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2011 Argyle Deal Making in Healthcare Thought Leadership Spotlight

"Key Federal Health Law Issues"

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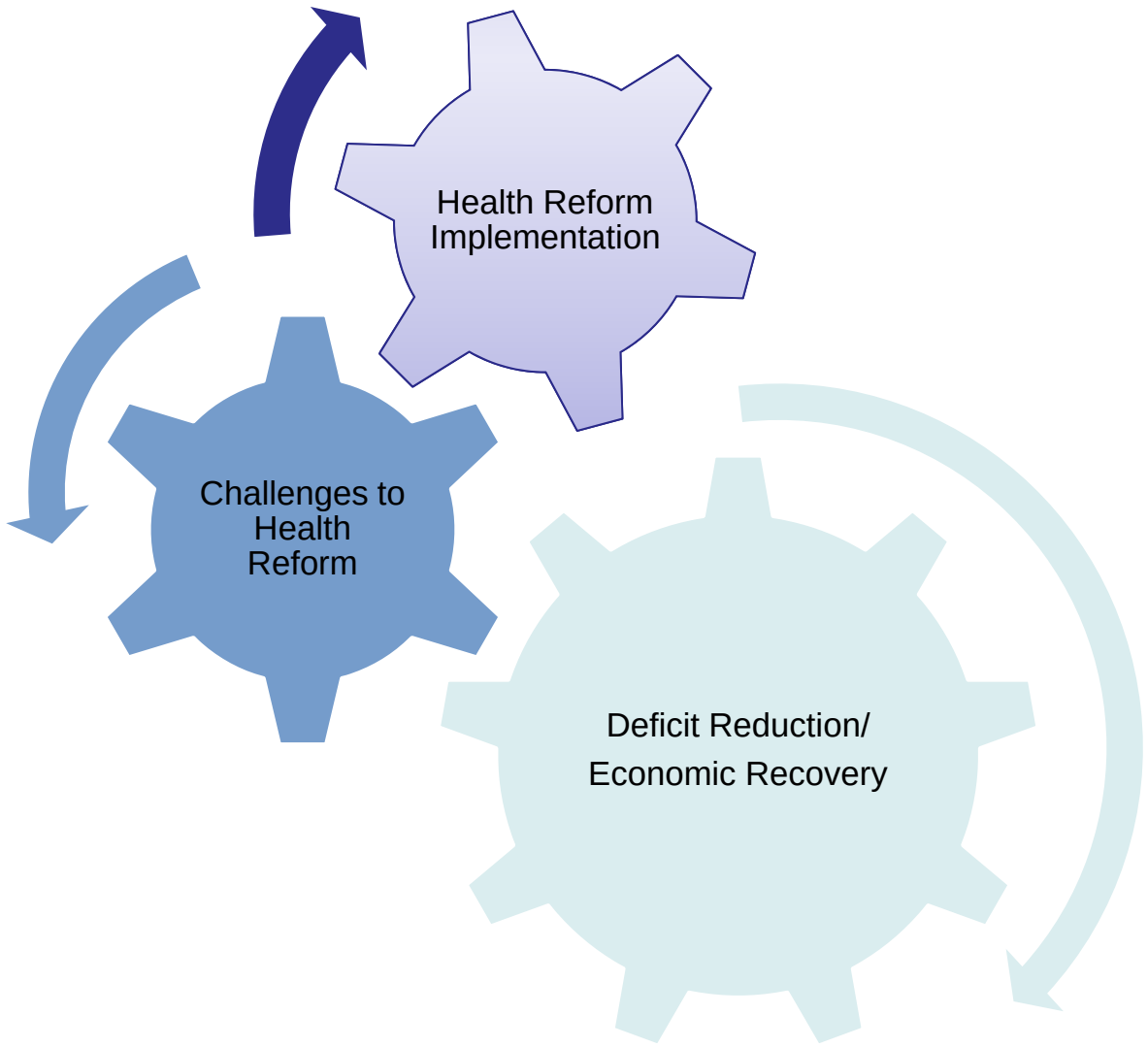
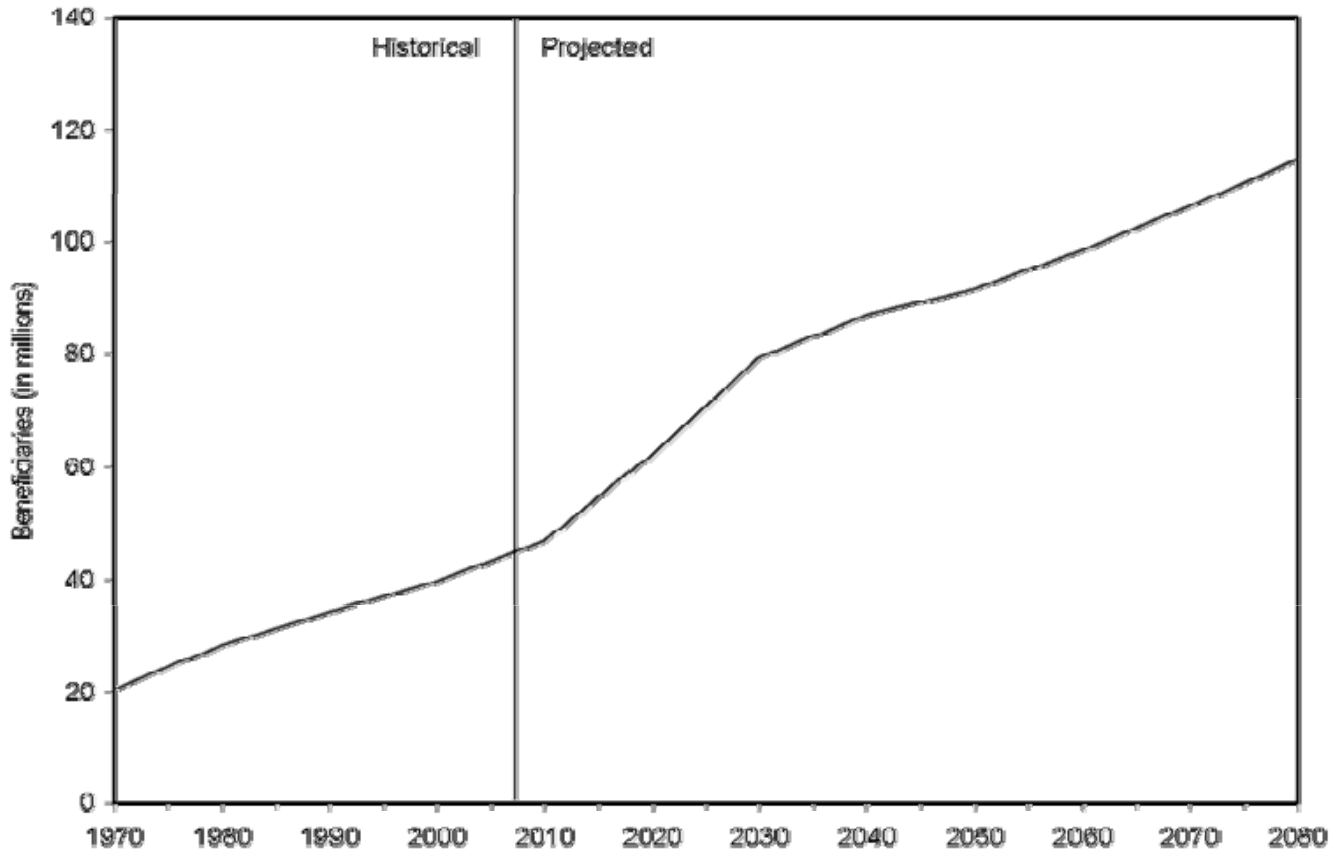
Current Landscape



