Beyond ‘Repeal and Replace’

Political division, public opinion and the future of the healthcare economy
Presenter

Merrill Goozner
Editor Emeritus
Modern Healthcare
Since taking over the House in the 2010 election, the GOP has promised to “repeal and replace” the Affordable Care Act.

- There were over 50 votes in the House repealing the ACA.
- In December 2015, the Senate and House both passed a repeal bill.
  - Ended premium tax credits, cost-sharing, Medicaid expansion and small business tax credits.
  - Held off repeal until 2018 to give GOP until after the 2016 elections to find a replacement.
  - NO Medicaid block grants.
- In January 2016, President Obama vetoed the bill.
Then came the 2016 election

Since Jan. 20, 2017, the Republicans have controlled all three branches of government
So why did the American Health Care Act fail?
What they said about “Obamacare”:

• It was a bill cooked up in secret without GOP input
• It was a government takeover of healthcare
• It would ration healthcare (“death panels”)
• It would eliminate ”choice” in healthcare providers
• It would force people to buy insurance products they didn’t want
• And since its launch, it has failed and is ”on the brink of collapse.”
The proposed AHCA

• It was cooked up in secret without Democratic input, or input from key stakeholders (providers, payers or patient/consumer advocacy groups)

• It represented a sharp reduction in the federal role of healthcare unrelated to ACA (Medicaid cuts)

• Would reduce access ("ration"?) healthcare

  —“CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under H.R. 1628 than under current law. The increase in the number of uninsured people relative to the number projected under current law would reach 19 million in 2020 and 23 million in 2026. In 2026, an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law.” (CBO May 2017 report)
The AHCA would have:

- Dramatically changed individual markets
  - Repealed individual and employer mandates (2018);
  - Repealed plan actuarial standards (2020);
  - Repealed premium and cost-sharing subsidies (2020).
- Turned all of Medicaid into per capita block grants
- Eliminated most ACA taxes and shortened life of Medicare trust fund by over two years
- Encouraged HSAs and a return to a largely unregulated individual market
- Cost tens of millions of Americans their insurance coverage (CBO)
Net Effects of H.R. 1628 on the Budget Deficit

Billions of Dollars

<table>
<thead>
<tr>
<th>Cumulative Increase or Decrease (–), 2017 to 2026</th>
<th>Major Components</th>
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<tbody>
<tr>
<td>Medicaid</td>
<td>• Termination of enhanced federal matching funds</td>
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<tr>
<td></td>
<td>• Per capita–based cap on Medicaid payments</td>
</tr>
<tr>
<td>−834</td>
<td></td>
</tr>
<tr>
<td>Tax Credits and Selected Coverage Provisions</td>
<td>• Reduced subsidies for nongroup health insurance</td>
</tr>
<tr>
<td>−276</td>
<td></td>
</tr>
<tr>
<td>Patient and State Stability Fund Grants</td>
<td>• Spending to reduce premiums</td>
</tr>
<tr>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Penalty Payments</td>
<td>• Reduced collections of penalty payments from employers and uninsured people</td>
</tr>
<tr>
<td>210</td>
<td>• Repeal or delay of taxes on high-income people, fees imposed on manufacturers, and excise taxes enacted under the ACA</td>
</tr>
<tr>
<td>Noncoverage Provisions</td>
<td>• Modification of various tax preferences for medical care</td>
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<tr>
<td>664</td>
<td></td>
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<tr>
<td>Total</td>
<td></td>
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<td>−119</td>
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Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.
These estimates are for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017.
ACA = Affordable Care Act.
The political realities:

President Obama had learned from the mistakes made by Bill and Hillary Clinton in 1993-94:

• He let Congress work out the details

• He engaged all stakeholders

• He let the Senate take the lead in building a bipartisan approach

  ▪ Remember the Gang of Six? GOP Sens. Grassley, Enzi and Snowe (moderate, conservative, liberal); and Democrat Sens. Baucus, Conrad and Bingaman (moderate, conservative, liberal)
The resulting legislation:

