Health Care Reform Update

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Objectives - Discuss and Clarify:

1. Status of ACA Repeal and Reform Efforts
2. Industry Reactions to Healthcare Reform Efforts
3. Healthcare Reform vs. Healthcare Spending
Status of ACA Repeal and Reform Efforts
Affordable Care Act 2017: Repeal and/or Replace if at first you don’t succeed, try, try again

**GOP House**

- American Health Care Act (AHCA) May, 2017

**GOP Senate***

- Better Care Reconciliation Act (BCRA) July, 2017

**Congressional Democrats**

Affordable Care Act (ACA) March, 2010

* plus Graham-Cassidy bill, not enough support to call for vote

**Bipartisan Committee** (Aug 2017 thru Mar 2018)

Senators Alexander & Murray led efforts to develop market stabilization bill
Republicans found no consensus on “Repeal and Replace”:

- Too much like ACA
- Subsidy calculations and thresholds
- Tax cuts / tax increases
- Payments to Insurers
- Insurance Plan design requirements
- Medicaid changes
ACA Exchange Marketplace

National Enrollment
- 11.8 million enrollees (2018) (3.3% decrease from 2017)

Receiving subsidies
- 83% of enrollees (2018)

Eligible for CSRs
- 57% of enrollees (2017)

Texas Enrollment
- 1,126,838 enrollees (2018) (8.2% decrease from 2017)

Receiving subsidies
- 86% of enrollees (2017)

Eligible for CSRs
- 63% of enrollees (2017)

Average monthly premium: $476 in 2017 / $621 in 2018 (30% increase)
Average monthly payment for subsidized participants: $106 in 2017 / $89 in 2018
Insurers lost money in the early years of the Exchange Marketplace because they collected less in premiums than they spent in claims.

Fundamentals of Insurance Rule #1:

*Somebody has to pay the claims.*

Some large insurers began recording profits on the Exchange Marketplace in late 2017, after they figured out how to price the plans.
October, 2017  President Trump issued Executive Order:
To “Promote healthcare choice/competition”, which directed federal agencies to consider/draft new rules and guidance to:

• Halt Cost-Sharing Reduction (CSR) payments to insurers
• Reduce Exchange Marketplace enrollment period
• Reduce allocations of financial assistance to Exchange Marketplace enrollers
October, 2017  Executive Order, continued:

Directed federal agencies to consider/draft new rules and guidance to:

- Expand access to association health plans
- Extend maximum length of short-term coverage plans (from <90 days to 1 year) and make them renewable
- Increase “usability” of employer-funded Health Reimbursement Accounts (HRAs), so funds could be used toward premiums for individual market health plans
December 2017

“Tax Cuts and Job Act” was signed into law. This tax reform bill includes elimination of the ACA Individual Mandate, effective in 2019.

The IRS says it will continue enforcing the mandate for tax years 2015-2018.
On February 26, 2018, Texas and 19 other states filed a lawsuit against the federal government to strike down the Affordable Care Act (ACA) following repeal of the individual mandate penalty.

Argument based on Supreme Court ruling that the mandate is a tax; therefore since the mandate is eliminated, the ACA is unconstitutional.
Elimination of the ACA Individual Mandate could potentially:

- Increase premiums for Exchange plans, because healthier people would drop their coverage, shrinking the risk pool (would not affect those who qualify for subsidies). CBO estimates that dropping the mandate will cause 13 million fewer Americans to be insured by 2027.

- Boost Republican agenda by eliminating an unpopular ACA element

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The Employer Mandate and ACA reporting requirements remain unchanged, along with the “Cadillac Tax” which is currently set to become effective in 2022.
Individual Mandate – Round Two

Nine states (California, Connecticut, Hawaii, Maryland, Minnesota, New Jersey, Rhode Island, Vermont, Washington, and the District of Columbia) are considering their own versions of a requirement that residents must have health insurance or face a financial penalty.

This push illustrates a shift in the health care battle from the federal level to the states, which could ultimately redefine access and coverage for millions of Americans.
Bipartisan Health Care Stabilization Act of 2018...
(Continuation of 2017 Alexander-Murray initiatives)

Primary aim: to stabilize the health insurance Exchange marketplace. Proposed $30 billion to be allocated to:

- Continuation of cost-sharing reduction (CSR) payments to insurers
- Money for state reinsurance programs
- Creation of cheaper “copper” marketplace plans
- Increased consumer education and assistance during Exchange open enrollment period
ACA puts a cap on the copays and deductibles that are paid out of pocket by Exchange enrollees who earn less than 250% of the federal poverty level (Federal Poverty Level is $25,100 for family of 4).

Cost Sharing Reduction (CSR) is a discount that lowers the amount Exchange participants have to pay for deductibles, copayments, and coinsurance.

In other words, the less money the participant earns, the more medical care the insurance company has to cover without reimbursement.
Cost Sharing Reduction (CSR)

- CSRs only apply to Silver-level marketplace plans
- The amount of the CSR is payable to the insurance company
- Purpose is to reimburse insurance companies in order to help offset losses, while making coverage affordable to low-income participants
- Federal government stopped CSR payments in October 2017 despite insurer lawsuits
Impact of eliminating CSR payments:

- Affects 22 million people who buy plans on their own (no employer coverage).

