PROVIDING HEALTH CARE AFTER HEALTH REFORM REPEAL

DATE: February 8, 2017
TIME: 12:30 pm - 1:00 pm
California State Bar Health Law Committee
Century City, CA

PRESENTER: Craig B. Garner

This Program Offers 0.5 Hour of MCLE Participatory Credit
DISCLAIMER

The information contained within this presentation is only fictional. Any similarity to events happening now, or soon to happen, is merely coincidental.
• Employment has been the foundation upon which health care in the United States historically rested. The changing landscape created by the Affordable Care Act (ACA) threatened to unravel this infrastructure.

• Modern American health care introduced alternatives for health care insurance that are separate and apart from employer-sponsored plans.

• The next chapter in United States health care may soon be rewritten.
GUARANTEED ISSUE AND MODIFIED COMMUNITY RATING

• As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions (under rules referred to as guaranteed issue and modified community rating, respectively).

• These aspects of the ACA – along with tax credits for low and middle income people buying insurance on their own in new health insurance marketplaces – make it easier for people with preexisting conditions to gain insurance coverage.
2017 PREMIUM CHANGES

• Health insurance premiums on the ACA’s marketplaces (also called exchanges) are expected to increase faster in 2017 than in previous years due to multiple factors, including substantial losses experienced by many insurers in this market and the phasing out of the ACA’s reinsurance program.

• As a result of losses in this market, some insurers like UnitedHealth and Aetna have announced withdrawal from the ACA marketplaces or the individual market in some states.
2017 BUDGET ESTIMATES

- Medicare outlays (net of premiums and other offsetting receipts and adjusted for shifts in timing) will rise by $23 billion (4.1%), according to CBO projections.
- Medicaid spending is expected to increase by $20 billion (5.5%).
- Health insurance subsidies and related spending are expected to increase by $9 billion to a total of $51 billion.
- An average of 12 million noninstitutionalized residents of the U.S. under age 65 will have health insurance in any given month because they were made eligible for Medicaid under the Affordable Care Act.
Glossary of Key Terms

When dealing with the insane, the best method is to pretend to be sane.

-- Hermann Hesse
GLOSSARY

- **Allowed Amount**: Maximum amount on which payment is based for covered health services.
- **Balance Billing**: When a provider bills you for the difference between the provider’s charge and the **allowed amount**.
- **Co-Insurance**: Your share of the costs of a covered health care service, calculated as a percent of the **allowed amount** (in addition to any deductible amount).
- **Co-Payment**: A fixed amount paid for a covered health care service.
• Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
• Home Health Care: Health care services a person receives at home.
• Hospice Services: Services to provide comfort and support for persons in the last stages of terminal illness and their families.
• Hospitalization: Care in a hospital that requires admission as an inpatient (typically requires an overnight stay, subject to observation rules).
• **Medically Necessary**: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms.

• **Obamacare**: A pejorative description of what would eventually become the Patient Protection and Affordable Care Act.

• **Patient Protection and Affordable Care Act**: The health care system in the United States facing threat of **repeal**.

• **Premium**: The amount that must be paid for your health insurance or plan.
more GLOSSARY

- **Usual, Customary and Reasonable**: The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.
- **Repeal**: The action of revoking or annulling a law or congressional act, like the Patient Protection and Affordable Care Act.
- **TrumpCare**: (a) Obamacare under a different name; (b) the health care reform plan designed to make America great again; or (c) none of the above.
REPEAL
What Could Go Wrong?

Nothing recedes like progress.
-- Edward Estlin (e.e.) Cummings
PROPHECIES OF DOMESTIC MEDICAL ARMAGEDDON

• In 1954, an article in Fortune Magazine associated advances in medicine with the end of the physician as the nation once knew.

• July 29, 1976: Final episode of Marcus Welby, M.D. airs.

