

Healthcare Organizations: [Financial Management Strategies]

February 2009 Newsletter



The CBO Health Insurance Financial Report - Discerning Insights into Obama Administration Policy -

Since our last issue, the Congressional Budget Office [CBO] - led by Director Peter Orszag - released a major report detailing financial options for health care reform. The title: "*Key Issues in Analyzing Major Health Insurance Proposals and Budget Options, Volume I: Health Care.*"

The work is an inventory of all health care reform options being discussed by the "change-seeking" Obama Administration with a cost/benefit analysis detailing the impact on federal spending. Of course, private spending would be affected as well, but it does give a relative cost index to compare the plethora of health care reform ideas. The 400 page document makes a number of critical points, summarized below:

Change the Health Insurance System:

- Foster the Formation of Association Health Plans.
- Allow Individuals to Purchase Non-Group Health Insurance Coverage.
- Impose a "Pay-or-Play" Requirement on Only Large Employers.
- Establish a National High-Risk-Pool Program.
- Establish a National Reinsurance Program Providing Subsidies for Privately Insured Individuals.
- Create a Voucher Program to Expand Health Insurance Coverage.
- Require States to Use Community Rating for Small-Group Health Insurance Premiums.

Change the Health Insurance Tax System:

- Reduce the Exclusion for Employment-Based Insurance and the Deduction for Self-Employed.
- Replace the Tax Exclusion for Employment-Based Insurance with a Phased-Out Deduction.
- Disallow New Contributions to Health Savings Accounts.
- Replace Income and Payroll Tax Exclusions on Employer Insurance with a Refundable Credit.
- Expand Access to Public Programs.
- Raise the Age of Eligibility for Medicare to 67.
- Create a Medicare Buy-In Program for Individuals Ages 62 to 64.
- Expand Medicaid Eligibility to Include Adults with Income below the Federal Poverty Level.
- Create a Medicaid Buy-In Program.
- Expand Medicaid Eligibility to Include Parents with Income below the Federal Poverty Level.

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Change Quality Initiatives and the Pay-for-Performance [P4P] Agenda:

- Reduce Medicare Payments to Hospitals with High Readmission Rates Above the 50th Percentile.
- Expand the Hospital Quality Incentive Demonstration to All Hospitals.
- Deny Payment under Medicaid for Certain Hospital-Acquired Conditions.
- Allow Physicians to Form Bonus-Eligible Organizations and Receive P4P Based Compensation.
- Pay Medicare Primary Care Physicians through Partial-Capitation, with Bonuses and Penalties.
- Pay for a Medical “Home” for Chronically Ill Beneficiaries in Fee-for-Service Medicare.
- Fund Research Comparing the Effectiveness of Treatment Options.

Change Medical Provider Payments:

- Reduce Medicare’s Fees for Physicians in Areas with Unusually High Spending.
- Reduce Medicare’s Payment Rates across the Board in High-Spending Areas.
- Reduce Updates in Medicare Fee-for-Service Payments to Reflect Expected Productivity Gains.
- Reduce the Medicare Update Factor for Hospitals’ Inpatient Operating Payments by 1 Percent.
- Reduce the Medicare Update Factor for Payments to Providers of Post-Acute Care by 1 Percent.
- Eliminate Medicare Inflation-Related Update Rates for Home Health Care for Five Years.
- Set Benchmarks for Private Medicare Plans Equal to Local per Capita Fee-for-Service Spending.
- Require Manufacturers to Pay a Minimum Rebate on Drugs Covered under Medicare Part D.
- Modify the Physician Sustainable Growth Rate [SGR] with Annual Updates.
- Base the SGR on the Medicare Economic Index [MEI] and Include a Part D Hold-Harmless.

Change the State Children’s Health Insurance Program:

- Eliminate Allotment Caps and Permit Expanded Coverage up to 400 % of Federal Poverty Levels.

Change Premium and Cost Sharing in Federal Programs:

- Require a Copayment for Home Health Episodes Covered by Medicare.
- Impose Cost Sharing for the First 20 Days of a Stay in a Skilled Nursing Facility Under Medicare.
- Impose a Deductible and Coinsurance for Clinical Laboratory Services Covered by Medicare.
- Institute a Premium for Higher-Income Enrollees under Medicare’s Drug Benefit, like Part B.
- Increase Funding for Medicare/Medicaid Fraud and Abuse Programs by \$1 billion.
- Increase the Payroll Tax Rate for Medicare Hospital Insurance by One Percentage Point.

