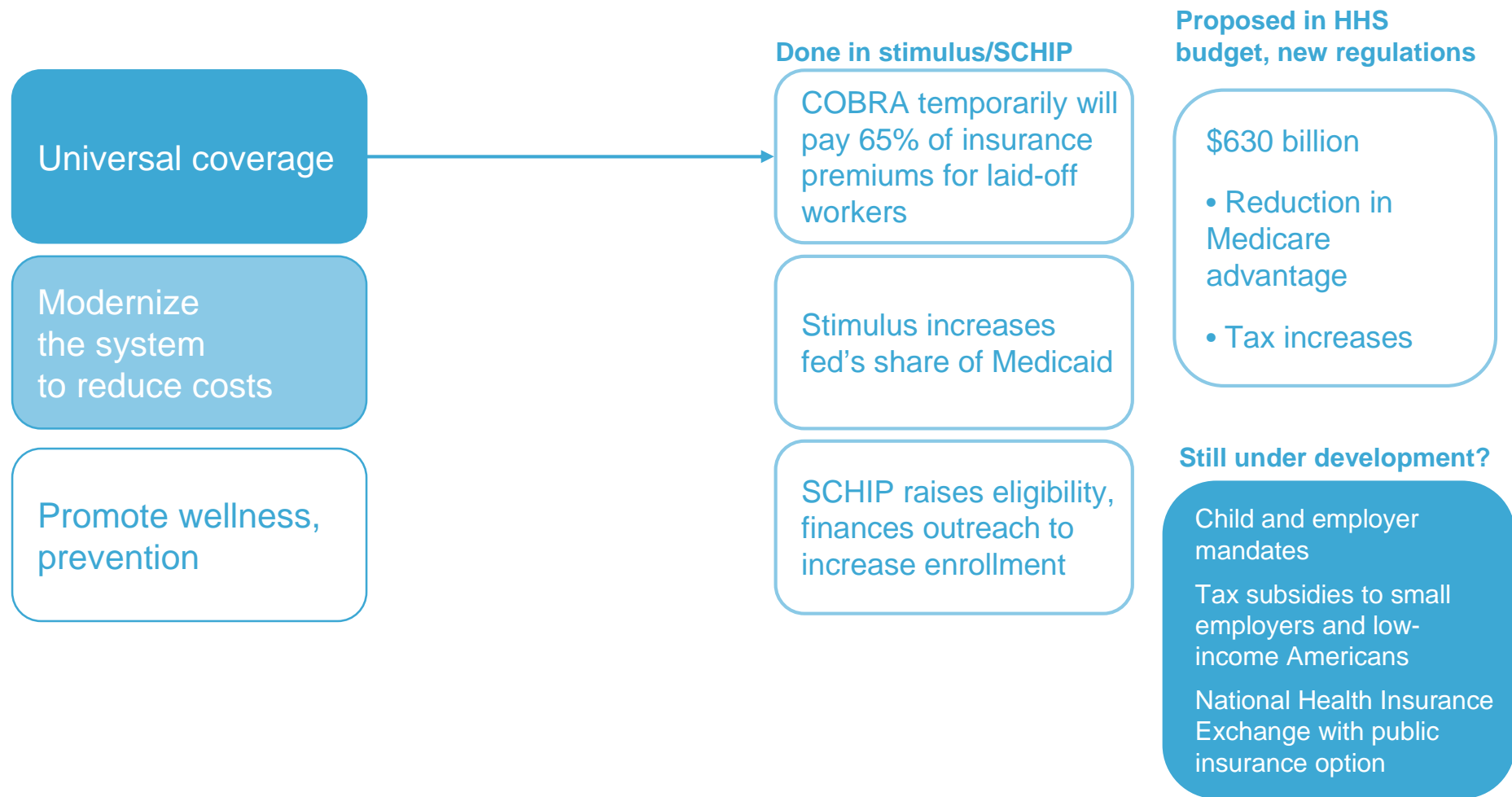
- \$176.6 billion, 28%, in Medicare Advantage reductions
- \$20.5 billion, 4%, reduce payments to hospitals with high readmission rates, low quality scores
- 17.8 billion, 3%, bundling acute and post-acute Medicare payments
- \$23.9 billion, or 4%, to reallocate resources toward fraud
- \$19.6 billion, 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:

