HFMA Annual National Institute
The Changing Landscape of Healthcare Reform: Washington Update

11 June 2013

Bank of America Merrill Lynch

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Health Care Reform Implementation

Health Insurance Exchanges
- Exchanges Open for Enrollment in October 2013
- Product and Premium Submissions in May; Rates announced in September (for Federal Exchanges)
- State Based Exchanges: 17 States + DC
- Federal-State Partnership Exchanges: 7 States
- Federally Facilitated Exchanges: 26 States that refuse to implement an exchange

Medicaid Expansion
- 18+ States are choosing not to expand their Medicaid programs
  - This means roughly 6 million fewer Medicaid covered lives;
  - Coverage would be available on exchanges, but, only for individuals above 100% of FPL
  - Texas is largest state, with almost 2 million people impacted
- 25+ States are planning to expand Medicaid
- 7+ States are still deciding whether to expand

State Medicaid Expansion Plans

Medicaid Eligible Uninsured Adults with income below 133% of FPL (Thousands)

Source: AP, Urban Institute, Politico
State Health Insurance Exchange Development

Federal Health Plan Certification Requirements

**Issuer Participation Standards**
- Licensed and in good standing
- Comply with risk adjustment standards
- Implement and report on quality improvement strategies

**Rates and Benefits**
- Must set rates and benefits for an entire plan year
- Justify rate increases

**Transparency in Coverage**
- Plain language requirements
- Must submit data across a number of areas to HHS and states

**Marketing and Benefit Design**
- Network Adequacy
- Rating variations
- Enrollment Periods
- Accreditation
Federal Exchange Health Insurers

- 120 Health Insurers have applied to participate in the HHS run Federal Exchange
- Administration expects over 90% of plan enrollees will have a choice of 5 or more health insurers
- Multi-State plans will be offered in at least 31 States nationwide in 2014, with coverage expanding to all 50 States and D.C. no later than 2017
- OPM is currently reviewing over 200 proposed Multi-State qualified health plan options
- Issuers plan to offer more than 15 qualified health plans per State (on average)
- Administration plans to release the final health insurance plan premiums for all the Federally run exchanges in September

Limited Number of Plans in Certain States

- Mississippi and New Hampshire reportedly only have 1 health insurer applying;
- Maine and Vermont have only 2 health insurers;
- Kansas, Montana, and North Carolina have only 3 health insurers;

Stronger Participation in Certain States

- Virginia (9 insurers); Georgia (7); Arizona (5); Indiana (5)
- Ohio announced 14 companies filed proposed rates for 214 different plans. A total of 14 companies filed proposed rates for 214 different plans to the Department. Projected costs from the companies for providing coverage for the required essential health benefits ranged from $282 to $577 for individual health insurance plans.

Individual and Small Group Market Premium Increases

- Ohio announced individual health coverage costs of $282 to $577 per month - an estimated 88% increase over average individual rates in 2013 (before subsidies)
- Comparisons can be deceiving given the range of health plan coverage available in 2013
States with Active Purchasing / Negotiations with Plans

• California
• Massachusetts
• Rhode Island
• Vermont

States Planning to Move to Active Purchasing in 2015 or 2016

• Connecticut
• Maryland
• Minnesota

States with Additional Certification Criteria, beyond Federal Minimum Standards

• New York
• Oregon

State Exchanges That Are Not Using Active Purchasing

• Colorado, Kentucky, Hawaii, Idaho, New Mexico, Nevada, and Washington

State Exchange Plan Deadlines

<table>
<thead>
<tr>
<th>State</th>
<th>QHP Solicitation Date</th>
<th>Plan Submission Deadline</th>
<th>Rate Submission Deadline</th>
<th>Plan Certification Date</th>
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<td>Maryland</td>
<td>Oct. 2012</td>
<td>April 1, 2013</td>
<td>April 1, 2013</td>
<td>July 1, 2013</td>
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<td>New Hampshire</td>
<td>April 10, 2013</td>
<td>June 1, 2013</td>
<td>June 1, 2013</td>
<td>July 31, 2013</td>
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</table>