• In 1986, an article in Health Affairs suggested that changes in health care could shutter as many as 1,000 hospitals before 1990.
More PROPHECIES OF DOMESTIC MEDICAL ARMAGEDDON

- In 1987, a Congressional subcommittee blamed the DRG system for placing the elderly at great risk.

- November 16, 2004: First episode of *House* is released in the United States.

- In 2011, the New York Times enumerated the inefficiencies of American health care, within which patients seemingly grew sicker, treatments became purportedly more complex, and overall health fell into a state of decline.
DONALD JOHN TRUMP, THE 45TH PRESIDENT OF THE U.S.

• January 20, 2017 (Executive Order): “Section 1. It is the policy of my administration to seek the prompt repeal of the Patient Protection and Affordable Care Act.”

• January 30, 2017 (Executive Order): “Section 2. Regulatory Cap for Fiscal Year 2017. (a) Unless prohibited by law, whenever an executive department or agency (agency) publicly proposes for notice and comment or otherwise promulgates a new regulation, it shall identify at least two existing regulations to be repealed.”
WHAT SHOULD NOT BE AT STAKE

• Elimination of preexisting conditions as a basis for health insurance

• Modifications to arbitrary limits in coverage

• Premium parity

• Coverage for children/young adults up to the age of 26
PRE-EXISTING CONDITIONS

• Up to 133 million non-elderly Americans (51 percent of the non-elderly population) may have a pre-existing condition.

• The likelihood of having a pre-existing condition increases with age: up to 84 percent of those ages 55 to 64 (31 million individuals) have at least one pre-existing condition.

• Among the most common pre-existing conditions are high blood pressure (46 million people), behavioral health disorders (45 million people), high cholesterol (44 million people); asthma/chronic lung disease (34 million people), heart conditions (16 million people), diabetes (13 million people), and cancer (11 million people).
more PRE-EXISTING CONDITIONS

• Between 2010 and 2014, when the ACA’s major health insurance reforms first took effect, the share of Americans with pre-existing conditions who went uninsured all year fell by 22 percent, meaning 3.6 million fewer people went uninsured.

• Tens of millions of Americans with pre-existing conditions experience spells of uninsurance. About 23 percent (31 million) experienced at least one month without insurance coverage in 2014, and nearly one-third (44 million) went uninsured for at least one month during the two-year period beginning in 2013.
WHAT THE CBO FEARS

• The number of people who are uninsured would increase by 18 million in the first new plan year, and then later increase to 27 million and 32 million by 2026.

• Premiums for individual policies purchased through the marketplaces would increase by 20 to 25 percent in the first year, and as high as 50 percent in the year following the elimination of Medicaid expansion.
ESSENTIAL HEALTH BENEFITS

Under the ACA, every qualified health plan must include the following services:

• Ambulatory patient services (outpatient care)
• Emergency services
• Hospitalization
• Pregnancy, maternity and newborn care
• Mental health and substance use disorder services, including behavioral health treatment
more ESSENTIAL HEALTH BENEFITS

• Prescription drugs
• Rehabilitative and habilitative services and devices (services and devices to help with injuries, disabilities or chronic conditions)
• Laboratory services
• Preventive and wellness services
• Pediatric services (including pediatric oral and vision care)
MHPAEA

• The 2008 Paul Wellstone and Pete Domenici Mental Health Party and Addiction Equity Act (MHPAEA) became effective January 2010.

• MHPAEA prohibits financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans from being more restrictive than those placed on medical and surgical benefits.

• MHPAEA applies to health plans provided by employers with more than 50 employees and individual plans purchased through a Health Care Exchange.
more MHPAEA

• Does not apply to Medicare or Medicaid.

• Fundamentally exists without the Affordable Care Act.

• California mandates “chemical dependency services” must be consistent with MHPAEA, including inpatient detoxification, outpatient evaluation and treatment for chemical dependency, transitional residential recovery services or chemical dependency treatment.
more MHPAEA

• There is an estimated annual $190 billion price tag on lost earnings due to issues brought about by mental health challenges.

