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Weekly insights from the Health Research Institute pwc.com/hri

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Week of 2/3/2014

This week's regulatory and legislative news:

- **Framework to repeal SGR formula reached, but 'pay-fors' still a challenge**
- **Arkansas Medicaid private option in jeopardy**
- **Risk corridor program faces legislative challenges**
- **Further delay of Medicare "two-midnight" rule could complicate workflow**
- **Final rule allows patients direct access to labs, clears way for new apps**
- **HRI on insurance premiums: Comparing employer and exchange rates**

Framework to repeal SGR formula reached, but 'pay-fors' still a challenge

Congressional lawmakers agreed to a legislative framework that would replace Medicare's current physician payment formula with one that rewards providers based on the quality of care they deliver and their willingness to adopt new payment models. Lawmakers, however, have yet to determine how they will pay for the package, which officially repeals the sustainable growth rate (SGR) formula in place since 2003. If left unchanged, doctors would see a 24% reduction in Medicare payment this year. Under the proposal, physicians would receive a 0.5% pay increase over five years while they transition to a new payment system, according to details circulated to physician groups on Thursday. But other increases are baked into the proposal. Physicians who receive a significant portion of their revenue from a so-called "alternative payment model," or a patient-centered medical home, are eligible for a 5% bonus. And overall, physicians who participate must receive 25% of their Medicare revenue through an alternative payment model in 2018. The revenue threshold will increase over time.

HRI impact analysis: The Congressional Budget Office has said that legislation simply repealing the SGR formula would cost around $117 billion. But the new legislative package will likely run higher because it includes five years of higher physician payments and could also include a number of Medicare "extender" payments to rural providers. How Congress decides to pay for the package will be crucial, potentially impacting hospitals, post-acute care providers, pharmaceutical companies and even individual Medicare beneficiaries. The negotiated package also consolidates three existing quality programs into a more streamlined program that rewards providers who improve care for seniors.

Arkansas Medicaid private option in jeopardy

Last year, Arkansas became the first state to gain approval for a "private option" that uses federal Medicaid dollars to purchase private health coverage plans in the state insurance exchange. Now the state's expansion plan faces defunding at the end of the fiscal year in June because of a legislative supermajority requirement. In order for the state to accept federal money again for the private option, it must obtain at least a 3/4 voting majority – meaning that just nine senators or 26 assembly members could block the appropriation. The expansion passed last year with a single extra vote in the senate, and is expected to face challenges this year with the resignation of one key supporter and rising uncertainty among swing votes .

HRI impact analysis: As the fate of Arkansas' private option hangs in the balance, many will be watching to see if other states face similar challenges. Nine other states are considering or actively pursuing alternative expansion options – including Pennsylvania, which is seeking federal approval for its private sector plan. Early numbers (through Jan 2) show that enrollees in the Arkansas private option tend to be

younger than those who enrolled directly through the federally-facilitated exchange. While the Arkansas numbers are still preliminary, they suggest that private expansion might help balance out individual insurance risk pools in some states. Hospitals serving lower-income patients are closely watching Medicaid expansion proposals: Many face ACA payment cuts for uncompensated care, which would otherwise be partially offset by health plans or government in the form of claims payments.

Risk corridor program faces legislative challenges

ACA-mandated risk corridors, which allow the federal government to share excess profits or losses with health plans, could face legislative challenges in the coming months. The Congressional Budget Office estimates that the program will collect $16B from insurers between 2015 and 2017 – but that it will only reimburse the industry with half that amount in repayments, meaning the federal government will pocket $8B. At the same time, new analysis from the Congressional Research Service questions whether the federal government is authorized by the ACA to redistribute risk corridor payments to insurers, opening the door for modifications to the program.

HRI impact analysis: Risk corridors, along with risk adjustment and reinsurance, form the cornerstone of the '3Rs' – a financial safety net meant to encourage health insurers to cover the largely unknown newly insured population. While changes to the program might be necessary to fill the ACA's legislative gaps, a severe scaling back of the program could have negative financial consequences for the industry, possibly forcing insurers to raise premiums to offset adverse selection.

