

Health Care Compliance LETTER

Volume 9, Issue 20

health.cch.com

October 2, 2006

On The Front Lines 4

Collision course: Consumer directed health care and compliance concerns

by Allan P. DeKaye, M.B.A.,
FHFMA, Contributing Editor

Tax-Exempt Organizations 1

- Grassley solicits proposals for charity care guidelines

Trends 2

- Prepare now for pay for performance, expert cautions
- Partnership key in Medicare pay-for-performance

Corporate Governance 8

- Executive compensation rule changes disclosure requirements

In the News 8

Grassley solicits proposals for charity care guidelines

by Catherine Hubbard, M.A., Contributing Editor

While federal charity care legislation is not anticipated in the near future, according to Senate Finance Committee Chairman Charles Grassley (R-Iowa), the committee met on Wednesday, September 13, 2006, to discuss legislative options and hear testimony.

Legislation proposals. Many of those present at the hearing discussed the Catholic Health Association's guidelines for charity care hospitals. The guidelines recommend that bad debt and the Medicare shortfall not be counted as part of community benefit. Sister Carol Keehan, chief executive officer of the association, said its model also lays out what activities a hospital can consider charity care. "Communities deserve to know what those costs are," she said. Grassley said the Catholic Health Association model could be used as a starting point for legislation.

Nancy Kane, a professor of health management at the Harvard School of Public Health, department of health policy and management, Boston, Massachusetts, said "[T]here needs to be a higher standard for charitable exemption." She advocated requiring increased reporting and transparency to the Internal Revenue Service (IRS), increased communication to the community, and requiring that hospitals partner with community groups. "Right now we have no measurable requirement" in exchange for the tax breaks, Grassley said.

Sen. Max Baucus (D-Mont.) noted that the IRS looks for a "plus factor" in addition to a hospital policy of open admittance, so, for example, a tax-exempt hospital also must have a charity care, medical research, or health education program. The IRS has not made clear how much of this a hospital has to do, he said, noting that some health care providers have taken advantage of these "loose standards."

Kevin Lofton, chair-elect of the American Hospital Association (AHA), Washington, D.C., said that uniform reporting would allow people to measure and compare what the charity care nonprofit hospitals provide. "Uniform reporting is where we need to go," he said. He added that the Catholic Health Association's model and guidelines developed by the AHA are similar.

Executive compensation. In addition to charity care and tax exempt hospitals, Baucus asked the panel whether some hospital executives are overpaid or receive too many perks. Lofton said the IRS Form 990 needs to be structured so that they look at total compensation. Kane suggested a separate Form 990 for charity hospitals. "The IRS is a great place to start," but state attorneys general

continued on page 2

Tax Exempt Organizations (cont.)

and private sector organizations also should take part in helping to improve quality, she said.

According to Grassley, Finance Committee staff are expected to develop a

discussion paper that will outline the different legislative options. He expects the proposal to be developed in consultation with minority staff and input from stakeholders. Baucus stressed

that he would like to work with the administration on a way to improve charity care and reduce the number of uninsured. ■

CCH Washington Bureau, Sept. 13, 2006.

Trends

Prepare now for pay for performance, expert cautions

by Catherine Hubbard, M.A.,
Contributing Editor

Health care organizations should prepare for pay-for-performance initiatives now by improving how they measure quality and outcomes, David Hammer, a vice president at McKesson Provider Technologies, Fort Lauderdale, Florida, said during a September 6, 2006, Healthcare Financial Management Association audio webcast.

Trends toward pay for performance. “The government is now keeping score of our clinical results,” Hammer said noting the administration is moving aggressively to introduce pay for performance to its reimbursement systems.

CMS outgoing administrator Mark McClellan has set a goal of tying up to 30 percent of Medicare payments to quality within the next 10 years, a goal the administration will likely hold to after McClellan departs. In addition, CMS has a demonstration project linking pay with quality, Hammer explained.

Private payors also are moving toward pay for performance. One payor has stopped paying for serious medical mistakes, such as when surgery is provided on the wrong side of the body or a foreign object is left in the body afterward, he noted.

Hammer suggested that organizations get started on their own before pay for performance is imposed on them. “Pay for performance initiatives will continue to accelerate, and proliferate, over time,” he said.

