



Executive Briefing

The Affordable Care Act and the Coming Impact

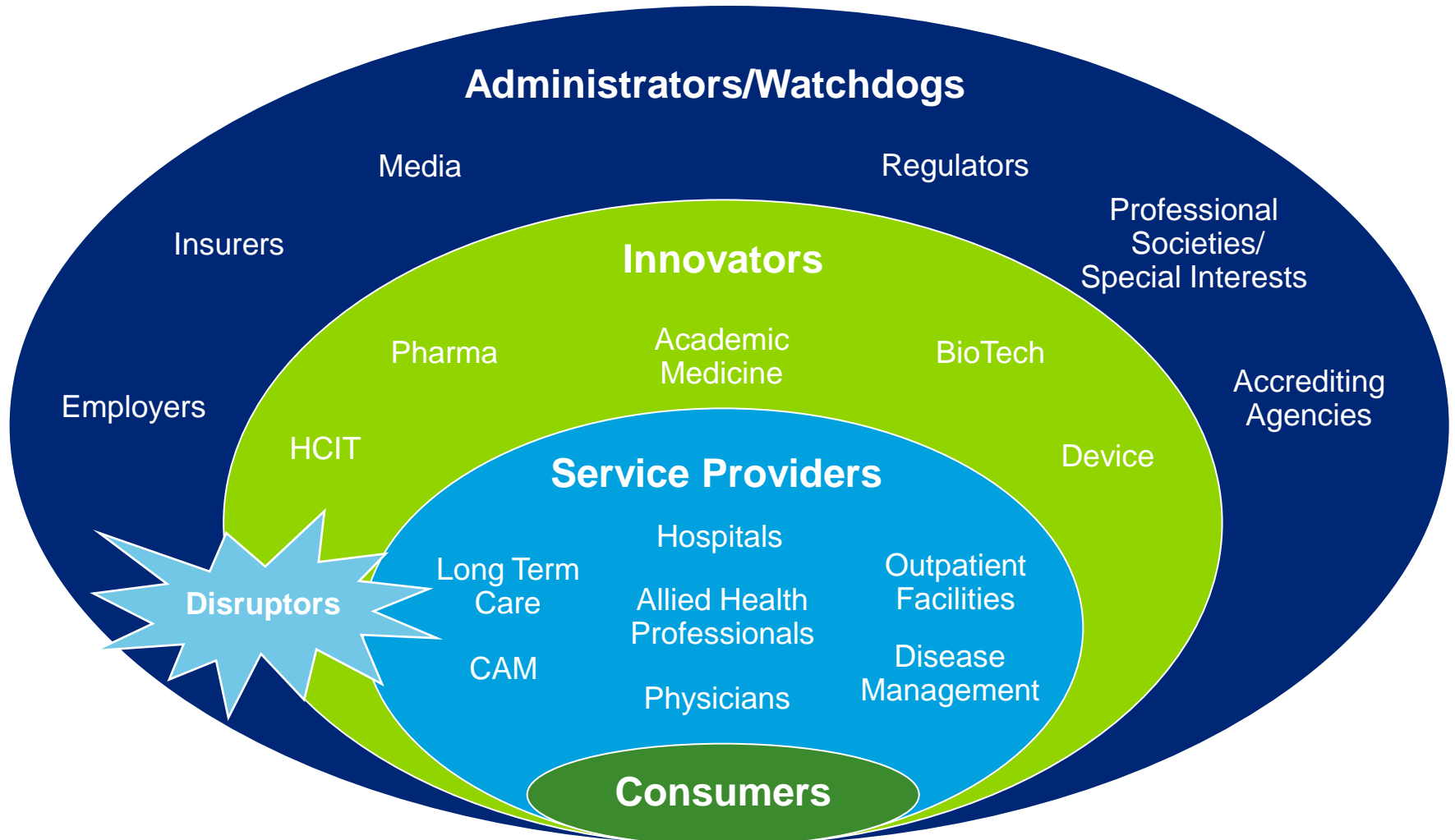
December 2011



Background

Framework: the U.S. health system: fragmented, expensive, complex

Compound growth rate of 7% per year, 17.6% of the U.S. GDP



Health reform: the composite of ACA: rules, amendments, and changes

Major federal health reform legislation: 2009-2010

- **American Recovery and Reinvestment Act (ARRA) and Health Information Technology for Economic and Clinical Health (HITECH) Act (2/09)**
 - \$814 billion stimulus package; \$146 billion earmarked for health care including \$87 billion for Medicaid, \$19 billion for HiTech, \$10 billion for National Institutes of Health (NIH), etc.
- **Children’s Health Insurance Program Reauthorization Act (CHIPRA) (2/09)**
 - Expanded coverage for 4 million kids, program enrollment increase to 11 million
- **Patient Protection and Affordable Care Act (ACA) (3/10) and Health and Education Reconciliation Act of 2010 (3/10)**
 - \$938 billion invested in delivery, insurance system reforms to bend the cost curve and reduce uninsured by 32 million
- **Food Safety Modernization Act (12/10)**
 - Modernize food safety processes and regulations in US
- **Medicare and Medicaid Extenders Act of 2010**
 - Extend physician pay for 2011 to avoid SGR-timed cut of 25%

ACA: the most significant of the laws

Its implementation will span five election cycles and occur simultaneously with efforts to reduce the federal deficit, restore economic growth, and reduce unemployment

Key near term dates:

