Deloitte Center for Health Solutions

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Monday memo
Health reform update

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Update: Reasonableness of premiums provisions for health insurance plans, National Association of Insurance Commissioners (NAIC)-Health and Human Services (HHS) deliberations

Section 2718 of Patient Protection and Affordable Care Act (PPACA) requires that by December 31, 2010, uniform definitions for “medical loss ratio” be determined. It leaves primary responsibility for premium approvals with the states, but requires insurance companies that propose "unreasonable" rate increases to file a disclosure form (being developed by the NAIC) justifying the request. The disclosure is accessible to the public along with state and federal officials to evaluate the premium request with underlying medical costs. It also sets aside $250 million in grants to states to improve their premium review processes. Note: the devil is in the detail. While underlying medical costs (units of service and volume of service X price/unit) might be a baseline for evaluation, insurance company costs associated with the new federal laws (example: pre-existing
conditions, rate bands, preventive health), mandated reserve requirements, state compliance issues and other factors complicate matters. Consumer advocacy groups have weighed in recently suggesting reasonableness be tied to medical inflation with a premium request of 10 percent or more, or one that exceeds 150 percent of the medical inflation index triggering the disclosure process. The American Medical Association (AMA) and Congress have called for detailed information in the disclosure sufficient to see specific categories of medical expense and along with various line items like marketing costs, executive compensation, brokers’ fees, lobbying activity and others. NAIC hopes to finalize the disclosure process and form within two months.

White House report: PPACA will extend the life of Medicare for 12 years to 2029
Monday, the White House released its report of PPACA’s impact on Medicare. Key data in the report:
- Medicare spending will decrease from 6.8 percent/year in 2010 to 5.3 percent/year in 2019
- Monthly premiums for enrollees will decrease $200 by 2018
- Savings of $7.8 billion will be seen before 2011–$5.3 billion taken from Medicare Advantage (Part C) cuts

Senate approves Federal Medical Assistance Percentage (FMAP) extension; $16.1 billion for state Medicaid
Late last week, the Senate approved a cloture motion extending the FMAP formula for state Medicaid payments an additional six months—until June 30, 2011. The provision will cost $16.1 billion. Note: In the stimulus bill (American Recovery and Reinvestment Act–ARRA), states were given $87 billion to shore up losses from Medicaid through December 31, 2010. In PPACA, states are set to receive $434 billion (2014-2019) for coverage of up to 16 million “new eligibles” per Section 2001. The six-month extension would help states manage Medicaid shortfalls for the balance of FY2011. The extension next goes to the House. Note: the National Association of State Budget Directors released data indicating most states are in fiscal distress due to decreased revenues and ongoing spending obligations. For most states, the fiscal year started July 1. This year, 42 cut payrolls, 41 reduced Medicaid funding, and 22 raised business excise and/or sales taxes.

Business reporting requirement in PPACA focus of revision
Section 9006 of PPACA is a requirement that businesses must file 1099 forms for every supplier/vendor/company with whom they spent $600 or more for goods/services for tax years starting after 2012. Lawmakers in both parties are leaning toward modifying or repealing this section due to the paperwork burden it adds to business. Importantly, these lawmakers have offered business tax increases to offset the cost of proposed changes. The Joint Commission on Taxation (JCT) currently estimates that full repeal of this rule would reduce revenue by $19.2 billion. Stay tuned—could be the first legislation passed that corrects a perceived problem in the PPACA as well as an action that established the budget ground rules for modifying the PPACA.
HHS awards grants for preventive medicine residency program expansion
Last week, HHS’s Health Resources and Services Administration (HRSA) awarded 15 grants ($9 million) for 56 new residency slots in preventive medicine. $6.65 million came from the American Recovery and Reinvestment Act of 2009 stimulus law; the balance from PPACA.

Bundled payments, value-based purchasing for dialysis: Update
End state renal disease (ESRD) is a $9 billion/year expenditure to the federal government. Next year, the Centers for Medicare & Medicaid Services (CMS) will pay a single, bundled payment for outpatient dialysis treatment, supplies, clinical lab tests, and certain drugs (some oral drugs added in 2014) (Section 2704). In 2012, CMS will start a value-based purchasing system linking ESRD payments to three quality and efficiency measures.

