




Health and Health Care Reform: The Long Journey Forward

Andrew Webber, President and CEO
National Business Coalition on Health

South Carolina Business Group on Health
May 10, 2011



***“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

- Defining Genuine Health Reform
- An Overview of National Health Reform Legislation
- Final Thoughts



National Business Coalition on Health

- **Identity:** National, non-profit membership association of **54** business and health coalitions. Network of **7,000** employers and **30 million** covered lives
- **Vision:** Better health, better care, lower cost, community by community
- **Mission:** Helping member coalitions be leaders in their communities



The Driving Principles of the Coalition Movement:

- All health and health care is **local!**
- Employers are a significant **change agent** in improving health and health care
- There are **limitations** to what a **single employer** can do to drive meaningful, sustainable, change
- Even a small number of **employers working together** can have a **powerful and amplifying effect!**



Defining Genuine Health Reform



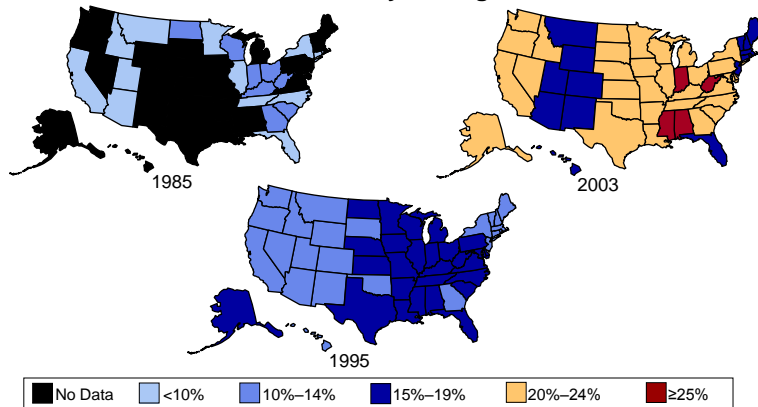
Poor Health:

*Why does the United States
rank 37th in population
health status among
industrial countries?*



US Obesity Epidemic

Prevalence of Obesity Among U.S. Adults



Source: Behavioral Risk Factor Surveillance System, CDC

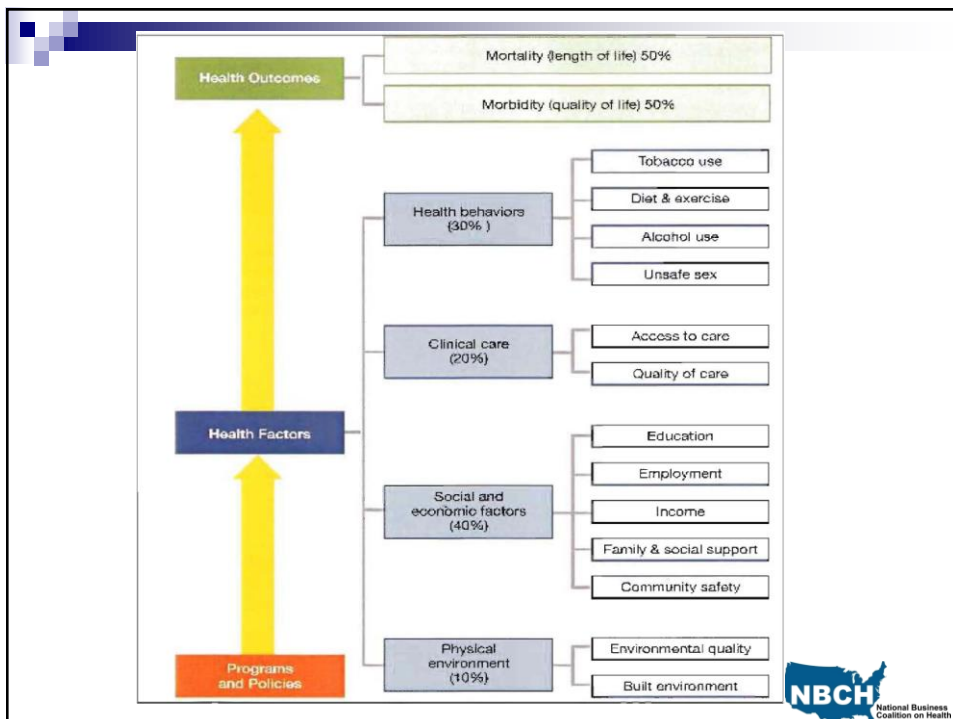


Population Health Improvement

My own epiphany:

*“If our **ultimate goal is improved health**, our **solutions must extend beyond health care** to other critical determinants of health. In the end, **health care is a relatively small influencer of health status.**”*

Are we in the Health or Health Care Business?



