SMALL BUSINESS MAJORITY

# Cost Containment Measures Under Healthcare Reform

Small businesses have a difficult time affording health insurance because costs continue to spiral out of control. Premiums for employer-sponsored health coverage have more than doubled over the last decade and would have only become more expensive if Congress didn't take action to address this problem by passing healthcare reform legislation in March, 2010.

The Patient Protection and Affordable Care Act includes many provisions to contain costs. These measures will be felt throughout the entire healthcare system, lowering premium costs for small business owners and consumers alike. The Congressional Budget Office estimates the new law will lower federal deficits by more than $143 billion by 2020, and by more than $1 trillion in the following decade. While there is still more than can be done to contain costs within the system, the new law is a great start. It moves our healthcare system toward greater financial stability and provides improved access to affordable, quality care for small business owners and their employees.

The following provisions are some of the main cost containment measures enacted by the ACA:

## Tax Credits for Small Businesses

One of the most important provisions in the law, which went into effect immediately, is a provision that provides tax credits small employers can use toward the purchase of health insurance for their workers. Starting in 2010, businesses with fewer than 25 workers and average wages of less than $50,000 will be eligible to receive a tax credit for the health insurance they provide their employees. More than 4 million small businesses nationwide were eligible for a tax credit for the purchase of employee health insurance in 2010. Small firms offering coverage will save up to an average of about $1,100 per worker due to the health insurance tax credit for small employers[1] and approximately 1.2 million American small businesses were be eligible to receive the maximum tax credit for tax year 2010.[2]

## Creation of Insurance Exchanges

The law establishes state-based health insurance exchanges, replacing today's small group and individual markets, to lower administrative costs and provide incentives to insurers to maintain lower premiums to attract millions of exchange enrollees. Small business owners and individuals in each state will be able to join a large pool that will give them more options and greater clout when negotiating for coverage, which will lower their costs.

By January, 2014, every state will have a health insurance exchange, whether it's set up by the state or by the U.S. Department of Health and Human Services (if a state has not yet set up its own). As of October 2011, 10 states are already working to form exchanges, including California, Colorado, Connecticut, Hawaii, Maryland, Nevada, Oregon, Vermont, Washington and West Virginia. Four states intend to establish exchanges by the 2014 deadline, including Illinois, North Carolina, North Dakota and Virginia. Massachusetts and Utah passed legislation establishing exchange-like marketplaces prior to the Affordable Care Act of 2010. Further information on where states stand on exchange formation is available from the National Conference of State Legislatures website.

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[1] The Lewin Group, 8 June 2010.

[2] Families USA and Small Business Majority, July 2010.

## Reining in Administrative Costs

Small businesses spend about 18% more on average than large businesses for comparable health policies. This is largely due to high administrative costs, which can be up to 30% of premiums. The new law includes administrative simplification programs, helping to put the country on a path to lower-cost, standardized administrative transactions, processes and forms. Additionally, it establishes insurer efficiency standards that require 80% of premium dollars be spent on care, not administrative overhead and executive compensation, for small group and individual plans. For large group plans, the standard will be 85%. All of these measures will lower the time doctors have to spend on paperwork.

## Medicare Reform

The Affordable Care Act includes numerous reforms in Medicare that will reward value of care, not the volume of care. It requires the Department of Health and Human Services (HHS) to adopt value-based purchasing and payment methods for Medicare reimbursements for both physicians and hospitals, and move away from the fee-for-service system that is so costly and inefficient. What's more, cost containment measures made to Medicare will have a ripple effect to other areas of the system, further reducing costs. These reforms include:

- Beginning in FY 2013, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.
- A new Center for Medicare and Medicaid Innovation has been established to research, develop, test, and expand innovative payment and delivery arrangements. The Affordable Care Act will invest $10 billion in the center by 2020. Its three research focus areas include[3]:
    - Patient Care Models: Improving care for Medicare, Medicaid, and CHIP beneficiaries by exploring specific innovations like using bundled payments as opposed to fee-for-service billing.
    - Seamless Coordinated Care Models: Developing new models that better enable doctors in different care settings to work together in providing services for Medicare, Medicaid and CHIP beneficiaries.
    - Community and Population Health Models: Testing care and payment models that impact underlying public health issues like smoking and obesity.

