

State Reform Provisions 2010-2014 and Beyond

4 Primary Issue Buckets for Implementation –
All require New State Laws 2010 thru 2013

- Medicaid Expansion
- Insurance Exchanges
- Insurance reforms
- Delivery System Improvements

State Implementation **2014 - Key Year**

- Individual and employer mandates effective
- Medicaid expands to 133% FPL
- State option to create a basic health plan 133-200% FPL
- State-based Exchanges and Small Business Health Options (SHOP) operational
- Require minimum insurance benefit standards – guarantee issue, community rating, no pre-existing conditions exclusions
- Begin reductions of Medicare Disproportionate Share Hospital (DSH) allotments
- Insurance plans to provide coverage for specified services and preventive care

Complex State Issues

Short Term

- State Budgets
- Medicaid
 - Rebate claw back – 8%
 - State Plan Amendments - 21
 - Enrollment Issues
 - Administration of MCO rebate
 - Grants – 20 available
 - Waivers – 13 available
- Insurance laws and regulations
- Development of Exchange & SHOP
- PBM Transparency

Long Term

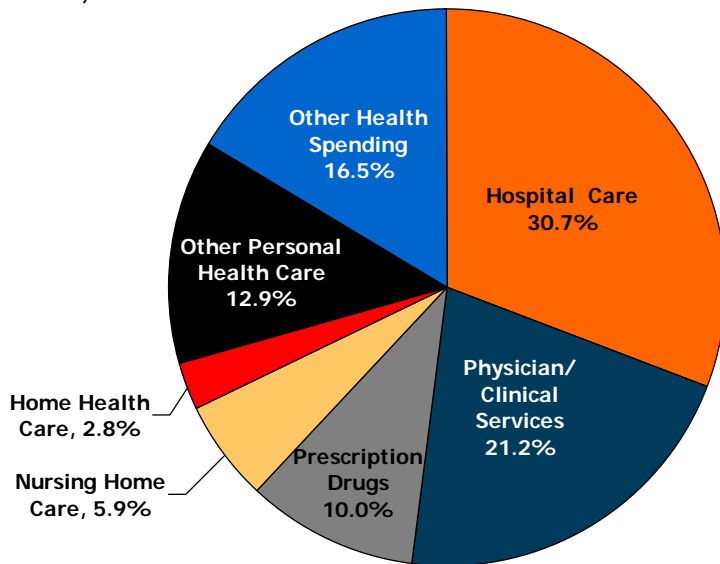
- Population shift between Medicaid and Exchanges
- State Compacts (effective 2016)
- Medicare retirees dropped from employer-based insurance
- Biosimilars authorized
- Comparative Effectiveness Review
- State to pay share of Medicaid expansion (2017)

Key Implementation Players

- Secretary of HHS
- Governors
 - National Governors Association
- State Insurance Commissioners
 - National Association of Insurance Commissioners (NAIC)
- Medicaid Directors and State Health Secretaries
- Health Insurers, Hospitals and Pharmacy Associations, Pharmacy Benefit Managers
- Patient groups
- Organized Labor & Business Groups

