



The Economics of Healthcare

Healthcare Reform

How it may affect your business?

Economics of Reform

- Economics 101
- Brief history of how we got here
- The problems that need to be addressed
- The impact to all small business and individuals
- The impact to your physician client businesses

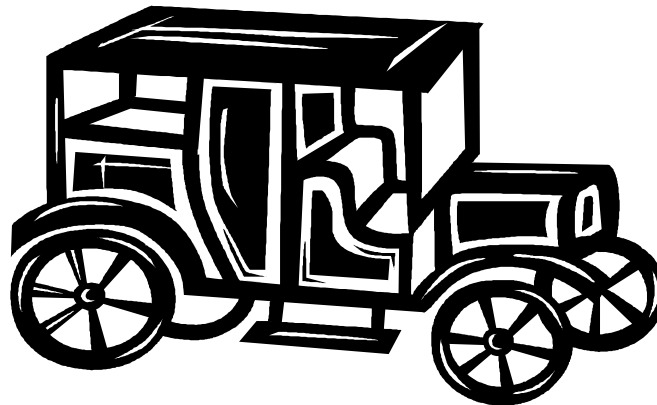


Economics

- It is the analysis of the production, distribution, and consumption of goods and services. Demand for a product will produce supply for it at a price consistent with the demand.
- All the discussions about reform, and all the discussions about reform prior to this, have been about who controls it.
- Supply and demand theories have not been discussed.

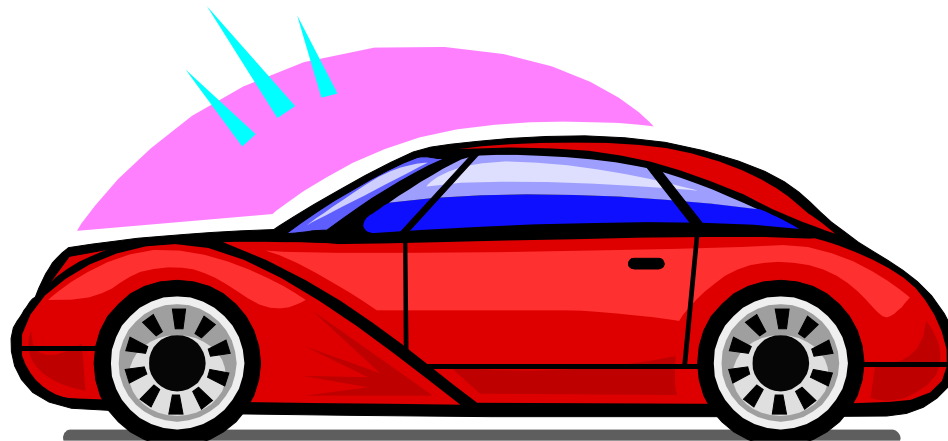
Economics

- Let's talk about automobiles



Economics

- Supply increased when GM entered market place, and
- Prices decreased



Economics

- **Supply, Demand, and Healthcare Reform**
- “Let's review some basic principles of supply and demand: If a government policy increases the demand for a service, the price of that service tends to rise. If the government prevents prices from rising, shortages develop. The quantity provided is then determined by supply and not demand. In the presence of such excess demand, the result could be a two-tier market structure. Consumers who can somehow pay more than the government-mandated price will be able to purchase the service, while those paying the controlled price may be unable to find a willing supplier.”

Greg Mankiw **Location: United States**

Professor of Economics at Harvard University

Medicare History and How we Got Here

BRIEF HISTORY OF THE MEDICARE PROGRAM

1945 Harry Truman sends a message to Congress asking for legislation establishing a national health insurance plan.

Two decades of debate ensue, with opponents warning of the dangers of "socialized medicine." By the end of Truman's administration, he had backed off from a plan for universal coverage, but administrators in the Social Security system and others had begun to focus on the idea of a program aimed at insuring Social Security beneficiaries.

July 30, 1965 Medicare and its companion program Medicaid, (which insures indigent recipients), are signed into law by President Lyndon Johnson as part of his "Great Society." Ex-president Truman is the first to enroll in Medicare.
Medicare Part B premium is \$3 per month.

