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RISK MANAGEMENT:
REVENUE GENERATING & TOP LINE GROWTH STRATEGIES FOR PROVIDERS

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Introduction
Faculty

Michael Hotz, LNHA, CNHA, FACHCA
Administrator
The Health Care Center at Bloomingdale

Arthur N. Krauss, MBA, CPA, CGMA
President
Woodlyn Associates, LLC

Kevin McLaughlin, CPCU, MAS
Director, Professional Liability
Marsh & McLennan Agency, LLC

Denise L. Angleman, CPIW
Regional Senior Vice President
Marsh & McLennan Agency, LLC

Section 1

RISK MANAGEMENT CHALLENGES – *AN ADMINISTRATOR'S PERSPECTIVE*

Michael Hotz, LNHA, CNHA, FACHCA
Administrator
The Health Care Center at Bloomingdale

Biography
Michael Hotz, CNHA, FACHCA

Michael Hotz, CNHA, FACHCA has been a practicing Administrator for almost 30 years. He is both Certified and a Fellow in the American College of Health Care Administrators, the Education chair of the Society of Licensed Nursing Home Administrators, long time member of the HCANJ, NJ Chapter President of the ACHCA and National Vice Chair of the American College of Health Care Administrators and the Administrator of the Health Center at Bloomingdale. NHA, FACHCA has been a practicing Administrator of the Health Center at Bloomingdale

Risk Management Challenges – *An Administrator's Perspective*

Overview of Risk Management

- What it means
- Goals
- How much will lawsuits costs (figures from Marsh please)
- Who owns the process

Risk Management Challenges – *An Administrator's Perspective*

Traditional Issues

- Dehydration
- Elopement
- Weight Loss
- Decubitus Ulcers
- Pain Management
- Falls and Injury
- Drug Utilization
- Resident Rights and Choice
- General Safety Hazards and Equipment Management
- Staff Education and Orientation
- Quality Assurance Program

Risk Management Challenges – *An Administrator's Perspective*

Hot Issues-Quick Mentions with Details from the other speakers

- Background Checks
- RAC Audits
- Workers' Compensation Claims and Safe Resident Handling
- Workplace Violence Prevention
- Rehospitalizations
- Due Diligence of Job Performance
- Collections
- Hot Topic currently - Rehospitalizations

Section 2

REVENUE CYCLE MANAGEMENT IS RISK MANAGEMENT

Arthur N. Krauss, MBA, CPA, CGMA
President
Woodlyn Associates, LLC

Biography
Arthur N. Krauss, MBA, CPA, CGMA

Arthur N. Krauss has practiced as a certified public accountant for over 40 years. He was a partner in a center city Philadelphia firm that specialized in senior health care institutions before founding Woodlyn Associates, a leading revenue cycle firm, in 1981. He also spent over a decade as a senior partner in a senior care management firm that specialized in turn-around situations, retained by the courts and both institutional and individual investors. Arthur received a BA from Dickinson College and an MBA from Temple University. He is a long-term member of HCANJ and serves on its reimbursement and convention committees, and is a member of the American and Pennsylvania Institutes of Certified Public Accountants as well as other professional organizations.

Revenue Cycle Management IS Risk Management

– Revenue Cycle Management

- What It Means
- Why It is Important

Revenue Cycle Management IS Risk Management
Planning, Protocols and Processes

- Cash Flow Planning – The First Step
- Protocols – Developing Procedures
- Processes – The Actual Steps and Tools Required

Revenue Cycle Management IS Risk Management
Healthcare Facility Specifics

- Pre-Admissions Evaluation
- Admissions Processing
- Billing Processes
- Collections Evaluation and Follow-Up

Revenue Cycle Management IS Risk Management
Pre-Admission Evaluation

- Clinical Evaluation
- Financial Evaluation

Revenue Cycle Management IS Risk Management
Admissions Processing

- Legal Steps
- Financial Steps

Revenue Cycle Management IS Risk Management
Billing Processes

- Creating The Bills
- Submission and Tracking
- Follow-Up and Appeals

Revenue Cycle Management IS Risk Management
Health Care Third Party Billing - NJ

Today

- Medicare – Single Payer
- Medicaid – Single Payer
- Commercial and Private

Tomorrow

- Medicare – Single Payer
- Medicaid – Managed Care HMOs
- Commercial – Similar to Medicaid
- Private

Revenue Cycle Management IS Risk Management
Medicare

- Single Payer Systems
- Easy to Pre-Qualify
- Clear Requirements
- Rapid Payment
- Cumbersome Appeals Process
- Risks of Retroactive Recovery (RACs, etc.)