Source: NAHP
California
• 13 insurers selected to participate in individual market (from 32 plans bidding)
• California estimates that 2014 rates will range from 29% below to 2% increase from comparable 2013 premiums for similar coverage
• California estimates that up to 5.3 million people eligible for exchanges (2.6 million eligible for subsidies)

Colorado
• 10 insurers in individual market; 6 insurers in SHOP exchange

Connecticut
• 9 insurers

Maryland
• 6 insurers for health coverage; 10 stand-alone dental plans

Oregon
• 12 insurers in the individual market; 8 insurers in the small group market

Washington
• 9 insurers plan to participate

Source: NASHP, Covered California

Health Care Reform Issues

1. Much Bigger Role for States
   • Medicaid Expansion (up to 30% increase)
   • State health insurance exchanges

2. Impact on Health Care Premiums / Costs

3. Health Care Exchange Product: What Will it Look Like?
   • Concern that Provider payment rates could come in well below current Commercial rates

4. Secondary Impacts from large Increase in Covered Lives?
   • Positive for volumes: Yes - But, cost increases may not be fully baked-in
   • Capacity issues / Increased Labor Costs

5. How do Employers Respond?
   • Will employers dump employees onto exchanges – and by how much?
   • Estimates range from 5% to 30% of Employers dumping coverage
   • Shift to part-time employees?
Updated Estimates of Coverage Expansion

Congressional Budget Office has Updated its Estimates for the Affordable Care Act

- Initial Coverage estimate (2010) of 33 million
- In 2012, CBO reduced its coverage estimate down to 30 million
- And, most recently, CBO (May 2013) estimates coverage gain to be 25 million

CBO Latest Estimates (in 2017):

- Medicaid and CHIP Expansion = 12 million
- Employer Coverage Dropping by 7 million
- Non-Group Coverage Dropping by 5 million
- Health Insurance Exchange enrollment of 24 million
- Number of Uninsured = 31 million (vs. 56 million est. pre ACA)

Exchange Coverage Estimates (in 2017):

- Total Enrollment of 24 million & total exchange subsidies of $108 billion (in 2017) vs. Previous estimate of $122 billion
- Subsidized coverage in exchanges = 20 million (down from 22 million)
- Employer Coverage (small group) in exchanges = 4 million

Health Care Reform – Coverage Estimates

Estimates of Insurance Coverage Under Health Reform Law – 27 million additional covered lives by 2017

Medicaid Enrollment - Up 12 Million

Employer Coverage - Down 7 Million

Source: Congressional Budget Office
HC Exchange Enrollment Ramping up to 25 Million by 2017

Source: Congressional Budget Office

Estimates of Number of Remaining Uninsured Under Health Reform Law – 25 million additional covered lives by 2017 (vs. Pre-ACA estimates)

Source: Congressional Budget Office
### Health Care Reform – Coverage Estimates

#### Estimates of Insurance Coverage Under Health Reform Law – 27 million additional covered lives by 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Prior Law Coverage</th>
<th>Changes due to Health Reform</th>
<th>Number of Uninsured - Nonelderly</th>
<th>Insured share of Population</th>
<th>Number of Unsubsidized Exchange Enrollees</th>
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<tr>
<td></td>
<td>Medicaid / CHIP</td>
<td>Medicaid / CHIP</td>
<td>% of All Residents</td>
<td>% Excluding Illegal Immigrants</td>
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<tr>
<td></td>
<td>Employer</td>
<td>Employer</td>
<td>% of All Residents</td>
<td>% Excluding Illegal Immigrants</td>
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<td>Nongroup/Other</td>
<td>Nongroup/Other</td>
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<td></td>
<td>-</td>
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<td></td>
<td>Uninsured</td>
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<td>2013</td>
<td>35</td>
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<td>82%</td>
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<td>34</td>
<td>9</td>
<td>84%</td>
<td>86%</td>
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<tr>
<td>2015</td>
<td>34</td>
<td>12</td>
<td>86%</td>
<td>89%</td>
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<td>33</td>
<td>12</td>
<td>89%</td>
<td>89%</td>
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<tr>
<td>2017</td>
<td>33</td>
<td>12</td>
<td>89%</td>
<td>89%</td>
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<tr>
<td>2018</td>
<td>33</td>
<td>12</td>
<td>89%</td>
<td>89%</td>
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<tr>
<td>2019</td>
<td>34</td>
<td>13</td>
<td>89%</td>
<td>89%</td>
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<tr>
<td>2020</td>
<td>34</td>
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<td>34</td>
<td>13</td>
<td>89%</td>
<td>89%</td>
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#### Health Care Reform Issues