History - continued

- 1972 Disabled persons under age 65 and those with end-stage renal disease become eligible for coverage. Services expand to include some chiropractic services, speech therapy and physical therapy. Payments to HMOs are authorized.
- Supplemental Security Income (SSI) program is established for the elderly and disabled poor. SSI recipients are automatically eligible for Medicaid.
- 1982 Hospice benefits are added on a temporary basis.
- 1983 Change from "reasonable cost" to prospective payment

Medicare - history

- 1986 Hospice benefits become permanent.
- 1988 Major overhaul of Medicare benefits is enacted aimed at providing coverage for catastrophic illness and prescription drugs. Coverage is added for routine mammography.
- 1989 Catastrophic coverage and prescription drug coverage are repealed. Coverage is added for pap smears.
- 1992 Physician service payments are based on fee schedule.

Medicare History

- 1997 Medicare+Choice is enacted under the Balanced Budget Act. Some provisions prove to be so financially restrictive when regulations are unveiled that Congress is forced to revisit the issue in 1999.
- 1999 Congress "refines" Medicare+Choice and relaxes some Medicare funding restrictions under the Balanced Budget Refinement Act of 1999.
- 2000 Medicare+Choice Final Rule takes effect.
- Prospective payment systems for outpatient services and home health agencies take effect.
- Medicare Part B premium is \$45.40 per month.

Why did we do it?

- Its original purpose was to provide a safety net for social security recipients (senior citizens) in their last years of life. Life expectancy at that time was 67 years; Medicare was structured to begin at 65 years of age. Government created “demand”.



Spending in Medicare

- At time of passage, CBO estimated that Medicare would cost \$3.5 Billion and that it would cover 19.1 Million residents (or 9.7% of population). Actual amount spent was \$5.5 Billion.
- From 1970 to 1990 Medicare payments went from \$7.2 Billion to \$108.9 Billion (14.5% increase per year). By 1990 13.8% of the population was covered.

Spending in Medicare

- In 1965, when the law was enacted, according to Wikipedia, “Medicare...shifted a large portion of the payments for the Nation’s health care from the private to the public sector.”
- Before Medicare 21.4% of dollars came from public sector; 78.7% came from private patients and insurers.
- By 1990, 41.3% of all dollars spent are from public sector; 58.7% is from private sector and of that amount **47% was from out of pocket payments from patients.**
- By 2008, public funds accounted for 47.32% and patient payments accounted for 11.88% and commercial insurance was 40.8%.

Societal changes

- What changed in public perception is subtle, but it must be examined to understand the overall economics.
 - Insurance coverage became coverage for all medical costs, not just traditional coverage for the unexpected. (demand change)
 - Medicare was perceived as not a “safety net” but a right as one aged. We began to “count” on it.
 - The average life span increased by almost 15 years. (demand increased)

Societal Changes

- The cost of research and technology, along with the change in covered costs paid out by insurance companies, increased the amount of premiums for private insurance and out of pocket costs.



Society changes

- The reaction to higher premiums from small business America was to demand price control.
- We got “managed care.” Price was to be controlled by shifting risk to the physicians and hospitals, away from the patient and the payer.

What are the problems?

- General agreement by both political parties that “something” needed to be done around three main issues:
 - the uninsured
 - premium increases
 - coverage denials

Insuring the Uninsured

- Who are the “uninsured”?
 - In 2006 the Census Bureau estimated that 47MM did not have insurance coverage. It is from this estimation that all the rhetoric has been based.
 - Within that estimate, they found that 43% (20MM) had incomes 2.5 times the poverty line and were without insurance by choice.
 - Particularly interesting was the group that made up approximately 12-15MM of this 20MM who are referred to as the “indestructibles”. They truly believe it is not worth the cost. It is also for this reason that insurance companies were not in a complete state of panic when the debate began. They wanted this relatively healthy group in the risk pools. *(June, 2009. Drs. June and David O’Neil, Baruch College, City University of New York.)*

Insuring the uninsured



- The reform bill has transferred much of the burden of the uninsured to the states, while at the same time cutting the subsidies to the states.

Insurance Premiums

- It will be very difficult to control cost of premiums until we control access (“demand”) . Access for all types of care causes a rise in costs. Yet, the government has not addressed the “supply”. These two competing concerns must be resolved.
- Demand - how does our society control it?
 - Either by price
 - By quality (price differentials)
 - By limiting service availability (everyone has coverage, but limited ability for actually obtaining services)
 - And with insurance – coverage denial.



