

# “A Policy Perspective on Health Care in 2017 and Beyond”

*Presentation to:*

**The Leadership Institute Roundtable Millennium Group**

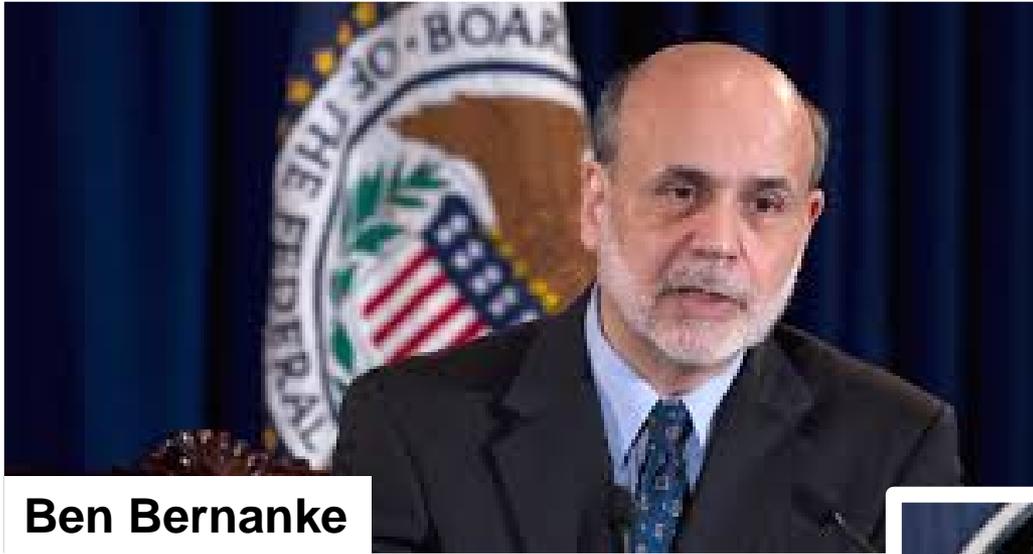
**May 18, 2017**



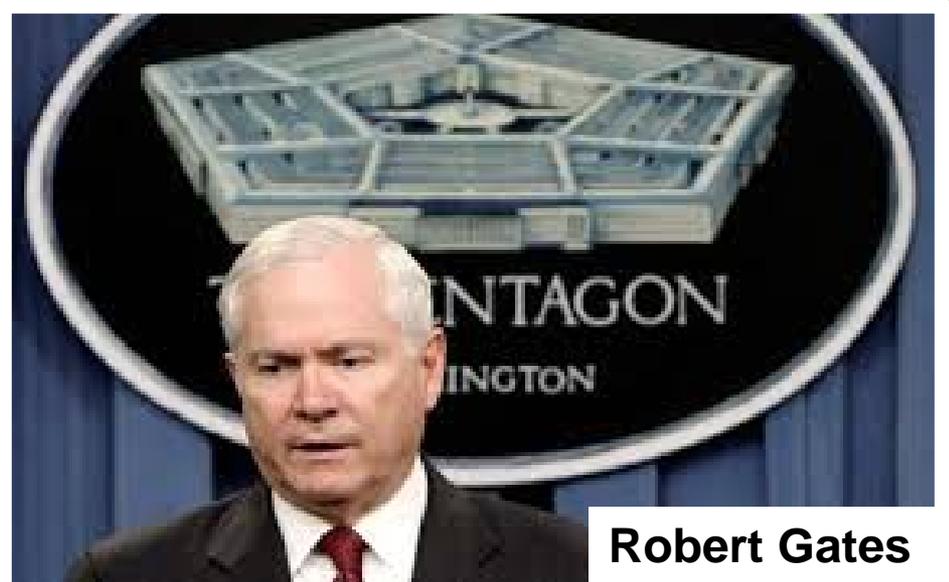
**Leonard D. Schaeffer**  
Judge Robert Maclay Widney  
Chair and Professor,  
University of Southern California

The Ritz-Carlton Hotel  
Washington, DC

# America's Real Health Care Experts



**Ben Bernanke**



**Robert Gates**

# Agenda

- **The Problem Is Health Care Costs**
- **ACA Challenges**
- **New Politics of Health Reform**
- **Payer Response to Cost Pressures**
- **Conclusion**