Revenue Cycle Management IS Risk Management
Medicaid – New Jersey Today

- Single Payer System
- Easy Qualification Confirmation, but
- Potential Long Delay if Patient Pending
- Room and Board Billing
- Professional Services Billing
- Rapid Payment
- Simple Appeals Process

Revenue Cycle Management IS Risk Management
Medicaid – New Jersey - Tomorrow

- Four Managed Care Payers
- Four Billing Protocols
- Cash Flow Uncertainty
- Increased Complexity in informal Dispute Resolution
- Complex and Costly, Appeals Process

Revenue Cycle Management IS Risk Management
Know Your Patient

- Understanding Coverage
- Understanding Pre-Authorizations

Revenue Cycle Management IS Risk Management
Resource Commitment

- Understand the Process and Requirements
- Organize and Plan
- Learn to Deal with New Payers

Revenue Cycle Management IS Risk Management
Diligent Follow-up

- Act Timely
- Maintain Strong Documentation
- Comply with Formal Requirements

Revenue Cycle Management IS Risk Management
What This All Means

- Revenue Cycle Management is Risk Management – The Ultimate Risk
- The Future is Uncertain
- There Will Be Risks and Opportunities
- Planning is Essential

Section 3

EXPOSURE, COVERAGE AND EFFECTIVE STRATEGIES FOR RISK MANAGEMENT

Kevin McLaughlin
Director, Professional Liability
Marsh & McLennan Agency LLC

Biography
Kevin McLaughlin

Kevin McLaughlin, Kevin McLaughlin, CPCU, MAS. Kevin has a broad range of knowledge in the healthcare field on issues such as HIPAA, Credentialing & Privileging, Billing & Coding, E&O, Captive Formation & Self-Insurance, contract issues (including construction, leases, events, insurance and environmental exposures), peer review, and Vicarious Liability. Much of this experience was attained by working with hospitals, nursing homes, physician groups, allied health care, medical products and manufacturers including research companies. He also has experience with other commercial clients including advertising agencies, banks and other large commercial accounts. Kevin also managed a unit that handled hundreds of individual physicians. He has acted as consultant on two Workers' Compensation captives and various hospitals. He has also worked as Director of a unit for two hospital-based captives.

Kevin attained a BS Degree in Business Administration from Seton Hall, a Master of Administrative Sciences from Fairleigh Dickinson University on a Fellows Scholarship and a CPCU Degree from the American Institute. He has instructed classes as Adjunct Faculty at Seton Hall and FDU on Risk Management and Insurance for the past 25 years. He also presented information to Hospital Risk Managers on behalf of The Institute of Medical Law at SUNY, Hofstra and the University of Maryland.

Exposure, Coverage and Effective Strategies for Risk Management
Current Developments

- Billing and Coding E&O
  - RAC Audits – Done on a contingency basis
  - Insurance Solution – Billing and Coding E&O Coverage – Defense costs, fines, penalties and audit expenses. Can include EMTALA and voluntary self disclosure.

Exposure, Coverage and Effective Strategies for Risk Management
Privacy and Security – Covers Electronic or Manual Record Event

- Third Party Liability
- Notification Costs
- Regulatory Fines and Penalties – Can extend to PCI Violations
- Media Liability
- Event Management
- Extortion
- Network Interruption
- Forensic Costs
- Crisis Management

Exposure, Coverage and Effective Strategies for Risk Management

Large Deductible Workers' Compensation

- Requires a focus on Loss Control
- Caps costs at or about a Guaranteed Cost Plan
- Allows for self-funding on a paid basis through a Loss Fund or secured by an LOC
- If done properly – short and long term savings

Risk Management

- "SUCCEED" a one stop solution
- Bilingual Risk Management Library
- Incident Tracking/Trending and Claims Reporting
- Job Hazard Analysis (JHA) Library
- Employee Training Program Management

Exposure, Coverage and Effective Strategies for Risk Management

What is the true cost of a Workers' Compensation Claim?