Pay for performance tools. Hammer discussed some tools that can be used to make the adjustment to pay for performance. For instance, he said that key performance indicators can be used to help organizations understand how it

is performing and to affect changes. Performance indicators can be used to:

- view a snapshot of performance at an individual, group, department, hospital, or regional level;
- assess the current situation and determine the root causes of identified problem areas; set goals, expectations, and financial incentives for any individual, group, or enterprise; and
- trend the performance of the selected individual, group, or enterprise over time.

Hammer stated that trending factors over time will provide better direction than one-time indicators.

Measuring outcomes. Organizations also should automate and support patient-facing workflow and measure and improve outcomes, said Hammer. Outcomes measurement should include the organization’s performance in the area of health status, patient satisfaction, cost and utilization analysis, clinical results analysis and the level of resource commitment. “Do not limit yourself to a reactive approach to outside influences—establish your own quality and outcomes goals and measures,” he emphasized.

At both patient and aggregate levels, initiatives will require data collection, retrieval and reporting, Hammer said. “Clinical information systems will become an economic necessity as the ability to collect, retrieve, and report process and outcomes data increases,” he said.

Consumer-directed health care. Hammer pointed out that the administration supports consumer-directed health care, which could lead consumers to demand increased transparency. Research shows that patients want to know more about how providers are paid and are now more likely to initiate negotiations to lower prices than in the past.

To foster consumer-directed health care, President Bush has called for establishing tax-favored health savings ac-

counts, which have potential pluses and minuses for health care organizations, Hammer said. While the accounts can lead to higher profits and improved cash flow in the near term, once the funds are

continued on page 3



Portfolio Managing Editor
Pamela K. Carron, J.D., LL.M

Coordinating Editors
Susan Smith, J.D., M.A.
Stacey Fahrner, J.D., M.P.H.

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC—John Scorza
SEC—Peter Feltman

Health Law—Catherine Hubbard, M.A.
Tax—Jeff Carlson, Steve Cooper

Designer
Laila Gaidulis

Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

CCH Health Care Compliance Letter is published 24 times a year by CCH, a Wolters Kluwer business, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is \$305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A. ©2006 CCH. All rights reserved.

No claim is made to original government works; however, the gathering, compilation, and arrangement of such materials, the historical, statutory and other notes and references, as well as commentary and materials in this Product or Publication are subject to CCH's copyright.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting or other professional service. If legal advice or other expert assistance is required, the services of a competent professional should be sought.

For more information about the CCH Health Care Compliance Portfolio, please visit our online store at <http://health.cch.com>.

depleted, health care organizations might experience more bad debt. The accounts also might lead to growing pressure to publicly disclose prices and details of reimbursement, he added. Consumer-directed health care initiatives, such as health savings accounts, will require an increased focus on pre-registration, insurance verification, financial counseling and on the need to collect, retrieve, and report data about consumer-directed health care-related patients, he concluded. See story on page 4.

CCH Washington Bureau, Sept. 8, 2006. ■

Partnership key in Medicare pay-for-performance

by Catherine Hubbard, M.A.,
Contributing Editor

CMS will increase collaboration with the private sector and other stakeholders to bring pay-for-performance to the Medicare program, Dr. Barry Straube, director of the Office of Clinical Standards and Quality and chief medical officer for CMS said at a meeting of America's Health Insurance Plans in Washington, D.C. in September. "We're focusing increasingly not just on quality of care but at value [and] efficiency in health care," Straube said, adding that the government needs to look at cost effectiveness "in a much greater and systemized way than we have been before."

Straube said the agency has "a tremendous amount of financial and influential leverage that could be expended to change not just the Medicare and Medicaid programs but to change the entire U.S. health care system in a positive way." He noted that President Bush issued an executive order in August charging federal agencies to develop a process by which they can share information on quality and costs more widely than they have in the past.

Health care spending. Health care spending, expected to exceed \$2 trillion by next year, is expected to reach 21 percent or 22 percent of gross domestic product by 2015. Meanwhile, the number of Medicare beneficiaries is expected to grow to 76.8 million by 2030, Straube noted. "For us in the

Medicare and Medicaid programs, this is clearly driving the imperative for us to focus on quality and value," said Straube.

