HRI as we see it
Weekly insights from the Health Research Institute pwc.com/hri

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Week of 7/08/2013

This week's regulatory and legislative news

- **Employers gain another year to offer workers coverage**
- **Some Pioneer ACOs pulling out**
- **Final Medicaid, CHIP, and exchange rule provides more implementation leeway**
- **White House hires UK company to process exchange applications**
- **CMS releases payment rules and boosts telehealth**
- **Lawmakers scrutinize payment program for durable medical equipment**

Employers gain another year to offer workers coverage

Under the ACA, companies with at least 50 full-time employees are required to provide health insurance to workers or face financial penalties. However, the IRS announced last week that employers will be given a one-year reprieve from the mandate. Administration officials say the decision is based on discussions with the business community. It will also give the government time to streamline new reporting requirements, which it has yet to issue rules on. Insurers will have a chance to adapt health coverage to meet the law's standards. And, perhaps most important, it buys employers more time to develop and implement "pay or play" strategies. Although, the government is still encouraging employers to voluntarily implement reporting and expand coverage in 2014. Read PwC's analysis of the employer mandate delay here.

Some Pioneer ACOs pulling out

Nine out of 32 accountable care organizations (ACOs) have indicated they may leave CMS' Pioneer program, now in its second year. This Medicare ACO program pays bonuses and levies penalties based on quality and efficiency results. Some are suggesting they will throw in the towel altogether, but at least four tentatively say they will join Medicare's lower-risk Shared Savings Program. With requirements growing more aggressive each year, Pioneers face the prospect of larger rewards and larger losses. In comparison, the Medicare Shared Savings Program enables ACOs to collect bonuses for the first three years without any penalties if they fail to meet the targets.

HRI impact analysis: Some see the shift in the Medicare ACO landscape as a threat to more ambitious, longer-term cost containment efforts. CMS has projected that ACOs, in total, could save as much as $940 million through 2015. Early data from a federal pilot program involving 10 physician groups point to modest savings of about $137 million over five years. HRI has found that it is likely to be years before evidence is available demonstrating ACOs' impact on overall U.S. health spending.

Final Medicaid, CHIP, and exchange rule provides more implementation leeway

CMS is not only delaying implementation of the employer mandate. It's now also relaxing—at least initially—its process for verifying an applicant's income and available employer coverage. In a final rule released last Friday, the agency postponed the requirement to verify access to employer-sponsored coverage until 2015. For the first year, states are only required to check a random sample of individuals who have reported a big drop in income if electronic data isn't available. In cases where applicants report higher incomes, exchanges must accept only a signed statement.

Another notable provision is a delayed requirement to provide electronic eligibility notices for Medicaid and CHIP. The final rule also establishes a framework for allowing Medicaid-eligibles to purchase coverage on the exchanges with premium assistance. In addition, CMS assures states that they won't be penalized next year if they haven't finished incorporating essential health benefits into so-called Medicaid benchmark plans that are designed to mirror the benefits found in the health plan with largest enrolment in the state.

White House hires UK company to process exchange applications

Last week, the White House announced that it awarded a one-year contract worth $114.3 million to Serco, a UK-owned, international service company, to handle health insurance exchanges administration. Tasks will include processing the approximately 19 million applications expected to be filed in the first year, running a mailroom to process the anticipated six million paper applications, identifying individuals who qualify for exemptions to penalty fees, notifying consumers of any missing information on their applications, and helping CMS resolve eligibility questions. While the company has contracted with the Department of Defense, Federal Aviation Administration, and State Department before, it has limited experience with HHS and healthcare. The company, which has a U.S. base in Virginia, plans to immediately hire 1,500 people for the effort. There is an option for the contract to be expanded and extended up to five years for a total value of $1.2 billion.

HRI impact analysis: The contract underscores the movement of non-healthcare companies into the health sector—a growing trend in recent history. These businesses, which often have backgrounds in technology, telecommunications, or retail, are seizing upon the opportunity for innovation and the convergence of industries in the healthcare market.

CMS releases payment rules and boosts telehealth

CMS released two new proposed rules this week—one on 2014 payment policies for Medicare physician fees, the other on outpatient and ambulatory surgical center payments. The first rule proposes a separate payment for complex chronic care management beginning in 2015. Currently, Medicare only reimburses for primary care management services as part of face-to-face visits. The rule also expands payment for telehealth services, makes changes to several quality reporting initiatives associated with the physician fee schedule, and continues the implementation of ACA quality and efficiency payment adjustments.

The second rule proposes a 1.8% increase in hospital outpatient payment rates and a 0.9% increase in ambulatory surgical center payments. The rule also expands the supporting services that are bundled into a single payment for a primary service. These changes make the outpatient payments more analogous to Medicare payment for hospital inpatient services. In total, CMS projects outpatient prospective payments and ambulatory surgical center payments to increase by $5.7 billion in 2014.

HRI impact analysis: The American Hospital Association has noted it strongly opposes the portion of the outpatient rule that would require direct physician supervision when Medicare patients receive outpatient services in "critical access" and small rural hospitals. Stakeholders have until September 6 to file comments, and final rules are expected in early November.

Lawmakers scrutinize payment program for durable medical equipment

More than 225 Democrats and Republicans in Congress recently teamed up to urge changes to the way Medicare pays for durable medical equipment, such as oxygen equipment, power wheelchairs, and mail-order diabetic supplies. Since 2007, Medicare has been trying to implement a program known as “competitive bidding,” in which suppliers compete against one another based on price. Lawmakers are concerned that in an effort to achieve savings, Medicare accepted low bids from unqualified suppliers. As a result, they’ve asked for the program to be delayed and for the HHS Office of the Inspector General to investigate. HHS is also facing a lawsuit from suppliers seeking to delay the program.

HRI impact analysis: The experience of Medicare’s competitive bidding program can be informative as more care moves to a retail setting and consumers exert more influence over the money spent on medical care. The program has struggled to strike an acceptable balance between access, quality, and price. In the new healthcare economy, purchasers will expect suppliers and providers to meet all three standards. If they can’t find them locally, they’ll search for high performers elsewhere.

Upcoming events & deadlines

- **July 22** – Comments due on the interim final rule setting payment rates for healthcare services provided to individuals in the Pre-Existing Condition Insurance Plan.
- **July 30** – Comments due to the FDA on new models of antibacterial drug development.
- **July 31** – CMS receives state recommendations and final plan data for state partnership exchanges.
- **September 6** – Comments due on the proposed rule on 2014 payment policies for the Medicare physician fee schedule.

- **September 6 –** Comments due on the proposed rule on the outpatient prospective and ambulatory surgical center payment systems.

Quote of the week

"This was like holding up a magnifying lens to the problems of our healthcare system," said Dr. Shreya Kangovi, physician at the Philadelphia Veterans Affairs Medical Center, about her recent study published in *Health Affairs* that examines the barriers poor patients face in getting care that prompt many to use emergency rooms instead of doctors' offices.

In the news

A study recently published in the *New England Journal of Medicine* suggests that a privatized Medicaid expansion, in which Medicaid is used to help people buy private health insurance in the exchanges, could help provide stable coverage to families that teeter between being eligible for Medicaid and subsidies in the exchanges.

Factually correct

33% - the percentage of primary care physicians who did not accept new Medicaid patients in 2011-2012 according to a new study published in *Health Affairs.*

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