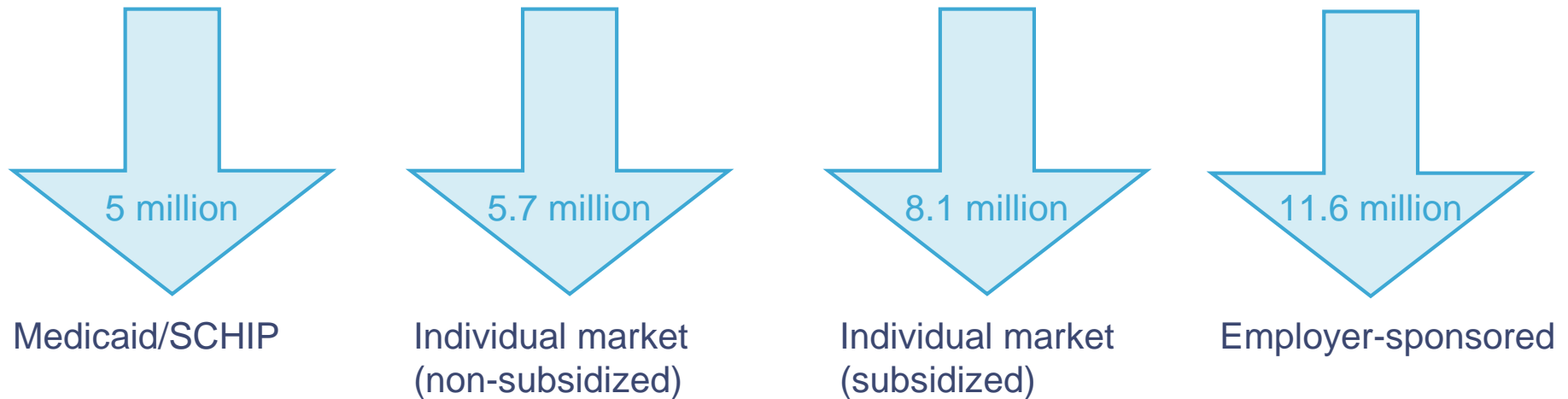
- Feds covering states' shortfalls for Medicaid
- COBRA changes mean feds will provide tax offset to employers for 65% of premium for laid-off workers
- Estimated to protect health benefits for 20 million
- Increase is temporary change in the FMAP (matching rate) - will return to baseline in 2012. Each 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



## Universal coverage

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

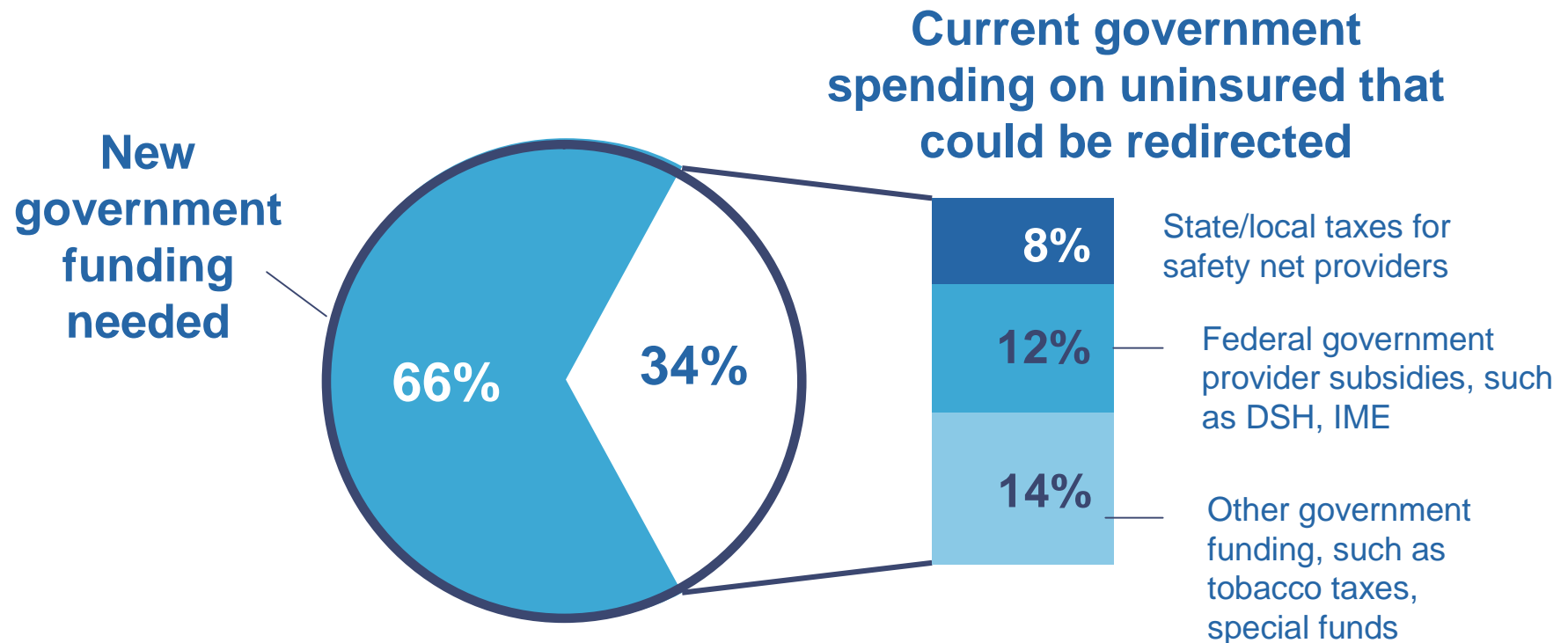
### Ways in which Obama's plan is similar