• One in five Americans experience any type of mental illness, including the six percent of the population living with severe mental illness and the two out of three who avoid treatment due to cost.

• Repeal may actually make it not okay to not be okay.
Mедикаид managed-care program

- The Medicaid program pays for medical assistance for certain individuals and families with low income and resources. The Federal and State Governments jointly fund and administer the program.

- CMS published a final rule on May 6, 2016, that requires Medicaid MCOs to achieve a minimum medical loss ratio ("MLR") of at least 85 percent, effective July 1, 2017.
CALCULATING THE MLR

- Incurred Claims plus
- Expenditure for Activities that Improve Health Quality

\[ \frac{\text{Inurred Claims plus Expenditure for Activities that Improve Health Quality}}{\text{Premium Revenue minus Taxes minus Licensing and Other Regulatory Fees}} \]
CALIFORNIA’S MEDICAID MANAGED-CARE PROGRAM

• Under California’s Medicaid (Medi-Cal) managed care program, the State pays its Medicaid MCOs fixed, monthly capitated payments to provide enrollees with Medicaid-covered services. These payments include administrative and medical expense components.

• The Office of the Inspector General (“OIG”) reviewed nine Medicaid MCOs in California that would not have realized Medicaid program savings in calendar year 2014 if the agency had (1) required the MCOs to meet a minimum MLR standard similar to the Federal standards and (2) required remittances when that MLR standard was not met.
HEALTH INSURANCE SUBSIDIES

The truth is rarely pure and never simple.
-- Oscar Wilde
FINANCIAL ASSISTANCE

• To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, the ACA includes provisions to lower premiums and out-of-pocket costs for people with low and modest incomes.

• The ACA also gives states the option to bolster public coverage by expanding their Medicaid programs to cover people with incomes under 138% of the Federal Poverty Level (FPL).
PREMIUM TAX CREDIT

• Reduces marketplace enrollees’ monthly payments for insurance plans purchased through the marketplace.

• Marketplace metals include bronze, silver, gold and platinum.

• Can be applied to any of the metal levels, but cannot be applied toward the purchase of catastrophic coverage (to qualify for a catastrophic plan, an individual must either be under 30 years of age or eligible for a “hardship exemption”).
ELIGIBILITY FOR PREMIUM TAX CREDIT

In order to receive the premium tax credit for coverage, an enrollee must meet the following criteria:

• Have a household income from one to four times the Federal Poverty Level (FPL).
• Not have access to affordable coverage through an employer (including a family member’s employer).
• Not eligible for coverage through Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), or other forms of public assistance.
• Have U.S. citizenship or proof of legal residency.
• If married, must file taxes jointly in order to qualify.
more ELIGIBILITY FOR PREMIUM TAX CREDIT

• Employer coverage is considered affordable if the employee’s contribution is less than 9.5 percent of his or her household income (for the employee’s coverage only, not including the cost of adding family members).

• The employer’s coverage must also meet the “minimum value” standard, meaning that the plan has an actuarial value of at least 60 percent (equivalent to a bronze plan).

• If the employer’s plan fails to meet one or both of these requirements, the employee (and family) may be eligible for subsidized coverage if they meet the aforementioned criteria.
GETTING YOUR PREMIUM TAX CREDIT

• To receive the premium tax credit, an individual or family must purchase insurance coverage through the marketplace.

• When applying for coverage, enrollees will receive a subsidy determination, letting them know whether they are eligible for a premium tax credit and the amount they may receive.

• The person or family then has the option to receive the tax credit in advance or wait until they do their taxes the following year.
COST SHARING SUBSIDIES

• Cost-sharing subsidies work by reducing a person or family’s out-of-pocket cost when they use health care services, such as deductibles, copayments, and coinsurance.

