

The Effect of Health Care Reform on Hospitals: A Summary Overview

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In this white paper we summarize the prospective impact of recent U.S. health care reform legislation on hospitals, as seen in four major areas: changes in funding and reimbursement, changes in clinical operations, transparency requirements, and additional oversight measures. The specific effects include increased reporting requirements, increased funding for Medicaid and primary care, and increased taxes on medical devices.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010.¹ The accompanying Health Care and Education Reconciliation Act of 2010² (the “Reconciliation Act”) was signed one week later on March 30, 2010. We refer to the two acts collectively as “PPACA” unless otherwise noted. Though many of the legislative changes do not take effect until 2014 or later, several provisions are self-implementing and took effect immediately.

When discussions on health reform began in earnest, the hospital industry believed that cuts in Medicare reimbursement were inevitable. Rather than opposing reform entirely, the industry worked with members of Congress to receive some offsetting benefits. By virtue of their involvement, the hospital associations believe they achieved several successes, such as: (1) inclusion of insurance coverage mandates, (2) expanded eligibility through enrollment in exchanges, and (3) defeat of the single-payor and public option proposals.

Despite these successes, various concerns remain for hospitals. Many do not believe PPACA will provide coverage to an adequate number of individuals in order to significantly increase insurance coverage for hospital patients. For example, the exclusion of illegal immigrants from the mandates and exchanges leaves a significant population uncovered. In addition, meaningful tort reform is not included in the legislation. Further, many provisions within PPACA call for expanded reporting requirements. Though the stated purpose of increased reporting is to promote quality of care, there likely will be further reimbursement consequences.



¹ H.R. 3590, Pub. L. No. 111-148.

² H.R. 4872, Pub. L. No. 111-152.

Moreover, many of the provisions within PPACA are vague and lacking definitions. Implementing the PPACA provisions, a daunting task at best, lies with the agencies and the regulatory process. The regulations must be carefully developed and monitored in order to provide meaningful and viable guidance to hospitals. It is also likely that additional legislation will be developed after the November, 2010 elections to resolve ambiguities and address any number of practical problems arising from the legislation.

Here is a brief summary of several of the more substantial changes:

Funding and Reimbursement Changes

Legislative changes that will significantly affect hospital reimbursement include:

1. **Insurance Coverage Requirement.** PPACA requires virtually every citizen (there are some exemptions³) to obtain health insurance. Individuals who do not comply will face a tax penalty.⁴ This should have a positive effect on hospitals by decreasing the amount of funds hospitals expend on unreimbursed care. This requirement, along with others⁵ is estimated to provide coverage to 32 million previously uninsured individuals by 2019. They have the potential to increase admissions while reducing the amount of charity care provided by hospitals, as insured individuals are more likely to seek care. Despite the individual mandate, however, PPACA precludes the Internal Revenue Service ("IRS") from certain enforcement actions.⁶ The use of liens and seizures otherwise authorized for collection of taxes may not be used for collection of the tax penalty. Further non-compliance with the personal responsibility requirement to have health coverage is not subject to any criminal or civil penalties under the IRS Code. Thus, the individual mandate may not be entirely effective in meeting its goals and improving provider reimbursement.

To assist individuals and companies in obtaining and providing the mandated insurance, PPACA requires each state to establish an American Health Benefit Exchange (referred to herein as an "Exchange" or "Exchanges") no later than 2014 to make available affordable health insurance to individuals and companies with 100 or fewer employees.⁷ Individuals may purchase coverage through the Exchanges, with premium and cost-sharing credits available to low-income individuals and families. Separate Exchanges will be created for small businesses through the Small Business Health Options Program.⁸ These Exchanges are considered a key element in providing coverage to the currently uninsured and facilitating changes in the insurance market.

Each state has the power to create regional Exchanges or allow more than one Exchange to operate within the state, as long as each Exchange serves a distinct geographic area. Federal funding to establish the Exchanges will be available to states by March 23, 2011 through January 1, 2015.

³ Including, but not limited to, financial hardship, religious objections, American Indians, undocumented immigrants, incarcerated individuals.