- December 2011: Congress was supposed to vote on the deficit reduction plan – default to 2% cuts in 2013
- March 2012: Supreme Court will hear arguments about the constitutionality of ACA
- June 2012: Supreme Court will issue ruling on ACA

Budget Control Act, HITECH, SGR

2010 - 2013

Rules, Regulations & New Funding

- Insurance compliance: medical loss ratio (MLR), premiums, coverage
- Coordination: state-federal governments, agencies
- Rules, guidelines, task forces, agencies
- Excise taxes—insurance, medical devices, drug companies
- Patient Centered Outcomes Research Institute (PCORI)

2014 - 2016

Mandates, Pilots & Exchanges

- Individual mandate
- Health exchanges
- Employer pay or play
- Independent Payment Advisory Board (IPAB)
- Accountable Care Organizations (ACOs)
- Value-based purchasing
- Episode based payments
- Medical home
- Self referral limits
- Transparency (Physician Quality Reporting Initiative [PQRI] etc.)

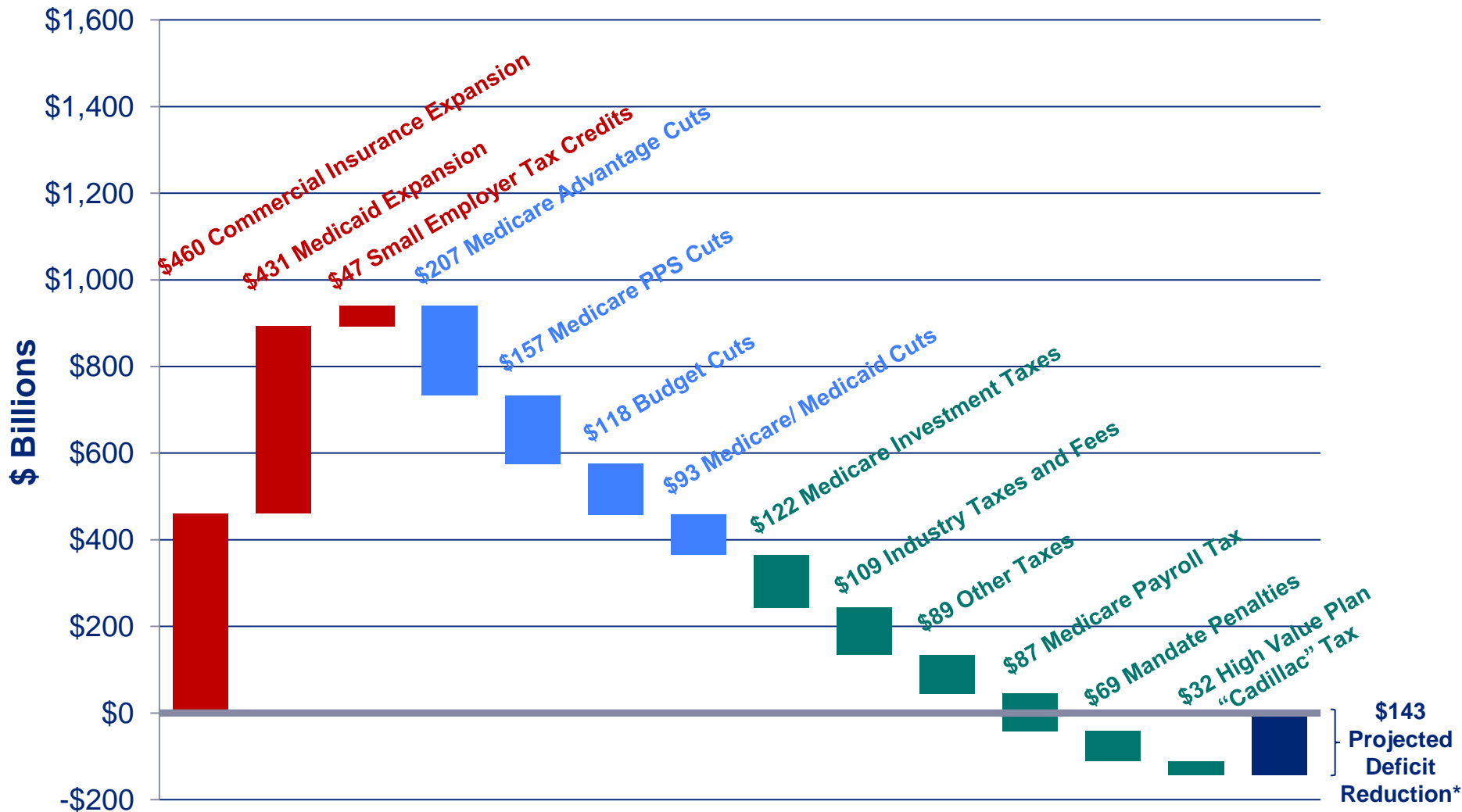
2017 +

“New Normal”

- Comparative effectiveness
- Delivery system re-alignment
- Value not volume
- Convergence: Public health & delivery system
- Retail insurance market
- Consumerism

ICD-10, Electronic Medical Records, Comparative Effectiveness Implementation

Legislation: funding for 2010-2019: investments – \$938B, spending cuts – \$575B, new revenues – \$508B

