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Reactions to Health Care Reform

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United States citizens keeping up with the status of health care reform have had a lot to say since the U.S. Supreme Court issued a final ruling in June largely upholding the Patient Protection and Affordable Care Act (PPACA). Like any discussion or debate, the controversial decision evoked responses of support and opposition from several different groups.

During a session at ACA International's 73rd Annual Convention and Expo, Michael Robbins, senior vice president of financial policy and advocacy at Maryland Hospital Association in Elkridge, Md., discussed the details of the PPACA and what the future of the new law may bring. The Supreme Court's decision that the individual insurance mandate was constitutional and that provisions of the proposed Medicaid expansion were unconstitutional generated a wide variety of responses from the American public.

Congress Plan of Action

With the upcoming presidential election in November, it is difficult to determine what actions Congress will take toward implementing the PPACA.

"How Congress responds to the Act and how they move forward with it will have an impact on who gets covered and how quickly they receive coverage," Robbins said.

Congress is responsible for passing budgets that will fund all of the financial commitments made in the Affordable Care Act. Robbins noted that despite which political party wins the election, both parties will need to recognize that the U.S. has a sizeable federal deficit when considering actions to implement the Act.

"Irrespective of what the political persuasion is, you may find both parties coming around back in January 2013 and deciding that many of the activities surrounding the Affordable Care Act and the expansion of coverage just can't be afforded in the federal budget," Robbins said.

States' Reactions and Dilemmas

Following the Supreme Court's decision to limit the federal government's ability to penalize states for failing to expand Medicaid, each state must individually make a decision about the commitment it wants to make to Medicaid expansion and determine whether it will set up health insurance exchanges.

"It's a question every state must face: whether they want the federal government to run the exchange in their state, or whether the state wants to set up their own exchange," Robbins said. "If states set up their own exchange, they can determine what kinds of plans are offered, who gets covered, and what the rules will be for being eligible for coverage."

The key question for many states considering state-driven insurance exchanges is whether the state has the ability to fund the exchange long term. Currently, the Act allocates millions of dollars to states to assist them in setting up exchanges. Robbins stated, however, that some state governors have chosen to reject the funds because the federal funding is only available until the exchange is up and running; funds do not support the ongoing costs of operating the exchange. Thus, once the exchange is fully operating, the state-based exchanges must be self-supported since there will be no further federal funding.

According to Robbins, one concern states have with a federal-driven exchange option is that the federal government would set the rules for coverage and may mandate certain types of services in the exchange that the states may not want to cover.

"It's a question of whether the states want to be in control of what is offered through their own state-based

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Pharmacies to Help Customers Learn About Benefits

In a report released on Aug. 15, 2012, Health and Human Services (HHS) announced partnerships with several pharmacies to help customers learn about new Medicare benefits available to them under the Affordable Care Act. These partnerships – with CVS Caremark, Walgreens, Thrifty White, Wal-Mart, and Sam's Club – will provide Medicare beneficiaries a range of educational materials on newly available preventive services, as well as savings on prescription drug spending in the "donut hole" coverage gap.

Some examples of how pharmacy partners are working to increase awareness of preventive services available under Medicare include the following:

- CVS Caremark is distributing material about new preventive services covered at no cost to beneficiaries at its more than 7,300 CVS/pharmacy stores and 600 MinuteClinic locations, through brochures, register receipt messages and online.
- Thrifty White Pharmacy is providing information on preventive services through its 85 locations throughout the Midwest.
- Walgreens is distributing information in nearly 8,000 pharmacies and over 350 Take Care Clinic locations, as well as using in-store announcements and providing this information as part of its Walgreens Way to Well Health Tour with AARP.
- HHS is working with Wal-Mart and Sam's Club to provide health care information to their shoppers online.

New Rules Could Save $9 Billion Over Ten Years

Health and Human Services (HHS) announced the release of a new rule on Aug. 7, 2012, that aims to cut red tape for doctors, hospitals and health plans. The regulation adopts operating rules for making health care claim payments electronically and describing adjustments to claim payments.

Studies have found that the average physician spends three weeks a year on billing and insurance related tasks, and, in a physician's office, two-thirds of a full-time employee per physician is necessary to conduct these tasks. Many physician practices and hospitals receive and deposit paper checks, and manually post and reconcile the health care claim payments in their accounting systems. By receiving payments electronically and automating the posting of the payments, a physician practice and hospital's administrative time and costs can be decreased.

The operating rules build upon industry-wide health care electronic fund transfer (EFT) standards that HHS adopted in January of this year. Together, the previously issued EFT standards and the EFT and electronic remittance advice (ERA) operating rules are projected to save between $2.7 billion and more than $9 billion in administrative costs over ten years by reducing inefficient manual administrative processes for physician practices, hospitals, and health plans.

Final Rule Increases Payments to Hospitals

On Aug. 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates fiscal year (FY) 2013 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs), and builds on the Obama Administration's work to slow growth in future health care costs by improving patient care.