• Unlike the premium tax credit (which can be applied toward any metal level of coverage), cost-sharing subsidies can only be applied toward a silver plan. In essence, the cost-sharing subsidy increases the actuarial value (protectiveness) of a silver plan, in some cases making it similar to a gold or platinum plan.

• The cost-sharing subsidies are available only to the lowest-income marketplace enrollees who meet all of the other criteria for receiving the premium tax credit.
If you have ten thousand regulations you destroy all respect for the law.
-- Winston Churchill
FOR SMALL BUSINESSES

PROVIDING HEALTH CARE AFTER HEALTH REFORM REPEAL

Craig B. Garner
Garner Health Law Corporation
### Key Benefits (2016)

<table>
<thead>
<tr>
<th></th>
<th>Blue Shield Platinum (90%)</th>
<th>Blue Shield Gold (80%)</th>
<th>Blue Shield Silver (70%)</th>
<th>Blue Shield Bronze (60%)</th>
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<td><strong>Individual Deductible</strong></td>
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<td>$0</td>
<td>$1500 (medical)</td>
<td>$6000 (medical)</td>
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<td>$250 (pharmacy)</td>
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<td></td>
<td></td>
<td>$0 (dental)</td>
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<td><strong>Family Deductible</strong></td>
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<td>$3000 (medical)</td>
<td>$12000 (medical)</td>
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<td></td>
<td></td>
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<td>$0 (dental)</td>
<td>$0 (dental)</td>
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<td><strong>Lab Testing Co-Pay</strong></td>
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<td><strong>X-Ray Co-Pay</strong></td>
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<td><strong>Emergency Dept. Co-Pay</strong></td>
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<td><strong>Inpatient Physician Fee</strong></td>
<td>$40</td>
<td>$55</td>
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<td><strong>Inpatient Hospital Fee</strong></td>
<td>$250/day (up to 5 days)</td>
<td>$600/day (up to 5 days)</td>
<td>20%</td>
<td>100%</td>
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<tr>
<td><strong>Imaging (MRI, CT, etc.)</strong></td>
<td>$150</td>
<td>$250</td>
<td>$250</td>
<td>100%</td>
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<td><strong>Mental Health Outpatient</strong></td>
<td>$20</td>
<td>$35</td>
<td>$45</td>
<td>$70 (deductible waived first 3 visits)</td>
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<tr>
<td><strong>Mental Health Inpatient</strong></td>
<td>$250/day (up to 5 days)</td>
<td>$600/day (up to 5 days)</td>
<td>20%</td>
<td>100%</td>
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<tr>
<td><strong>Substance Use Outpatient</strong></td>
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<td>$45</td>
<td>$70 (deductible waived first 3 visits)</td>
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<td><strong>Substance Use Inpatient</strong></td>
<td>$250/day (up to 5 days)</td>
<td>$600/day (up to 5 days)</td>
<td>20%</td>
<td>100%</td>
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**PROVIDING HEALTH CARE AFTER HEALTH REFORM REPEAL**

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FOR INDIVIDUALS AND FAMILIES

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PROVIDING HEALTH CARE AFTER HEALTH REFORM REPEAL

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LOS ANGELES COUNTY (NORTHEAST) 2017 RATE CHANGES

- Overall county area rate change is +16.4% (weighted average).
- Statewide rate change (weighted average) is +13.2%.
- Lowest-price Bronze plan (unweighted average) is -4.1%.
- Lowest-price Silver plan (unweighted average) is +3.3%.
- Weighted rate change if consumers switch to lowest-price plan available in the same metal tier is -1.3%.
<table>
<thead>
<tr>
<th>Carriers</th>
<th>Percentage of Enrollment</th>
<th>Weighted Average Increase (consumers staying in plan)</th>
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</thead>
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<tr>
<td>Anthem EPO</td>
<td>10%</td>
<td>27%</td>
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<tr>
<td>Anthem HMO</td>
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<td>4.6%</td>
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<tr>
<td>Blue Shield PPO</td>
<td>46%</td>
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<td>Health Net HMO</td>
<td>26%</td>
<td>12.1%</td>
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<td>Kaiser Permanente HMO</td>
<td>12%</td>
<td>5.7%</td>
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<tr>
<td>L.A. Care HMO</td>
<td>3%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Molina Healthcare HMO (coinsurance)</td>
<td>1%</td>
<td>-3.7%</td>
</tr>
</tbody>
</table>