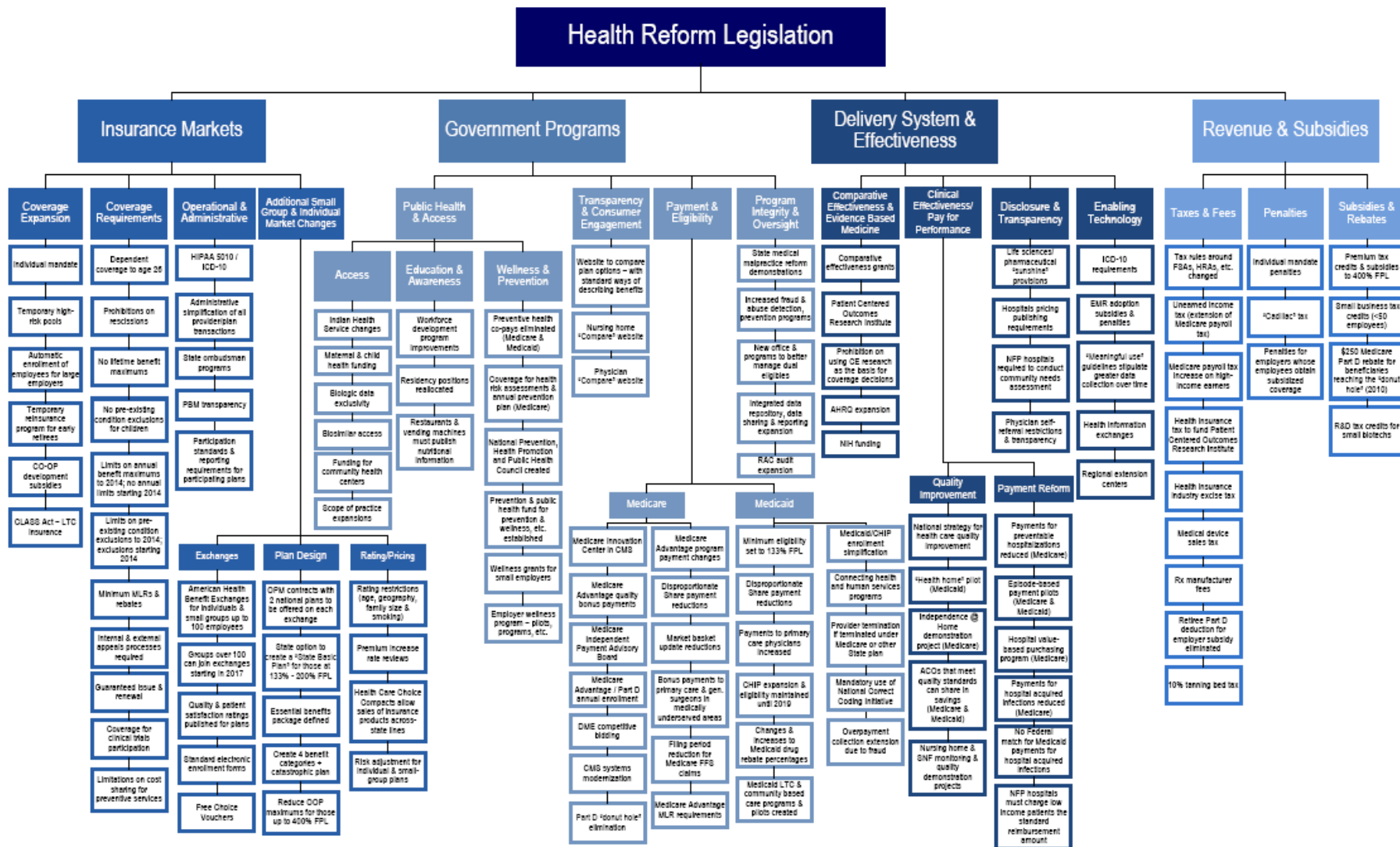


Source: Budget Office Estimates Health Care Law Could Cost More Than \$1 Trillion, Washington Post, 5/12/10

*Does not include CBO's additional projected costs of \$115 B, including \$10-20 B in administrative costs for federal agencies to carry out the law, \$34 B for community health centers, \$39 B for Native American health care

Implementation

Implementation: 100 new agencies, boards, and commissions



Note: The Health Reform Legislation map contains certain key provisions from the Patient Protection and Affordable Care Act (PPACA) passed on March 23, 2010 (Pub. Law No 111-148), the corresponding Health Care and Education Reconciliation Act (HCERA) passed on March 30, 2010 (Pub. Law No 111-152), and other reforms from the American Recovery & Reinvestment Act (ARRA) passed on February 17, 2009 (Pub. Law No 111-5). For more information, please see the accompanying reference guide.

Three groups will play key roles in implementation

CMS Center for Medicare and Medicaid Innovation

- Test innovative payment and service delivery models
- Broad authority to determine what models will be tested, in what populations, and for how long, with a preference for models that address deficits in care leading to poor clinical outcomes or potentially avoidable expenditures

Independent Payment Advisory Board (IPAB)

- The purpose is to reduce the per capita rate of growth in Medicare spending
- Operates independently of MedPAC
- Recommendations take effect absent Congressional action
- May recommend changes to Part D to generate required savings

Patient-Centered Outcomes Research Institute (PCORI)

- Broad scope of research (drugs, devices, procedures, delivery system) with a focus on clinical effectiveness research
- Findings are not coverage/payment recommendations, but can be used by HHS to inform coverage