Challenges to the Federal Health Reform Law

- The Supreme Court will provide the final word on the law's constitutionality
  - The Supreme Court granted certiorari on November 14, 2011 to review the decision of the Eleventh Circuit in *Florida v. The Department of Health and Human Services*
  - Four key issues that the Court will review:
    - Did Congress exceed its enumerated powers by enacting the minimum coverage provision?
    - Did Congress exceed its authority under the spending clause by expanding the Medicaid Program and "coercing" States into accepting onerous conditions that Congress could not impose directly?
    - Is the suit brought by respondents to challenge the minimum coverage provision barred by the Anti-Injunction Act (26 U.S.C. §7421)?
    - Is the minimum coverage provision severable from the remainder of the law?
  - Oral arguments may be in March with a decision expected by June 2012
  - Proposed legislation to amend the Anti-Injunction Act
- Implications for the Presidential Election
- A group of state lawmakers associated with the Progressive States Network are considering state-based legislation to encourage residents to buy insurance
- Some states already ban an individual mandate

Medicare Part A Enrollment Projections



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

Source: CMS, Office of the Actuary, 2009.

Key fact: Former President George W. Bush's birthday: July 6, 1946 and Former President Bill Clinton's birthday: August 19, 1946

Debt Ceiling Legislation – Medicare Sequestration

- On August 2, 2011, President Obama signed into law the new debt ceiling legislation to reduce the deficit and avoid default on the national debt
- The agreement:
  - Cuts $917 billion over 10 years in exchange for increasing the debt limit by $900 billion
  - Established a joint committee of Congress that would produce debt reduction legislation by November 23, 2011 to cut up to $1.5 trillion over the coming 10 years and be passed by December 23, 2011
    - **The joint committee failed**
  - Now Congress can grant a $1.2 trillion increase in the debt ceiling but this would trigger across the board cuts ("sequestration") of spending equally split between defense and non-defense programs
    - Across the board cuts would apply to mandatory and discretionary spending in the years 2013 to 2021
    - Across the board cuts would apply to Medicare, but not to Social Security, Medicaid, civil and military employee pay, or veterans
  - The debt ceiling may be increased an additional $1.5 trillion if either one of the following two conditions are met:
    - A balanced budget amendment is sent to the states
    - The joint committee cuts spending by a greater amount than the requested debt ceiling increase
  - This summary assumes no further laws enacted on these subjects between now and January 1, 2013

Entitlement Reforms under Deficit Reduction

- Common themes for cutting Medicare/Medicaid spending:

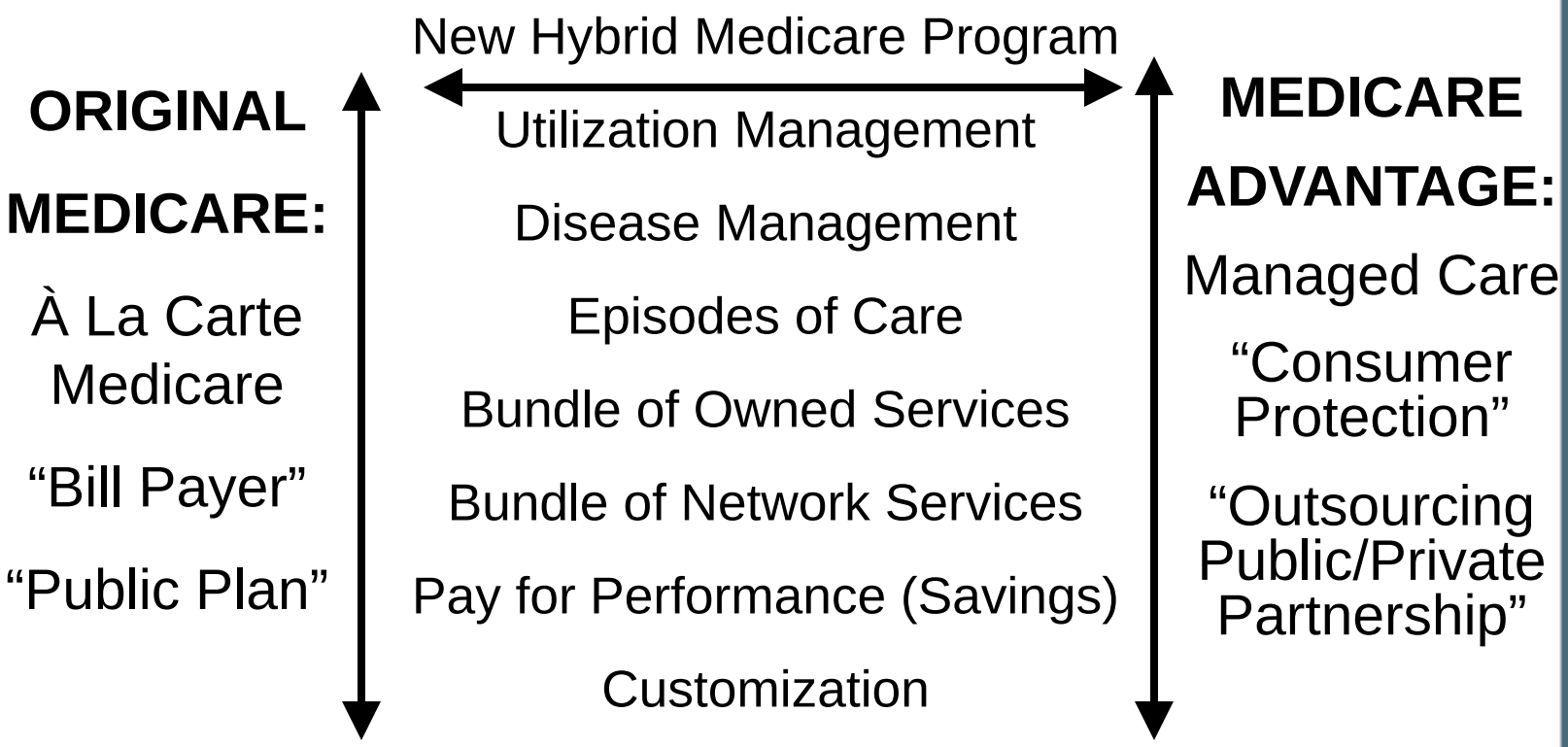
Increase efforts to curb Medicare fraud and abuse	Nursing homes/home health cuts
Raise the Medicare eligibility age	Premium support pilot program
Restructure Medicare benefits	Medicaid block grants
New rules for Medigap plans	Medicaid “blended” matching rate
Raise Medicare Part B premiums	Drug rebates for Medicare-Medicaid “dual eligibles”
Cut hospital payments for bad debts	Repeal the CLASS Act