Further delay of Medicare "two-midnight" rule could complicate workflow

The decision by CMS to partially delay for a second time its enforcement of the controversial two-midnight policy gives hospitals and health systems a temporary reprieve, although it could complicate the work providers have already undertaken to comply with the rule. Under the rule, certain hospital stays are considered by Medicare to not warrant inpatient payment if they do not span two midnights. The extension means that recovery auditor reviews for patient status will be delayed until October 1, 2014. Even so, hospitals are not entirely off the hook. While recovery auditor reviews are temporarily on hold, Medicare will continue to deny claims that are determined to be noncompliant under the rule.

HRI impact analysis: Hospitals may not like the rule - and some are fighting it in court - but many have already undertaken measures to comply with the directive. Some health systems have reprogrammed their electronic medical records to prompt physicians to indicate when they believe it is appropriate for a patient to be admitted and will require a stay of at least two midnights. Others have tapped a physician review board - often in addition to case management review - to double check medical records for the appropriate documentation and certification. The CMS delay buys hospitals additional time, but compliance with the rule is still critical because Medicare contractors can deny payment claims.

Final rule allows patients direct access to labs, clears way for new apps

Individual patients and their caregivers can now directly access laboratory test results, including those previously protected by federal privacy rules. A trio of agencies this week, including CMS, the CDC and the Office for Civil Rights, jointly released a final rule that allows lab results to be sent directly to the patient without first being ordered by a provider. Under the rule, labs will be required to provide patients with their completed test results within 30 days of a request but they are not required to explain or interpret the results. Providers will likely see an advance copy, allowing them time to consult with the patient first.

HRI impact analysis: "Information like lab results can empower patients to track their health progress, make decisions with their healthcare professionals, and adhere to important treatment plans," HHS Secretary Kathleen Sebelius said in a written statement. But the decision also benefits a number of healthcare players hoping to create digital apps that allow consumers to better manage their own care. "Studies show that patients who have access to their health records tend to be more engaged in decision making than those who don't, and may even be more likely to follow treatment protocols and other behaviors that promote favorable outcomes," Jon Cohen, senior vice president and chief medical officer for Quest Diagnostics, said in a company statement. The company offers a number of ways for patients to view such data, including its mobile health app, Gazelle.

HRI on insurance premiums: Comparing employer and exchange rates

Premium pricing on exchange plans is cheaper across the board than employer plans, in some cases substantially so. HRI found that the average median premium for gold plans was 8% lower than employer-sponsored plans, and 18% lower for the more comprehensive platinum plan. For an in-depth analysis read HRI's new report, *Health insurance premiums: Comparing ACA exchange rates to the employer-based market*.

Upcoming events & deadlines

- **February 28** – Deadline for eligible professionals to demonstrate meaningful use under the Medicare EHR incentive program,
- **March 3** – Start of CMS testing week for ICD-10, a new, more detailed set of diagnosis codes that CMS is requiring all providers and insurers to adopt.
- **March 7** – Deadline to submit letter of intent for last round of PCORI funding opportunities.
- **March 31** – Extended deadline for those in the Pre-Existing Condition Insurance Plan to gain coverage through exchanges.
- **March 31** – Open enrollment in health insurance exchanges scheduled to end for 2014.

Quote of the week

"Customer service is essential, and it is real private-sector-kind of customer service we need to provide," said Christine Ferguson, director of the Rhode Island Health Benefits Exchange, describing customer service as a differentiator for state based exchanges over the federal exchange.

In the news

CVS made nationwide news Wednesday when it announced that it would stop selling cigarettes and other tobacco products in all of its 7,600 pharmacy locations. CVS Caremark officials noted that they are "continually looking for ways to promote health and reduce the burden of disease," and that the sale of tobacco is "inconsistent with our purpose." The decision is estimated to cost $2 billion in sales.

Factually correct

Six million – The updated number of exchange enrollments according to a new report by the CBO. The estimate is one million less than CBO's original estimate in May 2013. CBO cites technical problems as the cause for the projected drop in enrollment.

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