Patient-Centered Outcomes Research Trust Fund Created

CMS Innovation Center Established

IPAB Begins to Propose Changes to Limit Medicare Spending

2010

2011

2012

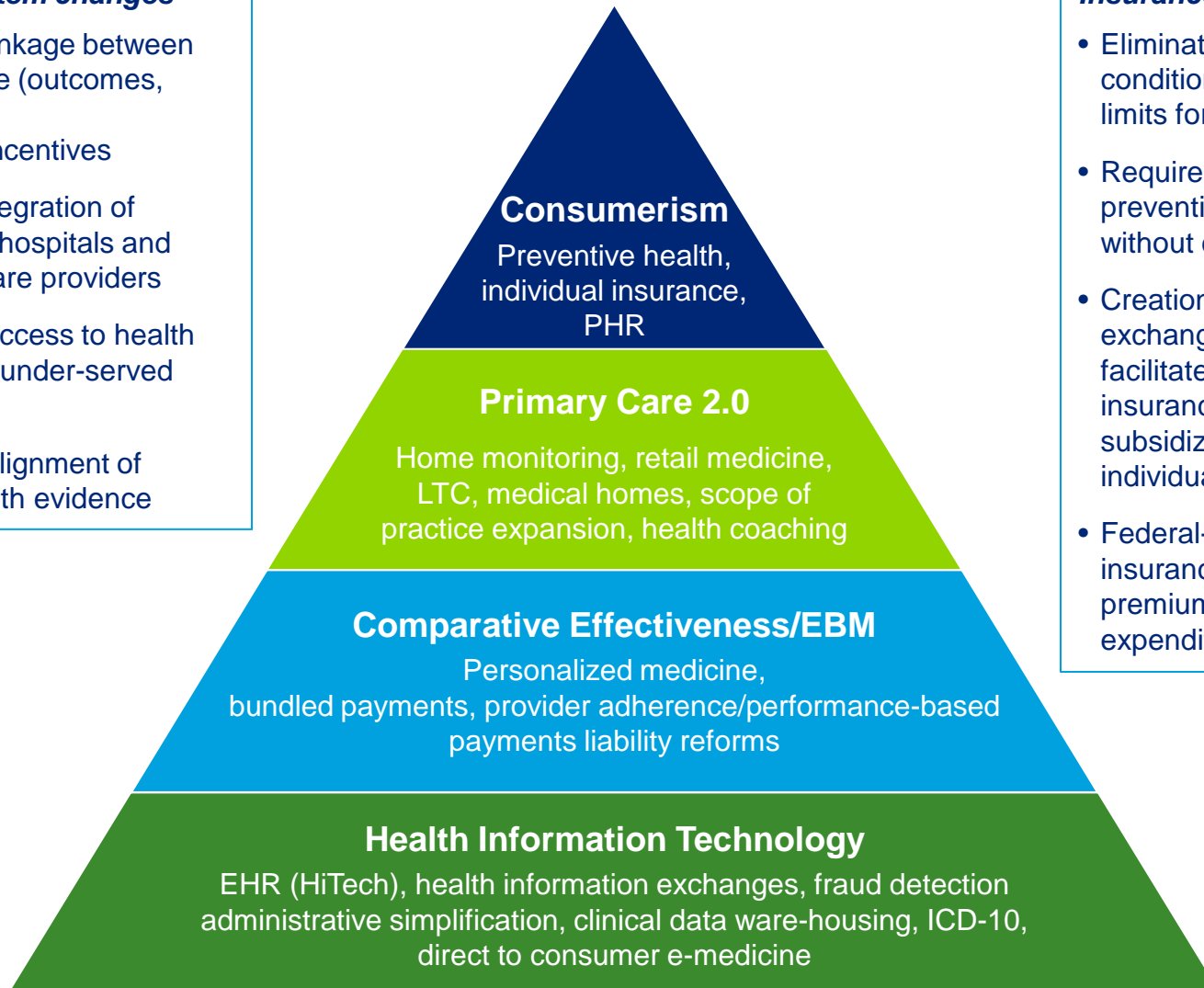
2013

2014

Intent: delivery system integration, payment system shift from fee for service to value/performance