- Various Proposals:
  - The President’s Plan for Economic Growth and Deficit Reduction (Sept. 2011)
  - Bi Partisan Commissions (Rivlin-Domenici Plan, Nov. 2010; Bowles-Simpson Plan, December 2010)
  - Ryan Medicare Proposal (Nov. 2010)

Medicare Reforms in PPACA

- Payment “Reforms” are Medicare reductions to hospitals and physicians on fee-for-service covered benefits
- Delivery “Reforms” are Medicare payments to hospitals and physicians to reward:
  - Population Health Management
  - Improved Quality/Outcomes
  - Integrated/Coordinated Care
  - Efficiencies

Themes for the new Medicare Programs



Medicare *“as we know it”*

New Medicare Patient Care Models

- PPACA includes a number of provisions that allow for testing of Medicare payment mechanisms that may increase coordination of care, improve quality, and reduce costs
  - Examples include:
    - Accountable care organizations
    - Payment bundling during an episode of care
    - Patient-centered medical homes
    - Value-based purchasing programs
- See EBG Client Alert; Health Reform: Health Care Innovation in the Medicare Program: Value-Based Initiatives Beyond Accountable Care Organizations, November 3, 2011

CMS Timeline for Payment Initiatives – Medicare Menu – Who is Monitoring these Initiatives?

- **Center for Medicare Initiatives**
  - Medicare Shared Savings Program – starting January 2012
  - Community-Based Care Transitions Program (Partnership for Patients) – starting second quarter 2011
- **Center for Medicare & Medicaid Innovation Initiatives**
  - Hospital Engagement Contractors (Partnership for Patients) – starting October 2011
  - Innovation Advisors Program – starting December 2011
    - **Applications due: November 15, 2011**
  - Pioneer ACO Model – starting fourth quarter 2011
  - Advance Payment ACO Model – starting January 2012
  - Bundled Payments for Care Improvement – starting first and second quarter 2012 (depending on model)
    - **Letters of Intent due: October 6 or November 4, 2011** (depending on model)
    - **Applications due: November 18, 2011 or March 15, 2012** (depending on model)
  - Comprehensive Primary Care Initiative starting second quarter 2012
    - **Letter of Intent due: November 15, 2011**
    - **Applications due: January 17, 2012**