# The Problem Is Health Care Costs



## What We Believed

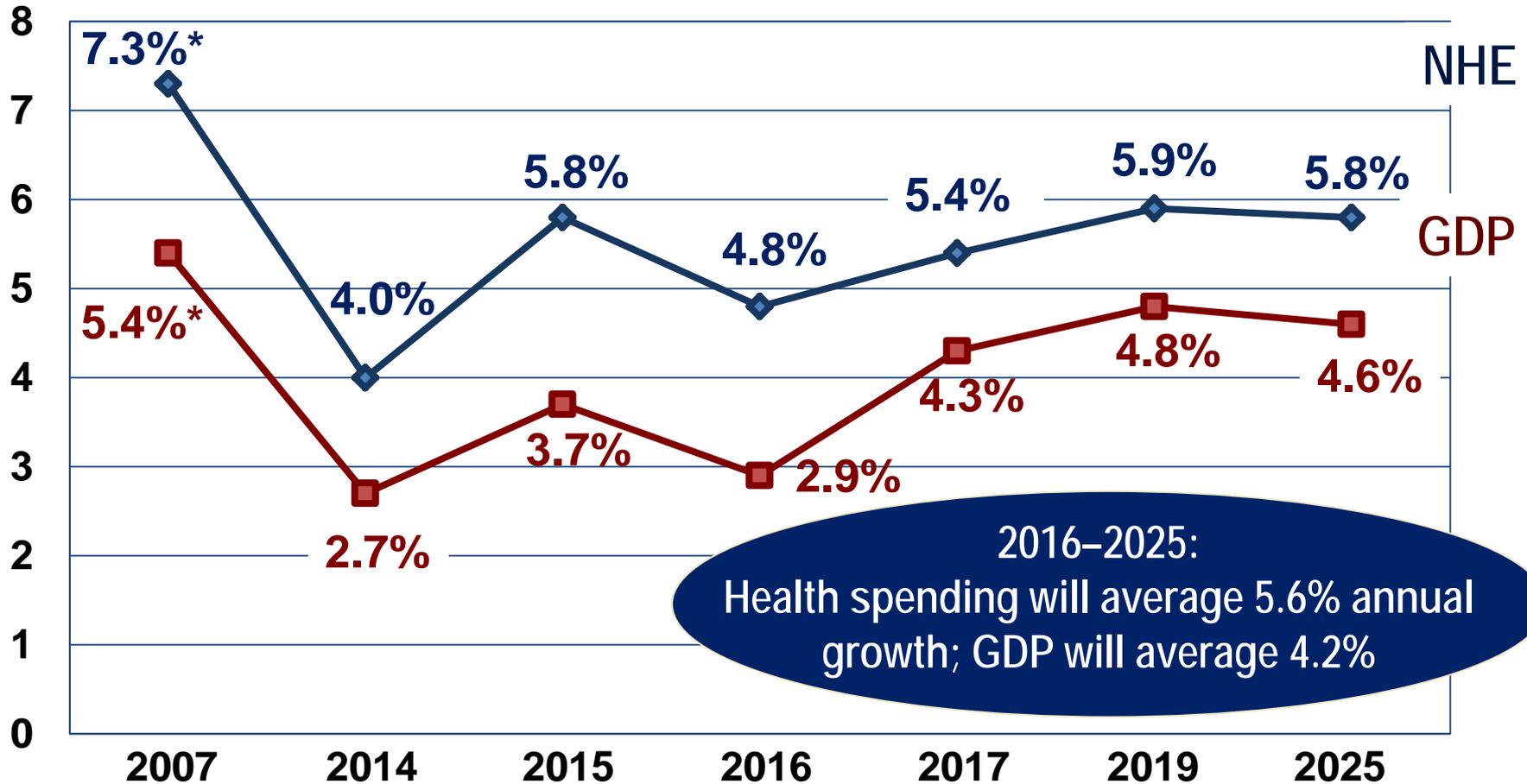
- U.S. = Highest Quality
- ∴ High Cost O.K.
- Limited Access = Market Economy

## What We Know

- U.S. = Uneven Quality
- = Highest Cost By Far
- High Cost + Stagnant Wages = ↓ Access

# After Recession, Health Care Cost Growth Resumes

## Annual Growth in National Health Expenditures (NHE) and GDP



# Rising Health Care Costs Impact Nation in Multiple Ways

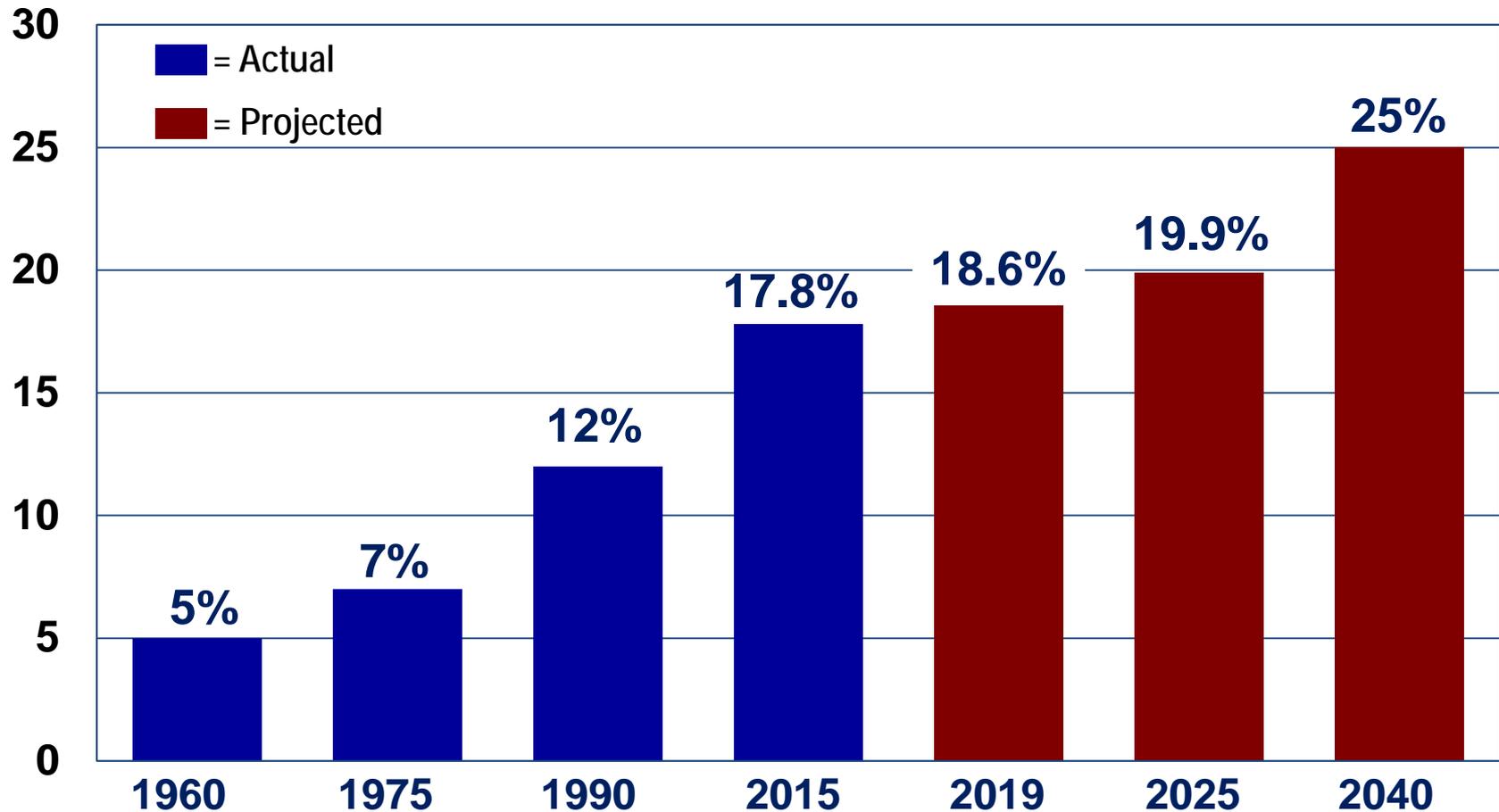
- **Affordability for individuals**
  - Health care costs continue to rise faster than wages
- **Percent of GDP**
  - Now 17.8% of GDP, h.c. spending crowds out priorities & continues to grow faster than economy
- **Increases in federal debt & interest costs**
  - Long-term, high and rising health care costs are significant threat to the economy