The U.S. spends more per capita on health care than any other country in the world, but in spite of these expenditures, U.S. health care quality is often inferior to other nations, Straube said. To a large extent, highest cost areas in terms of Medicare expenditures are associated with the worse outcomes for Medicare hospital quality, he added.

Developing quality measures. To set a foundation for pay-for-performance going forward, the government and private sector need to first develop quality measures, Straube said, adding that is no easy task. He emphasized that in partnership and collaboration, CMS and stakeholders must demonstrate leadership in addressing all of these issues.

Straube said CMS has developed five strategies to improve health care cost and quality:

- working through partnerships to achieve specific quality and efficiency goals;
- publishing quality measurements and information as a basis for supporting more effective quality improvement efforts;
- reforming the payment system and the reimbursement system to reward quality care;
- assisting practitioners in making care more effective and less costly, primarily

through adoption of health information technology; and

- bringing effective new treatments to patients more rapidly and help to develop better evidence so that doctors and patients can use medical technologies and treatments more effectively, improving quality and avoiding unnecessary costs and complications.

Demonstration projects. To gather more information on quality, CMS plans to expand its pilot sites soon to 15 or 16, and, eventually to as many as 60 or more across the country, he said. After collecting and reporting results, a feedback mechanism will be used to help providers improve care, he said. Increased physician/patient partnerships, integrated delivery systems, managing of chronic illness, increased prevention, special needs populations and innovative ways to deal with the most high-cost beneficiaries are some of the aspects pilots will focus on, said Straube.

Some of the current and planned demonstration projects are intended to reward physicians financially for achieving quality benchmarks for Medicare beneficiaries; reward health plans, physicians and other payors and providers for eliminating scientific uncertainty and variation in practice implementation; and provide quality payment incentives to nursing homes, Straube said. ■

CCH Washington Bureau, Sept. 20, 2006.

CCH Health Care Compliance Editorial Advisory Board

Timothy P. Blanchard, Esq.
McDermott, Will & Emery

Patricia L. Brent, J.D., M.P.H.
President, Morgan Hill Associates

Neil B. Caesar, Esq.
*President
The Health Law Center*

Paris Cavic, Esq.
Albany, New York

Michael E. Clark
*Partner
Hamel Bowers & Clark LLP*

Bill Dacey, MBA, MHA, CPC
*President
The Dacey Group*

Allan P. DeKaye, MBA, FHFMA
DeKaye Consulting, Inc.

Paul R. DeMuro, J.D., MBA
*Partner
Latham & Watkins*

Louis H. Feuerstein
*Corporate Compliance Program National Leader
Ernst & Young*

Cynthia Reaves, Esq.
Honigman Miller Schwartz and Cohn

Fay A. Rozovsky, J.D., M.P.H.
Quality Medical Communications, LLC

William P. Schurgin, Esq.
Seyfarth, Shaw, Fairweather & Geraldson

John E. Steiner, Jr., Esq.
*Chief Compliance Officer
UK HealthCare of Lexington, Kentucky.*

Sanford V. Teplitzky, Esq.
Ober, Kaler, Grimes & Shriver

Collision course: Consumer directed health care and compliance concerns

by Allan P. DeKaye, M.B.A., FHFMA, Contributing Editor

With estimates of 46 million Americans without health insurance, the nation and the industry have been attempting ways to mitigate this large number. As a result, hospitals have been especially vulnerable to criticism concerning the availability of charity (or reduced fee) care it makes available to its patients, as well as to allegations of overly aggressive collection practices when patient responsible amounts go unpaid. In response, hospitals have been reviewing their registration, billing and collection policies and procedures, often at the behest of state agencies, and in some cases as the result of litigation.

While many hospitals have revisited Federal Poverty Guidelines (FPG) and Medicaid reimbursement rates, and used these levels as a guide to providing discounts to uninsured and under-insured patients, these positive approaches may fail to consider the impact when patients elect to choose new health insurance plans with high deductibles and are faced with paying hospitals and physicians for services that previously were covered by insurance (in full or with smaller deductibles and co-payments), or went unpaid and uncollected.