⁴ Individuals who do not obtain health insurance, who are not subject to an exemption, will pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount per family or 2.5% of household income. The penalty will be phased in: flat fee—\$95 in 2014, \$325 in 2015, \$695 in 2016; percentage of taxable income—1% in 2014, 2% in 2015, and 2.5% in 2016. Beginning in 2017, the penalty will be increased annually by the cost-of-living adjustment.

⁵ Including provisions related to tax credits, subsidies, and others such as those that allow young adult children to be carried on their parents' policies and disallow insurance companies from denying coverage to children (effective September 23, 2010) and adults (effective January 1, 2014) based on preexisting conditions.

⁶ PPACA § 1501(g).

⁷ See PPACA § 1311.

⁸ *Id.*

Access to the Exchanges is restricted to U.S. Citizens and legal immigrants.⁹ Each Exchange must offer at least two multi-state plans.¹⁰ Each multi-state plan must be a “qualified health plan” and certified by the state as covering “essential health benefits.” These terms will be defined in forthcoming regulations. These provisions operate collectively to increase the number of insured individuals in the United States, which should have an overall positive impact on hospitals.

In addition, PPACA establishes an employer mandate, penalizing employers with more than 50 employees when even a single employee uses a subsidy to obtain health insurance through an Exchange. Employers that do not offer health benefits and have at least one employee receiving a subsidy to obtain health insurance through an Exchange will face a penalty of \$2,000 for each full-time employee. Employers who do offer health benefits will face a penalty of either \$3,000 per employee (full-time or part-time) who receives a subsidy, or \$750 per full-time employee, whichever is less.

2. **Bundled Payments for Episodes of Care.** PPACA establishes a five-year Medicare voluntary pilot program, beginning January 1, 2013, for integrating care across hospitals, physicians, and post-acute care providers during an episode of care¹¹ for certain medical conditions. If the pilot is successful in achieving its stated goals, PPACA allows for expansion of the program beginning January 1, 2016.

PPACA also establishes a five-year demonstration project to study bundled payments under Medicaid for hospital and physician services. The project begins on January 1, 2012. Participating hospitals must have, or establish, robust discharge planning programs for placing patients in post-acute care settings.

3. **Pay For Performance.** PPACA establishes a value-based purchasing (“VBP”) program for Medicare to pay hospitals based on performance compared to quality measures and extends the Medicare Physician Quality Reporting Initiative beyond 2010.¹² This program is similar to the VBP currently being evaluated by the Center for Medicare and Medicare Services (“CMS”) as required by the Deficit Reduction Act of 2005. Under the VBP, a percentage of payments to hospitals will be tied to a hospital’s performance on a number of quality measures for the following conditions beginning in 2013: acute myocardial infarction, heart failure, pneumonia, surgeries, and healthcare associated infections. Where a hospital meets or exceeds the performance standard for the performance period, the base operating diagnosis related group (“DRG”) payment amount is increased by a percentage for the fiscal year following the performance period. Where a hospital does not meet a performance standard for the performance period, the base operating DRG payment amount is decreased by a percentage for the fiscal year following the performance period. These quality measures and the accompanying reporting requirements are likely to increase hospital administrative costs. Whether the increased payments would offset the expected administrative costs remains to be seen.



⁹ Many provider advocates were disappointed that the legislation did not do more to ease the burden of unreimbursed care provided to illegal immigrants.

¹⁰ At least one plan must be offered by a non-profit health plan and at least one must not offer coverage for abortions. Abortion cannot be a mandated benefit as part of a minimum benefits package.

¹¹ Defined as beginning three (3) days prior to hospitalization and ending thirty (30) days post-discharge. See PPACA § 3023, as amended by § 10308.

¹² PPACA § 3001.