Update: Individual mandate challenges in Virginia, Missouri
Monday, Virginia federal judge Henry Hudson ruled that the state’s challenge to the PPACA individual mandate may proceed. The original suit was filed by Virginia Attorney General Ken Cuccinelli challenging the constitutionality of the mandate as a violation of the Commerce Clause of the Constitution (Article 10). The 32-page opinion by Judge Hudson ruled that “the guiding precedent [on the Commerce Clause] is informative but inconclusive…the court is not persuaded that the Secretary has demonstrated a failure to state a cause of action with respect to the Commerce Clause element… Neither the Supreme Court nor any court of appeals has squarely addressed this issue. No reported case from any appellate court has extended the commerce clause or tax clause to include the regulation of a person’s decision not to purchase a product, notwithstanding its effect on interstate commerce”.

Reacting on behalf of the government, Justice Department spokesperson Tracy Schmaler called the ruling a procedural decision and affirmed the constitutionality of the individual mandate. “We believe there is clear and well-established legal precedent that Congress acted within its constitutional authority. We are confident that the health care reform statute is constitutional and that we will ultimately prevail.” Meanwhile, Missouri became the first state to vote against the individual mandate in a referendum with 71 percent of voters opposed.

Note: Challenges to the individual mandate are active in 20 states, with at least six planning referenda on its constitutionality. The Virginia case is scheduled to be heard in court October 18. The arguments will center on the Commerce Clause in the Constitution (Article 1, Section 8, Clause 3) that addresses the supremacy of federal laws in matters of commerce. This clause has been used to defend federal oversight of wheat and marijuana production, and gun possession, among others. The states will likely argue that states’ rights are usurped in PPACA’s individual mandate provision and the mandatory purchase of health insurance violates individual freedoms guaranteed in the Constitution. The Department of Justice will argue health insurance is a matter of interstate commerce necessary to protect insurance markets and regulate how Americans buy insurance. The likelihood the issue might end up in the Supreme Court is high.
Study of anesthesia coverage by Certified Registered Nurse Anesthetists (CRNAs) illustrates scope of practice policy changes

CRNAs’ quality of work without physician supervision is comparable to physician performance based on a retrospective study of 481,440 hospitalizations comparing three coverage scenarios: Coverage by a CRNA working with no supervision, by anesthesiologists working alone and by both working in a team. Note: Medicare pays less for anesthesia coverage by CRNAs; CRNA coverage is allowed in 14 states. (Source: Research Triangle Institute)

Physician-owned hospital dates of compliance clarified; attention to physician ownership, conflicts of interest prominent in PPACA

In PPACA, five sections address physician ownership/conflict of interest issues:

1. Sec. 6001: Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals
2. Sec. 6002: Transparency of physician ownership and investment interests
3. Sec. 6003: Disclosure of in-office ancillary exception to physician self-referral on imaging
4. Sec. 6004: Prescription drug sample transparency
5. Sec. 6005: Pharmacy benefit managers transparency requirements

Last week, HHS proposed dates for compliance with physician owned hospitals stipulations for comment through August 31, 2010:

- Physician ownership must have been in place on or before March 23, 2010 to be subject to the provisions;
- The physician-owned hospital must have a Medicare provider agreement on or before December 31, 2010;
- All compliance provisions relative to investments, ownership, disclosures, and operation of the physician-owned hospital apply after September 23, 2011.

For the 262 physician-owned hospitals, and for hospitals joint venturing with physicians in stand-alone hospitals, the new PPACA rules are challenging. Three examples:

1. **Change of ownership:** Among the more challenging compliance issues will be prohibition of a change of physician ownership: section 6001 stipulates that the ownership structure (and the physician’s ownership percent) cannot change from what was in place March 23, 2010. Thus, a particular class of stock in the ownership pool would have to be permanently traded only among physician investors precluding a hospital/third-party investment in the class.

2. **Expansion:** Section 6001 sets baselines for hospitals’ operating rooms, procedures rooms and bed capacity at March 23, 2010 for those already operating and December 31, 2010 for those in development without a Medicare provider agreement. After these dates, the law stipulates the physician-owned hospital may not expand (regardless of state laws or Certificate of Need applications).