Enter Consumer Directed Health Care (CDHC)

Consumer Directed Health Care (CDHC) is here! Created largely to fill a void in the less costly health insurance premium market, CDHC plans offer both the individual and corporate employer a policy that combines a lower premium coupled with a higher out-of-pocket deductible. The two-pronged rationale provides a more affordable premium making it attractive to those uninsured but employed individuals, who either couldn't afford more traditional policies, or whose employers couldn't afford to offer such a benefit to its workers. The added attractiveness of the Health Savings Account (HSA) feature associated with these high deductible plans enables individuals to retain unspent contributions to these HSAs (either made by the individual or employer) in a manner similar to IRAs (Individual Retirement Accounts). With studies showing that "2.4 million people have enrolled in these plans,"¹ and with enrollment expected to be as high as "30 million by 2015 (or 17 percent of the enrolled population),"² healthcare providers will need to be able to recognize and administratively handle these emerging plans.

When consumers enroll in these plans, they usually are offered payroll deductions as a method to fund a portion of their anticipated high deductibles. The payroll deductions are then deposited to the consumer's HSA. These accounts also let an employer make contributions to an employee's HSA as

part of a benefits package. Most HSAs come with check-writing or debit card features that allow a consumer to make payment of their responsible amounts when they become a patient purchasing health care. The use of the term "purchase" is deliberate, and is meant to contrast "using" medical care. The difference is embedded in the underlying principles associated with high deductible plans that the consumer becomes more price conscious when taking on the role of patient in "shopping for" rather than "just seeking" medical care.

From the Provider's Perspective

On the surface, these high deductible health plans may just appear to be another product line being offered by insurance plans, not dissimilar to when health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans were introduced in prior years. The provider community, however, will argue that in operational and financial matters ranging from electronic insurance eligibility and benefits verification, service authorizations, billing and payment processing, the introduction of these new product lines has been anything but smooth.

Another element of concern continues to be the collectability of patient deductibles, coinsurance and co-payment amounts that vary by insurance plan and contract. Until the introduction of high deductible health plans, the typical outpatient co-payment amount (usually ranging from \$10-\$50) was an amount seemingly better collected at physician offices, and with varying degrees of success in a hospital ambulatory setting. With high deductible amounts anticipated to now be in the \$1,000-\$2,500 range (per qualified individual and family), collecting that amount will become an issue for both patient and provider.

How much of any issue will depend on a variety of factors. First, the high deductible amount will need to be conveyed to the provider; hopefully, in an electronic

manner that confirms eligibility levels, and as important, the accurate amount remaining as the patient's deductible. Second, the payment vehicle, either check or debit card, will need to demonstrate that it has sufficient funds available to match the remainder of the deductible that is due to the provider, and what will happen, if the available balance is insufficient.

This, of course, presupposes that at every point-of-service, whether in the doctor's office or in various inpatient and outpatient hospital service areas, the patient amount due is known. Generally, for the traditional office visit, whether to an internist or specialist, the amount due will be known. It is no longer going to be the \$10-\$50 co-payment, however, but the full value of the visit and ancillary charges (if applicable). The next question will be whether the amount is the provider's full charge or their negotiated rate with that particular payer. It may be the full charge amount if an out-of-network provider is selected, and there isn't a benefit for providers outside of the network plan.

If the service level is still a doctor's office visit or hospital clinic visit, the level of the payment due may still be in a "reasonable range" (i.e., \$100-\$300). If the setting changes to a minor (doctor's) office procedure, hospital ambulatory surgical procedure, diagnostic radiology or chemotherapy visit, however, the cost of the episode of care could range from \$1,000-\$5,000, and even higher. Sticker shock, not only for the patient, but the provider is a probable outcome.

The Collection Conundrum

In the best possible outcome scenario described above, the patient with a high deductible health plan chooses an in-network provider, who is able to electronically verify insurance eligibility and benefits, and prior authorization if required, as well as the remaining deductible amount (whether \$50 or \$1,500). The patient presents their debit card to pay the deductible amount due (whether \$50 or \$1,500); the provider has a debit card compatible device to process the transaction, and there is sufficient funds available to cover the cost of that day's care. [Note: Not all credit card transaction processing devices can accommodate debit cards.] Judging from the historical introduction of HMOs, PPOs, and POS plans, this ideal outcome will not always happen (especially in the early rollout periods), and the resulting actions (or inactions) are likely to trigger collection issues, and compliance concerns.