**Increased Premiums / Subsidy Impact**

**Components of Health Care Reform Increasing Insurance Costs**

- **Total Estimated Premium impact of 9-56% for individuals age 21-29**
  - **Health Insurance Industry Tax:** Approximately 2% increase beginning in 2014
  - **Essential Health Benefits Requirements:** Anywhere from 0% - 33% depending on current market
  - **Community Rating (Age Rating bands 3:1):** Est. 29% premium increase for ages 21-29; Reduced premiums for individuals above age 50
  - **No Pre-Existing Condition Exclusion / Guaranteed Issue:** Will also have an impact on premiums

**Availability of Subsidies to offset impact of increased Premiums**

- **Currently Uninsured:** 42% under 133% of Poverty; 46% between 133%-400% of Poverty
- **Current Individual Market:** 25% below 133% of Poverty; 40% between 133%-400% of Poverty

Source: Avalere Health
Managed Care and Hospital Views of HC Exchanges

Managed Care Company Views:

- United Healthcare:
  - "Very selective in where we participate…. We do not believe the exchanges will be a significant factor for us."
  - "Rates will vary from commercial rates to something less."

- Wellpoint:
  - "We have signed contracts with the majority of our providers"
  - "Focus on competing in the exchanges in all of our Blue markets"

- Cigna:
  - "Focused on a limited number of markets"
  - "You could argue that the networks will be a little bit more narrow"

- Aetna:
  - "Plan to participate in the individual exchanges in approximately 14 states"
  - "Those tend to be narrow networks that are generally 25% to 50% of the size of our base networks"
  - "Where we need to add providers for network sufficiency, we are pricing those at commercial pricing"
  - "We are also seeing in the large employer segment a lot of interest in private exchanges"

Hospital Company Views:

- HCA:
  - "Although we are not going to comment on the specific rates associated with executed contracts, they generally can be characterized as closer to commercial pricing than Medicare."

- UHS:
  - "For the most part, [exchange contracts] have been negotiated at our average, or maybe slightly below our average commercial rates"

- Tenet:
  - "Pricing for these exchange products remains broadly in line with commercial pricing."

- Community Health Systems:
  - "The prices, instead of getting into specifics, we’ve targeted to be close to commercial. We are in that range right now"

- LifePoint:
  - "We think we are well positioned in order to see rates in a commercial range"
  - "What happens with volume when patients have coverage? And we expect we’ll see some uptick in volume."

- Vanguard:
  - "Most of the exchange contracts have been done slightly – at a very small discount off of commercial"
  - "We can play in full-in and in narrow networks, within a fairly tight band of our commercial prices in most of our markets."
Managed Care and Hospital Views of HC Exchanges

Major Take-aways from HC Exchange Impacts:

• Blue Plans are leading the way with participation in exchanges

• Other Managed Care Companies taking a more Cautious Approach – Limiting initial entry to selected Markets

• Narrower Provider Networks

• Hospital Rates are Close to Commercial Rates – But, at some discounts

• Reduced Uncompensated Care Still Viewed as a Significant Positive – But, more caution

Health Care Reform Impact on Hospitals – Estimated Benefits and Cuts

We estimate that reform will add approximately $37bn to the hospital industry. A clear positive, but spread over 10 years, across 5,000 hospitals.