- Costs of Accidents Calculator – created by OSHA for US DOL
- Why are there hidden costs?
- Loss of productivity, distraction to management, patient injury, increased security, change or reinforcement of protocols, increased committee time, filing of reports and follow up, decreased morale, increased employment practices activity, retraining, damaged equipment, may cause an OSHA or DOH inspection and/or action, increased overhead.

Section 4

HEALTH CARE REFORM

Denise L. Angleman, CPIW
Regional Senior Vice President
Marsh & McLennan Agency, LLC

Biography
Denise Angleman

Denise L. Angleman, **CPIW** is an expert on design, implementation and compliance of employee benefits plans, and she possesses nearly 25 years experience in the employee benefits insurance industry and 20 years with MMA. Denise is a frequent lecturer on employee benefits topics affecting employers and their workforce, and she has presented on numerous issues ranging from employment practices and health care reform to creating benefits strategies for a multigenerational workforce. Business and professional publications, such as *The Wall Street Journal, Employee Benefit News* and *NJ Biz*, often seek Denise to comment on HR and employee benefit trends.

Denise's expertise lies in the large group experience rated account area, and she is proficient in all lines of group insurance coverage on a fully insured and self-insured basis. Her responsibilities for the Employee Benefits division includes managing insurance company relationships at a Regional and National level, long range planning, sales and revenue growth, pre-sale and renewal negotiations of group plans, training and educating the benefit account service representatives and producers, creating service quality account management standards and as the executive contact for all large group clients for MMA.

Biography
Denise L. Angleman, CPIW (cont'd)

Denise is a graduate of William Paterson University with a BA degree in Communications and Minor in Business. In addition to her degree, Denise has obtained her CPIW and HIA designation. She is a member of the National Association of Health Underwriters and the National Association of Insurance Women of Northern New Jersey where she served as past President. She also serves from time to time as a panelist on HR issues for the Commerce & Industry Association of New Jersey.

Health Care Reform
What is it?

- Patient Protection and Affordable Care Act (“PPACA”) – signed on March 23, 2010
- Health Care and Education Reconciliation Act (Reconciliation Act) – signed March 30, 2010
- The Health Care Reform law makes sweeping changes to our nation’s health care system
- Compliance with these reforms was required beginning the first plan year after September 23, 2010 or for plan years beginning October 1, 2010 going forward

Health Care Reform
What is next, 2012

Uniform Summary of Benefits and Coverage (“SBC”)

- Required for all insured and self-insured group plans (grandfathered or not), including stand-alone Health Reimbursement Arrangements, may apply to Health Flexible Savings Accounts and EAP’s that provide medical benefits.
- When?
  - **The first day of the first open enrollment period beginning on or after September 23, 2012**.

Health Care Reform
What is next, 2012

New Fee Called Patient-Centered Outcomes Research Institute (“PCORI”)
Fee formerly called Effectiveness Research Fee

- This new fee will apply to plan sponsors and insurers of individual and group medical policies, as well as some HRA’s and Health FSA’s.
- The fee is $1 per member per year for policies/plan years ending after September 30, 2012. The fee adjusts to $2 per member for policies/plan years ending 2012 through 2014. After September 30, 2014, the dollar amount will be adjusted by HHS.