Distribution of National Health Expenditures

by Type of Service, 2008

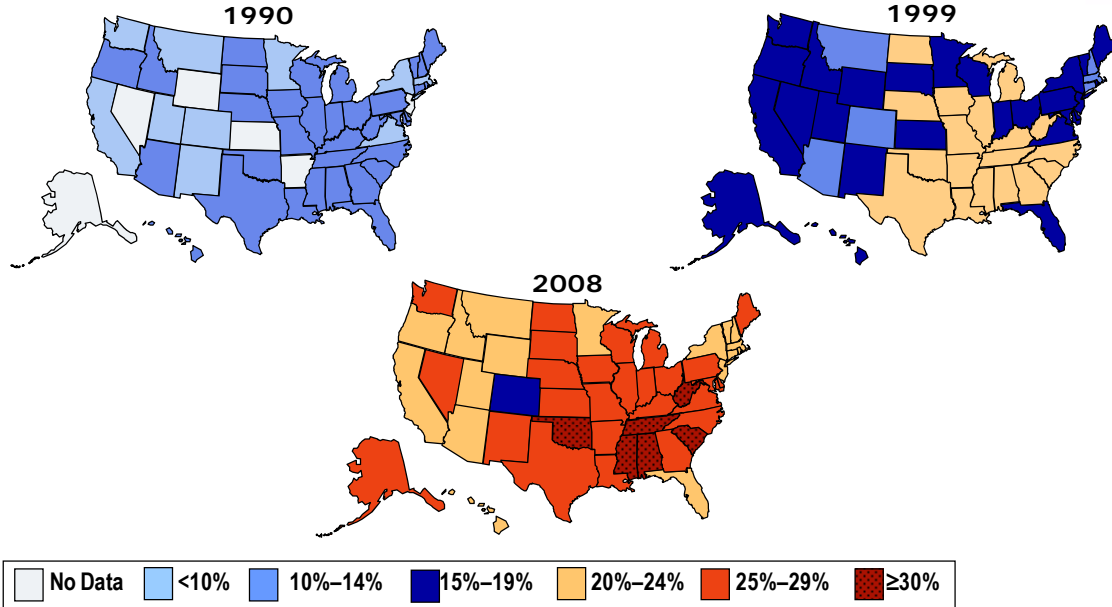


Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2008; file nhe2008.zip).

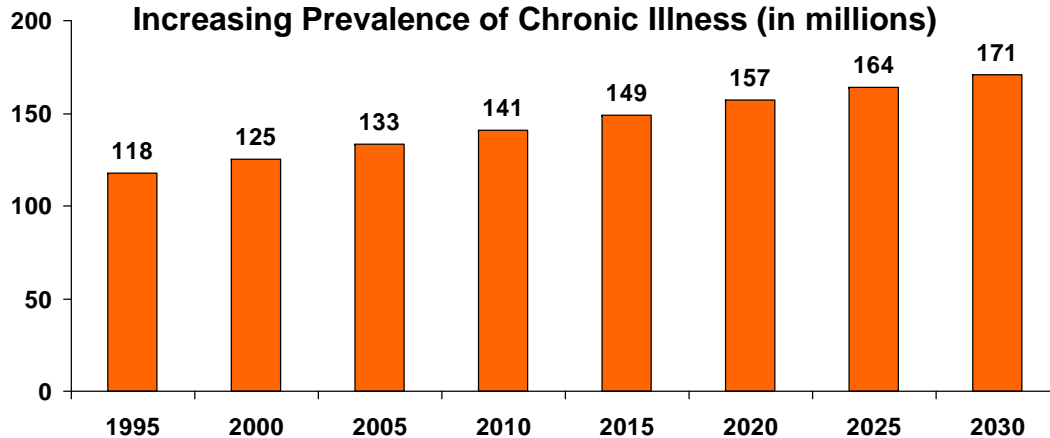
Obesity Trends* Among U.S. Adults

(*BMI ≥ 30 , or about 30 lbs. overweight for 5'4" person)