<table>
<thead>
<tr>
<th>Year</th>
<th>Uncompensated care cost ($bn)</th>
<th>% uninsured covered (based on CBO scoring of Recon Bill)</th>
<th>Uncomp. care benefit cost savings</th>
<th>Market basket/ Productivity adjustment cost savings</th>
<th>Total DSH payments reduction for hospitals</th>
<th>Savings from reducing readmits</th>
<th>Cuts for health care acquired infections</th>
<th>Net effect on hospitals</th>
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<td>2010A</td>
<td>($41.1)</td>
<td>6.9%</td>
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<td>$(0.3)</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$(0.3)</td>
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<td>2011E</td>
<td>($43.1)</td>
<td>3.3%</td>
<td>$1.4</td>
<td>$(0.8)</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
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<td>2012E</td>
<td>($45.3)</td>
<td>4.2%</td>
<td>$1.9</td>
<td>$(2.3)</td>
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<td>$0.0</td>
<td>$0.0</td>
<td>$(0.3)</td>
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<td>2013E</td>
<td>($47.5)</td>
<td>4.2%</td>
<td>$2.0</td>
<td>$(5.4)</td>
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<td>$(0.0)</td>
<td>$(0.5)</td>
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<td>2014E</td>
<td>($49.9)</td>
<td>41.5%</td>
<td>$20.7</td>
<td>$(8.0)</td>
<td>$(0.7)</td>
<td>$(0.3)</td>
<td>$(0.1)</td>
<td>$(11.9)</td>
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<td>2015E</td>
<td>($52.4)</td>
<td>49.2%</td>
<td>$25.8</td>
<td>$(10.8)</td>
<td>$(4.5)</td>
<td>$(1.1)</td>
<td>$(0.4)</td>
<td>$(34.9)</td>
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<td>2016E</td>
<td>($55.0)</td>
<td>57.2%</td>
<td>$31.5</td>
<td>$(13.7)</td>
<td>$(4.9)</td>
<td>$(1.3)</td>
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<td>2017E</td>
<td>($57.9)</td>
<td>57.4%</td>
<td>$33.1</td>
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<td>$(7.6)</td>
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<td>$(33.3)</td>
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<td>2018E</td>
<td>($60.7)</td>
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<td>$36.2</td>
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<td>$(11.6)</td>
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<td>$(33.3)</td>
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<td>2019E</td>
<td>($63.7)</td>
<td>56.7%</td>
<td>$36.1</td>
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<td>Cumulative 2010-2019E</td>
<td>($516.4)</td>
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<td>($37.7)</td>
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Payment Reforms are Taking Hold

Medicare Payment Reforms

Accountable Care Organizations / Bundled Payment Demonstrations
- Over 200 ACOs up and running, with more than 5% of Medicare Beneficiaries
- Over 500 Provider organizations include in Bundled Payment Demonstrations

Value Based Purchasing / Quality Measurement / Health Care IT
- Hospitals are fully engaged, with up to 6% of Medicare reimbursement at risk
- Most other providers will also see Quality Reporting and Pay for Performance in next several years
- Physician Payment Reforms to eliminate SGR, shift to VBP

Shift to Coordinated Care
- More than 20 states moving forward with Dual Eligible Managed Care Demonstrations
- Medical Home Models

Other Payment Reforms on Deck
- Home Health Reimbursement Cuts
- Hospice Payment Reform due in next several years
- Payment for Therapy Services remains a key issue
- Physician Payment Reforms under Medicare

Durable Medical Equipment Competitive Bidding
- 45% Savings for Round 2 (encompassing roughly 50% of US Market

Reform / Implementation Issues

Hospital Quality/VBP Programs

Roll-out of Hospital Quality Programs Began in 2013 — Leaving Hospitals Exposed to Up to 6% of Medicare Inpatient Payments

Source: BofA Merrill Lynch Global Research
Budget Issues for 2013

With Sequestration now in Effect, Attention Now Turns to Debt Ceiling Expiration

1. Sequestration – Automatic Cuts (2% Cuts to Medicare)
   • Effective March 1 – (Medicare provider reductions took effect April 1)
   • Overall Sequestration cuts of $85 billion for FY2013 likely to remain in effect with no major changes

2. FY2014 Budget Proposals
   • House Budget Proposal Passed including more than $2 Trillion in Health Care Cuts
   • Senate Budget Proposal included $275 billion in Medicare cuts
   • President’s Budget proposal called for $400 billion in Medicare/Medicaid cuts