***“Long-run fiscal policy is health policy”***

***Alice Rivlin***

# Long-Term: Rising Health Care Costs Significant Threat To Economy

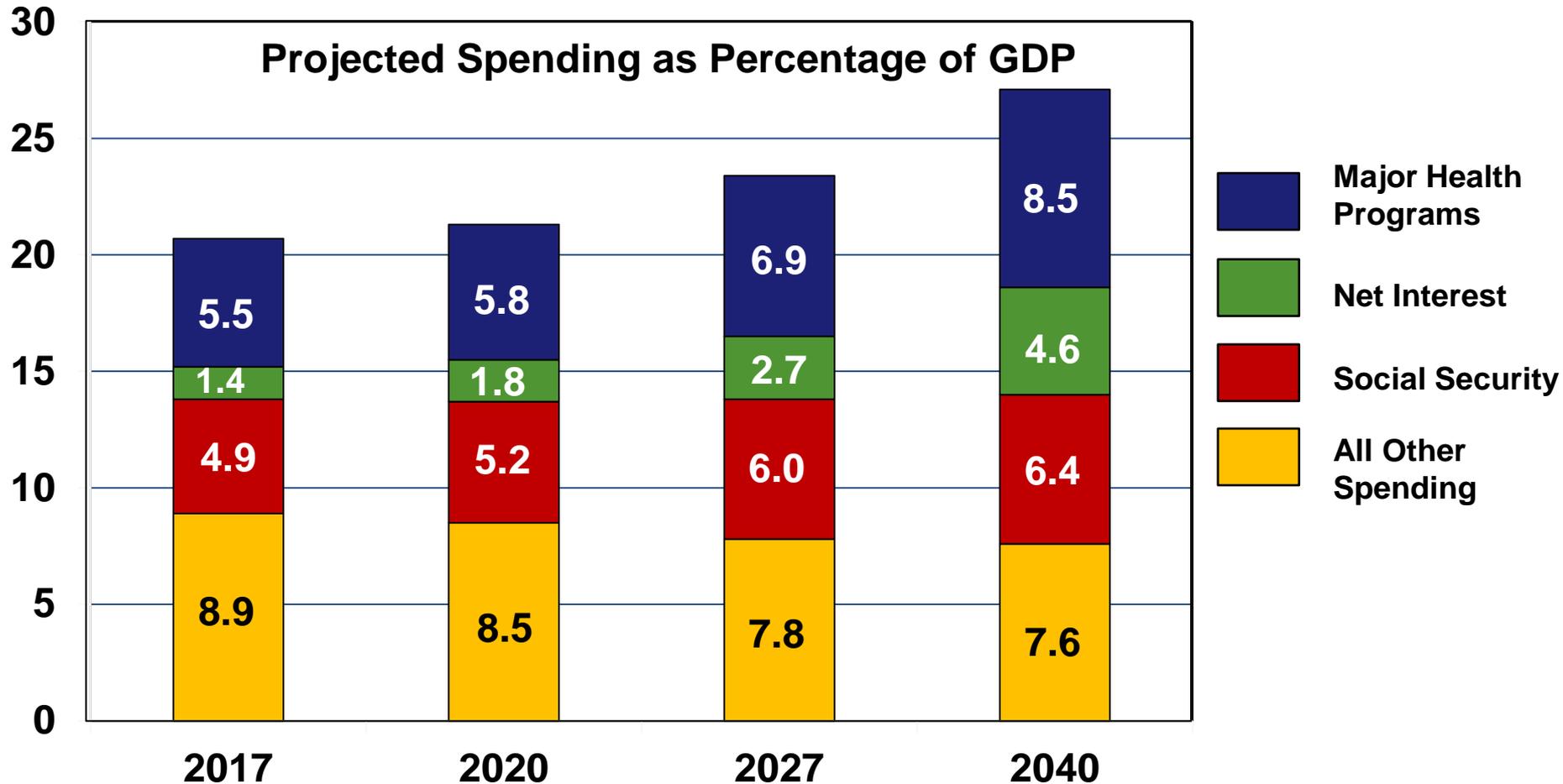
## Total U.S. Health Expenditure as % of GDP (Public & Private)



Source: 2015, 2019, 2025 figures from CMS, National Health Expenditures, reported in Health Affairs, March, 2017: "National Health Expenditure Projections, 2016–25: Price Increases, Aging Push Sector To 20 Percent Of Economy"; All other figures compiled by PGPF