Patient Protection and Affordability Act

- The economic and tax effects of the bill for small business:



Small Business and Individual Effect

- Tax and business changes-highlights only:
 - 0.9% additional FICA tax applied to wages in excess of \$200,000 (2013)
 - *An additional tax of 3.8% on all unearned income for interest, dividends, royalties, and annuities; form of organization will also affect this calculation for some individuals. (2013)*
 - *Employers will report value of health benefits on W-2 (optional for small employers for 2012 and until further notice – less than 250 W-2s).*
 - *40% nondeductible excise tax applies to health coverage in excess of \$8,500 (singles) and \$23,000 (families) beginning in 2012. Employer is required to file an information return indicating the amount subject to excise tax and tax is levied at insurance level.*

Small Business and Individual Effect

- HRAs, Cafeteria Plans, HSA, and MSA, medical expenses are limited to what is an itemized deduction on a tax return. All medications must be doctor prescribed to be reimbursed – even over the counter drugs. (2010)
- FSAs will be capped at \$2,500.
- *Hospitals will be subject to new regulations including community health needs assessment, promulgation and dissemination of a written financial assistance policy and new reporting and disclosure rules.*

Small Business and Individual Effect

- Beginning in 2011, the “medical loss ratio” provision of the Affordable Care Act requires health insurers to spend 80% to 85% of premium dollars on medical care and health care quality improvement, rather than on administrative costs (e.g., executive salaries, overhead, and marketing) and profit.
- If they do not, the insurance companies will be required to provide a rebate to their customers starting in 2012.
- Beginning in 2011, the law also requires insurance companies to publicly report how their premium dollars are spent. New regulations issued by the Department of Health and Human Services (HHS) explain the medical loss ratio disclosure and reporting requirements, how insurance companies will calculate their medical loss ratio and provide rebates, and how adjustments can be made to the medical loss ratio standard to guard against market destabilization.

Small Business and Individual Effect

- Beginning in 2011, 1099s will be required for all payments made to corporations (not just individuals for services). *Repealed*
- Floor for medical expense deduction on your returns is raised from 7.5% of AGI to 10% (2012).
- 10% excise tax on any indoor tanning service performed after June 30, 2010. Providers of indoor tanning services collect the tax at the time the purchaser pays for the tanning services. Quarterly, the provider pays these amounts to the government along with IRS Form 720 (Quarterly Federal Excise Tax Return).
- Insurance companies can only pay \$500,000 to an individual for their services *(there has been some change on this for exemptions for certain insurance companies)*

Small Business and Individual Effect

- *Multi-State Plans established in 2014 to compete with private insurers in state Exchanges.* Office of Personnel Management will enter into contracts and negotiate premiums with two private health plans (one for profit and one not-for profit) to create groups to be offered to anyone by 2017.
- Everyone is required to have insurance or pay a penalty. Penalty is either the flat dollar amount of \$95 (increasing to \$750 by 2016) or a percent of income (0.5% in 2014 to 2.0% by 2016.)

Small Business and Individual Effects

- Employers not required to offer insurance if you are a “small employer”. This is for employers between 1 and 100. There is no penalty if you do not. You may also use the state run exchange programs after 2014 if you are a small employer. However, there are additional provisions for employers over 50 FTE with penalties.
- Employers who offer coverage must provide “tax exempt free choice vouchers” to employees whose premium contribution is between 8% and 9.8% of their income to purchase through an exchange.
- Employers have a \$600 fee for a waiting period more than 60 days.

Small Business and Individual Effect

- *Employers may no longer discriminate by class of employee in insurance coverage.*
- *As a result of “interpretation differences”, this has been delayed until otherwise notified.*



Small Business and Individual Effect

- Low wage employers (average salary less than \$50,000) with 25 or less employees are eligible for up to a 35% premium credit for two years if they pay at least 50% of the premium.
- **Form for Small Employer Health Insurance Credit Issued** The IRS released Form 8941, which is the form that small businesses and tax-exempt organizations will use to calculate the small employer health insurance credit. The form is available on the IRS website at www.irs.gov. A for-profit employer claims the credit on its annual income tax return. The IRS announced that tax-exempt organizations, which do not generally file income tax returns, will claim the credit on Form 990-T.
- State can do its own waivers to impose its own rules
- As an employer, you will need to decide in the next couple of years whether or not you will offer insurance or put your employees in the state exchanges. If you are a large employer, you are required to offer insurance.

Small business tax credit estimator

- Calculated as follows:
 - Total hours worked by all staff divided by 2080. Do not include seasonal workers unless they work more than 120 days per year. This gives FTE.
 - Divide FTE into total wages paid for year (without considering overtime or owners' pay).
 - This gives your average salary. If = or > \$50,000, there is no credit.