It is anticipated that the patient will have an amount due that is within the limits of the high deductible amount.

If at the time service is being rendered, however, there is insufficient funds available in the HSA, the amount due will not likely be processed on the debit card. If an HSA checking account has been provided, the provider should have the technology to verify that the check is "good," and there is sufficient funding available to pay on this instrument and, in this case, that criteria would not be met. This may be due to the way payroll deductions or employee/employer contributions are made. According to

the terms and conditions of the plan, the amount is due. The provider may require that this amount be paid at the time of service. Seemingly, the following options are available:

1. Render service and bill the patient. The question remains how the account will be paid. Maybe a partial amount due was authorized at the time of service, but how will the provider know when the balance will be suf-

ficient to be transferred to the provider (and if that can be done electronically)?

2. Render service, bill the patient, and expect payment by cash, personal check or credit card (see also credit card considerations below).

3. Require cash, personal (non-HSA) check or credit card before rendering service. The key question to consider here is whether this is an acceptable provider condition of participation. Many providers will require full or partial payment when service is rendered in a nonemergent, nonlife threatening elective situation. The presentation of an under-funded HSA debit card or HSA issued check may void that condition of participation, and allow the provider to seek settlement of the account from another source.

4. Some HSA issued debit cards may provide for an associated line of credit or credit card feature to cover this type of situation. This would satisfy provider payment; however, it may raise truth-in-lending concerns, and require insurers and plan administrators to make certain the patient understands that they have, in effect, made a personal credit obligation, not to the provider, but to the issuer of the credit instrument. This would also require another level of integrated HSA account management to allow the patient to offset any temporary indebtedness (use of credit) with future HSA contributions by the employee or employer. This would seemingly be a timing issue, but the matter of interest (if any) also might have to be addressed.

5. Defer or delay a nonemergent, nonlife-threatening elective service. Though not a popular approach, this is used by

“Judging from the historical introduction of HMOs, PPOs, and POS plans, this ideal outcome will not always happen (especially in the early rollout periods), and the resulting actions (or inactions) are likely to trigger collection issues, and compliance concerns.”

some providers currently. Again, the question of whether this action is consistent with conditions of participation has not yet been resolved.

Hospitals and physician offices have been challenged by the need to collect from their patients. While time-of-service payment capability is advocated, the complexities associated with consumer directed healthcare plans are likely to be viewed as a setback to the provider community.

Charity Care and Bad Debt Determinations

With the growing numbers of uninsured patients, hospitals have come under direct review related to the amount of charity care that is rendered. The challenges that were mounted posed a direct threat to the tax exempt status afforded not-for-profit voluntary hospitals. The question was raised as to how hospitals can be meeting their stated purpose of caring for community when fees charged to uninsured were higher than those charged to insured patients, and with patients seemingly unaware of hospitals financial aid policies and procedures. With reports of aggressive collection efforts making front page news, hospitals were put on the defensive.

It might be hard to imagine the difficulties faced by providers in obtaining the information necessary to register a patient. Anyone who has visited an inner city emergency room or outpatient clinic, or seen how providers in border states, and those in high areas of undocumented patients render care, will know those difficulties; still, these providers render medical care. A good portion of this issue reflects the difficulties associated with the provider trying to collect demographic and financial information about its patients.

Hospitals can own some responsibility for not recruiting and training more qualified staff to be better able to handle the variations of healthcare insurance plans, as well as ensuring their staffs familiarity with internal policies and procedures, and not always using newer technology to assist in the registration process. Providers do face obstacles, however, and must deal with patients who often refuse to cooperate, or fail to provide proper demographic and financial information when requested not only to support charity care determinations, but to complete the basic registration itself.