# Federal Health Spending Drives Deficit

***Most projected growth in federal spending due to health care and interest***

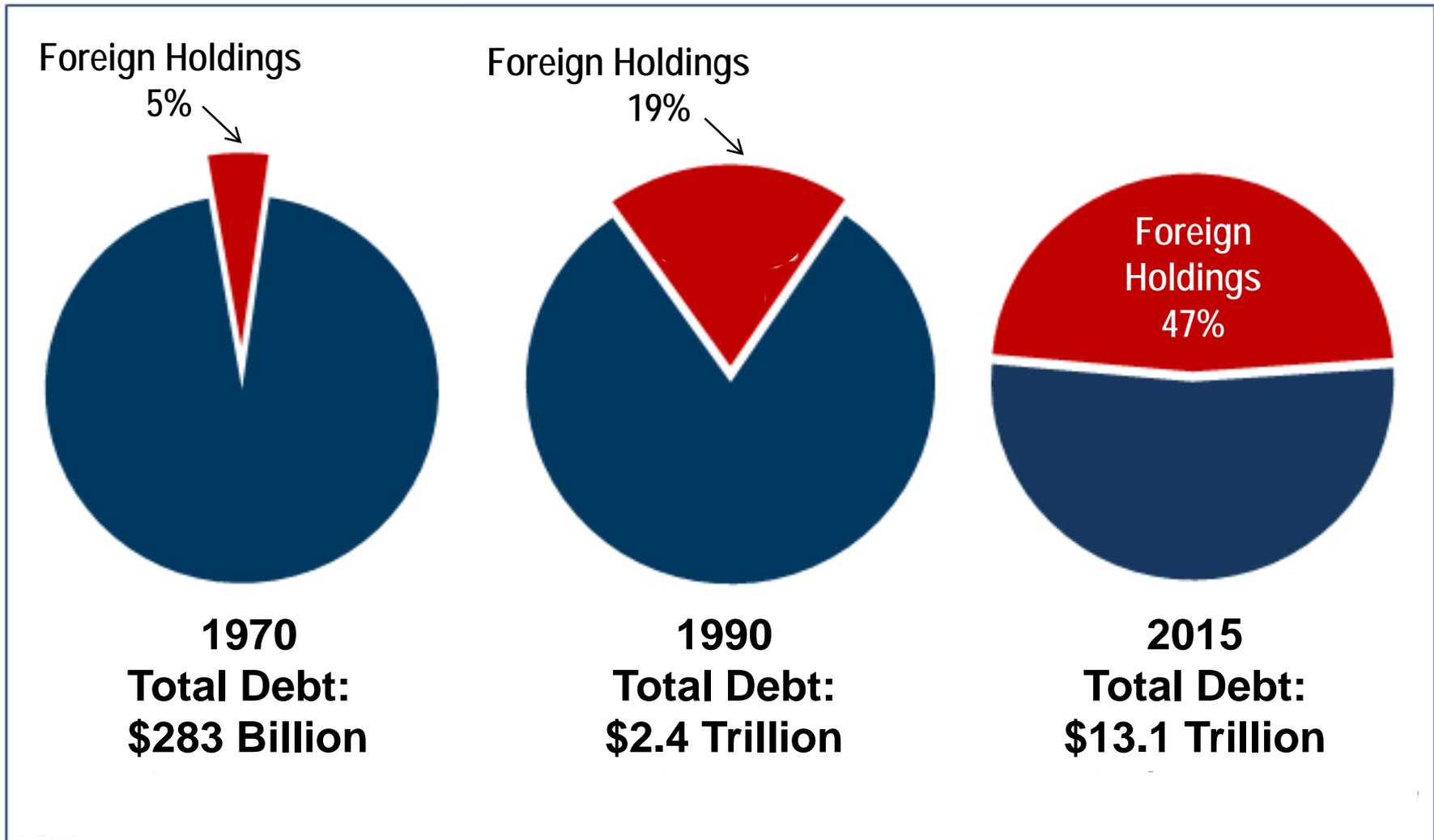


Source: CBO, The 2017 Long-Term Budget Outlook (March 2017)

Major Health Programs includes: Medicare, Medicaid, CHIP and exchange subsidies

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# Consequences: Dependency on Foreign Lenders ↑ & Creating Nat'l Security Issues



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# Status of ACA Marketplace

- Risk pool sicker than expected
- Many insurers priced too low initially
- Premiums accelerating
- Choice of insurers & policies shrinking
- Cost-control strategies upset consumers
- Federal “risk-mitigation” programs failing to fully compensate insurers
- State & insurer experiences vary widely

# State Experience: CA , AZ & TX

State	Exchange Type	Medicaid Expansion	Change in 2017 Premium from 2016	Change in Number of Participating Issuers	2015 Uninsured Rate (Change from 2013)
California	State-run	Yes	7% ↑	- 1 (12 to 11)	8.6% (↓ 8.6%)
Arizona	Federal	Yes	116% ↑	- 6 (8 to 2)	10.8% (↓ 6.3%)
Texas	Federal	No	18% ↑	- 9 (19 to 10)	17.1% (↓ 5.0%)
National Change			22% ↑	- 73 (298 to 228*)	9.4% (↓ 5.1%)