Health Care Reform
Looking Forward in 2013 and 2014

- Exchange notifications to employees (2013)
- Waiver of Annual Limit Rule for Mini-Med plans expire (2013)
- Plans must not have waiting periods in excess of 90 days (2014)
- Plans cannot impose pre-existing exclusions for any participants (2014)
- Exchanges initial open enrollment period begins (2013)
- Medicare Part D Subsidy Deduction eliminated (2013)
- Employer reward programs for wellness can potentially increase from 30% to 50% for participating in a wellness program (2014)
- The Medicare payroll tax increase of 0.9% goes into effect for individual filers with incomes over $200,000 and $250,000 for married filed jointly. In addition, there is a new 3.8% Medicare contribution on certain unearned income *(for example, capital gains, dividends, interest, annuities, and rent)* for high-income individuals (2013)

Health Care Reform
Looking Forward in 2013 and 2014

- **"Federal Insurer Annual Fee" (Premium Tax)**
  - Designed to help fund the PPACA, this fee places an additional premium tax on insurers. This fee is only applicable to fully-insured business and applies to medical, dental and vision plans. The assessment is based on all premiums collected in 2014 and includes plans that begin in 2013 and extend into 2014.
  - Fully Insured: Since the assessment is based on all premiums collected in 2014, and we have policy years that begin in 2013 and extend into 2014, insurers will need to add the fee to premiums for most plans beginning February 2013.
  - Self-Insured: Self-insured groups are subject to this fee if they purchase stop loss insurance. For billing purposes, it will be included in the stop loss premium with February, 2013 effective quotes for new business and renewals.

Health Care Reform
Looking Forward in 2013 and 2014

- **Transitional Reinsurance Program**
  - Intended to help offset the losses health insurance companies are expected to incur for providing coverage to high risk individuals buying coverage in State Insurance Exchanges.
  - Further guidance required on how this will be assessed.
  - We believe the assessment will be in the range of $60 - $90 per plan participant per year.
  - Pass-through tax.
  - Collection to begin the 1st quarter of 2014. This will impact any employer in 2013 starting with February 1, 2013 new business quotes and renewals.

Health Care Reform
Looking Forward in 2013 and 2014

- **“Medicaid Expansion”**
  - The Governors in about six States are stating they will not expand their Medicaid Program.
  - Employers, especially those with low wage earners, would feel the effect.
  - Law states if an employee is eligible for Medicaid they cannot receive a subsidy to buy coverage.

Health Care Reform

The Big Event in 2014: Health Insurance Exchange

- The Act requires Exchanges in each State by January 1, 2014. In 2014 – 2016, only individuals and employers in the small group market are eligible to participate in an Exchange.

  States seeking to operate a State-based exchange must submit a blue print to HHS by November 16, 2012 to receive the required approval by January 1, 2013 for plan years beginning 2014.

- State-based health insurance exchanges
  - Law requires the creation of an American Health Benefit Exchange (AHBE) (for individuals) and Small Business Health Options Program (SHOP) Exchange for small employers up to 100 lives
  - States can combine their individual and small employer exchanges
  - States can choose to expand their exchanges to serve employer groups of 100+ in 2017

Health Care Reform
The Big Event in 2014: Health Insurance Exchange

- State-based health insurance exchanges (cont'd)
  - Carriers need final regulations by June 2013 and file plans by October 2013 to be ready to start open enrollment late 2013 for the proposed effective date of January 1, 2014??
- Not Optional - If a State doesn't create one, federal government will
- Transparent and more standardized benefit packages
- Offer choice of plans, carriers, networks (comparison shopping)
- Develop menu of choices based on quality, access, and premium costs
- Premium tax credits only available for individuals purchasing through an exchange, not those in an employer group

Health Care Reform
The Big Event in 2014: Health Insurance Exchange

- **Employer Mandate (50 full-time employees or more)**
  - Effective January 1, 2014 employers must offer health insurance employees can afford.
  - Employer must count all full-time employees and part-time employees – on a full-time equivalent basis – in determining if they have 50 or more employees
  - New guidance was issued by the IRS on 8/31/12, and will provide greater flexibility for employers to reasonably determine whether a current or new variable hour or seasonal employee qualifies for full-time benefits for purposes of the employer mandate rules under PPACA.
  - Employers may now apply a so-called “look-back” period of up to 12 months to determine whether or not a variable hour or seasonal employee is “full-time” (i.e., averages 30 or more hours per week) under PPACA.
  - Penalties assessed for “no coverage” or coverage that is “not affordable”