Dual Eligibles

- We spend approximately $300 billion* annually in Medicare and Medicaid payments for the 9.2 million dual eligibles (as of 2008)
- These expenditures are approaching half of all Medicaid expenditures and a quarter of all Medicare outlays annually
- 80% of the dual eligibles are in uncoordinated fee-for-service systems
- 15% of total Medicaid beneficiaries, but 39% of Medicaid spending in 2007
- 16% of total Medicare beneficiaries, but 27% of Medicare spending in 2006
- *See* Center for Medicare & Medicaid Innovation, State Demonstrations to Integrate Care for Dual Eligible Individuals, *available at* http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/state-demonstrations-to-integrate-care-for-dual-eligible-individuals/

The New Insureds

Among 284 million people under age 65

- By 2020 under PPACA
  - 24 million in private plans through the Exchanges
  - 52 million Medicaid (instead of 36 million now)
  - 23 million still uninsured
  - 23 million “other” or “nongroup”
  - 162 million still in Employer sponsored health benefit plans (per CBO, March 2011)
- What will be the provider’s allowable charge in the products offered through the exchanges?

Where are the Uninsured?

By State 2009

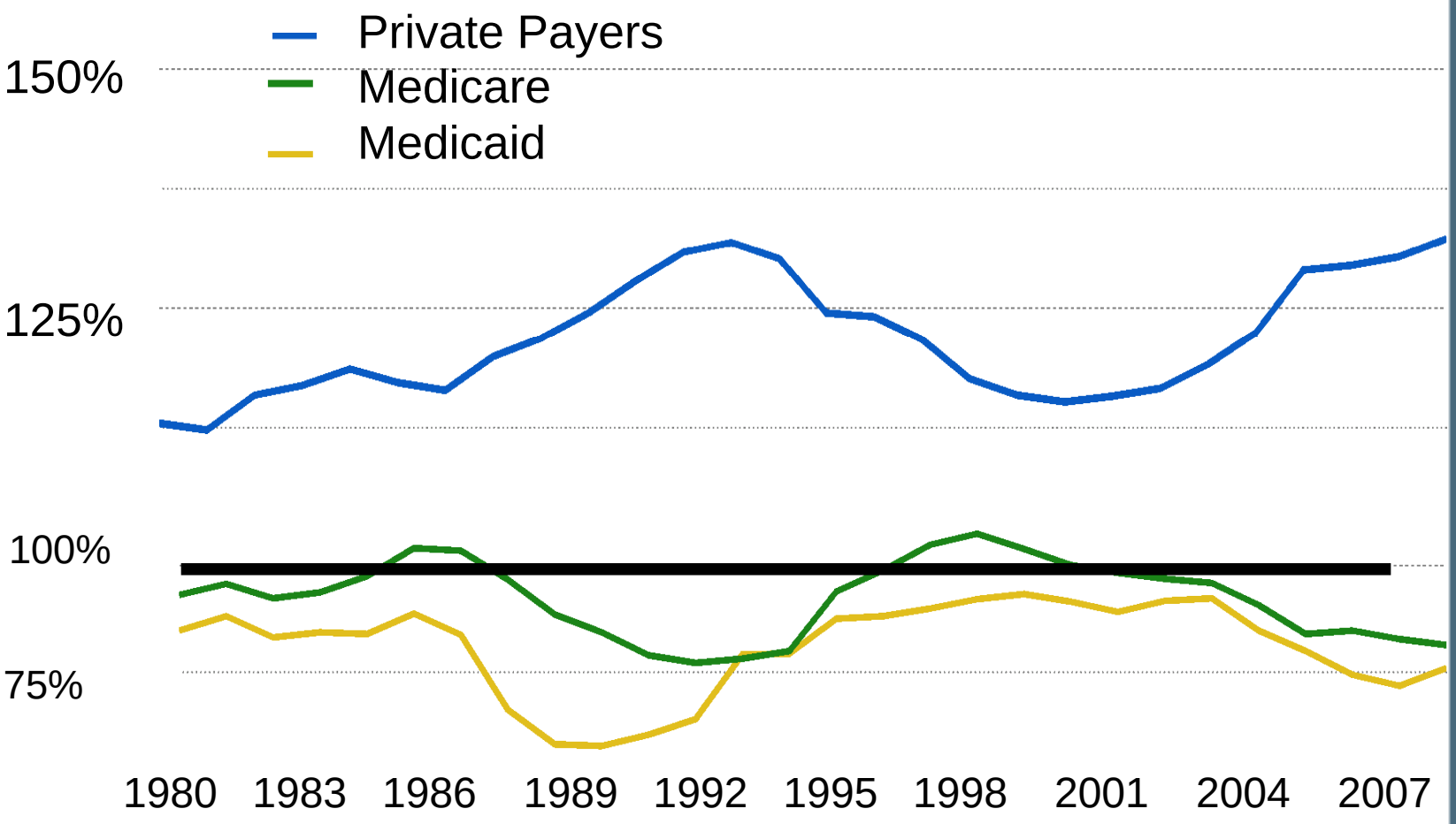
Total Non-Elderly Uninsured: 49.9 million