- Significant cost increases for Exchange participants who don’t qualify for subsidies. Some report their family premiums are tripling, with deductibles of over $12,000.

- Most Exchange participants who purchased Silver plan coverage and qualified for subsidies will not see higher premiums, because the amount of their subsidy will rise to cover the increase.
• Repeated criticisms about the “unsustainable costs” of the ACA.

• Yet, former Administration official claims the Administration knew eliminating CSR payments would increase federal spending;

• Because the increase in premiums would result in increases in subsidies to Exchange participants.
Spending bill ("Omnibus") passed and signed into law March 23, 2018 did not include the Bipartisan Health Care Stabilization Act.

But stay tuned.... Republicans and Democrats are working on several bills to address various changes to ACA provisions.
Looking ahead: 2018 and beyond

Short-term and Association health plans are being promoted by the Administration

- Secretary of HHS, Alex Azar II, supports guaranteed renewal of short-term plans.
- Plans lack many consumer protections required by the ACA.
- Not regulated by state departments of insurance.
- Plans are less expensive but offer restricted coverage.
- Healthier people may opt out of the individual market.
- 2018 Exchange enrollment numbers down 3.3% (mostly in under 35 demographic)
Looking ahead: 2018 and beyond

U.S. Department of Health and Human Services (HHS) makes strategic changes to support the Administration

- HHS budget eliminated future risk corridors funding to insurers --> move could discourage insurers from offering plans in the marketplace.

- IRS enforcing the individual mandate penalty but HHS issuing exemptions from the mandate based on personal ‘hardships’ that would dismiss penalty owed (homelessness, eviction, foreclosure, domestic violence, death of a close family member, unpaid medical bills, etc.).
Looking ahead: 2018 and beyond

Litigation re Trump Administration’s ruling to bypass ACA birth control requirements

- Massachusetts, March, 2018 – Federal judge dismissed lawsuit over Administration’s ruling, which allows any company to seek an exemption to ACA’s provisions on birth control based on moral or religious grounds.

- California and Pennsylvania, December, 2017 – Judges issued preliminary injunctions blocking the administration from enforcing the ruling.
Looking ahead: 2018 and beyond

A few states received “waivers” which allow them to change some ACA health plan requirements. These changes must:

• Provide equally comprehensive coverage to at least the same number of people,
• Not increase individuals’ out-of-pocket costs, and
• Not cost the federal government more than it would spend under the provisions of the ACA.
Looking ahead: 2018 and beyond

So far, most waivers allow the states to establish a state-run reinsurance program; however some states’ waiver applications have been rejected.

CMS says “the Affordable Care Act remains the law”.
Looking ahead: 2018 and beyond

Giving states more control to tweak ACA requirements is creating a landscape in which some states pursue initiatives to keep or expand the ACA, while others take actions to lessen the law’s effectiveness.

Coming years could see a growing gulf on issues such as Medicaid benefits, consumer protections, insurer regulations, and the availability of cheaper, less-comprehensive health plans.
Current polls suggest healthcare is the number one concern heading into the mid-term elections.
Health Care Reform and Medicaid

Most of the provisions of the ACA repeal and replace attempts focused on changes to the Medicaid program, which is a cornerstone of the Affordable Care Act.

- 32 states and D.C. accepted Medicaid expansion under the ACA
- Texas and 17 other states did not expand eligibility for Medicaid
- 72.3 million Americans were enrolled in Medicaid in 2017
Medicaid Section 1115 Waiver

Allows a state to receive federal Medicaid matching funds to operate its Medicaid program in ways not otherwise allowed under federal rules. Current Administration is allowing states more flexibility in their programs as long as there is no impact to federal funding amounts.

Waivers have been approved for program variances including:

- Drug screening and testing
- Premium surcharges for tobacco users
- Eligibility time limits
- Work requirements

Texas has 1 approved and 1 pending waiver; but no work requirement.
• Arkansas received approval in March, 2018 for the strictest work requirement yet.
• Adults without children required to actively look for a job or work at least 80 hours per month.
• Locked out of health coverage for the remainder of the plan year if they don’t comply.

• Currently, 3 states have imposed work requirements as a condition of eligibility for Medicaid: Arkansas, Indiana, and Kentucky.
• 7 other states have waiver applications pending that would impose work requirements.
Work Status and Reason for Not Working Among Non-SSI, Nonelderly Medicaid Adults, 2016

- Working Full Time: 42%
- Working Part-Time: 18%
- Not Working Due to Illness or Disability: 14%
- Not Working Due to School Attendance: 6%
- Not Working Due to Caregiving: 12%
- Not Working for Other Reason: 7%

Total = 24.6 million

Notes: “Not Working for Other Reason” includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one job.
Industry Reactions to Healthcare Reform Efforts
Trending: Healthcare Industry Mergers

- United Healthcare bought Optum (before ACA)
- Cigna buying Express Scripts (March 2018)
- CVS Caremark buying Aetna (Dec. 2017)

Post-merger, these 3 companies will:

- Insure more than 90 million people
- Process more than 70% of all U.S. prescriptions
- Generate more than $500 billion in revenue

- Will Walmart buy Humana??
Trending: Amazon in the Healthcare Business?