HealthCare Landscape

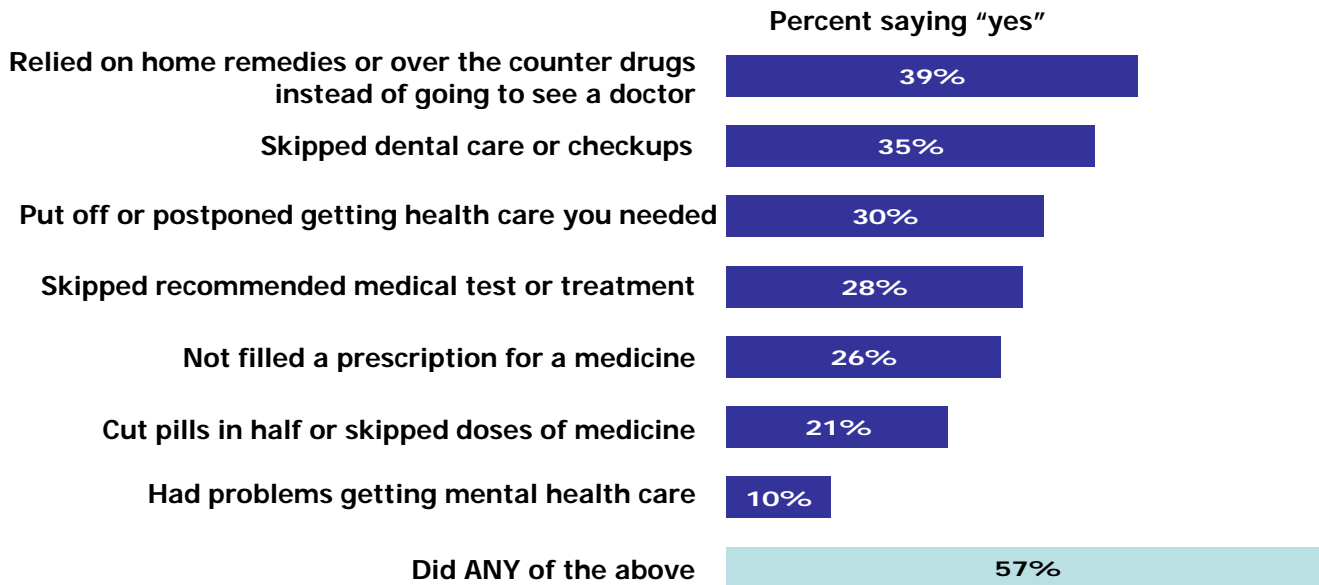
Increasing Impact of Chronic Conditions



Over 25% of young adults, roughly 50% of middle-aged adults and 69% of the elderly have one or more chronic conditions

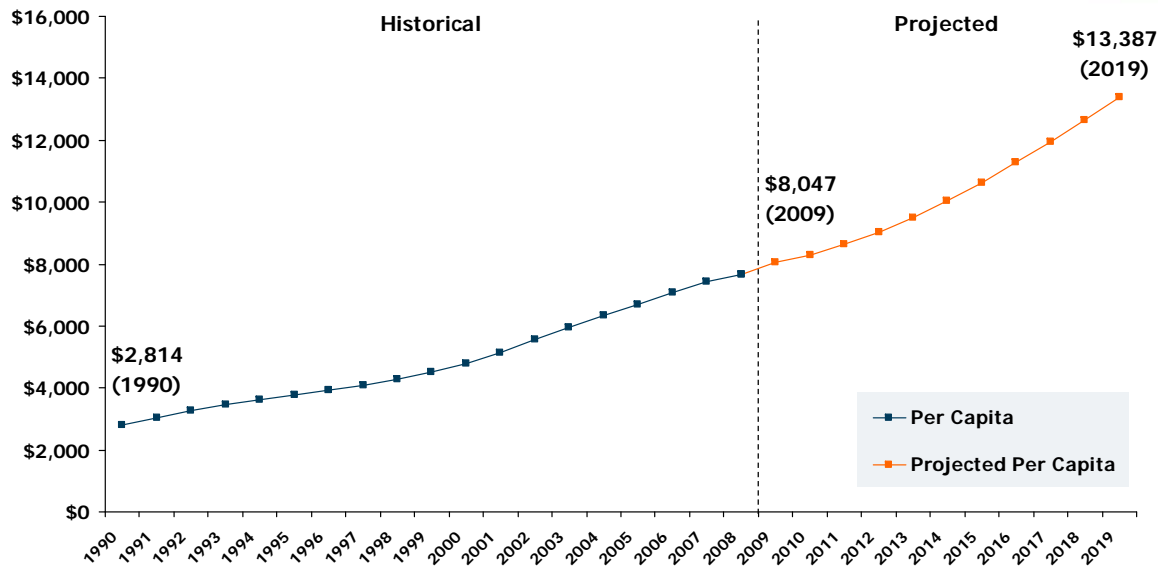
Putting Off Care Because of Cost

In the past 12 months, have you or another family member living in your household... because of the cost, or not?