Almost 50% of the Uninsured

California	7.0 million
Texas	6.2 million
Florida	3.8 million
New York	2.7 million
Georgia	1.8 million
Illinois	1.7 million

Source: Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of Nonelderly 0-64, states (2008-2009), U.S. (2009), *available at* http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=126&cat=3&sub=39.

Focus on a New Payer Mix: Community Hospital Payment-to-Cost Ratios, by Source of Revenue, 1980-2007



Note: Payment-to-cost ratios show the degree to which payments from each payer cover the costs of treating its patients. They cannot be used to compare payment levels across payers, however, because the service mix and intensity vary. Data are for community hospitals. Medicaid includes Medicaid Disproportionate Share payments.

Source: American Hospital Association and Avalere Health, Avalere Health analysis of 2007 American Hospital Association Annual Survey data, for community hospitals, Trendwatch Chartbook 2009, Trends Affecting Hospitals and Health Systems, Table 4.4, p. A-35, at http://www.aha.org/aha/trendwatch/chartbook/2009/appendix4.pdf.

Challenges for Private Payers Limit Provider Cost-Shifting

- Pricing pressures on payers and providers are built into federal health reform of the private health insurance market
  - Unreasonable Premium Review
    - 10% threshold for now
    - See EBG National Health Insurance Rate Review Scorecard, available at http://www.ebglaw.com/scorecard.aspx
  - Medical Loss Ratios
  - New Coverage Obligations
    - No annual or lifetime limits; no pre-existing condition exclusions; adult dependent coverage; coverage of preventive health services
    - Essential Health Benefits?
  - "Cadillac Tax"
    - Excise tax on insurers of 40% of the value of plans that exceed $10,200 for individual coverage and $27,500 for family coverage beginning Jan. 1, 2018
      - Threshold values indexed to the consumer price index for urban consumers (CPI-U) beginning in 2020
      - Boeing example: shifting costs to employees because of "cost pressure" from excise tax

Potential Provider Partnering Opportunities with Private Payers

- AHIP: Innovations in Recognizing and Rewarding Quality
  - March 2009 Report *available at* http://www.ahip.org/content/default.aspx?docid=26393

- BCBS, Building Tomorrow's Healthcare System: The Pathway to High-Quality, Affordable Care in America (Oct. 2011), *available at* http://www.blueadvocacy.org/plans

Health Care Fraud Enforcement Update

- Growing, a source of deficit reduction
- More matters based upon analytics
- Personal liability is increasing
- Kickbacks are now false claims
- "Reverse false claims" liability expanded to include the ongoing possession of a government overpayment where there is an "obligation" to repay
- Self-policing through effective compliance programs is essential for any company that submits data to CMS
- 4th Edition: Answering the Call: The Duties, Risks and Rewards of Corporate Governance, see www.wbl.org

What Can Make a Difference for All Health Care Costs?

- Shifts in the health status of the population
- Changes in the way health services are delivered
- Payment methods that bundle payments; pay for efficiencies or “savings”; aggregate payments
- Malpractice reform
- Changes in consumer engagement and consumer preferences (e.g., end-of-life services)

What Can Make a Difference for All Health Care Costs?