3. FY2014 Appropriations Remain an Issue (October 1, 2013)
   • Congress passed a 6-month CR for the remainder of FY2013
   • Significant differences remain in funding levels between House and Senate for FY2014 sequestration cuts
   • President Obama has called for Congress to agree on a budget before extending a new CR for FY2014

4. Debt Ceiling Expiration, with “Extraordinary Measures”, default date probably not until October or later
   • Efforts to Incorporate Larger Deficit Reduction Proposals / Tax Reform - Fading

President’s FY2014 Budget Proposal

President Released his Budget April 10
   • Reiterated much of President’s Recommendations from last year
   • Total Health Related Savings of $400 billion over ten years
   • Budget proposals include:
     — Rebates for Medicare Part D Drugs - $123 billion over ten years
     — Additional discounts for Medicare Part D drugs in donut hole (50% to 75%) - $11 billion
     — Reduce Part B Drug payments to ASP+3% (down from ASP+6%) - $4.5 billion
     — Other Pharmaceutical reforms (Branded-Generic Settlements, Exclusivity period for biosimilars)
     — Post-Acute Provider Payment Reductions - $79 billion
     — Additional Post-Acute Provider Payment Reforms / Bundling - $14.8 billion
     — Further Reductions in Bad Debt Payments (Hospitals/SNFs) - $25 billion
     — Teaching Hospital payment reductions - $11 billion
     — Critical Access Hospital Payment Cuts - $1.4 billion
     — Additional Medicare Advantage coding intensity adjustment - $15 billion
     — Additional Clinical Lab payment reductions - $9.5 billion
     — Eliminate In-Office Ancillary Exception for Radiation therapy/Imaging/Therapy - $6 billion
     — Medicare structural reforms (additional means testing, home health copayments, Medigap reforms)
     — Medicaid reductions of $22 billion (Medicaid DME / drug rebates)
### House Republican FY2014 Budget Proposal

**House Budget Proposal**

- Similar to Ryan Budget Proposal from last year
- Passed with slim majority – no Democrats supporting
- Repeals Health Care Reform Coverage Expansion – But, maintains Medicare Cuts
- Proposes Medicaid Block Grants – Yielding $810 billion in cuts over 10 years
- Medicare Premium Support Proposal
  - Shifts new Medicare enrollees into Premium Support beginning 2024
  - Enrollment through Medicare exchange mechanism
  - Spending growth capped for Premium Support at GDP+0.5%
  - Additional Means Testing for Medicare Part B and Part D
- Additional $129 billion in Medicare cuts also proposed
- Repeals Independent Payment Advisory Board
- Calls for Malpractice Reforms

### Senate FY2014 Budget Proposal

**Senate Budget Proposal – Passed on March 23**

- First Budget in 4 years for the Senate
- Passed with bare majority of Democratic support – No Republicans supporting
- Maintains Health Care Reform
- Includes $275 billion in Medicare Reductions
- Fully Replaces Sequestration Cuts (would add back $120 billion in Medicare cuts)
- Also included a non-binding amendment calling for the repeal of the Medical Device Industry Tax (2.3%) which is in place since January 1
Sequestration

Impact of Sequestration Cuts

• 2% Across-the-Board Cuts for Medicare ($120 billion over nine years)
  — Medicare cuts became effective April 1
  — Exempts Medicaid and low-income programs (dual eligibles, etc.)
  — Medicare Advantage Plans & PDPs will see 2% cuts as well

• Additional Across-the-Board Cuts (Defense & Non-Defense)
  — Defense program cuts of roughly 8%
  — Non-Defense discretionary program cuts of 5%

• FDA Funding Cuts of $209 million
  — Key questions around how FDA would prioritize funding and approvals
  — User Fees continue to be paid, but, FDA’s budget would still be limited by sequestration

• NIH Funding Cuts of $1.5 billion
  — 1,400 fewer grants; 700 fewer funded new grants; Continuing grants cut by 4%
  — Reduced success rates