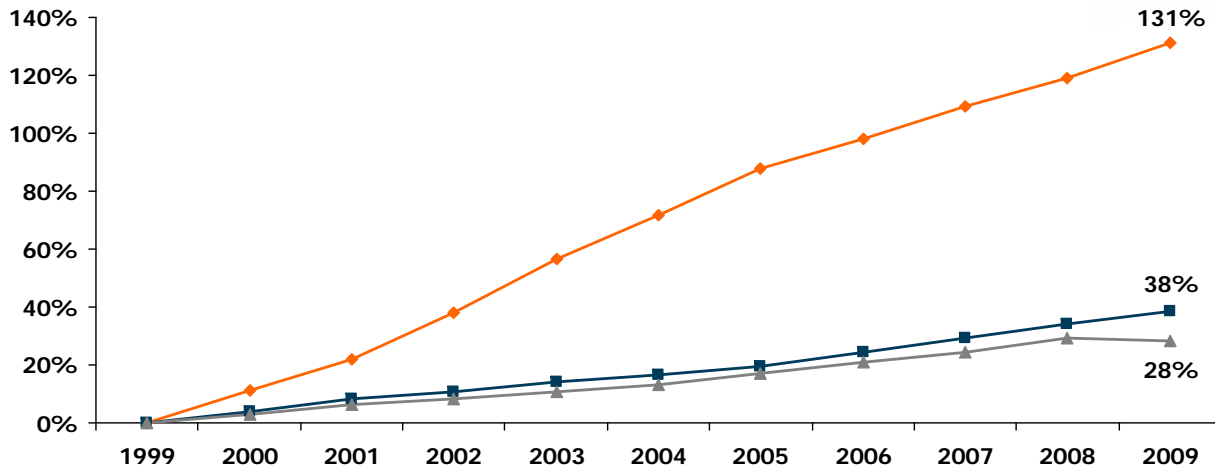
National Health Expenditures Per Capita

1990-2019



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (Historical data from NHE summary including share of GDP, CY 1960-2008, file nhegdp08.zip; Projected data from NHE Projections 2009-2019, Forecast summary and selected tables, file proj2009.pdf).

Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999-2009



Note: Due to a change in methods, the cumulative changes in the average family premium are somewhat different from those reported in previous versions of the Kaiser/HRET Survey of Employer-Sponsored Health Benefits. See the Survey Design and Methods Section for more information, available at <http://www.kff.org/insurance/7936/index.cfm>.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2009 (April to April).

—◆— Health Insurance Premiums
—■— Workers' Earnings
—▲— Overall Inflation

Physicians Slow To Adopt Connectivity

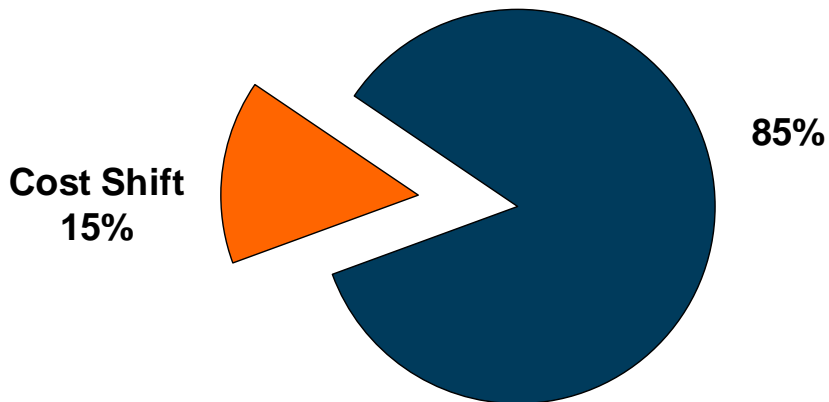
- More than 20% of physicians have a basic Electronic Medical Records system; about 6% have a fully functioning EMR system*
- The average cost per physician to implement an EMR system is \$44,000**
- Physicians from solo practices and those over 55 years of age are less likely to adopt EMR systems. ***
- 18% of nonusers do not have any plans to implement an EMR system in their practice. ***

Source: * American Medical News, February, 2010, **Miller RH, West C, Brown TM, Sim I, Ganchoff C: The value of electronic health records in solo or small group practices. Health Aff 24(5):1127-1137, 2005

*** Accenture Survey, March, 2010

Government Programs Cost Shift – 1

Medicare & Medicaid Cost Shift as percent of Commercial
Hospital & Physician Costs