Delivery system changes

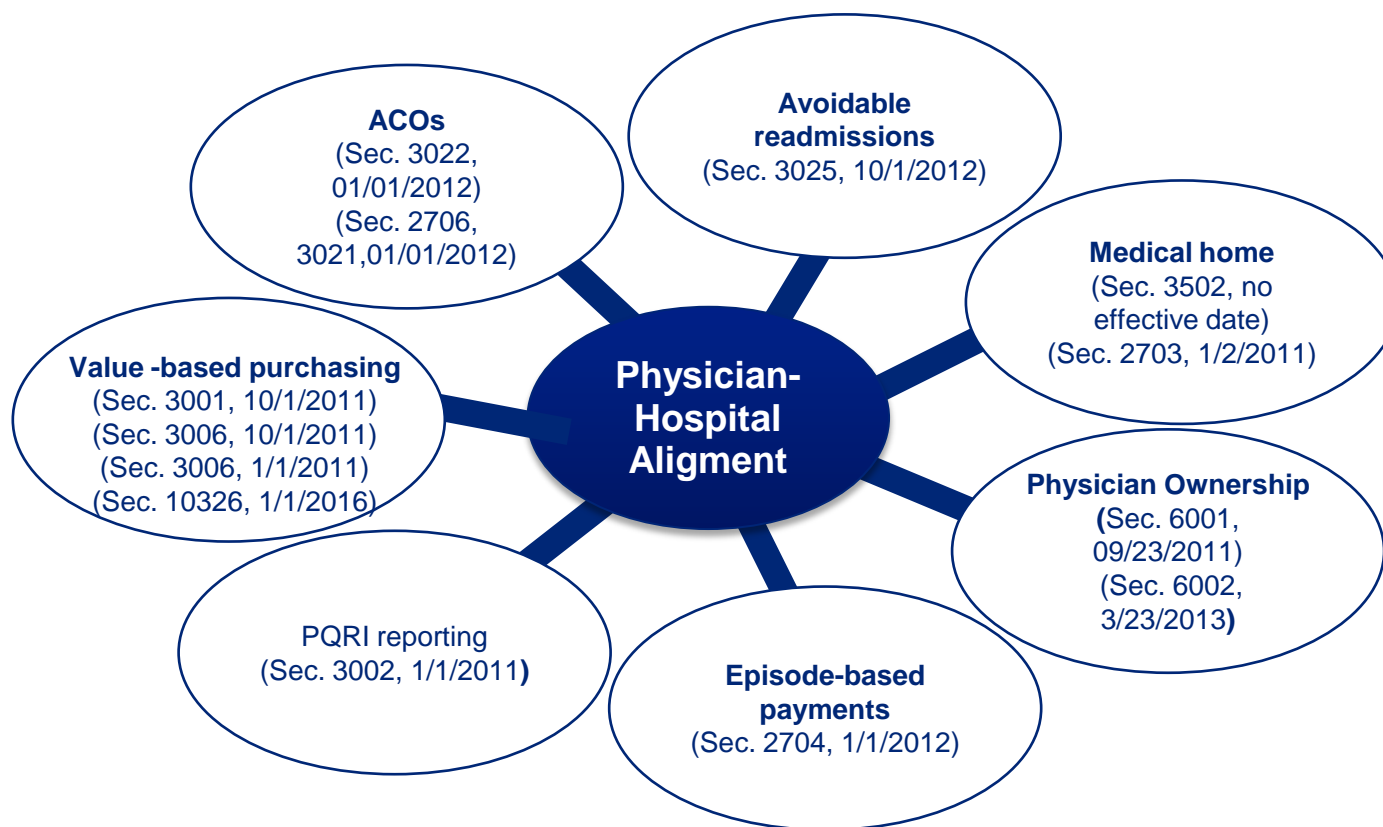
- Increased linkage between performance (outcomes, costs) and payments/incentives
- Increase integration of physicians, hospitals and long term care providers
- Increased access to health services by under-served populations
- Increased alignment of coverage with evidence



Insurance system changes

- Elimination of pre-existing condition, lifetime and annual limits for insurance plans
- Required coverage of preventive health services without co-payments
- Creation of health insurance exchanges in each state to facilitate access to affordable insurance and manage subsidized purchases by individuals and employers
- Federal-state regulation of insurance plan coverage, premiums, and medical expenditures

Delivery system integration: reflected in seven major areas of ACA: physician-hospital alignment is key



Clinical Integration Operational Competencies

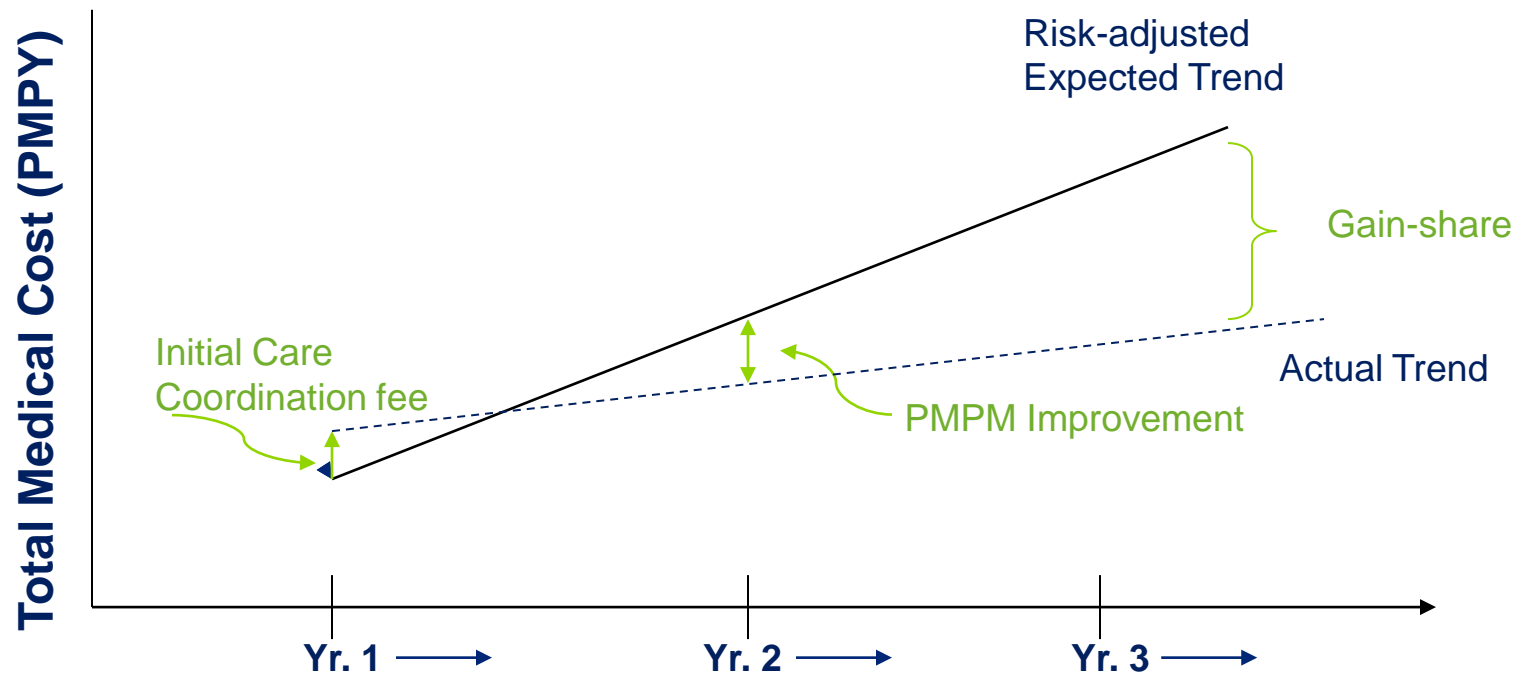
- Evidence-based guidelines embedded in clinical IT applications system wide
- Quality management and measurement: safety, outcomes, efficacy
- Shared governance: physician-hospital alignment
- Gain-sharing-based compensation for providers