- 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

About one-third of the needed \$75 billion could come from existing government funding that now goes to hospitals



Source: PricewaterhouseCoopers' estimates, 2008

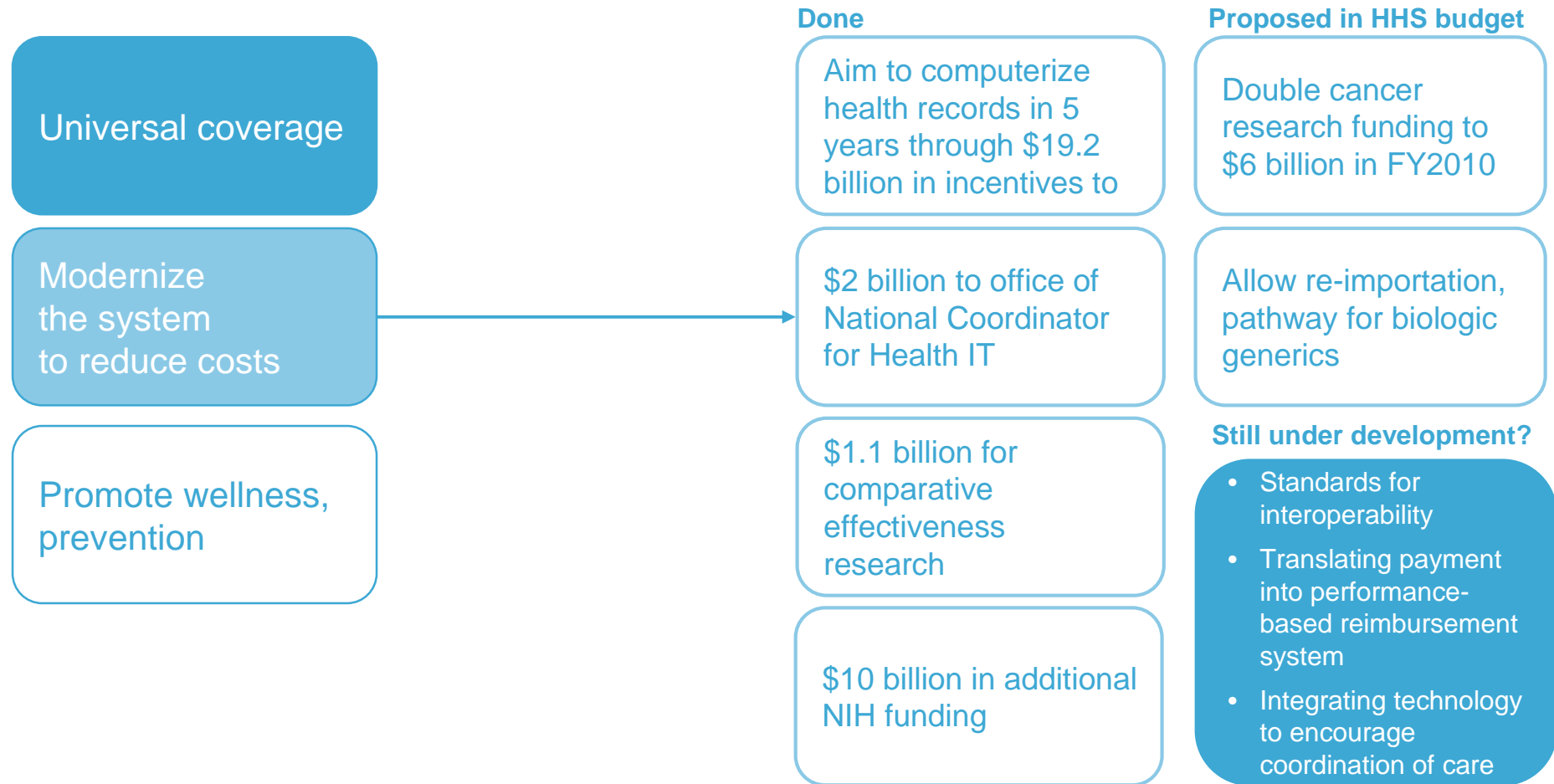
## Universal coverage

# Details of universal coverage are yet to be addressed

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

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

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#### Government starts to pay bonuses in 2011

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- 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.