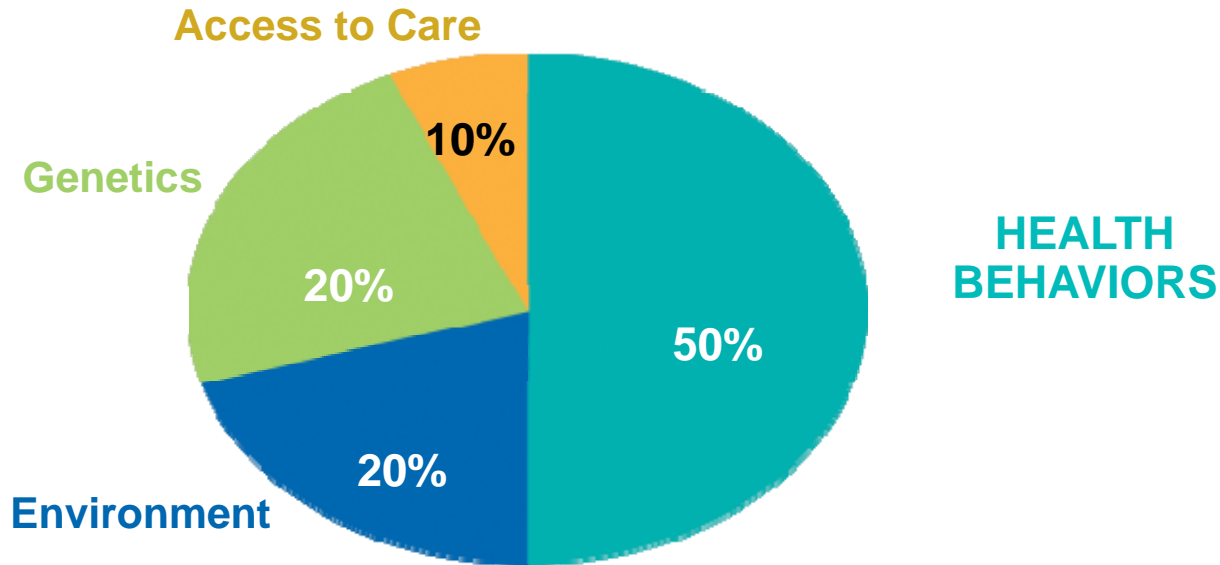


Government Programs Cost Shift – 2

- We estimate the total annual cost shift in the United States from Medicare and Medicaid to commercial payers is approximately \$88.8 billion
- We define the cost shift for each payer as the difference between the actual payment and the payment amount that would have resulted in an equal margin by payer

Medicare & Medicaid Cost Shift in Billions			
	Medicare	Medicaid	Commercial
Hospital	(\$34.8)	(\$16.2)	\$51.0
Physician	(\$14.1)	(\$23.7)	\$37.8
Total	(\$48.9)	(\$39.9)	\$88.8

Determinants of Health

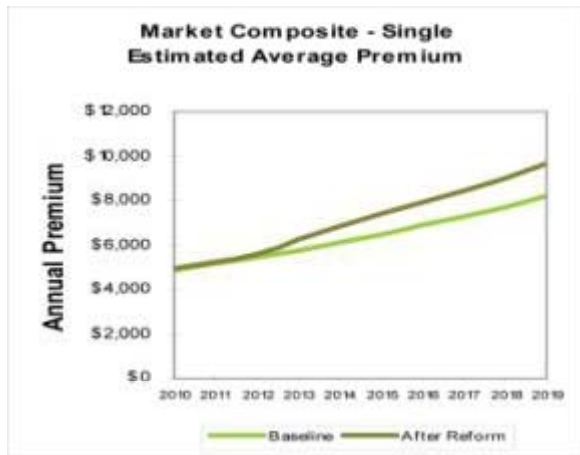


85 percent MER – Unintended Consequences

	THIS YEAR		NEXT YEAR	
Premium	\$100	100%	\$110	100%
Medical Spending	\$85	85%	\$93.50	85%
Admin	\$10	10%	\$11.06	10%
Profit	\$5	5%	\$5.44	5%
	\$100	100%	\$110	100%