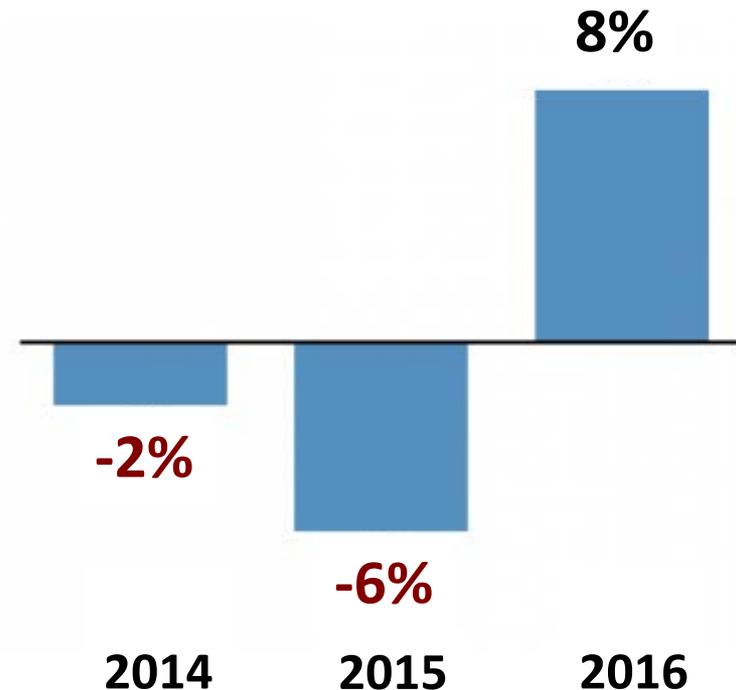
# Potential for Exchanges to Stabilize

## S&P Analysis of Blue Plans in 34 States:

- Most insurers' 2016 results were better than 2015
- Insurers, on average, close to break-even in 2017
- Most insurers likely to become profitable in 2018
- 2016 results and 2017 enrollment show market is not in a "death spiral"

## Blue Cross Blue Shield Plans Made Progress Toward Profitability in 2016

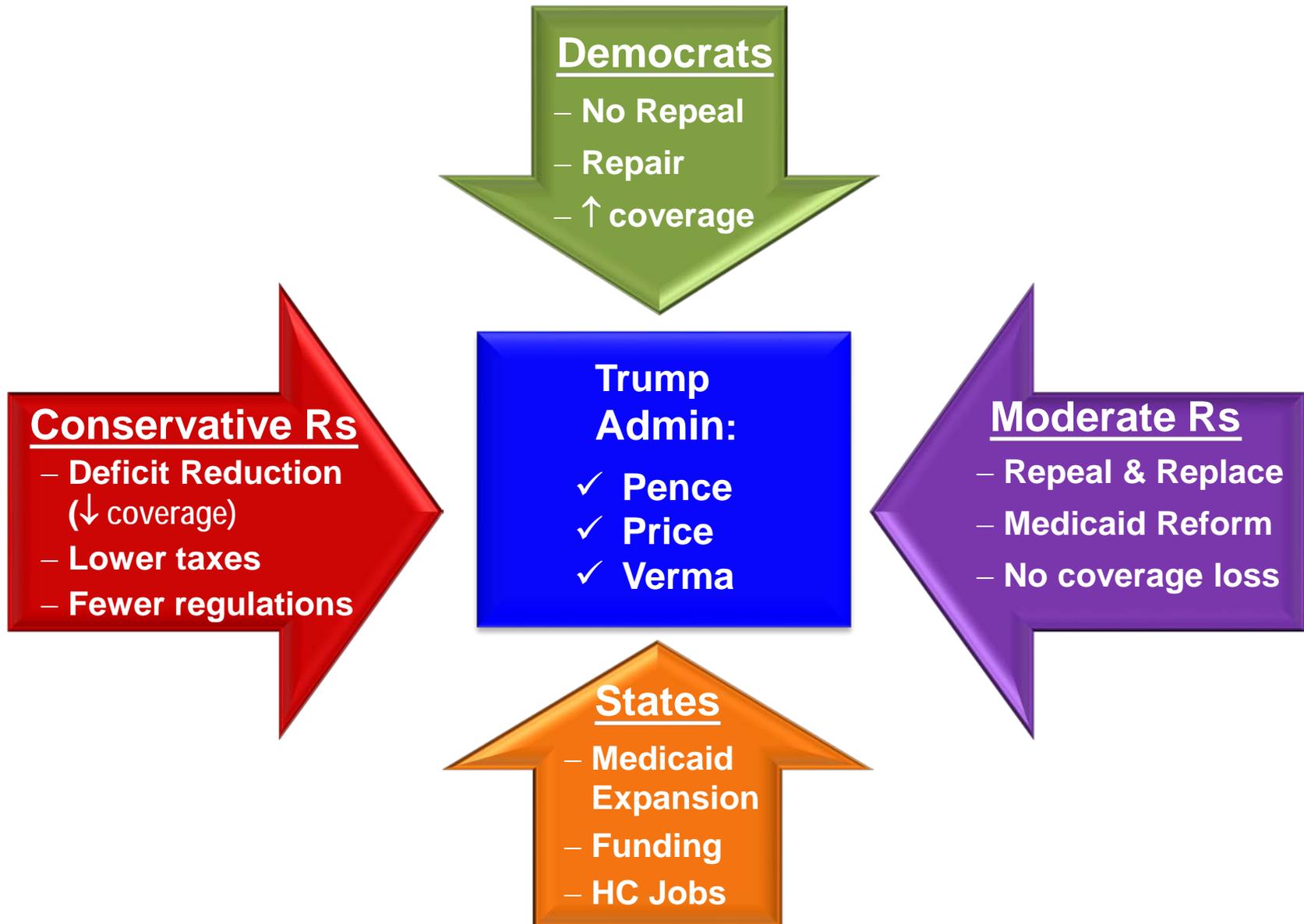
Gross profit or loss in individual market as share of premiums before taking into account administrative costs



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# New Politics: “Nobody knew health care could be so complicated”