4. **Market Basket Updates and Reductions.** PPACA modifies the market basket updates for hospitals providing inpatient and outpatient services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals beginning in 2012. The update also incorporates a productivity adjustment. The market basket will be reduced by .25% for both 2010 and 2011, by .1% in 2012 and 2013, by .3% in 2014, by .2% in 2015 and 2016, and by .75% in 2017-2019.¹³ The productivity adjustment is the 10-year moving average of changes in private business productivity. The productivity adjustment may result in a negative market basket update, with a resulting reduction in payment rates. Failure to report the required data will result in a reduction in the hospital's annual market basket update.
5. **Expansion of Medicaid.** The federal Medicaid program, which currently reimburses 65 cents for every dollar of cost, will be significantly expanded.¹⁴ Medicaid will cover individuals up to 133% of the federal poverty level ("FPL").¹⁵ The purpose of this expansion is to help reduce state-by-state variation in eligibility for Medicaid and to include non-Medicare eligible adults under age 65 without dependent children. The mandatory Medicaid income eligibility level for children increases from 100% of FPL to 133% of FPL. States have the option to expand eligibility to individuals with higher incomes through a state plan amendment. Individuals eligible for Medicaid are not eligible for the subsidies in the Exchanges.

Full federal financing is available from 2014 through 2016. The federal government will pay 100% of the cost of coverage for newly-eligible individuals. In 2017, states will receive a 95% Federal Medical Assistance Percentage ("FMAP"), 94% FMAP in 2018, 93% FMAP in 2019, and 90% FMAP for 2020 and subsequent years.
6. **Primary Care Funding.** PPACA increases the focus on primary care by increasing Medicaid reimbursement for primary care to 100% of Medicare rates in 2013 and 2014. Further, for physicians in health professional shortage areas with 60% of their Medicare billing in primary care, PPACA provides a 10% Medicare bonus from 2011 to 2015.
7. **DSH Payments.** Beginning in 2014, payments to disproportionate share hospitals ("DSH") will be dramatically reduced. The initial reduction amount is 75%.¹⁶ After the initial reduction, increases in payments will be based on the percentage of the population that is uninsured and the amount of uncompensated care provided. The reasoning behind this reduction is that by 2014, due to the coverage mandate, most individuals should have insurance coverage. There is no published objective data on this theory, however. Hospitals have expressed concern that an increase in insured individuals will not make up for the decrease in revenue.
8. **Independent Payment Advisory Board.** PPACA establishes a fifteen-member Independent Payment Advisory Board (the "Board") to submit legislative proposals containing recommendations for reducing the per capita rate of growth in Medicare spending in the event spending exceeds a target growth rate. Beginning in 2015, the Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality. However, PPACA states that the Board's proposals shall not include any recommendations to ration health care, raise revenues, raise Medicare beneficiary premiums, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance and copayments) or otherwise restrict benefits or modify eligibility criteria.

¹³ PPACA § 3401, as amended by § 10318 and Reconciliation Act, § 1105.

¹⁴ PPACA § 2001.

¹⁵ Approximately \$14,000 for an individual and \$29,000 for a family of four.

¹⁶ PPACA § 3133.

Therefore, from a practical standpoint, the Board will likely utilize reductions in provider and supplier payments as a means for limiting growth. The focus will be on high-volume and high-cost services. It will be easier for the Board to propose savings by reducing fee schedule updates rather than proposing novel payment structures that may or may not yield near-term cost savings. The effects of this Board on hospitals will of course depend upon the Board's recommendations, but there will probably be additional administrative costs for the increased reporting requirements resulting from the Board's emphasis on quality measures.