Health Care Reform
The Big Event in 2014: Health Insurance Exchange

- **No Coverage**
  - If an employer fails to provide its *full-time* employees (and their dependents) the *opportunity to enroll* in "minimum essential coverage," **and**
  - One or more *full-time* employees enrolls for coverage in an exchange and qualifies for a premium tax credit or cost-sharing reduction, **then**
  - Employer penalty = $2,000 for each of its *full-time* employees in the workforce
    - This penalty is non-deductible
    - Penalty does not offset the cost of employee coverage

Health Care Reform
The Big Event in 2014: Health Insurance Exchange

- **Unaffordable Coverage**
  - If an employer offers its *full-time* employees (and their dependents) the *opportunity to enroll* in minimum essential coverage, **and**
  - One or more *full-time* employees enrolls for coverage in an exchange and qualifies for a premium tax credit or cost-sharing reduction because:
    - The employee's share of the premium exceeds 9.5% of income, or
    - The actuarial value of the coverage was less than 60%, **then**
  - Employer penalty = $3,000 for each of its full-time employees who receives a tax credit or cost-sharing reduction
  - If the employer has many employees in this category, the alternative penalty reverts to $2,000 per full-time employee.

Health Care Reform
The Big Event in 2014: Health Insurance Exchange

- **Additional Details**
  - Penalties assessed on a monthly basis.
  - No penalties assessed on first 30 full-time employees.
  - No penalties apply to part-time employees.
  - No penalties for waiting periods (if any), not exceeding 90 days.
  - Total “affordability” penalty is capped. May not exceed penalty for “no coverage.”

Health Care Reform

Employer Contributions: “Pay or Play”? Individual and Employer Mandates

- **Employer Challenge (Pay)**
  - Penalty
  - Gross up to allow employees to purchase post-tax coverage
  - Possible issues with retention and attraction of talent
  - Unknown cost/trend of exchange premiums
  - Lack of consistency across States
  - Productivity impacts

Health Care Reform

Employer Contributions: “Pay or Play”? Individual and Employer Mandates

- **“Pay”**
  - Employer doesn’t offer a health care benefits plan to full-time employees and pays the $2,000 annual penalty for each full-time employee (FTE = average 30+ hours/week)
- **“Large Employers 2017 to State-based Health Exchanges”**
  - The Health Care Reform law allows employers with more than 100 employees (“large employers”) in 2017 to offer full-time employees the government Health Exchanges as a health plan option
- **“Play”**
  - Employer offers a health care benefits plan to full-time employees that complies with some or all of the Employer Mandate provisions

Health Care Reform

Employer Contributions: “Pay or Play”? Individual and Employer Mandates

- **“CDHP/Health Management”**
  - Employers that “play” need to take greater control of future plan costs, using consumerism (CDHP), and results-based health management plan strategies
- **“Defined Contribution/Private Exchange”**
  - An emerging strategy for employers that “play” is to offer employees a defined annual employer subsidy for purchasing health plan benefits and sponsor a health exchange with multiple insurer and benefit plan options
- **What will an employer glean from a Health Care Reform “Pay or Play” Analysis?**
  - Review current definition of eligibility and determine what increased costs may arise from a change of definition.
  - Provide to you the lowest annual income of a Heath Care Reform eligible employee based upon your current census.

Health Care Reform

Employer Contributions: “Pay or Play”? Individual and Employer Mandates

- **What will an employer glean from a Health Care Reform “Pay or Play” Analysis?**
- Determine the actuarial value of the “lowest value plan” at 60%.
- Perform the Affordability Test (<9.5% Annual Income) to employee contributions.
- Calculate the number of eligibles with 2012 income below the affordable limit to project possible penalty.
- Illustrate your options and costs moving into 2014.
  - Maintain current benefits & eligibility.
  - Comply with PPACA Benefits, Eligibility and Affordability criteria.
  - Eliminate benefits without any contribution for employees to purchase benefits in the Exchanges.

Health Care Reform

Employer Contributions: “Pay or Play”? Individual and Employer Mandates

- **What will an employer glean from a Health Care Reform “Pay or Play” Analysis? (cont’d)**
- Excise Tax Review
- This powerful information will offer a solid plan and strategy

QUESTIONS