# Basics of AHCA Proposal

## Medicaid

- Ends Medicaid expansion
- Caps federal Medicaid payments to states

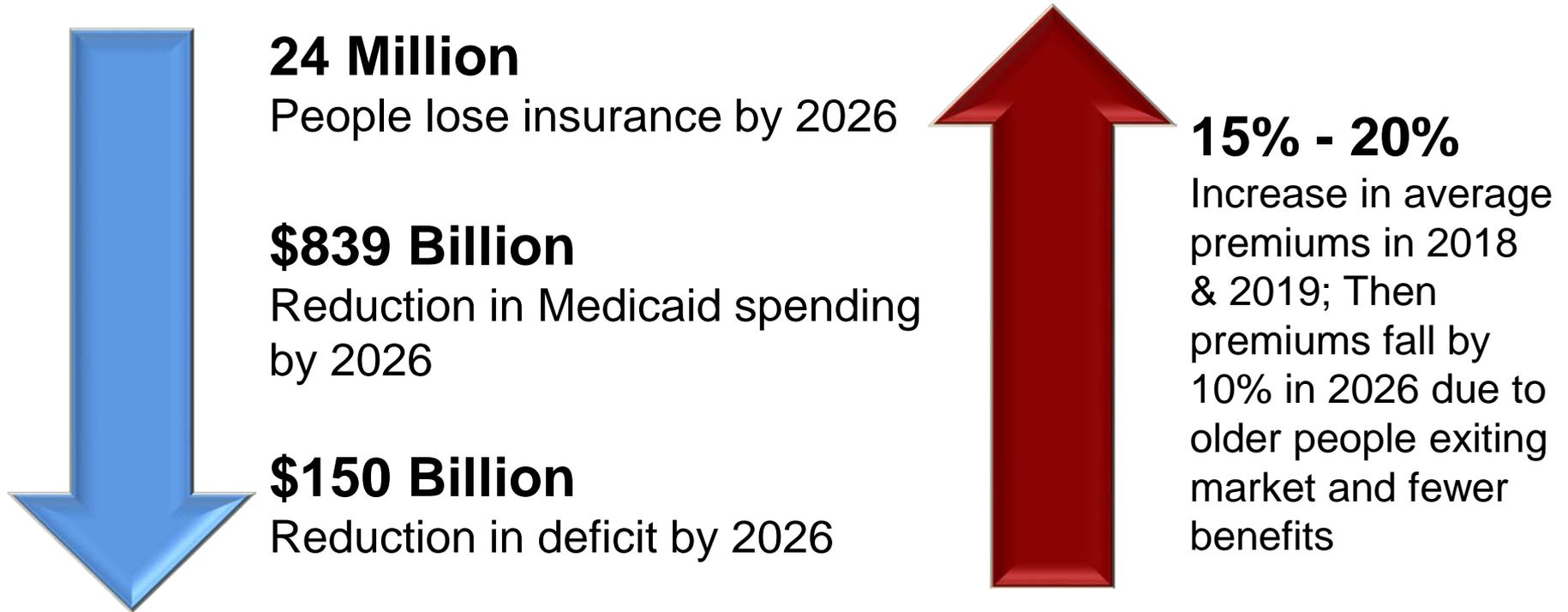
## Insurance Reforms

- Ends CSR payments for out-of-pocket costs for low-income
- Establishes flat, age-adjusted premium tax credit subsidy
- Ends employer mandate and penalty
- Replaces individual mandate w/ continuous coverage penalty
- Loosens ACA's age-rating band ratio from 3:1 to 5:1

## Financing & State Role

- Repeals taxes on higher-income, device/drug cos, & insurers
- Provides \$130 B in state funding over 10 years to help cover higher-cost people and stabilize individual market

# CBO Score Reduced Support: Bill Pulled



**Only 17% of Americans  
Support House Republican bill**

# “Waiver” Strategy Giving States More Control (& No CBO Score) Got Bill Passed

## Essential Health Benefits

ACA: Established minimum set of essential health benefits (EHBs) and limited patient out-of-pocket costs.

AHCA: Waiver-states can define own EHBs; Patient financial protections apply only to redefined list of EHBs.

## Community Rating

ACA: Bans charging people with preexisting conditions higher premiums.

AHCA: Insurers in waiver-states can charge higher rates to sick people with a lapse in coverage if state has high risk pool or reinsurance program. \$8 Billion over 5 years added to help cover people with pre-existing conditions.

## Age Rating

ACA: Limits insurers from charging older adults more than 3 times what young adults pay.

AHCA: Insurers in waiver-states can charge older adults 5 times *or more* than for a young adult.

# Still Far From Law: Senate Up Next

- **Senate GOP centrists' concerns:** Pre-existing condition protections; Medicaid funding and enrollment
- **Senate to write own version:** 51 votes required for budget “reconciliation” process:
  - Significant changes expected
  - Goal is to avoid Democratic filibuster
  - Senate rules exclude policy changes that don't impact deficit
  - CBO score required before vote
  - Then, House-Senate negotiation
- **Timeline:** Unknown but critical for GOP because repealing ACA necessary for bigger tax cuts

*Political process will continue to sow uncertainty and influence decisions that destabilize marketplace*

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# Shift to Value-Based Payment to Continue But Federal Leadership May Slow

- ACA's **CMS Innovation Center (CMMI)** tests large-scale payment and delivery system reforms to validate value-based models
- Price opposes mandatory initiatives, (esp. **CMMI's bundled payment**)
- **MACRA** supposed to support shift, but Price concerned re: patient-doctor relationship and performance measures
- If HHS changes direction, **future** of government-led, value-based initiatives in doubt