The following programs reform additional areas of the system (beyond Medicare) to further contain costs:

- Establishing pilot programs to expand accountable care organizations (ACOs), bundled payments, medical homes and chronic disease management—approaches that reward doctors and hospitals for providing high-quality care rather than simply continuing to pay for a high volume of treatments. The Center for Medicare and Medicaid said that in 2012 it will begin allocating $170 million for physician-owned and rural providers to start ACOs:[4]
    - ACOs will have to meet 33 quality measures to qualify for performance bonuses.
    - Community health centers and rural health clinics will be allowed to lead ACOs.
    - Providers will be able to participate in an ACO and share in savings with Medicare without risk of losing money—ACOs will be able to start sharing in the savings earlier rather than letting Medicare retain all the initial savings.
    - Groups are allowed to apply throughout 2012.

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[3] Center for Medicare and Medicaid Services, 2011.

[4] Kaiser Health News, 20 Oct. 2011.

- Setting up the Independent Payment Advisory Board to study and present recommendations on private sector health spending and Medicare to drive savings across the entire system. IPAB will begin its work in 2012. It will submit recommendations to Congress annually, outlining how to cut the growth rate of Medicare costs and improve care for beneficiaries. If Congress does not accept these recommendations, it must either enact policies that achieve equivalent savings or let the HHS Secretary follow IPAB's recommendations.[5] IPAB is projected to reduce Medicare costs by almost $24 billion by 2019.[6]

## Medicaid Reform

Mirrored on the reforms for Medicare, states can help lower their healthcare costs by utilizing Medicaid reform options provided by the new federal law. These options are set to encourage cost containment and include:

- Promoting medical homes, where states have the option to enroll Medicaid beneficiaries with chronic conditions.
- Creating pediatric accountable care organizations, where pediatric providers who qualify may be recognized and receive Medicaid payments. Those that meet quality guidelines and provide services at a lower cost will share in a portion of the savings they generate.
- Encouraging healthy living through quitting smoking, weight loss and diabetes prevention programs. Healthier Medicaid enrollees mean lowered costs for the program.

## Investments in Primary Care

Prevention and wellness programs will help reduce the need for more costly treatments of health conditions later in life. The Affordable Care Act enhances cost-cutting programs by:

- Establishing grants for up to 5 years for small employers who establish wellness programs. In 2011, HHS granted $9 million to help reduce the risk of chronic disease among employees and their families through evidence-based workplace health interventions, promoting sustainable and replicable workplace health activities and promoting peer-to-peer healthy business mentoring. Examples of such strategies include establishing tobacco-free campus policies, promoting flextime to allow employees to be more physically active, and offering more healthy food choices in worksite cafeterias and vending machines.[7]
- Eliminating patient co□pays for preventive services in Medicare, Medicaid and private plans.
- Allocating $15 billion by 2020 to a Prevention and Public Health Investment Fund to expand and sustain national investment in prevention and public health.[8] In 2010, $500 million was allocated and another $750 million was given in February 2011. The funding sum will increase each year, leveling off at $2 billion per year for 2015-2019. Specifically, $145 million was announced for Community Transformation Grants, which will support state and community efforts to reduce tobacco use, increase healthy eating and activity, and reduce inequities.[9]
- Authorizing grants for eligible entities to promote community and individual health and to prevent chronic disease. In February 2011, the Centers for Medicare and Medicaid Services announced $100 million in grants for states to offer incentives to Medicaid

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[5] The White House Blog, 20 Apr 2011.

[6] Center for Medicare and Medicaid Services, 2010.

[7] Department of Health and Human Services, 23 June 2011.

[8] Prevention Institute, February 2011.

[9] Department of Health and Human Services, 9 Feb. 2011.

beneficiaries who participate in prevention programs and demonstrate improvements in health risk and outcomes.[10]

- Funding research in public health services and systems to examine best prevention practices. High-value preventive care will not be subject to insurance policy deductibles under the new law.

## Cracking Down on Waste, Fraud and Abuse

Waste, fraud and abuse within the healthcare system have cost employers and consumers vast sums of money over time. Healthcare fraud schemes commonly include billing for services that were not provided or were not medically necessary, purposely billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying kickbacks, and/or stealing providers' or beneficiaries' identities. Here are some examples:[11]

- In South Florida, investigations found that criminals set up sham durable medical equipment storefronts to appear to be legitimate providers. They then fraudulently billed Medicare for millions of dollars, closed up shop and reopened in a new location under a new name and repeated the fraud.
- In 2007, Medicare reimbursed suppliers for pumps used to treat pressure ulcers and wounds based on a purchase price of more than $17,000. However, suppliers paid, on average, approximately $3,600 for new models of these pumps.
- In 2006, Medicare allowed approximately $7,200 in rental payments over 36 months for an oxygen concentrator that cost approximately $600 to purchase. Beneficiary coinsurance alone for renting an oxygen concentrator for 36 months exceeded $1,400 (more than double the purchase price).