- Advances in medical technology (disruption and adoption)
- Advances in timely access to quality and cost data of patient services
- Transparency/individual responsibility
- Health care workforce
- Political/fiscal discipline

What is on the Immediate Horizon?

- Essential Health Benefits
  - HHS has said that it will seek public input on the development of the essential health benefits through listening sessions
  - It is not clear when HHS will issue a list of essential health benefits, but the IOM recommended that such a list be developed by May 1, 2012
  - Plans in the Health Insurance Exchanges, which must offer the essential health benefits package, will be available starting January 1, 2014
- "Extenders" Legislation
  - Three areas where legislation is needed:
    - Extension of the SGR fix
      - Physician payments will be cut 27.4% on January 1, 2012 unless Congress acts
      - CBO recently estimated that the cost of fixing the SGR formula for two years would be $38.6 billion
    - Extension of unemployment insurance
    - Extension and expansion of the "payroll tax holiday"

Appendix

- Enterprise Risk Assessment Facilitates Fiduciary Decision Making
- The Top Ten Questions Management Should Address to its Board for New Medicare Payment Options (e.g., ACOs)

Enterprise Risk Assessment Facilitates Fiduciary Decision-Making

What are the High Risk Areas? What Risk Mitigation Exists? How has the CMS Contracting Organization, such as an ACO, prepared for these High Risk Areas?

– Top Ten Questions management should address to its boards:

1. What are the marketplace risks for establishing the ACO as it relates to current patient demand patterns?
2. What are the vehicles under consideration for protecting the ACO and its sponsors from liability for shared losses? (*e.g.*, reinsurance, escrow, surety bonds, lines of credit, key terms in the ACO participant agreements)
3. What is the governance structure of the ACO as the CMS contracting organization and how does that structure affect the sponsors' commitments for capital and compensation related matters?
4. What is the ACO's capabilities and plans for reporting and satisfying the 33 quality measures in the four quality domains since these outcomes will now have significant financial consequences?
5. What are the processes in place to assure that anything submitted to CMS in the context of the ACO program is "accurate, complete, and truthful" and is recorded in a chron file so that there is institutional memory? For example, what processes are in place for the legal representative of the ACO to be capable of giving CMS the certifications required regarding the eligibility requirements? Does the ACO have the necessary back- up documentation?
   – Some of this data may be displayed by CMS to the public under the transparency provisions

Enterprise Risk Assessment Facilitates Fiduciary Decision-Making (cont.)

What are the High Risk Areas? What Risk Mitigation Exists? How has the CMS Contracting Organization, such as an ACO, prepared for these High Risk Areas?

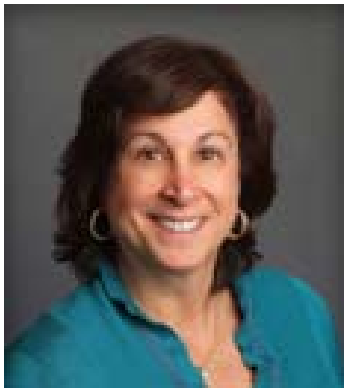
– Top Ten Questions management should address to its boards (cont.):

6. What will be the ACO's conflict of interest policy? Who will be the decision-maker in this regard?
7. What is the compliance plan for making sure that the plan for developing and executing the ACO is in legal compliance with the key areas of antitrust, fraud and abuse, and tax exempt issues, among other legal issues? How does that compliance plan fit into the broader corporate compliance program for the affiliates of the ACO?
8. What is the compliance plan for protecting the personal health information of the ACO patients when there is going to be so much sharing of this data across independent organizations? Is the ACO prepared for the contractual obligations that arise under a data utilization agreement with CMS – which is required under the ACO program?
9. What remedial processes and penalties will be in place to apply if an ACO provider/supplier fails to comply with or fails to implement the desired ACO processes? Who will be the decision-maker in this regard?
10. What are the data assumptions in the proposed benchmarks and what are the patient/provider changes that are expected to make a difference in achieving the savings? What is the ACO's likelihood of success in this regard?

EBG Alerts

- Visit the www.ebglaw.com website for the various alerts we have published on a wide range of issues related to health reform and the Medicare program

Q's & A's



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