# ACA Medicare Experiments: Mixed Results Could Weaken Support for More Initiatives

Cost Containment Pilots/ Demos	Results
32 Original Medicare Pioneer ACOs	<ul style="list-style-type: none"> <li>• Only 9 of original 32 Pioneers remain</li> <li>• 2015: 6 of 12 rec'd bonuses; 4 had losses</li> <li>• 9 of 12 had quality scores of about 90%</li> </ul>
220 Original Medicare Shared Savings Program (MSSP) ACOs	<ul style="list-style-type: none"> <li>• Program growing: Now 392 MSSP ACOs</li> <li>• 2015: 119 of 392 rec'd bonuses (30%)</li> <li>• Quality improving</li> </ul>
Value-Based Payment Demos	<ul style="list-style-type: none"> <li>• Little or no effect on spending; Bundled payment exception</li> <li>• First-ever decline in HAls</li> </ul>
6 Disease Management & Care Coordination Demos (34 orgs)	<ul style="list-style-type: none"> <li>• No net benefit on hospital admissions or spending</li> </ul>

**Is shifting 50% of FFS payments to alternative payment models by 2018 still HHS's goal?**

# Private Payers Will Continue Implementing Cost-Control Strategies

## Public & Private Payer Strategies

Value-based payment to move from volume to value

↑ Patient cost-sharing shifts more financial responsibility to patients

PBMs pressured to control drug costs for payer clients

Narrow networks to encourage patients to use cost-effective providers

Provider performance measured and reported to change behaviors

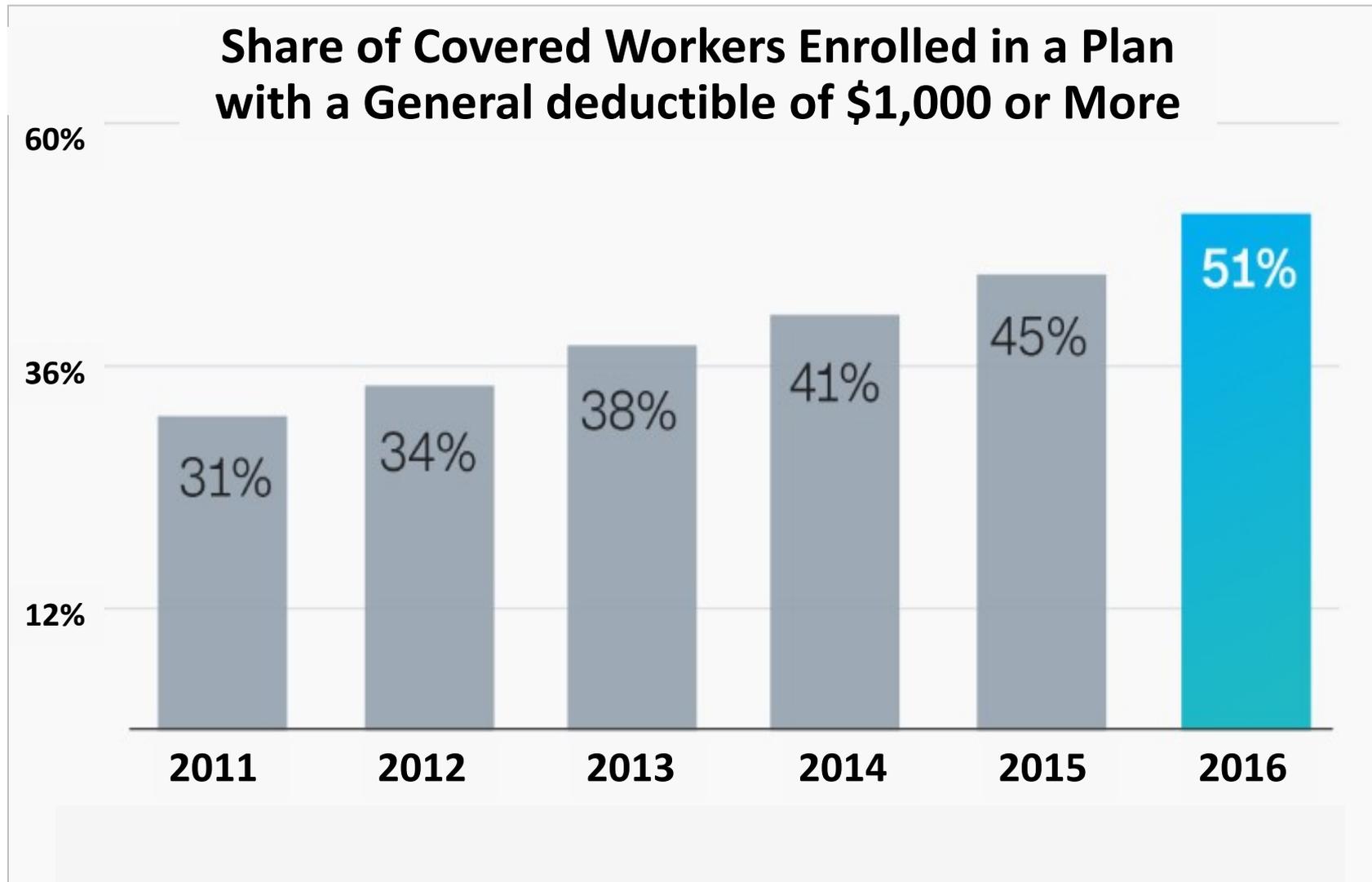
Providers engage patients in shared decision-making that includes costs

More treatment and drug decisions made by private & public payers

Network participation requires demonstrating cost-effectiveness

## Impact on Providers

# Consumers, Paying More Out-of-Pocket, Put Added Pressure on Costs



Source: Kaiser /HRET Employer-Sponsored Health Benefits Survey, 2016: Share of workers with an annual deductible of \$1,000 or more for single coverage; Graphic: <http://money.cnn.com/2016/09/14/news/economy>