Physician office effect

- *Medicare Advantage program has been reduced in payments.*
- *There will be created a competitive bidding process and financial incentives for care coordination programs and quality achievement.*
- *Provider payments dependent on quality outcomes.*
- *“Innovation Center” to test and implement new provider payment methods and change payment incentives to reduce hospital acquired infections and readmissions.*

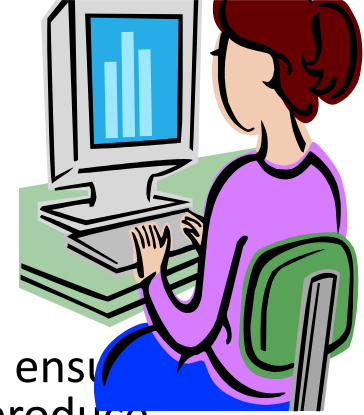
Physician Effect

- Medicare 10% bonus to primary care physicians and general surgeons practicing in health professional shortage areas
- Taxes on medical device companies, pharmaceutical companies, insurance companies, and others.
- *No physician owned hospitals unless Medicare contract in place before February 2010 (supply limit)*

Effect on physicians

- Administrative burdens for physicians will increase for reporting to federal agencies. As an example, under the Stimulus Bill, the Department of Health & Human Services was directed to, and is now developing, a national all-payer, all claims database to use for comparative effectiveness research. It is to be used for “evidence-based information to make informed decisions about healthcare.”

Physician Effect



- CMS says the database, “would allow for greater power in analysis, ensure that the data infrastructure the Secretary supports will be able to produce robust analysis. Claims data, especially if established in a manner where it can be linked to other data over time, can be powerful for CER and ultimately improve care for all Americans.”
- The concern here is that under currently passed legislation – and with funding under the Stimulus bill and the proposed 2011 budget – medical necessity will be judged. In a recent case against Small Smile Centers, under “HEAT” (Health Care Fraud Prevention and Enforcement Action Team) there was a \$24 MM judgment for “unnecessary procedures” performed on children. The National Center intends to use information from “all providers” to investigate anomalies, “utilization aberrations, CMS to IRS data matches,…”
- Anti-kickback rules extended to not require intent and does not even have to be an actual claim submitted or the recipient of the kickback. These are criminal rules.
- FERA (Fraud Enforcement and Recovery Act) amendments – allows government additional access to your records and puts overpayments under the False Claim Act with whistleblower protection.

Effect on Physician Practices



- They will have a “concentration” which subjects them to extreme financial risk. (Medicaid pool expansion)
- They will have additional reporting requirements after implementation if you get dollars for EMR, (e.g. you will be required to have the reporting function to the national database). They will have these reporting requirements regardless after 2014.

Effect on Physician Practices

- Primary care practices will sell to hospitals (already underway)
- Older providers will retire, leaving more room for new practitioners.
- Collection efforts eventually will be for government payments rather than individual payments (or even commercial).



Effect on Physician Practices

- Medical home concept will be utilized. This is an important concept. Practices will be held accountable; information must be shared; and IT will drive most of this.
- Accountable care organizations will start to arise meaning a streamlining of administrative positions.
- Increased public expectation of coverage with no cost.

What happens in the near term?

- Physicians will increase number of patients seen but at lower reimbursement
- The population proportion from Medicaid will increase
- There will be other insured persons with higher deductibles and co-pays which physician will be responsible for collecting.



So what can you do as an advisor to physicians?

- Understand, that like it or not, for awhile, increased accessibility will be required combined with consumer type issues of friendliness, timeliness of appointments, and doctor concern. The practices will need to be able to adjust hours, e-mail, and web access for appointment scheduling and test results.
- They should consider Medical Home certification and Accountable Care Organization formation
- They must have EMR which will allow them to be a practice leader in linkage with other healthcare providers and hospitals. This can be done in a medical home setting or accountable care organization.
- Understand meaningful use of EMR and work toward it now.
- Remind them of the ICD-10 implementation.
- Consider high deductible plans and HSAs. This has the effect of putting the burden for routine care back on your employee.

What can they do?



- Tighten their internal controls within their office. Fraud occurs at all times, but never as much as when economic times are hard. This includes billing controls as a result of law changes.
- Tighten up front office with patients and their insurance. With more uninsured and high deductibles, they will have to get payment up front-no exceptions.
- Increase employees' deductible for routine services or consider self-insurance for prescriptions or other types of services for employees.

So what can you do?

- Look at the physician's succession plan within the practice. Have an exit strategy.
- Stay informed.

Summary

- The history
- The issues
- The law
- What you can do



Questions?

- Cheryl L Yarbrough
cyarbrough@windhambrannon.com
770-730-5000
Windham Brannon, P.C., CPAs