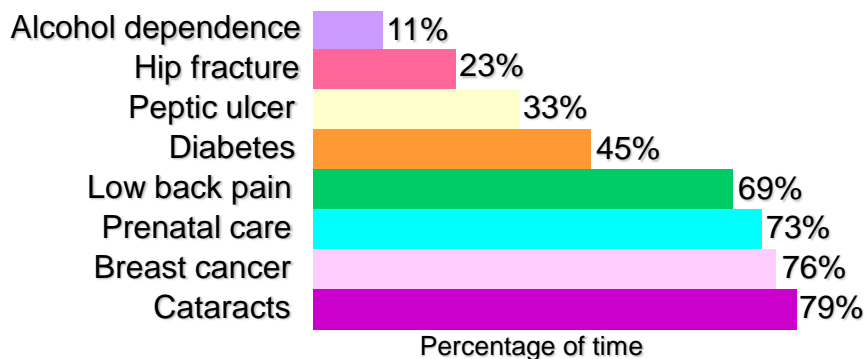
Uneven Health Care:

- **Safety** - Tens of thousands die due to medical errors (IOM, 99)
- **Effectiveness** - 50/50 chance of getting appropriate care (McGlynn, 03)
- **Costs of Poor Quality** – 30% of direct expenditures due to overuse/misuse/waste (Juran & MBGH, 03)
- **Unexplained Medical Practice Variation** - (Wennberg, 1973 - present)
- **Fragmented Care Delivery and Acute Care Focus**
- **Absence of HIT** (Brailer, 05)



Quality

Rand Study: Doctors provide appropriate health care only about half the time



E. McGlynn, S. Asch, J. Adams, et al., The Quality of Health Care Delivered to Adults in the United States, *N Engl J Med*, 2003

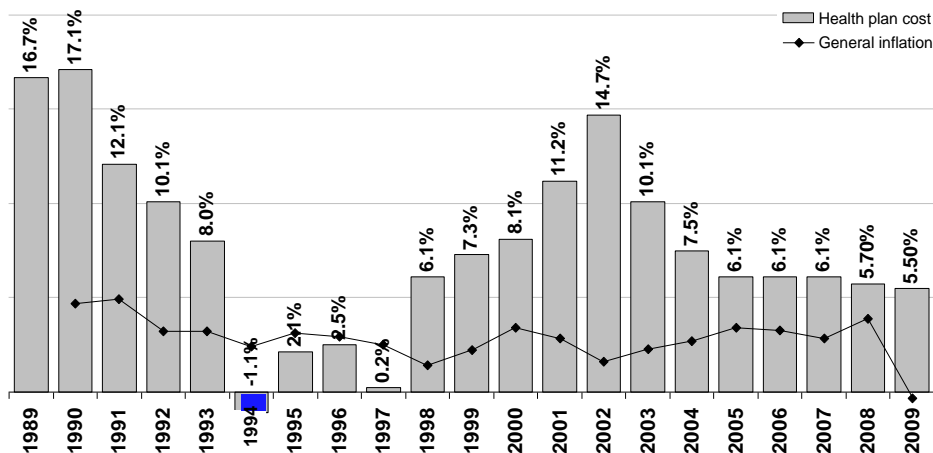


High Costs

*Why does the United States spend **twice** as much per citizen on health care than the next closest country?*



Health Costs Far Exceed General Inflation



SOURCE: Mercer and InflationData.com



So What is Health Reform?

- It can't be simply defined as universal coverage: the Democratic Party's goal since the 1940's.
- Getting everyone access to a still broken delivery system is not genuine reform! Important but insufficient.



Genuine Health Reform is the Triple Aim

Marriage of:
Population Health Improvement
+
Health Care Transformation
=
Cost Containment





An Overview of National Health Reform Legislation



The Three Chapters of Health Reform Legislation

- **Chapter One:** *Health Insurance Regulation, 2010 - 2013*
- **Chapter Two:** *Coverage Expansion, 2014 - Forward*
- **Chapter Three:** *Health and Health Care Delivery Reform, 2011 - Forward*



Quick Word about the Politics of Reform

- **New political landscape:**
 - Republicans control House not Senate
 - Repeal a remote possibility
 - Likely piecemeal changes, oversight hearings, purse string tug-of-war
- **Legal challenge:**
 - constitutionality of individual mandate
 - Supreme Court ruling likely
- **2012 Presidential Election:** in part, a referendum on health care reform legislation



Chapter One Overview

Or why is the Federal Govt looking over my shoulder?