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#### Penalties begin in 2015

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- 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%.
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## 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

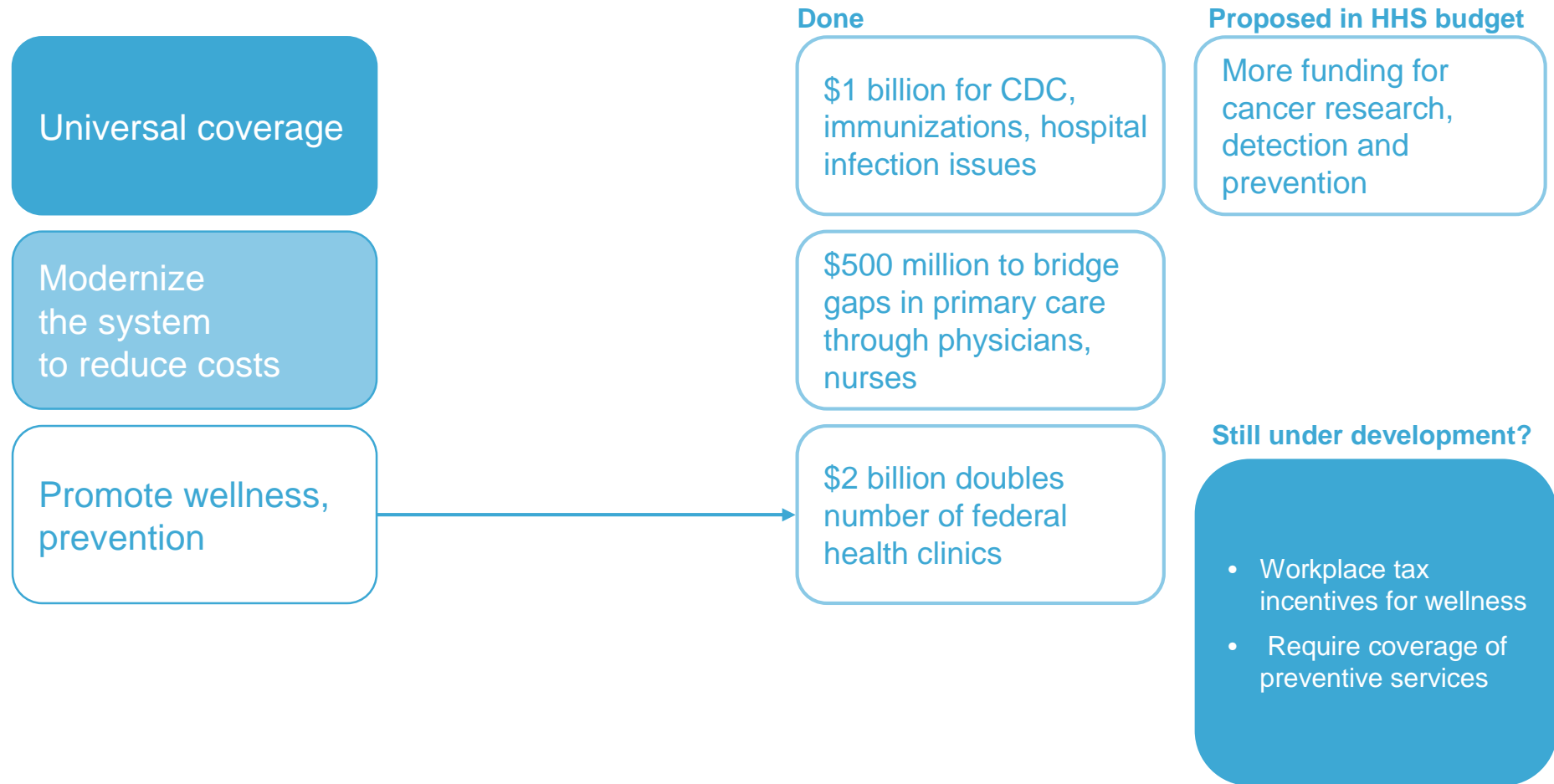
### Cost: \$11.5 billion

#### 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 pharma faces

- Growing patient centricity
- Continued pharma restructuring from a blockbuster to specialty model
- Growing pressure for more regulation over promotion practices and R&D
- Reduced revenues as a result of branded drug conversions to generics
- Increasing demands for value-based pricing and fewer “Me Too” products
- Consumer and payer product influence complicates S&M mission
- Growing influence of government on pricing

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### Positive implications

- More coverage will continue demand for drugs during the downturn
- ...and prompt less need for free drug programs
- Big boost in NIH funding
- Incentives and funding for personalized medicine research could follow

### Negative implications

- Profit erosions resulting from direct Medicare drug price negotiations
- Comparative effectiveness could reduce branded drug revenue
- Increased pressure on branded biologics from a new generic biologic FDA approval process
- Reimportation could put downward price pressure on branded drugs in the U.S. and raise safety concerns

# 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

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### 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

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### 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

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### 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

## For more information

Benjamin Isgur, Director

Health Research Institute, 214-754-5091

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