The final rule also implements key elements of the Affordable Care Act's hospital value-based purchasing and hospital readmissions reduction programs. The rule advances Administration efforts to tie Medicare payments to quality health care across the delivery system, with new quality reporting measures for general acute care hospitals in FY 2015 and FY 2016; new measures for long-term care hospitals in FY 2016, and new quality reporting programs for psychiatric hospitals and cancer hospitals. In addition, the rule establishes new reporting and other requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program.

Under the final rule, payment rates to general acute care hospitals will increase by 2.8 percent and LTCH payments are expected to increase by $92 million or 1.7 percent in FY 2013.

To provide hospitals with an incentive to reduce hospital readmissions and improve care coordination, the Affordable Care Act created a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 (for discharges on or after October 1, 2012) to certain hospitals that have excess readmissions for three selected conditions: heart attack, heart failure and pneumonia. The rule finalizes a methodology and the payment adjustment factors to account for excess readmissions for these three conditions.

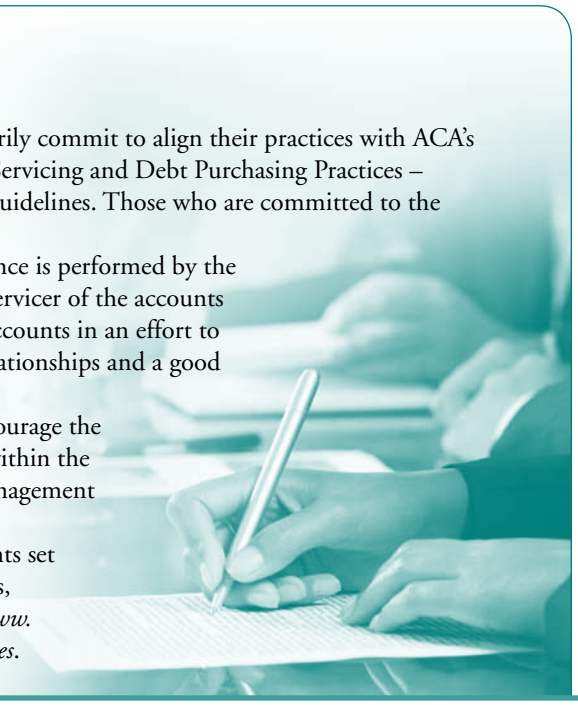
For further information, please visit *http://www.cms.gov/apps/media/press_releases.asp*.

Did You Know?

ACA members can voluntarily commit to align their practices with ACA's Health Care Collection, Servicing and Debt Purchasing Practices – Statement of Principles and Guidelines. Those who are committed to the principles agree to:

- Encourage that due diligence is performed by the health care provider, the servicer of the accounts or the debt buyer of the accounts in an effort to promote solid business relationships and a good reputation for all.
- Actively promote and encourage the highest level of integrity within the health care receivables management industry.

To view other commitments set forth by the guiding principles, visit ACA's website at *http://www.acainternational.org/hcguidelines*.



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exchanges, or if they want the federal government to dictate the rules," Robbins said.

The Public's Concerns

The PPACA's individual insurance mandate requires almost everyone in the U.S. to obtain health care coverage. At this point, however, it is unknown whether individuals who are not currently insured will buy insurance through the health insurance exchanges, go through plans that are already in the marketplace, or opt to pay the penalty.

"That's a decision people will look at and say, 'Well, if it's more expensive for me to buy health insurance in the marketplace, then I might as well just pay the penalty,'" Robbins said. "The choice will vary from person-to-person and state-to-state, depending on the cost of care."

A main goal of the Act is to try to reduce the cost of health insurance, particularly the cost of insurance purchased through the government exchanges. In order to persuade people to buy health care coverage, the penalty for not having insurance will be, in some cases, more costly to a person than actually having insurance. For some people, however, it still may be less expensive for them to pay the tax penalty.

"None of these changes are going to happen overnight," Robbins said. "When the PPACA becomes fully effective, we will have a clearer picture on the insurance exchanges and the total effect the Act has on health care."

Watch next month for an article discussing the impact health reform may have on health care accounts receivable.

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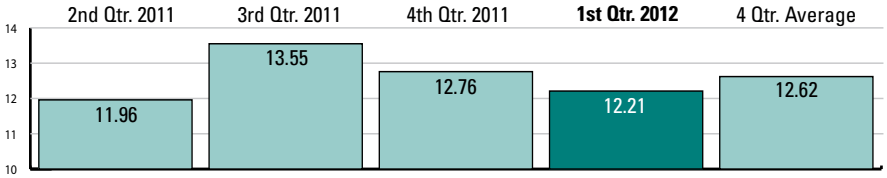
DATA WATCH

Days from Discharge to Bill

U.S. hospitals continue to chip away at the national discharge-to-bill time average, reporting a half-day improvement for this major financial indicator. Still, benchmark level bill time performance remains elusive.

U.S. hospitals reported a 12.21-day discharge-to-bill time average in first quarter 2012, or 2.21 days greater than the benchmark, which is to submit claims within ten business days. The four-quarter average, which spans second quarter 2011 through first quarter 2012, also exceeds the benchmark at 12.62 days.



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