Providing health care after health reform repeal

Craig B. Garner
Garner Health Law Corporation
SPECIAL ENROLLMENT

- Losing health coverage
- Income changes so much
- Turning 26 years old
- Moving
- Having a child or adopting a child
- Getting married
- Becoming a citizen.
The secret of being a bore . . . is to tell everything.

-- Voltaire
PROTECTIONS UNDER HIPAA

• In direct opposition to the fundamental tenet for which it now stands, the introduction of the 1996 Health Insurance Portability and Accountability Act ("HIPAA") did not originally include privacy legislation, but was modified in November 1999 to address patient concerns.

• Some 52,000 public comments and another year later, the U.S. Department of Health and Human Services ("HHS") issued final regulations known as the HIPAA Privacy Rule.

• HHS again modified the Privacy Rule in March 2002, and after 11,000 more public comments, issued its directive in August 2002.
more PROTECTIONS UNDER HIPAA

• HIPAA’s Security Rule governing “e-PHI” (2003)

• Enforcement Rule (2006)

• Breach Notification Rule as well as HITECH (the Health Information Technology for Economic and Clinical Health Act) Enforcement Rule (2009)

• Updated Administrative Simplification Rule (2013)
• Psychotherapy notes receive special protections under the HIPAA Privacy Rule.

• Section 164.510(b)(3) of the HIPAA Privacy Rule permits a health care provider, when a patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, to determine whether disclosing a patient’s information to the patient’s family, friends, or other persons is in the best interests of the patient.
THERAPIST NOTES

- Federal law refers to psychotherapy notes as excluded from access (45 CFR Section 164.524).

- But California does not set aside psychotherapy notes. California law wants to provide access to such health care records by patients. There are limits to this disclosure, however (Health and Safety Code Section 123115 (b)).

- Providers should make a determination if there would be a "substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient."
WHO ARE WE KIDDING?

• Before HIPAA takes its next evolutionary step, modern medicine must ask itself if it is worse to fail in the attempt to protect that which is held sacred by law or ignore the transgressions occurring below the surface that so desperately need to be targeted.

• To heal the body it may also be necessary to treat the mind, but HIPAA only protects both when medicine recognizes one as a comorbidity of the other. When this is not the case, all of HIPAA’s power slices the treatment in half, at least in terms of confidentiality.

• What remains of the act’s reach is therefore totally ineffective in light of it’s ultimate intent.
PENALTIES

Reason has always existed, but not always in a reasonable form.

-- Karl Marx
PENALTIES FOR EMPLOYERS NOT OFFERING COVERAGE

• Did the employer have at least 50 full-time equivalent employees in the previous year?

• If employer has 25 full-time employees with average annual wages of about $50,000 or less, and covers at least 50% of full-time employees’ premium costs, the employer may be eligible for a health insurance tax credit to purchase coverage through the SHOP Marketplace.

• Federal tax credits are only available to small businesses that purchase health insurance through Covered California for Small Business. The maximum available tax credit is 50 percent of insurance premium expenses and is available for a total of two consecutive years.
more PENALTIES FOR EMPLOYERS NOT OFFERING COVERAGE

- Does the employer offer health insurance coverage to at least 95% of its full-time workers and their dependent children? Did at least one full-time employee receive a premium tax credit or cost-sharing subsidy in the marketplace? If no, penalty does not apply.