- Relied on private insurance companies to expand insurance coverage to people whose employers did not provide coverage. No single payer, no public option;
- Relied on Medicaid, a program that enjoyed bipartisan support for most of the past 50 years, to cover the near poor without employer-based coverage;
- Left the employer-based system intact, and aside from the Cadillac tax, largely unaffected;
- Extended the solvency of the Medicare trust fund by a decade;
- Committed the delivery system to experimenting with reforms aimed at cutting costs.
In short:

- Without a single Republican vote, the Democratically-controlled White House and Congress in 2010 passed a moderate Republican bill.
And it succeeded, although not in the way it was anticipated

- In 2012, CBO projected ACA would reduce the uninsured rate to 11% by 2016. Today, it is < 9%
- CBO said number of uninsured would drop to 30 million. In March 2017, it was 28.1 million
- However, CBO predicted 23 million would buy coverage through exchanges; only 11 million did
- CBO predicted 10 million low-income workers would join Medicaid; in fact, there were close to 15 million new enrollees despite 19 states refusing to expand coverage for people earning up to 138% of poverty.
How about the delivery system reforms?

Health Care Spending as % of GDP
1995-2014

Source: World Bank
The Great Recession and health spending

• Healthcare grew substantially faster than the rest of the economy in 2008 and 2009

• Hospitals and physician offices added jobs at a steady clip, while the rest of the economy shrank dramatically

• Result: share of GDP jumped in those years

• But in 2010, economic growth resumed and NHE share held steady through 2013. Slight uptick in recent years, but still just 18% of GDP, compared to 17% of GDP in 2010
Can ACA take credit for the slowdown?

• “Although it is unclear how much of that slowdown is attributable to the recession and its aftermath and how much to other factors, the slower growth has been sufficiently broad and persistent to persuade CBO and the Joint Committee on Taxation to dramatically lower their projections of federal costs for healthcare.” -- Congressional Budget Office, March 2015
Can ACA reforms take credit for the slowdown?

Figure 1. National Health Expenditure Projects ($ billions)

Source: Robert Wood Johnson Foundation, June 2016
Possible factors:

• The rise of high deductible plans and narrow networks?
  – Yet Medicare and Medicaid costs, where these are not factors, have slowed at same pace as private sector

• Shift in balance of power from providers to payers?
  – Yet consolidation among providers has accelerated; recent Health Affairs study of 346 metro areas in U.S. showed 90% of hospital markets and 65% of physician specialty markets are now “highly concentrated; only 57% of insurance markets are
How about delivery system and payment reforms in the ACA?

- **Incentive programs**
  - Readmissions; value-based purchase; hospital acquired conditions

- **Payment reforms**
  - Shared savings; bundled payments; episode payments; Accountable Care Organizations; CMS pledge to tie 90% of payments to either value or quality by 2018

- **New care delivery models**
  - Medical homes; care coordination; prevention pilots
Many economists remain skeptical

- “It seems unlikely that, at least for the period 2010-2014, the ACA can claim much credit for the slowdown in the increase in spending growth.”
  - Jonathan Skinner and Amitabh Chandra, JAMA, August 2016
- “There is reason to be skeptical that a federal agency can engineer a higher-value health system relying solely on regulatory carrots and sticks.
  - Joseph Antos and James Capretta, American Enterprise Institute, April 2017
Do delivery system reforms matter?

- All evidence from Medicare; no public reporting on the more than 600 private ACOs promoted by insurers
- Modest results to date for Medicare ACOs
- 31% of MSSP and Pioneer ACOs received shared savings bonuses in 2015, up from 27% in 2014 (Health Affairs, Sept. 2016)
  - 400 ACOs in 2015 v 330 in 2014
  - Avg. quality score on 33 measures: 91% in 2015 v 86% in 2014
In ACOs, experience matters

![Graph showing the rate of earned shared savings over years in the program. The graph indicates an upward trend with increasing years, suggesting that experience matters in ACOs.]
Did Medicare’s value-based purchasing programs matter?

- Readmission penalties – up to 3% penalty
- VBP – up to 4% reward or penalty (fiscally neutral for CMS)
- HACs – a 1% penalty for lowest quartile
Figure 2
National Medicare Readmission Rates Started to Fall in 2012

Performance (measurement) Time Period

Notes: National readmission rates include unplanned hospitalizations for any cause within 30 days of discharge from an initial hospitalization for either heart failure, heart attack, or pneumonia. Readmission rates are risk-adjusted for certain patient characteristics, such as age and other medical conditions.