More recently, providers, who in the past resisted attempts to use individual (patient) credit data and scoring, are now embracing the idea, not only to determine the patient's propensity to pay, but his or her wherewithal to pay as well. Many providers also have found that there is a correlation between credit data and scoring and potential eligibility for programs such as Medicaid, and they are using this information to further support the charity care process.³

While hospitals were able (and continue) to set their own policies and criteria for financial aid independently, the mounting industry pressure resulted in the American Hos-

pital Association's (AHA's) involvement with the issuance of "a set of guidelines and a legal white paper on billing and collection practices."⁴

As other state hospital associations weighed in on the matter, the Association of American Medical Colleges (AAMC) issued a statement reflecting the complexity of the issues, "Important as they are, reforms in hospital billing and collection practices will only solve part of the problem. A more comprehensive and lasting solution requires that our nation find a way to provide health coverage to the 43 million uninsured Americans and the 30 million who do not have adequate coverage."⁵

The controversy also includes the concern over the charge structure hospitals use to calculate bills to non-insured (and under-insured) self-pay patients. With much said about the way in which the self-pay, or "unaffiliated" (with any consumer group or insurance plan) patients pay full (or retail) charges, this practice was rooted in the long established practice of hospital's needing to ensure that charges exceeded cost to comply with Medicare reimbursement regulations. Providers now are closely examining their cost structure, as they grapple with ways to demonstrate public policy responsiveness, while not running

afoul of reimbursement regulations. The same also could be said for the notion that somehow Medicare regulation had not conveyed the premise that providers should apply consistent collection efforts to both Medicare and non-Medicare patients. This has left many providers instinctively pulling back from commencing justifiable legal action on accounts in collection fearing a public relations backlash from being perceived as overly aggressive.

Compliance Concerns

Healthcare providers will need to examine their corporate compliance plans to ensure that adequate attention is paid to effectively handling the situations posed by the emergence of CDHC. The major concerns are as follows.

1. **Charge structure** - ensure consistency with reimbursement and cost reporting regulations; while addressing the public policy concerns over cost-of-care for those deemed to be uninsured and under-insured;
2. **CDHC payer contracts** - review conditions of participation as they relate to establishing payer and patient responsibility, and providing electronic eligibility systems to verify coverage and extent of deductible remaining unpaid as of the current date of inquiry;
3. **Patient registration** - ensure that proper recognition and assignment of an insurance plan codes correctly reflects the coverage benefits and patient responsible amounts;
4. **Patient payment responsibility** - clearly define parameters to promote understanding of amounts due, and the

“Healthcare providers will need to examine their corporate compliance plans to ensure that adequate attention is paid to effectively handling the situations posed by the emergence of CDHC.”

payment vehicles and conditions associated with making those payments; and

5. Provider CDHC charity care and collection practices - develop well-defined parameters to promote a clear understanding of policies and procedures to prevent complaints and promote customer satisfaction with all insurance plans.

While existing compliance plans likely address registration, billing and collection, as well as reimbursement and cost-reporting concerns, the changes in practices and protocols associated with CDHC are strong indicators that providers should reexamine their current plans and make changes as indicated. The training of staff also is a critical component to prevent lapses in performance that might trigger adverse patient, payer or public reactions.

With the increasing availability of CDHC, employers will find the need to recognize the impact of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations. With the potential for the exchange of even more medical and benefits information between employer and provider, both will be challenged with regard to administrative costs, as well as preserving privacy.⁶

Conflict Resolution

With the emergence of new alliances among the banking, credit granting, human resources/benefits consulting and insurance companies poised to blanket the CDHC market, one has to wonder whether this is “consumer directed” healthcare, or healthcare being marketed directly to the consumer. While the preventive actions noted above should mitigate or prevent problems from occurring in the first place, there are likely to be some unintended consequences associated with CDHC.