• CDC Funding Cuts of $289 million

Larger Deficit-Reduction Efforts

Larger Deficit-Reduction Effort – No Real Active Negotiations

• Proposals for $1.5 Trillion to $2.5 Trillion in Additional Deficit Reduction

• However, Likelihood of a Larger Deal is fading

• A Larger Deal would pose Additional Risks for Medicare
  — Estimated $400-to-$600 billion in Health Care Savings
  — Primarily from Medicare
  — Could include a mix of Beneficiary and Program Reforms, Provider Payment Reductions, and Other reforms

• Medicare Proposals include:
  — Medicare provider cuts for Hospitals, Post-Acute, and Prescription Drugs
  — Increases in Eligibility Age (less likely)
  — Increased means testing for Medicare Part B and Medicare Part D
  — Reform and Streamline Medicare co-payments and deductibles
  — Medigap reforms – eliminate first dollar coverage

• Medicaid Reductions Possible, but, less likely
Deficit-Reduction Efforts

Targeted Areas for Future Cuts

Post-Acute
- Home Health payment reforms / MB cuts / copayments
- Skilled Nursing Facilities payment reforms / MB cuts / copayments
- Accelerated bundled payments

Hospitals
- Further bad debt payment Reductions
- Hospital Outpatient Payment Reductions (E&M and other codes)
- Teaching hospital payments / Rural hospital payments (Critical Access Hospitals)

Other Providers
- Clinical Labs – copayments / payment reductions
- Imaging
- Therapy Providers

Pharma
- Medicare Part D Rebates
- Additional Part D Donut Hole discounts
- Medicare Part B payment reductions (ASP)
- Encourage use of generics for low income beneficiaries

Beneficiary Impacts
- Medigap / Cost Sharing / Combining Part A & B cost-sharing
- Means Testing
- Other Structural Reforms
- Medicaid (Less Likely now)

Medicare Margins

While a 2% Medicare sequestration reduction was implemented in April, there remain potential risks to reimbursement levels. Post-acute providers remain a target as they have historically had higher Medicare margins.

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<tr>
<td>Post Acute SHFs</td>
<td>10.8%</td>
<td>13.7%</td>
<td>12.9%</td>
<td>13.1%</td>
<td>14.5%</td>
<td>16.5%</td>
<td>18.1%</td>
<td>18.5%</td>
<td>23.0%</td>
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<td>12.5%</td>
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<td>Home Health</td>
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<td>16.0%</td>
<td>17.4%</td>
<td>15.8%</td>
<td>16.6%</td>
<td>17.4%</td>
<td>17.7%</td>
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<td>14.8%</td>
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<td>Inpatient Rehab Facilities</td>
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<td>6.9%</td>
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<td>-1.4%</td>
<td>-3.0%</td>
<td>-3.0%</td>
<td>-4.7%</td>
<td>-6.0%</td>
<td>-7.1%</td>
<td>-5.1%</td>
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<td>Outpatient Dialysis</td>
<td>2.0%</td>
<td>3.9%</td>
<td>5.8%</td>
<td>5.9%</td>
<td>4.8%</td>
<td>3.1%</td>
<td>3.1%</td>
<td>2.3%</td>
<td>2.5%</td>
<td>2.7%</td>
<td>3.5%</td>
<td>60%</td>
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</tbody>
</table>

Source: MedPAC
For 2014 Physician payments are due for another 25% payment cut

CBO Just Released Revised Estimates of a Permanent Physician Payment Fix
- $139 Billion over ten years (vs. previous estimate of $240 billion)
- 1-year fix would cost $15 - $20 billion (with extenders)

House Ways and Means and Energy and Commerce Committees are Actively working on Permanent Fix
- Recent Hearings on Doc Fix
- Proposals have not gained as much momentum as hoped for (split between House E&C and W&M committees)
- Chairmen Upton would like to complete work on a Permanent Fix by August in the House

Even with lower Cost Estimate of $139 billion over 10 years – How to Pay for an SGR Fix Remains an open issue
- Likely to see range of Medicare provider cuts that have been on the table over last few years
- And, may well end up back at a 1-year fix, as we approach November/December

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**Medicare Physician Payment Formula**

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**Medicare Physician Payment Fix for 2013**