Source: Kaiser Family Foundation analysis of CMS Hospital Compare data files.
Value-based purchasing

- Penalties and rewards can now be as much as 4% of Medicare payments
- Yet half of 3,000 hospitals in programs saw payments go up or down by 0.5% or less
- More hospitals penalized in 2016 compared to 2015: 1343 versus 1236
- Fewer earned bonuses in 2016 compared to 2015: 55% versus 59%
  - “Inherently flawed program”: it measures relative improvement, not absolute improvement, i.e., if everyone improves, your relative position could still worsen; also results not known until end of program year
Hospital Acquired Condition Rates, 2010 to 2015

HAC reductions, 2010-2015

[Diagram showing percentage breakdown of HAC reductions]

- Adverse Drug Events: 42.3%
- Catheter-Associated Urinary Tract Infections: 15.2%
- Central Line-Associated Bloodstream Infections: 10.1%
- Falls: 9.6%
- Obstetric Adverse Events: 6.4%
- Pressure Ulcers: 2.9%
- Surgical Site Infections: 2.4%
- Ventilator-Associated Pneumonias: 2.0%
- (Post-op) Venous Thromboembolisms: 0.8%
- All Other HACs: 1.2%
HAC deaths averted

• 2015 estimates indicate that more than 37,000 fewer patients died in hospitals in 2015 as a result of the decline in HACs compared with the number of deaths related to HACs that would have occurred if the rate of HACs had remained steady at the 2010 level.

• Cumulative deaths averted from 2010 through 2015 are estimated at nearly 125,000

• If this were a drug, the FDA would approve it in a heartbeat and PhRMA would call it a “miracle” cure
Public opinion and the ACA

- Public knows little about delivery system reforms
- It knows a lot about the coverage expansion
- Reasonable to assume public opinion reflects the insurance expansion, not provider reform

![Gallup Approval Percentage Chart]

**Gallup**

**Publics who approve of the Affordable Care Act**

- **Nov 2016**: 42%
- **Apr 2017**: 55%
Public opinion

• Aug. 2017 Kaiser Family Foundation tracking poll:
  – 60% say it is a “good thing” that the Senate did not pass the bill that would have repealed and replaced the ACA;
  – 57% want to see Republicans work with Democrats to improve the 2010 health care law; just 21% want to see Republicans work on their own plan;
  – 78% want the Trump administration to do what it can to make the law work; just 17% support withdrawing support so it can be replaced later;
  – 80% opposed cutting off outreach support; 65% oppose ending the individual mandate
Bottom line

President Donald Trump and the Republican Congress in eight months completely reversed the anti-ACA mood that Republicans succeeded in creating after the law’s enactment.
Pew Research Center poll in January found that “60% of Americans now say the government should be responsible for ensuring health care coverage for all”

Gallup noted the same reversal:
The political debate has shifted to the left

The reemergence of bipartisan centristim:

*One party healthcare plans are “doomed to fail.”*

- *Gov. John Kasich (R-Ohio) and Gov. John Hickenlooper (D-Colorado)*
  - Fund cost-sharing subsidies
  - Preserve Medicaid expansion
  - Lift employer mandate, keep individual mandate, but give states flexibility to set benefits standards
  - Stabilize exchanges with reinsurance pool for high-cost patients
  - Create a public default program (FEHBP) for areas without sufficient insurer competition (the public option returns!)
• The reemergence of single-payer, but still a minority view

Support for single-payer

2015: 21%
2016: 28%
2017: 33%

Source: Pew Research
HHS and the ACA

HHS Secretary Tom Price and CMS administrator Seema Verma have already taken steps to:

• Weaken enforcement of the individual mandate
• Eliminate advertising to encourage enrollment
• Use HHS websites to advertise “failures” of the ACA
• Encouraged states to apply for waivers with work requirements to discourage sign-ups
Insurers and the ACA

