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

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Week of 6/23/2014

This week's regulatory and legislative news:

- **Administration releases final rule on employee waiting periods**
- **Providers wary of payment, contractor status as VA bills advance**
- **Lawmakers set sights on digital health**
- **Medicare commission examines medication adherence for potential savings**
- **Healthcare spending projected to rise by 6.8% in 2015**
- ***HRI as we see it* will not publish the week of 06/30/14**

Administration releases final rule on employee waiting periods

A final rule from the Administration may create tough choices for businesses—at least when it comes to employee insurance coverage waiting periods. The recent rule states that employers must offer health insurance to employees within a 90-calendar-day waiting period, but a month-long "orientation" period is permitted before the clock starts. This effectively extends the possible wait period for providing coverage from 90 days to up to four months. Orientation periods are commonly used by employers to evaluate new hires and conduct training. However the new rule could create confusion for large employers because companies must offer coverage by the first day of the fourth month following date of hire in order to comply with the ACA's employer mandate. If an employee purchases coverage on a public exchange and receives subsidies after three months employers could face fines.

HRI impact analysis: The final rule adjusts the 90-day coverage waiting period so the fine doesn't kick in before the employer mandate penalty. The first day of the fourth month often falls a few days after the 90-day deadline, so the orientation period adjusts for this slight difference. However, employers must determine if and how they apply an orientation period, because the full month allowed under the final rule may trigger the mandate penalty. The employer mandate applies to companies with 50 or more full-time employees, and the penalty only kicks in when an employee purchases coverage on the public exchanges and receives subsidies. More than 96% of US businesses have fewer than 50 employees, according to a White House report.

Providers wary of payment, contractor status as VA bills advance

National hospital and physician groups are asking federal lawmakers to require the Veterans Health Administration to promptly pay non-VA providers who treat veterans, and to allow direct contracting between the two to avoid stricter government regulations. Legislation that passed both the House and Senate this month would allow veterans to seek care at non-VA medical centers if they experience excessive wait times or do not live near a VA hospital. In a letter sent to key lawmakers in the Senate, the American Medical Association said it wants the bill to set payment rates "at least" to Medicare levels for non-VA providers, and to exempt any agreements or arrangements from "federal contractor" obligations. Similarly, the American Hospital Association is pressing Congress to "establish and implement a system for prompt payment of claims" to non-VA providers in response to reports of long wait times for payments.

HRI impact analysis: House and Senate members are now negotiating the two versions of the legislation —and what was once a fast-moving process has slowed with concerns over cost and reach. Some health systems—especially those near communities with a strong military presence—are eager to extend care to veterans, and providers are pursuing a strategy similar to the one they used to capture the

newly insured under the ACA. The bill would give veterans more flexibility to seek care outside of the VA—a policy both the AHA and AMA say they support. The Senate bill caps payment rates at Medicare levels, while the House bill would pay non-VA providers not under a current VA contract the highest rate billed among Medicare, the VA, and TRICARE. Both bills also require providers who agree to treat veterans to essentially become federal contractors, which could subject them to affirmative action requirements and a range of other regulations. Medicare and Medicaid currently exempt providers from such rules.

Lawmakers set sights on digital health

Existing laws and regulations are hampering innovation in healthcare. That's the message that lawmakers received from industry representatives during a roundtable discussion held this week on advancing digital and personalized health. Executives lamented the current regulatory system and the high burden it imposes on entrepreneurs. Athenahealth CEO Jonathan Bush pointed to the fact that only $2.2 billion in venture capital flowed into disruptive healthcare technology last year. HIPAA, the law that protects patient privacy, was mentioned several times as a barrier to the free flow of health information. FDA Device Chief Dr. Jeffrey Shuren proposed the solution of "smart regulation," or "knowing when to regulate and how to regulate." He pointed to FDA's efforts to provide greater clarity and predictability about its regulatory requirements, such as the recent guidance FDA published on mobile medical apps.

HRI impact analysis: In the new health economy, organizations are finding ways to work around regulatory issues that have kept disruptors at bay. For example, Anne Wojcicki, CEO and co-founder of 23andMe, a company that offers DNA testing, told lawmakers that her company has avoided pursuing traditional reimbursement by directly offering consumers genetic testing for $99. Consumers' views on privacy may also be shifting. As patients become more discerning, their willingness to trade some privacy for easy access to information may be evidence that healthcare needs more data transparency and access. Revising regulatory requirements is not the only solution. Healthcare companies will also have to rethink business models. For example, companies should consider a consumer-to-business strategy, using consumer data to refine business models, enhance customer experience, and earn greater customer loyalty.

Medicare commission examines medication adherence for potential savings

Congress' panel of Medicare experts released its regular June report examining delivery system issues. The seven-chapter volume from the Medicare Payment and Access Commission (MedPAC) covers a range of topics including improving risk adjustment, measuring the quality of care, and payments for primary and acute care. The report also examines the effects of medication adherence on medical spending for the Medicare population. For patients with congestive heart failure, they found that greater medication adherence was associated with lower medical costs, but that effect was dependent on a number of other factors, such as previous health status.

HRI impact analysis: The report is an important resource for healthcare executives to understand key changes being considered by Medicare administrators and Congress. Recommendations from the report are often implemented through regulations issued by CMS or used as the basis for new legislation. Measures that have the potential to lower Medicare's costs, such as medication adherence, are particularly attractive to lawmakers eager to reign in federal healthcare spending. According to HRI's report on customer experience in pharmaceuticals, there are a range of techniques for overcoming consumer behaviors that lead to poor medication adherence, from blister packs that make pills easier to track, to reminder calls, to waiving co-payments.

Healthcare spending projected to rise by 6.8% in 2015

A new report from HRI projects a healthcare spending growth rate in the employer-sponsored market of 6.8% in 2015, up from 6.5% this year. Major factors include the improved economy and the high cost for specialty drugs. Next year's projected uptick is a change in direction from years of significantly slower growth, but it does not necessarily mean a return to the double-digit increases of past years.

HRI as we see it will not publish the week of 06/30/14

HRI will not publish a newsletter for the week of 06/30/14. Publication will resume on Friday, July 11.

Upcoming events & deadlines

- **June 27** – 2015 federal exchange premium rate filing deadline for health insurers
- **June 30** – Deadline for drug makers and group purchasing organizations to register and report financial relationships with physicians under the Sunshine Act's Phase 2 of Open Payments
- **August 12** – Deadline to submit ideas to the Senate Finance Committee on how to increase the transparency of healthcare data
- **August 15** – PCORI matchmaking app challenge application deadline

Quote of the week

"Medicine needs to come out of the dark ages now," said Bill Maris, managing partner at Google Ventures, on healthcare companies leveraging big data, cloud processing, and genomic sequencing to improve the quality of diagnostics and treatments.

In the news

A majority of accountable care organizations across the US are led by physicians—a fact policy analysts say could result in improved quality and care coordination while slowing cost growth. Fifty-one percent of ACOs have a physician at the helm, and another 35% of ACOs are jointly led by doctors and hospitals, according to a report in the journal Health Affairs. Only 3% of ACOs are run solely by a hospital system, while the remaining 13% are run by other provider organizations.

Factually correct

761 – The number of US hospitals that could see their Medicare payment reduced this year under the ACA's hospital-associated infections program, according to an analysis by Kaiser Health News.

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