**American Tax Payer Relief Act – Fiscal Cliff Legislation – Enacted January 1**

**Medicare Extender Provisions ($28 billion)**
- 0% Medicare Physician payment update for 2013 - $25 billion cost
- Medicare Physician Work Geographic Floor (1-year) - $500 million
- Part B Therapy Caps Exceptions Process (1-year) - $1.0 billion
- Ambulance Payment add-ons (1-year) – $100 million
- Low Volume Inpatient hospital adjustment - $300 million
- Extension of Medicare Dependent Hospital program - $100 million
- Extension of Medicare Advantage SNP plans - $300 million

**Medicare/Medicaid Payment Reductions ($28 billion)**
- Inpatient Hospital Coding Adjustment - $10.5 billion over 10 years
- Rebase Medicare Dialysis Bundle - $4.9 billion over 10 years
- Medicaid DHS cuts in 2022 - $4.2 billion
- Medicare Advantage Coding Intensity Adjustment - $2.5 billion over 10 years
- Multiple Therapy Services Payment cut - $1.8 billion over 10 years
- Imaging payment cuts - $800 million over 10 years
- Retail Pharmacy diabetic supplies payment cut - $600 million over 10 years
- HOPD Gamma Knife payment reduction - $400 million over 10 years
- Non-emergency ESRD ambulance transportation cuts - $400 million over 10 years
Regulatory Key Issues

Hospital Inpatient PPS
- Inpatient Hospital proposal included a net -0.1% update for FY2014
- Mandated coding and documentation adjustments of -0.8% for FY2014, and likely to see 0.8% reductions for each of next 4 years
- DSH payment reduction proposal calls for 0.9% reduction in Medicare payments in FY2014

Long-Term Acute Care Hospitals
- Payment update of 1.1% less impact of 25% Rule (3.3%), yields a net impact of -2.2%
- Proposal calls for 25% Rule to be implemented in FY2014
- CMS is now working on “alternative payment reforms” for LTCHs for implementation in FY2015

Inpatient Rehab Facilities
- Net payment update of 2.0% for FY2014
- Proposal calls for significant revisions in codes that qualify for 60% rule – impact is unclear

Skilled Nursing Facilities
- Net payment update of 1.4% for FY2014
- CMS notes that it continues to study potential reforms for Medicare therapy payments in SNFs

Hospice
- Net payment update of 1.1% for FY2014
- CMS begins discussion of potential payment system reforms – which won’t be implemented until FY2015 or beyond

Inpatient Psych Hospitals
- CMS is not issuing a proposed regulation for FY2014 – only a rate update notice, with no significant policy changes

Recent FY2014 Proposed Provider Regulations

CMS Proposed FY2014 Payment Regulations Released in April/May

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CMS Released its Final Medicare Advantage Rate Update Notice for 2014

- Net MA rate increase estimated at +3.3% for 2014 – A Significant improvement over Proposed rate reduction of -2.2%
- CMS revised its assumption on Medicare physician payment cuts for 2014 (now assuming Congress will enact a “Doc Fix” with a 0% rate update, instead of -25%)
- However, other adjustments will drive the net payment reduction even lower:
  - 1.5% Coding Intensity Adjustment (mandated in statute)
  - 2-3% reductions due to phase-down in benchmarks (per ACA)
  - Additional 2% impact from Industry fee assessment (taxes) imposed in 2014
- We also note MLR requirement of 85% also will take effect for MA plans in 2014
- Medicare Advantage enrollment growth may still be impacted – especially after recent years of strong enrollment growth
- Current enrollment of 14 million+ expected to be flat for 2014

CMS Upcoming Proposed CY2014 Payment Regulations due in June/July

- **Hospital Outpatient PPS**
  - Estimated MB of 2.5% less productivity of 0.4% less 0.3% additional ACA reduction
  - No major policy changes expected

- **ASC Payments**
  - Estimated CPI update of 2.2% less productivity factor will yield an estimated update of 1.5 – 1.8%

- **Home Health PPS**
  - Rebasing of payments could result in up to 14% cuts over 4 years beginning in 2014
  - CMS scrutiny on therapy payments remains an issue

- **Dialysis Payments**
  - Bundled payments to be rebased for 2014 to reflect lower EPO utilization
  - Congress delayed the inclusion of Part D Oral drugs into the bundle until 2016