- If yes, employer must pay penalty ($2,260/12) for each month the employer fails to offer coverage x the number of full-time employees (subtracting up to 30).
more PENALTIES FOR EMPLOYERS NOT OFFERING COVERAGE

- Does insurance pay for at least 60% of the covered care expenses? *If no, penalty may apply.*

- Did at least one full-time employee receive a premium tax credit to help pay for coverage on the marketplace?

- Employer must pay a penalty for not offering coverage that is affordable and provides minimum value.

- Do any employees have to pay more than 9.69% of their household income for employer coverage? *If no, penalty does not apply.*
EMPLOYER PAYMENT PLANS

• What happens if the employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance (either through a qualified health plan in the marketplace or outside the marketplace)?

• This is an employer payment plans. An employer payment plan generally does not include an arrangement under which an employee may have an after-tax amount applied toward health coverage or take that amount in cash compensation.
more EMPLOYER PAYMENT PLANS

• These employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits and the requirement to provide certain preventive care without cost sharing.

• Consequently, such an arrangement fails to satisfy the market reforms and may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee).
HIGH COST EMPLOYER-SPONSORED PLANS

• Applies to taxable years beginning after December 31, 2019 (delayed from 2017).

• Under this provision, if the aggregate cost of applicable employer-sponsored coverage provided to an employee exceeds a statutory dollar limit, which is revised annually, the excess is subject to a 40 percent excise tax.
TAX PENALTY FOR REMAINING UNINSURED

• This shared responsibility payment is required to be part of the health insurance system – buying health coverage for individuals and families rather than relying on others to pay for health care.

• Those who do not buy health insurance in 2016 may be subject to the penalty, which is $695 per person in a household or 2.5 percent of their income, whichever is greater.
WHAT IF WE LOST:

The evolution of sense is, in a sense, the evolution of nonsense. -- Vladimir Nabokov
MEDICARE

Picture a law written by James Joyce and edited by E.E. Cummings. Such is the Medicare statute, which has been described as ‘among the most completely impenetrable texts within human experience.’…

The Court clarifies, however, that by making this analogy, it is referring not to Joyce’s early work, such as Dubliners or A Portrait of the Artist as a Young Man, but his later period, specifically Finnegans Wake.

• – Chief Judge Royce Lamberth (U.S.D.C., D.C.)
more MEDICARE

- Hospital Value-Based Purchasing Program
- Hospital Readmission Reduction Program
- Physician Merit-Based Incentive Payment System
- Electronic Health Records
- Hospital Acquired Infections
- Stark Laws
- Federal Anti-Kickback Statute
more MEDICARE (according to kff.org)

- Medicare is not “going broke” even though it does face financial challenges.
- The aging of the U.S. population, along with higher health care costs, are contributing to the growth in Medicare spending over time.
- The Affordable Care Act reduced Medicare spending.
- Repeal would increase Medicare spending.
- Medicare spending was 15 percent of the federal budget in 2016.
more MEDICARE (according to kff.org)

• Medicare spending is projected to increase gradually as a share of the federal budget and the nation’s economy over the next ten years.
• Medicare spending is projected to increase at a faster rate in the coming years than in the five years following enactment of the Affordable Care Act.
• Spending on Part D is expected to grow even faster.
• Medicare benefits are funded mainly by a combination of general revenues, payroll taxes, and premiums paid by beneficiaries.
Craig B. Garner  Garner Health Law Corporation

• Craig is an attorney and health care consultant, specializing in issues pertaining to modern American health care and the ways it should be managed in its current climate of reform.

• Craig’s law practice focuses on health care mergers and acquisitions, regulatory compliance and counseling for providers. Craig is also an adjunct professor of law at Pepperdine University School of Law, where he teaches courses on Hospital Law and the Affordable Care Act.

• Between 2002 and 2011, Craig was the Chief Executive Officer of Coast Plaza Hospital in Norwalk, California. Craig is also a Fellow Designate with the American College of Healthcare Executive.

• Additional information can be found at www.garnerhealth.com.