**Assumption: Medical Costs ↑ 10%
in a year**

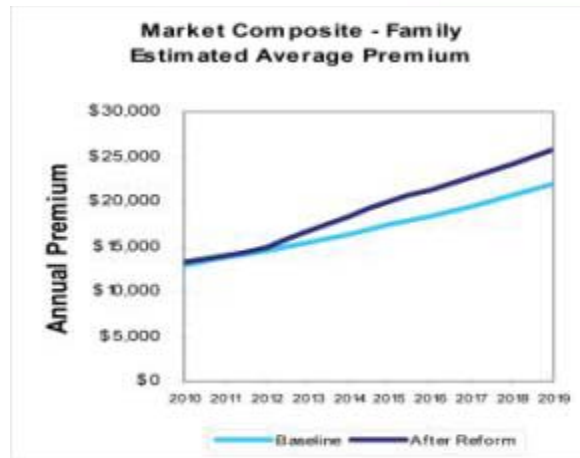
Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage



2010 Individual average premiums = ~\$4,800

2019 Absence of reform = ~\$8,200

2019 Reform becomes law = ~\$9,700



2010 Family average premiums = ~\$13,000

2019 Absence of reform = ~\$22,000

2019 Reform becomes law = ~\$26,000

Key Elements of Reform

Insurers

- Prevents insurance companies from denying coverage based on pre-existing conditions; eliminates lifetime caps
- Establishes minimum spending levels for health plans (80-85% MLR requirements)
- Brings Medicare Advantage rates down in line with traditional Medicare FFS
- Establishes a process for reviewing health plan premium increases; requires health plans to justify increases

Individuals

- Increased options for insurance coverage
- Penalties for not carrying insurance in 2014
- Expansion of Medicaid eligibility by 2014
- Subsidies for low income households in 2014
- Dependents on insurance until age 26 in 2010
- Medicare Part D “donut hole” is reduced gradually
- New taxes on wealthy and “cadillac” plans beginning in 2011
- Lower limits on FSAs

Providers

- \$500B in cuts to federally funded programs over 10 years
- Reduced bad debt exposure in 2014

Key Elements of Reform

Employers

- Penalties of \$2,000 for not providing insurance for companies with more than 50 employees (2014)
- Loss of Medicare Part D tax subsidies (2013) → Hits being recognized now according to GAAP

Other

- New taxes on insurance (2014), pharma (2012), and device companies (2013)
- Creation of health insurance exchanges (2015-2017)

Impact on Health Insurance and Providers

Health Insurance:

Pros

- Expansion of coverage provides new members
- No public option
- Expansion of Medicaid program
- Most negative provisions don't occur until 2014 and beyond

Cons

- Prohibits denial for pre-existing conditions
- No lifetime caps on benefits
- Minimum expenditure levels for health benefits
- Minimal incentives for uninsured to buy health insurance
- Increased regulatory scrutiny
- Reduces Medicare Advantage reimbursement
- Does not bend cost structure
- \$61 billion in new taxes over ten years

Conclusion

- Premiums will likely rise in anticipation of reforms going into effect in 2014
- Profits will be pressured, particularly for Medicare Advantage plans
- Cap on health insurance gross margins eliminates incentive to increase efficiency
- Expect health insurance companies to pressure providers on future rate increases as they adjust to negative reform provisions
- Expect new wave of consolidation in the health insurance sector

Providers:

Pros

- Fewer uninsured reduces bad debt exposure
- Extended reimbursement visibility

Cons

- A fix to the 21% Medicare Physician rate cut remains unresolved and goes into effect April 1, 2010. Legislative fix likely to remain a patch
- Bad debt exposure related to 20 million illegal aliens

Conclusion

- Providers will benefit from treating fewer uninsured patients, although this will be somewhat offset by commercial payer pricing pressure and a higher mix of lower margin Medicaid admissions
- Growth of insured population will lead to higher service volume for providers. Access to primary care physicians will tighten and excess provider capacity will diminish
- Extended Medicare reimbursement visibility should drive growth spending and trigger a new wave of M&A and capital raising activities, near-term

Other Areas of Healthcare Impacted

Pharma/Biotech

- Prescription drug utilization should increase with decline in uninsured
- Reduction of Medicare Part D “donut hole”
- \$16 Billion in new taxes and fees over the next 10 years plus “donut hole” concessions
- Increased protection for branded drugs
- Increased usage of generics

Healthcare IT

- Healthcare IT sector largely immune to reform bill as \$35 billion worth of “incentives” passed in \$787 stimulus bill
- Opportunities to address the government’s call for increased use of technology

PBMs

- Growth of insured population should increase prescription volumes for PBM administrators
- Rising healthcare costs will prompt plan sponsors to seek greater pharma cost controls