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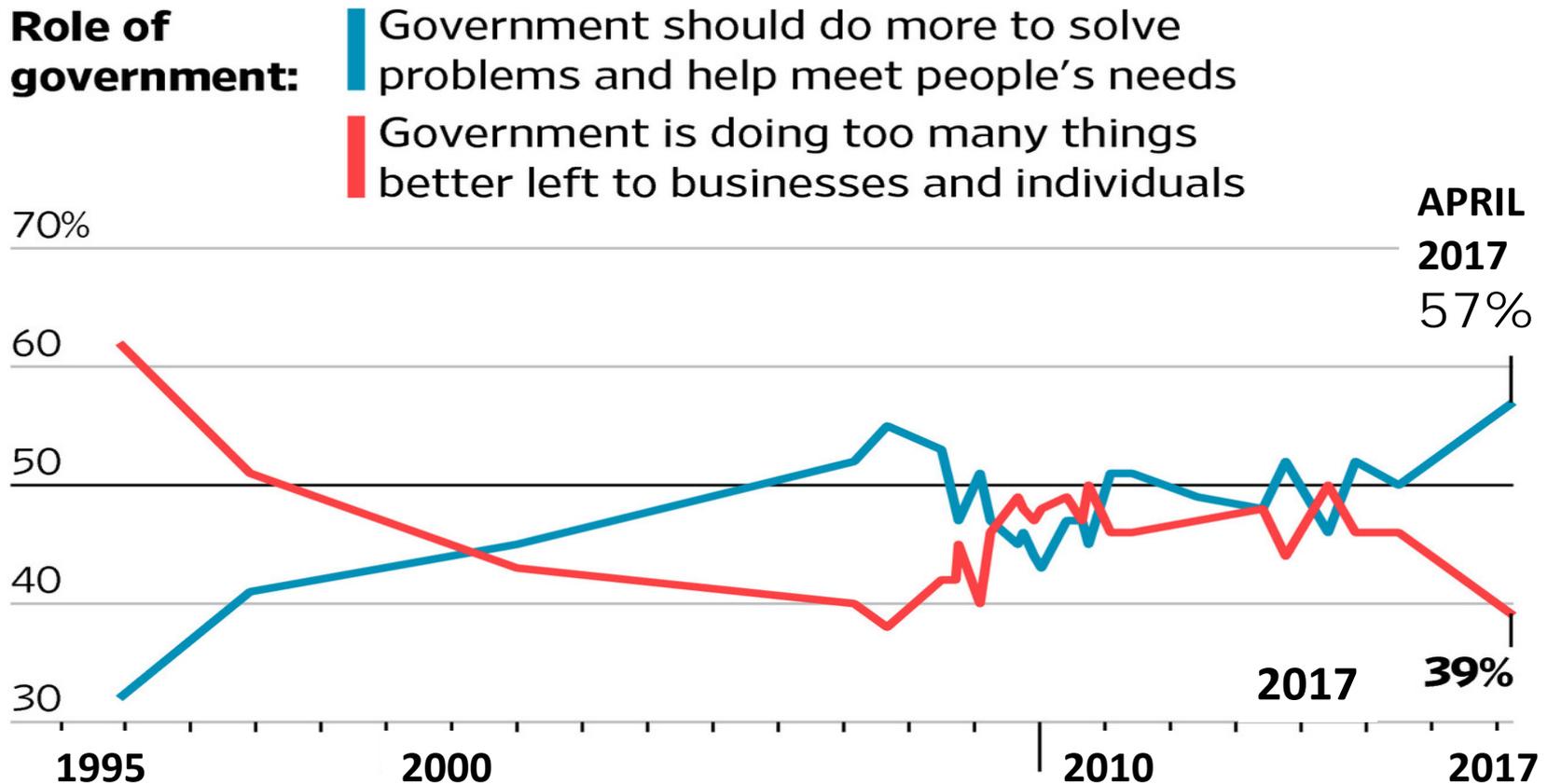
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# If We Fail To Control Costs, Blunt Cuts & Heavy Regulation Possible

- **Health care legislation is never about health care**
  - Real drivers: \$, role of gov't, and social values
- **Health care costs drive accumulated debt that threatens economy and national security**
  - Deficit hawks and national security experts join to cut federal budget/debt
  - Sequester-type across-the-board h.c. cuts easiest
  - Possible price (and wage) controls
- **American version of “single-payer”**
  - Gov't regulates everything as the majority payer
  - Administration and care through non-gov't entities to keep it “market-based”

# Don't Believe Single Payer Possible?

Percent of respondents that want federal government to do more to solve people's problems is at highest level since first asked in 1995



Source: WSJ/NBC News Telephone polls. Most recent of 900 adults conducted April 17-20; margin of error: +/-3,2 pct.pts

# Long-term: What Happens When the Dust Settles?

## **A uniquely American healthcare system?**

- Insurance companies become heavily regulated utilities
- Providers become more integrated, but also heavily regulated
- State & federal gov'ts regulate exchanges, insurers and providers
- Federal government becomes *the* major payer
- Research and training funded separately from care delivery
- Patients act more like consumers
- IT platforms connect all sites and include patients

**But, this is America, and the dust never settles**

# Conclusion

- Delivery system *is* changing, but cost problem persists
- Future of AHCA uncertain, but change in American values re: gov't role in ensuring affordable coverage more clear
- Gov't & private sector will intensify pressure to lower costs
- Failure to control costs threatens economy and national security and will lead to crisis-driven fiscal policy

*Social, demographic & economic forces creating environment where providers must achieve better outcomes at lower costs to succeed*