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Change the Current State of Health Information Technology:

- Create Medicare Incentives for Adoption of HIT Including Bonuses/Penalties for Physicians.
- Require the Use of Health Information Technology as a Condition of Participation in Medicare.

Change the Legal System and Institute Medical Malpractice Reform:

- Limit Awards from Medical Malpractice Torts.

Now, while we do not necessarily agree with all of the above, considering each line item is a prudent way to launch any healthcare financial reform initiative. Nevertheless, the capitalistic conclusion is that *what* we pay has the potential to matter more than *how* we pay for healthcare in the US. And most, if not all items, are - or will be - addressed in future issues of Healthcare Organizations [Financial Management Strategies].

PS: *Don't forget to review-read-rave and rant online at our web-blog and new communications forum.*

Faternally,

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U.S. GOVERNMENT HEALTHCARE REVIEW SUMMARY*

By Richard Frye; PhD

Forte Information Resources, Denver, Co.

This healthcare review digest features a comprehensive overview of the Medicare and Medicaid programs for 2007, including data on Medicare prescription drug coverage and common diagnoses and procedures of Medicare beneficiaries and Medicaid recipients in hospitals.

Medicare Industry Summary

- The total number of Medicare beneficiaries receiving their benefits from Medicare Advantage (MA) plans jumped more than 20% in 2007, to 8.7 million from 7.2 million the previous year.
- At year-end 2007, 19.9% of the 43.6 million Medicare beneficiaries in the U.S. were enrolled in MA plans. Since 2005 (14.0%), MA penetration into Medicare has grown by nearly six percentage points.
- More than half (227 of 443, or 51.2%) of all HMOs operating in the U.S. enrolled Medicare beneficiaries, up notably from 43.5% (195 of 448) in 2006. Enrollment in these plans rose 11.6% over this time, to 6.2 million from 5.5 million in 2006, the highest such total since 2000 (6.7 million).]
- After three consecutive years in which the average length of stay (ALOS) per Medicare hospital admission held steady at 5.7 days, this measure increased 5.3% in 2007, to 6.0 days. This growth occurred at HMOs in all three member ship size categories.
- HMOs that enrolled Medicare beneficiaries averaged 39.4 specialists per 1,000 HMO members in 2007, up 5.9% from 37.2 the year before, the fifth consecutive annual rise.

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- The percentage of Medicare HMOs that allowed their members to choose between brand name and generic drugs was 87.2% in 2007, up more than eight percentage points from 79.0% the previous year.
- Between January 2007 (78.4%) and January 2008 (85.0%), the overall percentage of Medicare beneficiaries with some form of creditable prescription drug coverage grew nearly seven percentage points.

Medicaid Industry Summary

- The total number of Medicaid recipients enrolled in managed care organizations (MCOs) fell, to 28.5 million in 2007 from 28.9 million in 2006.
- Of these Medicaid recipients enrolled in MCOs nationwide in 2007, 19.5 million (68.4%) were in HMOs, up notably from 18.4 million (63.6%) in 2006.
- The average number of physician encounters per Medicaid HMO member was 4.1 in 2007; up 10.8% from 3.7 in 2006. Medicaid HMOs with fewer than 5,000 members experienced the most dramatic percentage growth in this measure, to 3.1 from 2.6 in 2006, or 19.2%.
- In 2007, Medicaid HMOs with 18,000 or more members averaged 12.2 primary care physicians (PCPs) per 1,000 Medicaid members, down 12.9% from 14.0 in 2006. By comparison, Medicaid HMOs with 5,000 to 17,999 members staffed a notably higher 23.2 PCPs per 1,000 Medicaid members, up considerably from 19.0 in 2006.
- Of hospital patients diagnosed with drug dependence in 2007, a notable 40.4% were Medicaid recipients, down slightly from 41.2% in 2006, but still the highest percentage of the 19 common diagnoses listed.
- For the second consecutive year, the Medicaid patient share of all patients undergoing ophthalmologic and otologic procedures at hospitals grew, to 33.9% in 2007 from

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31.6% in 2006 and from 29.5% in 2005, the highest share of the 19 common hospital procedures profiled.

- The number of prescriptions per member per year (PMPY) at HMOs that enrolled Medicaid recipients increased 5.6% in 2007, to 9.4 from 8.9 the previous year.
- Of all Medicaid HMOs using formularies, 47.9% used proprietary (self-developed) formularies as the controlling document in 2007, down from 51.2% in 2006. Conversely, Medicaid formularies were the controlling document at 35.0% of Medicaid HMOs, up more than seven percentage points from 27.4% the previous year.

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