Medical Devices

- 2.3% excise tax beginning 2013
- Manufacturers could benefit from increased volumes driven by expanded insurance coverage

Labs

- Growth in insured population should drive increased lab testing volume
- Lab providers could see increased health plan pricing pressure

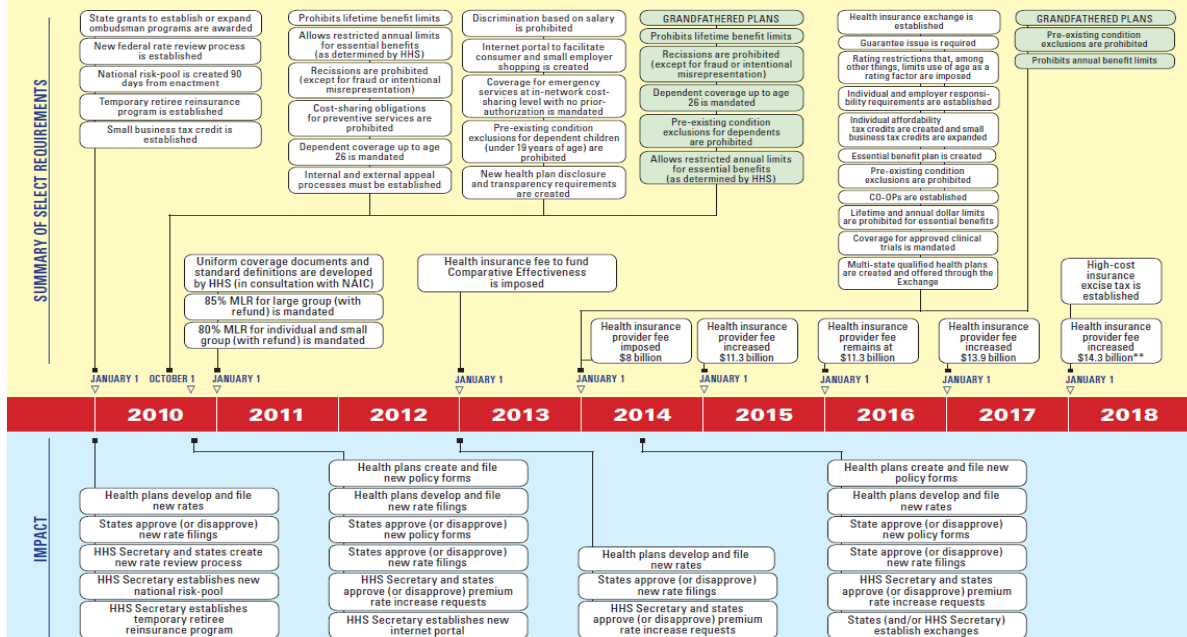
Did this legislation achieve what it set out to do? Is this Health Care Reform or Health Insurance Reform?

Jury' s still out

1. it's not over yet – 8 years of critical regulatory implementation (see slide)
2. Legislative tweaks will happen (see second slide)
3. Mid term elections could impact changes – very divided electorate but seniors who vote are opposed(see 3 & 4th slides)
4. 20 states have sued

Implementation: 8 Years – It's Not Over Yet

Health Care Reform Bill Insurance Market Provisions Timeline (as revised by the House Reconciliation Bill)*



How will the passage of Health Reform impact elections this year? How angry are Americans and will the anger last into the next election cycle?

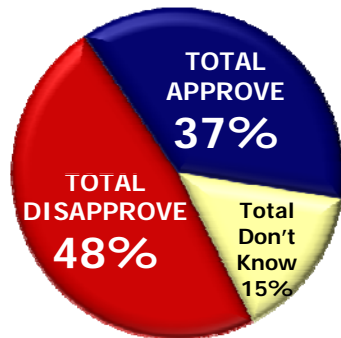
Nothing's ever finished in politics . . .



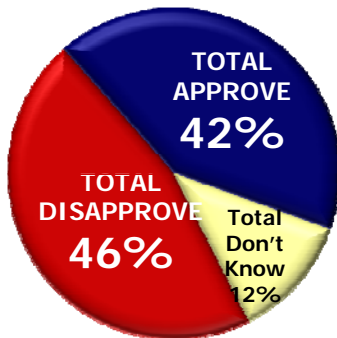
If it feels like a country divided on health care, it is . . .