With the increasing prevalence of CDHC, consumers are expected to inquire more about the cost and prices for healthcare. Some patients will forego testing and other services, so as to allow their HSA account balances to grow for use on other than healthcare services. “Those with CDHPs may be more aware of what their costs are, but the ‘Consumerism in Health Care Survey’ indicated some of these cost-conscious consumers are more likely to avoid needed care.”⁷ Others, however, may simply not be satisfied with the selection of this type of healthcare insurance plan. The survey revealed that “those enrolled in HDHPs [High-Deductible Health Plans] and CDHPs are less satisfied with their health plan than those with comprehensive health insurance, and are less likely to recommend the new plans to a friend or colleague.”⁸

Technology may support the types of benefit transactions available with CDHC insurance plans. “The ultimate level of convenience for employees is to have one health care card that serves as the health plan ID card with debit functionality, linked to various benefit accounts.”⁹ Even if we reach that level of technological support, the overall level of uninsured patients continues to threaten how the healthcare system will work. In recent Healthcare Finance Management Association (HFMA)

news stories, it was reported that there was a “5.1 percent decline in employees accepting health insurance.” The data contained in a Robert Wood Johnson report noted that “...employers continued to pay 82 percent of the cost of health insurance during a five-year period...[while] premiums employees paid skyrocketed 42 percent after being adjusted for inflation.”¹⁰

Even with all of the rush to CDHC, there are other skeptics. “Consumer information about healthcare costs, quality and treatment alternatives could help stem health costs, but some are overselling the potential of consumer empowerment to reshape the healthcare system...”¹¹ In the final analysis, it will likely come down to the individual deciding, that if they can afford health insurance, which plan will be right for them. As this occurs, payers and providers will continue to be challenged to ensure that they can properly handle all of the related transactions efficiently and effectively. In the end, however, it will be up to the patient. *Caveat emptor*. Let the buyer beware! ■

Mr. DeKaye is President and Chief Executive Office of DEKAYE Consulting, Inc. His firm assists healthcare clients with financial, compliance and operational issues. He is a frequent speaker at national conferences, and is author/editor of “The Patient Accounts Management Handbook” (Aspen). Mr. DeKaye also is a member of the CCH Health Care Compliance Editorial Advisory Board. For more information: call: (516) 678-2754; write: dkconsult1@aol.com, or visit: www.dekaye.com

¹ “The Consumer-Directed Health Market: Implications of New Benefit Designs,” by John Sheehan, The Zitter Group, January 2006, p. 3.

² Ibid.

³ “Utilizing Credit Scoring to Predict Patient Outcomes,” Martin, T., *Healthcare Technology*, Montgomery Research, Inc., Volume 3, 2005, pp. 188-190.

⁴ “AHA Guidelines on Providing Financial Assistance to Uninsured Low-Income Americans,” Hospital Billing and Collection, Access Project (www.accessproject.org/hospital.html).

⁵ “AAMC Statement on Teaching Hospital Billing and Collection Practices,” Press Release, December 17, 2003, Washington, D.C. (www.aamc.org/newsroom/pressrel/2003/031217.htm).

⁶ “Strategically Aligning the Implementation of Consumer-Directed Healthcare and HIPAA,” M. Thompson, J. Fusile, and J. Nieditz. *PriceWaterHouseCoopers (Web Site Publication)*, 2002, pp. 1-2.

⁷ “Survey Findings Buck Trend, Indicate Dissatisfaction with CDHPs.” *Consumer Driven Healthcare*, Volume 5, Number 1, January 2006, p. 2.

⁸ Ibid., p. 1.

⁹ “The Role of Debit Cards in Consumer-Centric Health Plans,” R. L. Natt. *Advance for Health Information Executives*, June 2005, p. 61.

¹⁰ *HFMA News Report*, May 9, 2006, “5.1% Decline in Employees Accepting Health Insurance;” Also includes reference to “Shifting Ground: Changes in Employer-Sponsored Health Insurance” report by Robert Wood Johnson Foundation. [www.hfma.org/hfmanews/PermaLink.guide,0c04dcc-ec20-42e8-92cb-5b5c3812112].

¹¹ *HFMA News Report*, May 11, 2006, “Informed Consumers No Silver Bullet for Healthcare Cost Crisis;” Quote by: Paul Ginsburg, PhD, president of the Center for Studying Health System Change, at Congress; Joint Economic Committee hearing on “The Next Generation of Health Information Tools for Consumers.” [www.hfma.org/hfmanews/PermaLink.guide,e0c04dcc-ec20-42e8-92cb-5b5c3812112].

Executive compensation rule changes disclosure requirements

by Katherine G. Geraghty, J.D.,
Contributing Editor

The Securities and Exchange Commission (SEC) has adopted amendments to the disclosure requirements for executive and director compensation as well as related party transactions, director independence, and other corporate governance matters.