- Host of near-term regulations that apply to health benefit coverage
 - application depends 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+

REPEALED
- 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
- As of January 2011, 5,452 employer applicants accepted and \$535,000,000 expended
- 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 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



State Insurance Exchanges

- Effective 2014, states must establish insurance exchanges or delegate to feds
- 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



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?***



“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**)



Minimum Essential Coverage

- Definition not determined in statute
- Feds to set minimum floor with states having option to expand definition
- If self-insured, may be able to avoid certain benefits and still qualify as MEC
- IOM to make recommendations to DHHS Secretary



Affordability 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



Chapter Two Summary

- Key employer decision point: should I play or pay?
- Economic calculus must be balanced by need to compete for talented labor and commitment to human capital investment as business imperative
- Also whether exchanges prove effective as a viable alternative to employer based coverage
- 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)



Chapter Three (Health Reform) Overview

- Encourages more integrated delivery system models
- Builds a federal infrastructure and investment in measuring health care value
- Directs Medicare to become a value based purchaser
- Establishes major new investment in community based population health improvement
- Creates mechanisms and funding for public/private partnerships



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



Value Based Purchasing

Measuring Value:

- 2010, Patient Centered Outcome Research Institute
- 2011, Measures Application Partnership

Payment Reform:

- October 2011, Independent Payment Advisory Board
- October 2012, Medicare hospital pay for performance
- January 1, 2013, bundled payments for care episodes
- January 1, 2015, physician pay for performance

Seeding VBP Innovation and Partnerships:

- 2011, Center for Medicaid/Medicare Innovation



Partnership for Patients

- April 12th launch of Obama Administration's first major health delivery reform initiative
- With ambitious goals to reduce Hospital Acquired Conditions and Preventable Readmissions
- And asking each stakeholder group to "pledge" support
- The Employer Ask:
 - accelerate hospital performance based payments
 - work with the public sector on standardized measures
 - educate workforce on patient safety



Population Health

- Cabinet Level National Prevention, Health Promotion and Public Health Council
- 2011, \$15 billion Prevention and Public Health Fund
 - Community Transformation Grants to Multi-stakeholder Organizations
- Value Based Insurance Design, (i.e. waiving co-pays for high value clinical preventive services)
- Employee wellness incentives
- Small business wellness grants



Chapter Three Summary

- Represents the **most important chapter** in national health reform legislation
- Commits the federal government to be a **catalyst** for delivery reform through value based purchasing
- Biggest concern: **Medicare acts in silo** with cost shifting consequences for private sector; critical that delivery reform and VBP strategies be harmonized across sectors



Final Thoughts

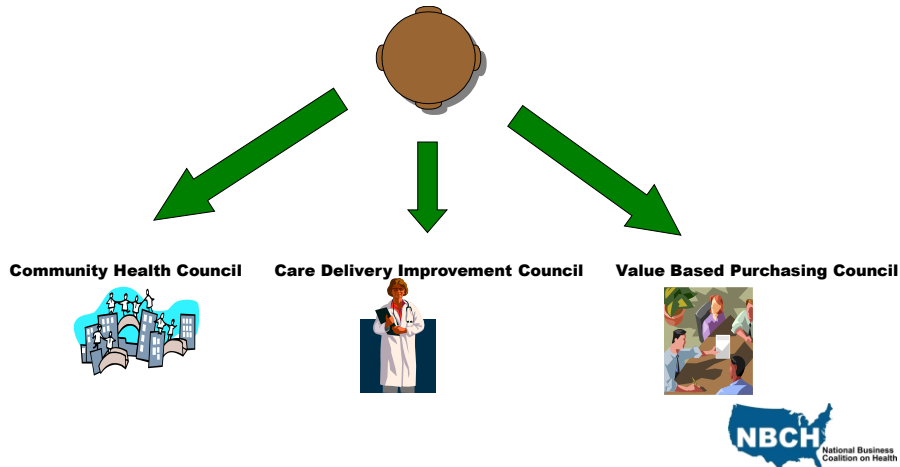


Coalition Health Reform Opportunities

- Policy advocate for employer community, particularly at state level
- Establishing Co-ops on the State Insurance Exchanges
- Applicant for Center for CMS Innovation funding: coordinating all payer/purchaser payment reform strategies
- Applicant for Community Transformation Grants



Community Common Tables For Health and Health Care Reform



Final Thoughts

- Remember that genuine health and health care reform **is all local ..**
- And must be **framed by the Triple aim – better health, better care, lower cost –** as a business and societal imperative
- Don't let national health care reform legislation be a **distraction/excuse**
- Triple aim success will depend on **employer/coalition leadership!**



Contact Information:

Andrew Webber, awebber@nbch.org

www.nbch.org