Health Care Bill Approve/Disapprove

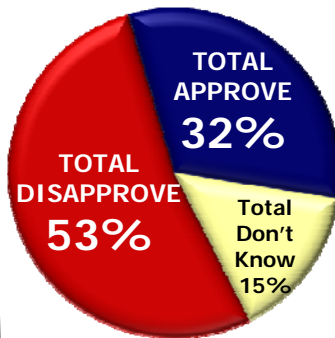
Immediately
Before Vote



Immediately
After Vote



TODAY
(April 2, 2010)



The age divide over health care reform support



“The biggest shift toward support of the bill was among low-income Americans, minorities, and those under 40. That has created a yawning age divide: a solid majority of seniors oppose the bill; a solid majority of those younger than 40 favor it.”

**– USA TODAY
March 23, 2010**

Political Challenge – Democrat Support More Lukewarm



Views About The Health Care Bill (March 25-28, 2010)

Approve of the bill becoming law
and have no reservations about it

15%

Approve of the bill becoming law
but think it did not go far enough

27%

42%

Disapprove of the bill becoming
law but support a few of its
proposals

31%

Disapprove of the bill becoming
law and oppose ALL of its
proposals

25%

56%



9. How will Health Reform change your business model?
 1. Exciting new cures part of model patients don't want changed – (see slide on new paint treatment)
 2. Changing mix of payers (see slide)
 3. Our business model is tied closely to prescribers and payers (see slide)

- Sodium channels are responsible for detection and conduction of pain
- Human sodium channel mutations cause extreme pain syndromes



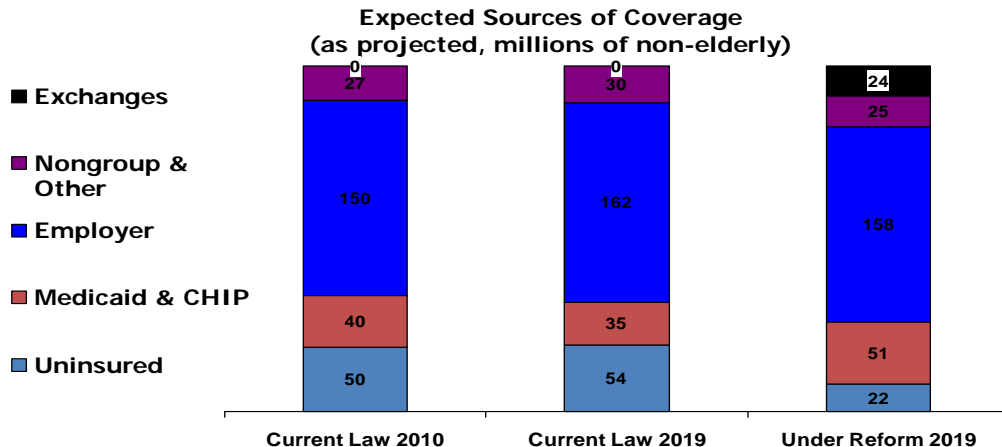
Congenital Indifference to Pain



Erythromelalgia

Therefore: Blocking human sodium channels will block pain

Likely Effects of Reform on Insurance Coverage



Reform expands Medicaid by 16 million and enrolls 24 million in the health insurance exchange (most with a government subsidy), there will be some small erosion of employer coverage. The net effect is 32 million fewer uninsured by 2019.

Sources: CBO Preliminary Analysis of HR 3590 + Reconciliation HR 4872, March 2010 projections

Physician Squeeze

***59% Think the Quality
of Medicine will Decline
in the Next Five Years***



***Change to Electronic
Medical Records***



***64% Believe Clinical
Decisions are Based
What Payors Will Cover
Rather Than What They
Think is Best for Patients***



***Medicare & Medicaid
Reimbursement Challenges***



2. What, in your view, was a critical missing factor in the legislation and do you see it ever getting addressed in the foreseeable future?

Act Two? Consumer responsibility towards cost containment, Medical liability reform, More uninsured

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"I don't feel quite as fulfilled when I've saved a lawyer."

We need to find a way to make it work