3. **Disclosures:** For physician-owned hospitals and imaging facilities owned by physicians, disclosure requirements include written notification to patients that the physician is a beneficial owner of the hospital in advance of admission for inpatient/outpatient care, and in the case of the physician-owned hospitals, a patient must consent that treatments/services they get from providers other than the referring physician are approved.

Note: These sections make clear the intent of the law to increase regulation of
physician ownership and conflicts of interest. Other sections increase physician reporting and transparency activities (Sections 3001, 3002, 3003 and 10331), expand scope of practice for allied health professionals and mid-level practitioners (Sections 3108, 3114), create the Independent Payment Advisory Board (IPAB) to set payment rates (Section 3403), and sets up the Patient Centered Outcome Research Institute (PCORI) to establish evidence-based standards for care (Section 6301). In Section 3022, the bill allows “physician groups, hospitals, nurse practitioners and physician assistants, and others” to operate as Accountable Care Organizations (ACOs) starting January 1, 2012, so conceivably physicians might operate ACOs independently. PPACA does not include a permanent fix to the contentious physician pay formula (sustainable growth rate) and liability reform—the American Medical Association’s two top lobbying goals as the health reform process began in early 2009. Therefore, physician discontent will likely accelerate into the 2010 election cycle, potentially creating challenges and opportunities for plans and hospitals seeking strategic collaboration, investors seeking innovative models of delivery and life science companies seeking adoption of emergent diagnostics and therapeutics.

Food and Drug Administration (FDA) proposes increased regulation of Class II devices
Last week, the FDA proposed tighter restrictions for device approvals covered under the 510(k) process—a fast-track approval procedure for devices that prove they are similar to a device already in the market. The agency’s focus will be to define new parameters for determining when a “predicate” device may be used as the benchmark for 510(k) approval. It also announced proposed changes to regulation of Class II devices (i.e. drug infusion pumps and other devices that carry a moderate safety risk) requiring additional information about clinical and manufacturing processes (ex. design schematics available on a public website) to establish their equivalence to predicate Class II devices. Note: the Advanced Medical Technology Association’s responded that these changes will be challenging to their companies and might make it easier for foreign competitors to compete in the U.S. market.

Employer deadlines approaching

Quotable
“1965. A lot of good things came out that year like Medicare. This year like always, we’ll have our guaranteed benefits and with the new health care law, more good things are coming like free check-ups, lower prescription costs and better ways to protect us and Medicare from fraud. See what else is new. I think you’re going to like it.” – Source: New CMS television advertisement commemorating the 45th anniversary of Medicare, featuring Andy Griffith
“Seniors were the target of a major misinformation campaign that was designed to scare and confuse older Americans about the real impact of reform. We are committed to correcting the record and ensuring seniors have the information they need and get the high quality care they have earned and deserve.” – Source: Stephanie Cutter, Special Assistant to White House Office of Communication responding to criticism of television advertisement

“…putting Medicare and Medicaid recipients in private insurance plans that could cost the government less but potentially offer fewer benefits; gradually raising the retirement age to 70; and reducing future Social Security benefits for wealthy retirees.” – Source: Representative Paul Ryan, R-WI

“Government programs aimed at reducing obesity have had limited success. They emphasize educating people in the dangers of obesity and in means of avoiding it. But knowledge of proper diet and the importance of exercise has risen together with weight, indicating lack of knowledge is not the major cause of obesity—it’s lack of strong enough incentives. The private market offers an abundance of weight management programs, but their long-term effects on weight are small and public programs are unlikely to do better…medical innovation may be the most promising solution…and here the government may serve a useful role by subsidizing basic research.” – Source: “Fat New World”, Thomas J. Philipson and Richard A. Posner, Wall Street Journal, August 1, 2010

“Absent a waiver, I believe that the federal standard may disrupt our individual health insurance market.” – Source: Commissioner, Maine Department of Insurance, Mila Kofman who is seeking a waiver from HHS from provisions of PPACA requiring health insurance plans to spend 80 percent of individual premiums on medical care