Clinical Operations Changes

1. **Accountable Care Organizations.** PPACA allows providers organized as accountable care organizations (ACOs) and that voluntarily meet quality thresholds to share in cost savings realized by Medicare. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have "adequate" participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. Successful completion of these goals will likely reduce hospital utilization rates. This anticipated reduction may create direct competition between physicians and hospitals, as the physicians will be incentivized to reduce hospital admissions. Ultimately, the potential exists for a restructuring of the traditional hospital-physician relationship.¹⁷
2. **Hospital-Acquired Conditions.** PPACA reduces Medicare payments to certain hospitals for hospital-acquired conditions by one percent (effective fiscal year 2015). This will incentivize hospitals to improve their infection control programs and pay particular attention to the potential for other pay-for-performance indicators. Hospitals are concerned, however, that PPACA does little to define the word "condition." Under PPACA, "hospital-acquired condition" means "a condition identified for purposes of subsection (d)(4)(D)(iv)"¹⁸ and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital as determined by the Secretary." Due to the vagueness of this language, hospitals are awaiting further guidance from the Secretary regarding the scope of these provisions. Hospitals will want to participate in the notice and comment opportunity regarding these definitions, so as to avoid being penalized for conditions that may be acquired through no fault of the hospitals. In addition, administrative costs will increase due to PPACA's additional reporting requirements. A report on these infection rates will be provided to hospitals and made available to the public.¹⁹
3. **Preventable Readmissions.** PPACA reduces Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (i.e. preventable) hospital readmissions (effective October 1, 2012). The Secretary is to determine what conditions are to be included and what amounts to a readmission. The legislative text suggests that an admission to the same hospital within 30 days of the date of discharge could be considered a readmission. Again, hospitals will want to participate in the regulatory process regarding definition of hospital readmissions to ensure that the definition of hospital readmissions does include individuals who are readmitted through

¹⁷ PPACA § 10307.

¹⁸ 42 U.S.C. § 1395ww(d)(4)(D)(iv) reads: "By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements (as determined by the Secretary): (I) Cases described by such code have a high cost or high volume, or both, under this subchapter. (II) The code results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis. (III) The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines."

¹⁹ PPACA §§ 3008, 10302.

no fault of the hospital (e.g. individuals who do not follow physician or hospital orders). A report on readmission rates will be provided to hospitals and made available to the public.

Transparency

1. **Limits on aggregate physician whole ownership interests in hospitals.** PPACA narrows the Stark exception for physician ownership of hospitals. Existing physician-owned hospitals are now limited in two respects: (1) their aggregate physician ownership percentage may not increase from current levels; and (2) they may not add beds, surgical suites, or procedure rooms. Newly-constructed hospitals and hospitals currently under construction must obtain Medicare provider numbers by December 31, 2010 to avoid permanent exclusion from Medicare.²⁰
2. **Disclosure of Financial Relationships.** PPACA requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies to participate in Medicare, Medicaid or the Children's Health Insurance Program.²¹ The Secretary is authorized to deny enrollment in these programs if the affiliations pose an undue risk to the programs. Hospital compliance officers will need to draft disclosure of financial relationship policies and ensure compliance.
3. **Community Needs Assessments for Non-Profit Hospitals.** PPACA imposes a requirement on non-profit hospitals to conduct a community needs assessment every three years. An implementation strategy addressing the identified needs must be drafted. A patient financial assistance policy indicating whether free or discounted care is available from the hospital and how members of the community may apply for assistance must also be adopted and publicized. Charges to patients who qualify for financial assistance must be limited to the amount generally billed to insured patients. The hospitals must make reasonable attempts to determine a patient's eligibility for financial assistance before undertaking extraordinary collection actions. Hospitals failing to meet these requirements will be taxed \$50,000 per year.²² This provision will result in increased administrative costs to non-profit facilities.
4. **Publication of Charges.** Each hospital operating within the United States must establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups. The effective date is not specified.²³ Again, increased administrative costs are likely in order to implement this provision. In addition, this publication requirement could have an impact on negotiations with health plans and may affect the competitive position of hospitals in their communities.

Other Oversight Measures

1. **Provider Screening & Enhanced Oversight.** PPACA attempts to reduce waste, fraud and abuse in the Medicare and Medicaid programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and increased penalties for the submission of false claims. Further, an integrated data repository, which will facilitate the sharing of data across all agencies, will

²⁰ PPACA § 6001.

²¹ PPACA § 6401.

²² PPACA § 4959.