The law also lowers costs by cracking down on waste, fraud and abuse by:

- Requiring HHS to institute a new screening process for all providers and suppliers before granting Medicare billing privilege; and provides states with new authority to impose screening procedures on Medicaid providers.
- Instructing providers and suppliers to adopt compliance programs as a condition of participating in Medicare and Medicaid.
- Eliminating wasteful overpayments to Medicare Advantage plans that increase private plan profits, not patient care.
- Increasing funding for the Health Care Fraud and Abuse Control Fund to fight Medicare and Medicaid fraud.
- Establishing new penalties for submitting false data on applications, false claims for payment, or for obstructing audit investigations related to Medicare, Medicaid and the Children's Health Insurance Program (CHIP).
- Increasing federal sentencing guidelines for all federal healthcare offenses that involve a loss greater than $1 million.

## Consumer Operated and Oriented Plans (CO-OPs)

Healthcare reform has created the opportunity for states to build CO-OPs with the aid of $3.8 billion in federal financing. CO-OPs are consumer-controlled nonprofit organizations that provide new health

[10] Kaiser Family Foundation, 2011.

[11] Department of Health and Human Services, 19 Apr. 2011.

insurance options in each state that develops them. There are already successful ones in Minnesota, Wisconsin and Washington.

As of October 2011, new CO-OPs have formed in the majority of states and more states will apply for funding in coming months. Small businesses need more options for affordable healthcare and CO-OPs will serve this need: since many business groups are involved in creating health CO-OPs, they are often designed with small business owners' needs in mind. A few examples of business groups backing successful CO-OPs include:

- Healthcare 21 in Tennessee, which sponsors a health CO-OP that spans the Georgia, Tennessee and North Carolina region. More information about the purchasing partnership they've cultivated between businesses and employers is available on their website: http://www.hc21.org
- South Carolina Business Coalition on Health, which has applied to create a CO-OP in South Carolina with the South Carolina Small Business Chamber of Commerce as one of its coalition members. Find more information here: http://www.scbch.org

## Additional Cost Containment Measures

The ACA reduces medical malpractice burdens. Defensive medicine is a small but important driver of medical spending, and the law encourages states to experiment with alternative mechanisms to reduce malpractice burdens. It also reduces Medicare Advantage overpayments and others to different providers.

## What Others Are Saying

The Center for American Progress noted that new authority giving HHS the ability to review and change fees that often lead to higher costs will limit cost-raising behavior such as "hospital-acquired infections, inappropriate hospital readmissions and, even more egregious, outright fraud." In addition, it notes that "the Affordable Care Act's cost-containment strategies were set in motion long before the passage of the Affordable Care Act…Key provisions in the Affordable Care Act promise improvements in the quality of our nation's health care at lower costs. This promise will take time, yet actually operating right now across America, hidden in plain sight, are initiatives in the private sector and state Medicaid programs that will change the way health care is delivered. The Affordable Care Act not only builds upon these efforts but also will significantly reinforce them."[12]

A joint study by The Commonwealth Fund and the Center for American Progress concluded the healthcare legislation: "will introduce a range of payment and delivery system changes designed to achieve a significant slowing of health care cost growth…We estimate that, on net, the combination of provisions in the new law will reduce healthcare spending by $590 billion over 2010–2019 and lower premiums by nearly $2,000 per family."

An issue brief released by Health Policy Center of the Urban Institute in June 2011 summed up the findings of multiple studies it conducted: "We find generally positive effects of the ACA on small employers and their workers. Employers with fewer than 50 workers will experience substantial savings on health costs…the smallest firms are expected to have higher offer rates, resulting in a small increase in employer coverage. Small firm workers and their families will reap substantial benefits from the Medicaid expansion and subsidies to low-income families." What's more, "firms of all sizes will see substantial savings on premium contributions."[13]

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[12] Center for American Progress, 29 Apr. 2011.

[13] Urban Institute 21 June 2011.