“Recently enacted health reform legislation will have mostly positive effects on large employers, as millions more Americans gain access to affordable insurance and, potentially, primary care. But the law will impose new administrative burdens and financing costs on employers, while raising concerns about provisions that could allow their lower-wage employees to obtain coverage through insurance exchanges. Given the need to restrain the rate of growth of health spending, the private sector, especially large employers, must collaborate with the public sector to drive delivery system reform.” – Source: Helen Darling, “Health Care Reform: Perspectives From Large Employers”, Health Affairs, June 2010

Fact file
- Physician income: In 2009, 76 percent of all specialties saw an average 3.4 percent increase in compensation—3.8 percent for primary care, 2.4 percent for medical specialists, 3.8 percent for surgical specialists. The biggest increases were pulmonary disease 10.37 percent, dermatology 7 percent, urology 6.36 percent, family medicine 5.67 percent, hypertension and nephrology 5.54 percent, and cardiac and thoracic surgery 5.12 percent. (Source: American Medical Group Association’s (AMGA) 2010 Medical Group Compensation and Financial Survey)
- Open seats in November election cycles: 24 of 37 gubernatorial, 42 of 435 House races and 14 of 35 Senate. (Source: Politico)
- Prison health population: Of 2.4 million incarcerated, 200,000 are older than 50. Costs per inmate range from $18K-$50K per year. (Source: Economist)
- Obesity update: Incidence by ethnicity—35 percent of African Americans are
obese, 29 percent of Hispanics, 24 percent of Caucasians. Impact—healthy
days lost/year due to obesity doubled in the past two decades from 7.5 in 1993
to 17 in 2008. 50 percent higher among African American females primarily
lost work time, and 31 percent higher for African American males primarily
in early death. (Source: CDC report released Tuesday)

- Estimates of new offices, agencies, boards range widely; for example, the
  Center for Health Transformation estimates 159 new offices, agencies and
  programs created by PPACA while the Joint Economic Committee estimates
  47. (Sources: Center for Health Transformation and Joint Economic
  Committee)

- DNA testing industry: $58.8 billion (2009)—60 percent done by hospitals, 35
  percent by independent operators, and 4 percent in physician offices. (Source:

- One-third of Americans are obese; there are three drugs in the FDA approval
  pipeline to treat it: Onexa (Vivus), Lorcaserin (Arena), Contrave (Orexigen).
  (Source: FDA)

- 55 percent of drug and 50 percent of biologic clinical trial sites are offshore; 80
  percent of FDA approved drugs/biologics contained foreign subjects in trial
  data. (Source: Association for Clinical Research Organizations)

- Physician Consortium for Performance Improvement, comprised of 170
  medical societies and quality improvement agencies plus consumer and
  purchaser advisory panels, has produced 270 measures including 90
  measures endorsed by the National Quality Forum. (Source: American Medical
  Association)

- Consumer spending update for June 2010: Unchanged from May. Personal
  savings increased slightly to a 6.4 percent rate from 6.3 percent and 6.0
  percent in April; incomes were flat. (Source: Tuesday report from U.S.
  Department of Commerce)

- One in three American adults has high blood pressure—above 140/90—
  including more than half of those over 55. Having high blood pressure puts a
  person at greater risk for stroke, heart attack, and kidney disease. Cost—$75
  billion annually. (Source: American Heart Journal study of 35,000 patients,
  Centers for Disease Control and Prevention)

- Seven hours of sleep per day is ideal to reduce risk of cardiovascular disease
  per study. Sleeping fewer than five doubles risk; sleeping nine or more
  increased risk 50 percent. (Source: University of Pennsylvania study of 142
  adults published in Sleep, August 1, 2010)

- Insurance premium forecast: 9-11 percent increase expected for 2011. The
  survey data concluded a 9 percent increase likely for HMO coverage and 11
  percent for PPO. (Source: Milliman Health Insurance Survey released
  Monday)

National health reform: What now?
National health reform is here. The health reform bills (HR3590 and
HR4872) are now law and will trigger sweeping changes and
disruptions – some rather quickly and some over many years. The
industry is asking, “What now?” At Deloitte, we continue to explore
and debate the key questions facing the industry, and we look forward to helping our clients find and implement the right answers for their organizations. To learn more, visit www.deloitte.com/us/healthreform/whatnow today.

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