²³ PPACA § 2718, as amended by § 10101.

increase the likelihood of follow-up enforcement actions should any one action be filed against a provider.²⁴ The Secretary is authorized to suspend Medicare or Medicaid payments to a provider pending an investigation of a “credible allegation” of fraud lodged against the provider. The Secretary must consult with the Office of the Inspector General to determine whether there is a credible allegation of fraud and to promulgate regulations implementing this provision. Compliance with the enhanced screening and oversight will likely result in increased administrative costs for hospitals and, of course, the potential for increased enforcement exposure.

2. **Enhanced Data Collection & Reporting Requirements.** PPACA requires the Secretary to ensure that any federally conducted or supported health care program, activity, or survey collects and reports data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations, to the extent practicable. The legislation also requires collation of access and treatment data for people with disabilities.²⁵
3. **Device Taxes.** Medical device manufacturers must pay a 2.3% excise tax on medical device sales starting in 2013. The tax will apply to products intended for human use, but exempts eye glasses, contacts, hearing aids, and other devices often purchased by the public for personal use. Class I devices such as bedpans and other “low risk” hospital supplies are included in the tax. The provision is expected to raise \$20 billion over 10 years. It is likely that the costs of the excise tax will be passed on to hospitals and patients in the form of increased device costs.
4. **Excise Tax on High-Cost Health Plans.** Beginning in 2018, the so-called “Cadillac” plans will be subject to a 40% excise tax on the amount by which the aggregate costs of coverage (including the portions borne by both the employer and the employee) exceed an annual limit of \$10,200 for individuals and \$27,500 for families, indexed for inflation.²⁶ Higher limits apply to retirees between the ages of 55 and 64, and employees engaged in high-risk professions.²⁷ The tax is designed to discourage the offering of generous coverage plans that experts say lead to over-utilization of health care resources. The lessening of demand will eventually lead to lower volume for hospitals.
5. **1099s.** For-profit hospitals²⁸ will be subject to a requirement that will significantly increase the burden of reporting payments to third parties. In 2012, all companies will have to issue 1099 tax forms to any individual or corporation from which they buy more than \$600 in goods or services in a given tax year. Currently, 1099s are used only for contract workers. The bill makes two key changes on how 1099s are used: (1) it requires them to track payments not only for services but also for tangible goods; and (2) it requires that 1099s be issued not only to individuals, but also to corporations.²⁹ The final impact of this provision will not be known until the IRS issues its regulations, which are not expected until 2011.

 ²⁴ PPACA § 6402.

²⁵ PPACA § 3101.

²⁶ PPACA § 9001.

²⁷ \$11,550 for singles and \$30,500. *Id.*

²⁸ Non-profits are specifically excluded.

²⁹ PPACA § 9006.

6. **Trauma Center Development.** PPACA establishes a new trauma center program to strengthen emergency department and trauma center capacity. The legislation provides funding for research on emergency medicine, including pediatric emergency medical research, and develops demonstration programs to design, implement, and evaluate innovative models for emergency care systems.³⁰
7. **Center for Medicare and Medicaid Innovation.** PPACA established within CMS the Center for Medicare and Medicaid Innovation (“CMI”). The purpose of the CMI is to “test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals”³¹ CMI is tasked with addressing the fee-for-service reimbursement system in a way that is more effective and sustainable than previous federal experiments. The CMI has a \$10 billion budget through 2019. Pilot programs will be voluntary, and details on hospital participation are forthcoming.

Conclusion

Hospitals will of course be significantly affected by PPACA’s provisions. However, the full extent of PPACA’s effects cannot be ascertained at this time due to the wide latitude granted by the legislation to the Secretary of Health and Human Services in drafting the implementing regulations for the statute. The positive side of this substantial uncertainty is that hospitals now have a prime opportunity to influence the scope of the legislation by participating in the notice and comment periods for the proposed regulations as they are published. Regardless of the regulatory effects, it seems clear that hospitals will experience an increasing shift to outpatient care and that admissions for higher cost care will decline.

If you have any questions regarding the content of this white paper, please contact the Pillsbury attorney with whom you regularly work or the authors below

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³⁰ PPACA § 3505.

³¹ PPACA § 3021.

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