The amendments make proxy statements, reports, and registration statements easier to understand, in part by requiring the use of plain English and providing investors with a complete picture of the compensation earned by a company's principal executives, financial officers, and members of its board of directors. Additionally, the amendments offer better information about key financial relationships among companies and their executive officers, directors, significant shareholders, and immediate family members.

The amendments apply to disclosures in proxy statements, periodic reports, current reports, and other filings under the Securities Exchange Act of 1934. They also apply to registration statements filed under the Exchange Act and the Securities Act of 1933. The final rule becomes effective November 7, 2006.

Request for comment. The SEC also published a request for additional comments regarding a portion of the proposed rule, which was not adopted in the final rule, that would required compensation disclosure for three additional highly compensated employees. Specifically, the proposed amendment would have require disclosure of the total compensation and job description of up to an additional three directors earning more than any of the named executive officers.

The SEC has made a specific request for comments regarding whether the proposed provision should be modified to apply only to large accelerated filers. ■

Notice, 71 FR 53157, Sept. 8, 2006, Health Care Compliance Reporter ¶700,016, Request for comment to proposed rule; 71 FR 53267, Sept. 8, 2006, Health Care Compliance Reporter ¶730,010.

In the News

OIG recovers over \$1 billion in first half of FY 2006

According to its semiannual report to Congress, the Office of Inspector General (OIG) expects to recover from health care providers over \$1 billion from efforts to reduce fraud, abuse, and waste for the first half of fiscal year 2006. OIG reported exclusions of 1,540 individuals and organizations for fraud, 226 criminal actions, and 119 civil actions. In addition, Medicaid audits discovered potential overpayments of \$243.2 million from the use of upper payment limit calculations that did not comply with federal requirements.

OIG Press Release, June 2, 2006.

Norwalk to be acting head of CMS

Leslie Norwalk, CMS deputy administrator, has been selected to take the role of acting administrator on October 15, 2006, after current administrator Mark McClellan departs on October 14. As acting administrator, Norwalk will continue implementation of the Medicare Part D prescription drug benefit including the upcoming open enrollment period. As deputy administrator, Norwalk has worked on implementing the changes under the Medicare Modernization Act and directed the operations of Medicare, Medicaid, Child Health Insurance Programs, Survey and Certification of health care facilities and other federal health care initiatives. Prior to working for the Bush administration, she practiced law in the Washington, D.C. office of Epstein Becker & Green, P.C., and served during the first Bush administration in the White House Office of Presidential Personnel.

CCH Washington Bureau, Sept. 27, 2006.

Part D overpayment recovery efforts cease

In response to a lawsuit filed on September 15, 2006, CMS no longer will send mailings requesting recovery of overpayments to Medicare beneficiaries who received incorrect Part D premium refunds. Over 230,000 Medicare beneficiaries received incorrect refunds in August. The Center for Medicare Advocacy, Inc. represents Action Alliance of Senior Citizens and Gray Panthers, two beneficiary organizations, in litigation challenging HHS process for recovering the overpayments. Because of the hardship this type of recovery would cause for beneficiaries with fixed low incomes, statutes provide for waiver of recovery when the beneficiary is not at fault and certain other conditions exist. The Center for Medicare Advocacy hopes that CMS will refund any overpayments repaid and inform all beneficiaries who received the incorrect refunds of their right to seek waiver of recovery.

HHS Press Release, Sept. 18, 2006.

IOM payment recommendation causes concern

While Federation of American Hospitals (FAH) supports the Institute of Medicine's (IOM) commitment to quality care, it expressed concern that a "pay-for-performance" system could cause arbitrary Medicare cuts in an effort to meet budget targets. The FAH made this statement in response to an IOM report that recommended that Congress cut base payments and use the savings to create pools that reward providers when they do work that has been proven effective in improving a patient's health. The quality of health care should be the federal government's guide in setting payments to physicians, hospitals and other health care providers, the IOM report concluded. Many health care providers, including the FAH, are wary of the IOM's recommendation.

Federation of American Hospitals Press Release, Sept. 21, 2006.