Risk-based Contracting Operational Competencies

- Contract negotiation, adjudication and distribution of funds
- Medical management: provider credentialing and performance reviews
- Provider discipline
- Quality, cost reporting
- Patient adherence management

Replacement of fee-for-service payments: a desirable outcome

(in addition to standard fee-for-service payments)



In the various models of physician-hospital alignment, the implicit mechanisms that will reduce costs over time are (1) adherence to evidence-based practices facilitated by use of clinical IT and (2) payments based on value, not volume. Providers will share in upside savings but also share downside risk.

ACOs

ACOs

ACOs are legal structures that allow health care providers to collectively share risk to improve outcomes, enhance patient experience and satisfaction, reduce costs, and reduce errors

- **ACA Section 3022: Medicare Shared Savings program “ACOs” (final rule: October 20, 2011)**
 - Two tracks with different risk models
 - Four key takeaways that CMS addressed in their final rules:
 - Initial concerns about the costs associated with the implementation of ACOs
 - Anti-trust issues
 - Reducing the level of risk associated with participation
 - Clarifying the role of scope of opportunities for business partners to collaborate with provider organizations
 - CMS estimates median savings of \$470 million to the federal government for CYs 2012 through 2015 from the implementation of the Shared Savings Program

Center for Medicare and Medicaid Innovation:

ACA Section 3021/10306 created the Center for Medicare and Medicaid Innovation to test and expand innovative payment and delivery arrangements such as ACOs and bundled payment models

Pioneer ACO Model

“The Pioneer ACO Model is an Innovation Center initiative targeted at organizations that can demonstrate that improvements in financial and clinical performance with respect to the care for Medicare beneficiaries that are possible in a mature ACO” – *Center for Medicare and Medicaid Innovation, May 17, 2011*

- **Focus:** more rapid transition from fee for service to value-based purchasing; only includes a two-sided risk model with higher levels of savings and risk than under the Medicare Shared Savings program
- **Scope:** 30 ACOs serving a minimum of 15,000 Medicare enrollees
- **Duration:** three-year commitment, program starts January 1, 2012; in the third year, ACOs that have shown savings over two years can move to a population-based model
- **Estimated Medicare Saving:** \$430 million over three years (CMS Office of the Actuary)

Advanced Payment Initiative

“The Advance Payment Model is designed to provide support to organizations whose ability to achieve the three-part aim would be improved with additional access to capital, including rural and physician-owned organizations.” – *Center for Medicare and Medicaid Innovation, October 20, 2011*

- **Focus:** provides advanced savings to support capital investments in infrastructure and for care coordination and staffing
- **Eligibility:** organizations must be participating in the Medicare Shared Savings Program; only two types of ACOs are eligible: (1) ACOs that do not include any inpatient facilities and have less than \$50 million in total annual revenue and (2) ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than \$80 million in total annual revenue.
- **Structure of payments:** ACOs will receive three types of payments: (1) an upfront, fixed payment, (2) an upfront, variable payment, and (3) a monthly payment of varying amount depending on the size of the ACO

CO-OPs

Consumer Operated and Oriented Plan (CO-OP) Program

CO-OPs are private, nonprofit organization that will offer qualified health plans (QHPs) through the health insurance exchanges

- **Section 1322: CO-OPs (proposed rule: July 18, 2011)**
 - Intended to be noncommercial alternatives for insurance consumers joining health insurance exchanges that will launch in 2014
 - Provides consumers with more choices, greater plan accountability, and helps ensure a more competitive market
 - Funded through \$3.8 billion in government loans and governed by consumers
 - Key requirements in the proposed rule:
 - CO-OPs profits must be used to lower premiums, improve benefits, expand enrollment, and generally make coverage more stable for its members
 - Subject to the same market rules as other health insurers
 - Two-thirds of business must be in the individual or small-group markets

Health Insurance Exchanges

Health insurance exchanges

Health insurance exchanges (HIX) are new entities intended to create a more organized and competitive market for health insurance by offering a choice of plans and establishing common rules regarding the offering and pricing of insurance

- **Section 1311: HIX (proposed rule: July 11, 2011)**

- Per CBO, HIX facilitate coverage for up to 23 million (individuals and small employers)
- Per Center for Health Solutions analysis, HIX might accommodate up to 65 million if employers drop coverage
- 44 – 49 states likely to develop state-run exchanges; 1-6 possibly federally operated
- Final rule is expected later this year