• Despite these moves:
  – Nearly every county in America has at least one insurer offering plans (some withdrawals in early September)
  – While 47% of counties in the U.S. have only one plan offered on the exchanges, four in every five Americans live in the half of all counties that offer multiple plans.
  – Rates are rising by about 20% on average for next year, about the same as for this year
  – But about 70% of 2017 plan purchasers could still get a silver plan for under $75 because of premium subsidies, i.e., the feds pay most of the cost of rising rates
Scaling back ACA delivery system reforms

- Voluntary, not mandatory
  - Bundled payments initiative, slated to become mandatory for knee and hip replacement in 67 markets in 2018
  - Proposal: Voluntary in nearly half those markets
  - Proposal: Eliminate expansion to heart attacks, bypass surgery, hip and femur fractures, and cardiac rehabilitation
  - Proven to save CMS money, yet being cut back
    - Hospitals in CMS' orthopedic bundled-payment program cut costs by $864, or 3% per episode
Fate of other ACA reforms unclear

• Accountable Care Organizations
  – Still slated to rise to 11.3 million Medicare beneficiaries by 2018, up from 8.7 million this year
  – But % in shared savings or other risk models "TBD"

• Value-based purchasing for Medicare Part B outpatient drugs
  – In 2016, proposed tiered co-pays; reference pricing; pay for outcomes
  – Scrapped after drug companies, oncology practices and patient advocacy groups protested
…Other ACA reforms (continued)

• CMMI budget – still unclear, no signal in Trump’s proposed budget
• Departure of Dr. Patrick Conway to BCBS of North Carolina … no replacement named
• MACRA implementation – more exemptions and simplification
  – Just 36% of clinicians under MIPS (but 58% of Medicare Part B charges)
  – Hospital-based physicians can let facility report
  – 1-year delay in adding cost to reward formula
The future of value-based reimbursement?

• It remains the law ... In ACA, in MACRA
• But HHS is clearly easing up on the accelerator
• The private sector will likely emerge as the primary driver of value-based reimbursement, at least for the next few years
Economic factors driving value-based reimbursement

• The new political realities do not change the long-term socio-economic facts on the ground:
  – The U.S. is an aging society; immigration restrictions will make it more so
  – Increasing chronic disease prevalence threatens to reverse progress
    ▪ Opioid, obesity epidemics
    ▪ Declining longevity among economically depressed
CMS: prices tame, use rising in recent years

But sees a return to rising medical prices in the next decade
New technologies, especially drugs, remain a major cost-driver

- Oncology and specialty drugs – now 43% of drug spending
- Express Scripts: Total drug spending will grow between 6% and 8% between 2016 and 2018. Spending for specialty meds jumping 17% annually
- Despite political rhetoric, little is being done to rein in drug prices
Can providers continue to improve?

- Continued shift to less costly settings
- Hospital systems (as opposed to individual hospitals) that thrive in the years ahead will need to rely on greater integration
  - Inpatient to outpatient (a trend that is well underway and will accelerate)
  - One-day orthopedic implants
Figure 3. Revenue share for inpatient and outpatient services at private community hospital

Click legend items to change data display. Hover over chart to view data.
Other moves to less costly settings:

- Storefront medicine
- Telemedicine
- More aggressive post-acute care management
- Greater emphasis on primary care, prevention and care coordination
- Bottom line: The great hospital hiring binge is slowing, and will soon be over (and could reverse)
Final thoughts:

• Healthcare will be under constant pressure in the years ahead to keep cost growth at or below overall economic growth

• Based on the achievements of the past decade, that is possible …
  – In 2009, CMS projected NHE would equal 19% of GDP by 2016. We’re a full percentage point below that
  – Current projections show all the growth will come in Medicare as a share of GDP, i.e., primarily because of our aging demographics
Healthcare as share of GDP

Contributors to national healthcare spending

Source: CMS
So what has to change?
Inside the hospital, this has to change:

Labor Productivity 1995 – 2014 (BLS new series)
Outside of healthcare, these have to change

• If we’re going to continue to have an employer-based insurance system, we can’t continue to rely on Medicaid to serve as the insurer of last resort for employers who rely on low-wage workers
• Must figure out how to pay for long-term care
• Must create more realistic expectations about end-of-life care