- **Physician Payments**
  - SGR formula will call for a 24.7% payment cut in 2014 – However, Congress will likely reverse through a doc-fix later in 2013
  - Payment areas of interest given last year’s payment changes include:
    - Pathology lab payments
    - Radiation therapy
    - Imaging
Slowing Health Care Growth

Medicare Spending Projections – Revised in May 2013
- CBO estimates Medicare Spending Growth of 6.1% over next 10 years (down from 6.9% growth)
- This results in $228 billion less Medicare spending over 10 years (compared to last year’s estimates)
- CBO is now beginning to incorporate lower HC spending trends into their estimates
- And, they believe that some of the slowdown in spending is not cyclical
- These revisions have an impact on estimates for Physician Payment SGR Projections and also on MA rate update projections

Medicaid Spending Projections – Revised in May 2013
- CBO estimates Medicaid Spending Growth of 7.6% over next 10 years (down from 9.3% growth)
- This results in $316 billion less Medicaid spending over 10 years (compared to last year’s estimates)
- CBO is now beginning to incorporate lower HC spending trends into their estimates, as well as lower enrollment projections in Medicaid
- Medicaid enrollment is still projected to grow significantly, to 71 million, by 20236 (up from 57 million in 2013)
Health Care Spending Growth has Decelerated Substantially over the last 10 Years

Historical Growth (1990-2011) = 6.5%

Source: CMS & CBO

Medicare Growth has Also Decelerated over the last 5 Years
With Payment Reforms and Reimbursement Reductions from the ACA, next few years will also see slower than average growth in Medicare

Historical Growth (1990-2011) = 8.0%

Source: CMS & CBO
Medicare Trust Fund Solvency

Medicare HI Trust Fund is Projected to Remain Solvent Through 2026
- Latest Trustees Report Finds Slowing Medicare Growth

![Graph showing years until Medicare HI Trust Fund insolvency](image)

Source: CRS, Medicare Trustees Report

Medicaid Spending Growth

CBO Has Revised its Estimated Medicaid Spending Growth Down from 9.5% per year to 7.5% per year – From 2012 Estimates to Most Recent 2013 Estimates

![Chart showing Medicaid Spending Growth](image)

Source: CBO
CBO Has Revised its Estimated Medicaid Spending Growth Down to 6.3% per year from 6.9% -- 2012 Estimates to Most Recent 2013 Estimates

reasons for slower projected health spending

Cutler, et al Study (Health Affairs, May 2013)
- Medicare Policy Changes
- Changing Technology
- Pharmaceutical Spending (more generics, fewer branded blockbusters)
- Increased Cost Sharing
- Greater Provider Efficiencies

Ryu, Chernew, et al Study (Health Affairs, May 2013)
- Overall health care spending slowed from 5.9% per year (1999-2009) down to 3% per year (2009-2011)
- 20% of slowdown in costs due to increased cost sharing
- Reductions in the rate of new technologies may have helped slow down health cost growth
- Also notes changes in provider practice patterns
- No conclusion, as to whether the slowdown in spending growth is temporary or permanent

What Does it Mean for Policymakers – No Consensus
- Different views on entitlement reforms
- No consensus on which policies to pursue
**BofAML Credit Opinion Key**

**BofA Merrill Lynch Credit Opinion Key**

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**Recommendation**

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<th>Investor Action Points: Cash and/or CDS</th>
<th>Primary Investment Return Driver</th>
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<tr>
<td><strong>Overweight</strong> 100%</td>
<td>Compelling spread tightening potential</td>
</tr>
<tr>
<td>Overweight 70%</td>
<td>Curvy plus some spread tightening expected</td>
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<tr>
<td>Overweight 50%</td>
<td>Good carry, Curvy plus some spread tightening expected</td>
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<tr>
<td>Underweight 40%</td>
<td>Down to 50% Underweight of investor’s guidelines</td>
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<tr>
<td>Underweight 70%</td>
<td>Expected spread underperformance</td>
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<tr>
<td>Underweight 100%</td>
<td>Material spread widening expected</td>
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*Time horizon – our recommendations have a 3 month time horizon*
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