Exchanges may enroll up to 65 million individuals by 2020

Projected enrollment in millions in year 2020

Health insurance market segment	Range
Employer-sponsored insurance, excluding Small Business Health Options Program (SHOP)	76-133
SHOP	13-21
Individual, excluding health insurance exchanges	3-7
Health insurance exchanges	23-65
Medicaid	51
Medicare	61
Uninsured	29-53

Exchanges: fulfilling a broad range of roles and responsibilities



Advisor/Navigator

Provide assistance in navigating the shopping and enrollment process



Marketing/Public outreach

Promote the exchange and regulate marketing of products and services



Eligibility/Subsidy determination

Determine who may participate and who is eligible for subsidies



Product availability/Specifications

Decide which carriers and products will be available and what information is required



Comparison shopping tools

Provide tools that consumers and small businesses can use to identify, review, and select products and prices



Enrollment and eligibility maintenance

Support standard enrollment processes and ongoing maintenance



Customer service

Respond to inquiries, grievances, and appeals



Premium collection/Reconciliation

Determine premium obligations and combine with subsidies to ensure payment for coverage

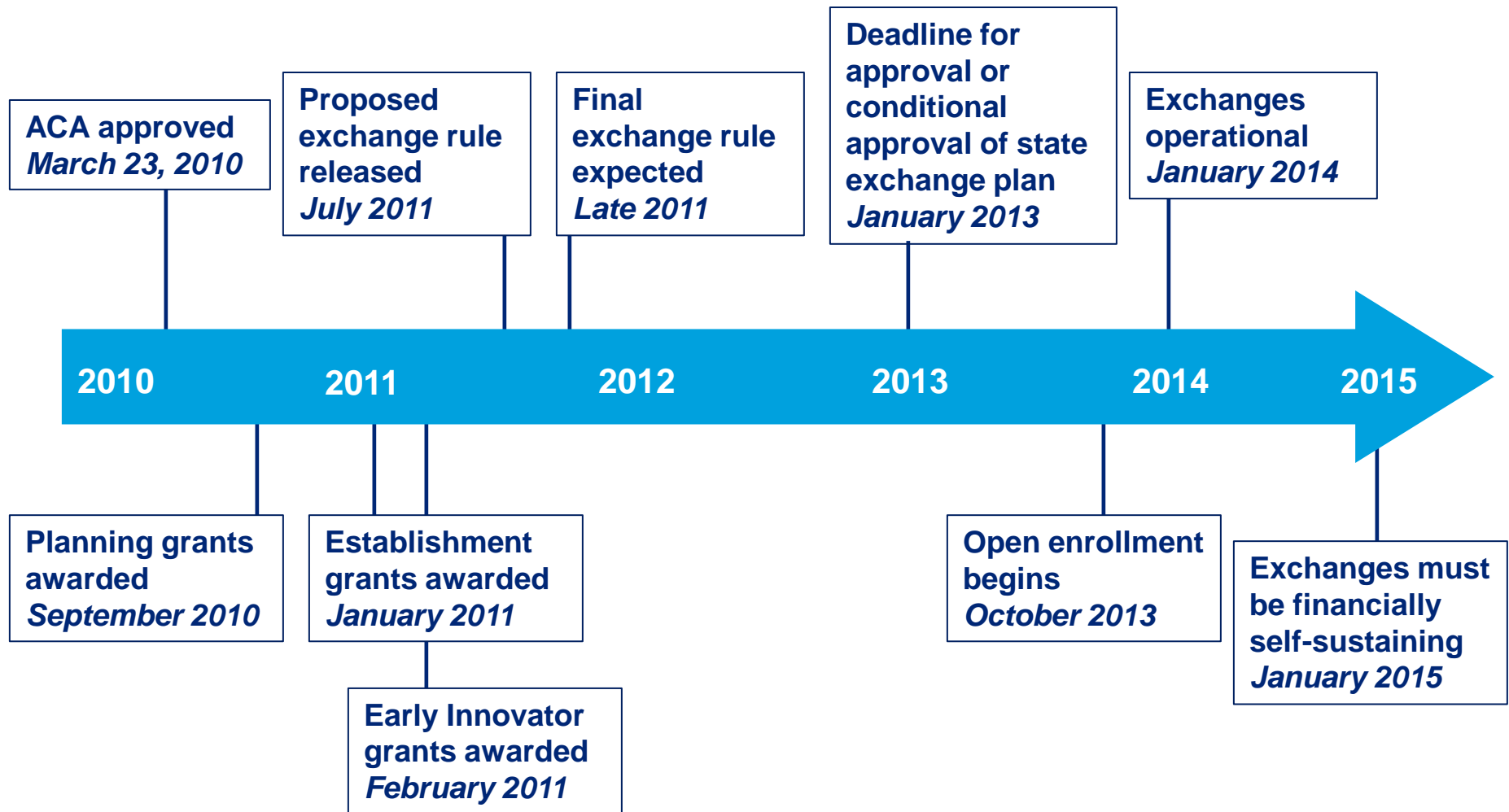


Federal/State coordination

Manage numerous intragovernmental data and process interactions and dependencies

Exchange timeline

While exchanges become operational in 2014, implementation efforts for some states began in 2010



Supreme Court and ACA

Supreme Court and ACA

The U.S. Supreme Court will hear arguments on ACA in Spring 2012 (likely March)

