MEDICAL FACILITIES CORPORATION

HEALTHCARE REFORM

2014 ANNUAL REPORT

OVERVIEW OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

MARCH 2010

The President of the United States, Barack Obama, signed into law two pieces of legislation, the ***Patient Protection and Affordable Care Act*** ("PPACA") and the ***Health Care and Education Affordability Reconciliation Act*** of 2010 ("HCEARA"), which contains a number of amendments to PPACA.

GOAL

Extend health coverage to substantially all U.S. citizens and reduce the overall cost of healthcare through a combination of private sector health insurance reform and public program expansion.

HEALTH INSURANCE MARKET REFORM

Individual Mandate

- As of January 1, 2014, all U.S. citizens must have a minimum essential health insurance coverage through:
  - Government-sponsored plan
  - Employer-sponsored plan
  - Individual plan
- Non-compliance with the minimum essential health insurance coverage will be subject to a tax penalty from the federal government (subject to certain exceptions)
- Deferrals until 2016 have been issued for certain groups of individuals

Employer Mandate

- Employers with 50 or more employees to offer affordable health insurance coverage to employees working 30 or more hours per week
- Employers who fail to comply will be subject to penalties
- Larger employer provisions that were to take effect on January 1, 2014, were delayed to 2015 and 2016

GROUP HEALTH PLANS AND HEALTH INSURANCE COMPANIES REFORMS
May not establish lifetime limits or annual limits on the dollar value of benefits
May not drop coverage, except for certain instances
May not exclude individuals based on pre-existing conditions
Must reimburse hospitals for emergency services
Must continue to make dependent coverage available to unmarried dependents until age 26

Source: http://www.hhs.gov/healthcare/

PUBLIC PROGRAM REFORMS

Medicaid Expansion

- Expanded categories for individuals eligible for Medicaid coverage to include virtually all individuals under age 65 with income up to 138% of the federal poverty level

State Subsidies

- Subsidies to states that create non-Medicaid plans called "Basic Health Programs" for residents with income greater than 133% but less than 200% of federal poverty line. Expected in 2015

Medicare & Medicaid Spending Reductions

- Reduction to the Medicare annual input price index or "market basket" expected to continue to 2019
- Productivity adjustments to Medicare adjustment basket
- Reduction to Medicare & Medicaid disproportionate share payments expected to begin in 2016

Quality & Efficiency Improvements

- Value-based purchasing programs for inpatient hospital services which reward hospitals based either on their performance or improvements on certain performance measures from their performance during a baseline period
- All inpatient payments are reduced if a hospital experiences "excessive readmissions" within a 30-day period of discharge of designated conditions
- Establishment of a national pilot program to study the use of bundled payments relating to single admission to promote collaboration and alignment
- Expansion of recovery audit contractors' ("RACs") scope to include Medicaid claims and requirement for all states to enter into contracts with RACs
- Establishment of Medicare Shared Savings Program to promote accountability and coordination for providers and designated professionals to work together to invest in infrastructure and redesign delivery processes

Source: http://www.hhs.gov/healthcare/

LIMITATIONS ON PHYSICAN-OWNED HOSPITALS

Formation or development of any new physician-owned hospitals after December 31, 2010, is prohibited

Grandfathered physician-owned hospitals can continue their operations and billings to Medicare and Medicaid for hospital services provided they meet certain investment and patient transparency requirements

- Percentage of the total value of the physician ownership or investment interests held cannot increase beyond the percentage held by physicians on March 23, 2010
- Must distribute investment returns to each owner or investor in an amount that is directly proportionate to the ownership position of such investor
- Physician-owned hospitals:
  - May not offer investment opportunities to physicians on terms that are more favorable than those offered to non-physicians
  - May not condition investment on the physician making or influencing referrals or otherwise generating business for the hospital
  - Must disclose to patients physician-ownership and require referring and treating physician-owners to inform prospective patients of their financial interest in the hospital
  - Must disclose to the patient if the hospital does not have a physician present 24 hours a day, seven days a week on the premises
  - Must submit an annual report containing a detailed description of each physician-owner and the nature and extent of all ownership interests
- Physician-owned hospital and any owner or investor in the hospital may not:
  - Directly or indirectly provide loans or financing for any investment in the hospital by a physician
  - Directly or indirectly guarantee a loan for any individual physician or group of physicians in connection with their acquisition of an ownership in the hospital

Grandfathered physician-owned hospitals are prohibited from increasing their baseline number of overnight beds, operating rooms or procedure rooms (used for catherterizations, angiographies, angiograms and endoscopies) for which they were licensed as of March 23, 2010, unless permission is granted

Source: http://www.hhs.gov/healthcare/

FUTURE KEY PROVISIONS

2015

- Employers with 50+ employees to provide affordable and minimal value for full-time employees and their children up to age 26
- Employers with 100+ employees must offer health benefits to 70% of full-time employees and their children up to age 26
- Employers with 50+ employees to report on their compliance with employer mandate
- Insurers and employers with self-funded group health plans to provide information on compliance with minimum essential coverage

2016

- Small employer will be defined as 1 to 100 full-time employees resulting in essential health benefits coverage, coverage on small business insurance exchanges, and deductible cost sharing limits
- Employers with 50 to 99 employees must offer health benefits to 95% of their full-time employees and their children up to age 26
- Individuals without insurance will be taxed 2.5% of income

2018

- Cadillac excise tax of 40% on employers that provide excessive benefits to certain employees under an employer sponsored group health plan. Coverage valued in excess of $10,200 for a single person and $27,500 for family plans will be deemed excessive. These thresholds are subject to inflationary indexation

2020

- Closure of Medicare Part D coverage gap. Medicare Part D was created in 2003 to provide prescription drug benefits to Medicare recipients

Source: http://www.hhs.gov/healthcare/

DISCLAIMER

Information and materials in this document are based on publicly available information and reports found on the U.S. Health and Human Services website, as of December 2014 *(http://www.hhs.gov/)*.

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