- **Supreme was petitioned six times to hear arguments on ACA:**
 - Five petitions for challenging the law from: the state of Virginia, the Thomas More Law Center, Liberty University, the National Federation of Independent Businesses (NFIB)
 - One petition from the U.S. Department of Justice (DOJ) supporting the law
- **Arguments will be made by the NFIB, 26 states, and the DOJ on four main issues:**
 1. Commerce clause
 2. Anti-injunction Act
 3. Severability
 4. Medicaid expansion
- **What to watch for:**
 - Impacts to the Presidential campaign
 - State implementation
 - Alternatives to the individual mandate
 - Industry reaction



“Big Questions” and Implications

Five "big questions" in ACA

- **Coverage:** Will the uninsured and newly eligible for Medicaid enroll? Will the insurance market expand by 32 million? *Will the insurance market expand to offset the new plan excise taxes, increased costs of underwriting, and required coverage?*
- **Employer exit:** Will employers drop health benefits after 2016 to facilitate direct consumer engagement and reduce their operating costs? *Will their employees purchase through the exchanges, or go without? Will employers in targeted industries exit benefits? Will insurance companies successfully transition to a retail/individual market? Should plans compete in the individual market at all? How should plans mitigate new employer need for workforce sustainability?*
- **States:** Will states be able to manage their expansion of new responsibilities and obligations? *How big is the opportunity in managed Medicaid? How likely are states to compete via state run co-ops? Will states successfully operate exchanges? How will competing plans respond to the new normal?*
- **Cost reduction:** Will delivery system reforms-ACOs, value-based purchasing, medical homes, bundled payments, comparative effectiveness-- reduce costs over time? *Is physician-hospital integration likely to commoditize plans? Shift leverage to providers? Increase costs?*
- **Federal spending:** *How will the Joint Select Committee on Deficit Reduction change ACA?*

Major implications for providers

- Radical cost reduction is key; additional Medicare cuts are inevitable and short-term increased insurance coverage not expected
- Plans will scramble; negotiations will be tougher
- Liquidity and sustainability may be stressed: accessing capital and effectively and strategically deploying it; HIT compliance, workforce re-design, clinical portfolio reviews—necessary starting points
- Physician-hospital alignment is essential to clinical integration and performance-based payments

Major implications for plans

- Radical cost reduction is key; additional Medicare cuts are inevitable and short-term increased insurance coverage not expected
- Plans will scramble; negotiations with providers will be tougher
- Liquidity and sustainability will be stressed: accessing capital cost effectively and strategic deployment necessary; transparency in business operations, compliance key focus
- Physician-hospital alignment a potential threat
- Consolidation, diversification key strategies necessary

Major implications for life sciences

- Evolving risk management strategies are key
- Impacts on the supply chain due to provider consolidation are likely
- Potential for gain-sharing models (participating with providers, health plans); new pricing models and bundled payments with providers/health plans
- Newly insured could lead to added revenue
- Increased need to employ a comparative effectiveness lens during all stages of drug development and marketing; technologies with high incremental value are likely to be rewarded

Major implications for government

- Increased use of managed care and medical management programs/services in Medicaid is likely
- Will likely see improvements in IT infrastructure, provider screening, and enrollment process
- Set-up and operation of exchanges will have vast impacts
- Increased oversight responsibility of health plans
- Seamless transition between states and federal agencies for subsidies, individuals, and tax breaks to companies

Major implications for employers

- Impact on current and retiree employee benefits costs
- Effects of design regulations (lifetime limits, dependents, pre-existing conditions, health incentives)
- Cash flow impact on projections, covenants, etc.
- Downstream effects of health insurance, pharma and device company taxes
- Effects on your suppliers and customers

Major implications for employers - HR

- Changes to current and retired employees' benefits
- HR strategy
- Off-shoring considerations
- Employee portability
- Effects of design regulations (lifetime limits, dependents, pre-existing conditions, health incentives)
- Changes to post-retirement health benefit plans

Contact Information and Recent Publications

Contact information

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Health Reform Memos

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ACO Medicare Shared Savings Program final rule summary

On October 20, 2011 CMS released the final rule for its Medicare Shared Savings Program for Accountable Care Organizations. This summary reviews the rule’s key takeaways, provides estimated program savings, and lists stakeholder implications. www.deloitte.com/us/acofinalrulesummary

The fiscal impact to states of the Affordable Care Act: A comprehensive analysis

States play a critical role in the implementation of the ACA. To inform stakeholder discussions and potential decision making, this research piece uses the Deloitte Health Reform Impact Model and the ACA Provision Mapping Tool to construct plausible scenarios to identify cost and savings drivers and evaluate the net financial impact to states of ACA. www.deloitte.com/us/acafiscalimpactstates

The impact of health reform on the individual insurance market: A strategic assessment

Changes in the individual insurance market could ripple across every sector of the U.S. health care delivery system. This issue brief investigates several potential scenarios and their impact on the individual insurance market (using analysis from Deloitte’s Health Impact Reform Model). Based on this assessment, the brief explores implications for states, health plans, and other stakeholders as they prepare for a dramatic uptick in enrollees and associated expectations.

www.deloitte.com/us/acaindividualinsurancemarket

Survey of health care consumers

Since 2008, DCHS has conducted an annual survey of health care consumers to assess behaviors, attitudes, and unmet needs, and to quantify year-to-year changes. The Survey offers health care industry leaders and policymakers a comprehensive and timely perspective about how consumers approach their health and health care. Materials include: a global report, individual country reports, and fact sheets on specific health care topics and key U.S. states. www.deloitte.com/us/2011consumerism



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