- **Amazon**: largest online retailer
- **Berkshire Hathaway**: most famous investor (Warren Buffett)
- **JPMorgan**: largest U.S. bank by assets

The trio announced an alliance in January 2018. They intend to manage health care for their combined 1.2 million employees.

In addition, Amazon is positioning itself to impact the pharmacy supply chain, dominate sales of durable medical equipment and medical supplies, and use its existing Alexa technology for telemedicine and in-home health care applications.
Trending - Hospital systems are hiring individual physicians and purchasing group practices

- As hospitals acquire physician groups, costs increase
- The number of hospital-employed physicians reached 155,000 in 2016, an increase of 63 percent from 95,000 in 2012
Healthcare Reform vs. Healthcare Spending
The 2 Fundamental Issues in Healthcare Reform:

COST

ACCESS

The ACA and various replacement attempts were intended to impact ACCESS to health care*, but don’t significantly address the COST.

*Access to care was increased by way of insurance coverage, either through Exchange Marketplace, Medicaid, or expanded Employer benefits.
The U.S. spends twice as much on healthcare as a percentage of its economy compared to other developed countries. Totaling $3.3 trillion or 17.9 percent of GDP in 2016.
2016 Healthcare Spending By Source Of Funds

- $352.5 billion
- $672.1 billion
- $1.1 trillion
- $565.5 billion

- Medicare
- Medicaid
- Private Insurance*
- Out of Pocket

* Employer-sponsored and individual health plans
Why is health care spending in the U.S. so much greater than other high-income countries?

Harvard Global Health Institute compared potential drivers of spending in the United States with 10 of the highest-income countries to gain insight into what the U.S. can learn from these nations.

United Kingdom | Canada | Germany | Australia | Japan | Sweden | France | the Netherlands | Switzerland | Denmark

Review includes single-payer systems and competitive private insurance markets.
U.S. Health Care System: Common Assumption #1

We rely too much on specialty care.

Findings when compared to other peer nations

- The U.S. landed in the middle of the road when comparing health system function measures.
- The study found that 43 percent of U.S. doctors practice primary care medicine, about typical for the group.
The system is wasteful.

Findings when compared to other peer nations

The U.S. had similar rates of utilization for:

- Acute myocardial infarction
- Pneumonia
- COPD
- Hip replacements
- Knee replacements
- Coronary Artery bypass graft surgery
- Hospital beds
U.S. Health Care System: Common Assumption #3

Too many patients getting unnecessary services

Findings when compared to other peer nations

Study shows that patients in the United States went to the doctor or hospital less often compared to the group.
Two Areas Where The United States Is Different Than Other Nations

1. The U.S. pays more for medical services, including hospitalization, doctors’ visits and prescription drugs.

2. Our complex system causes us to spend much more on administrative costs.
Where The U.S. Ranks Higher Than Peer Nations In Healthcare Spend

- For **pharmaceutical costs**, spending per capita was $1,443 in the U.S. vs a range of $466 to $939 in other countries.

- **Administrative costs of care** accounted for 8% in the U.S. vs a range of 1% to 3% in the other countries.
Where the U.S. ranks higher than peer nations in healthcare spend

• Top tier for use of certain medical services, including imaging tests and surgical procedures.

• Physician and nurse salaries

• Highest rates of poverty and obesity among all peer nations
How Much Are Hospitals Marking Up Drug Prices?

On average, hospitals mark up medication prices nearly 500 percent, according to an analysis.

- Cancer
- Autoimmune disorders
- Arthritis

Analysis compared 20 different physician-administered medications across a range of therapeutic areas.
Hospitals receive 2.5 times what they paid to acquire these medications (after price negotiations).
Health Care Fraud and Waste

**FRAUD**

- Civil health care fraud cases have recovered $21.6 billion since 2009
- 89 defendants charged in 2013, 412 in 2017
- 1/3 of health care waste is attributed to fraud

**WASTE**

- In 2012 the National Academy of Medicine estimated the U.S. health care system squandered $765 billion a year, more than the entire budget of the Defense Department.
CMS analysis shows that the increase in spending differs by the source of the health insurance:
**Medicare, Medicaid or Private insurance.**

Scholars added another health spending bucket to the three used by CMS for comparison.
Accounting for Health Care Spending Growth

CMS Data show national health spending grew an average of 4.8% from 2008-15.

<table>
<thead>
<tr>
<th>Program</th>
<th>Growth from 2008-15</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>• From 2008-15, spending grew 5.4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>• From 2008-15, spending grew 7.4%</td>
</tr>
<tr>
<td>Private Health Insurance</td>
<td>• From 2008-15, spending grew 4.8%</td>
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Projected growth from 2017-26 is 5.6 percent per year.
Distinctive Factors Accounting for Growth in Spending by Payer

Medicare

• Some spending growth due to enrollment increases.
• 61 percent can be traced to the growth in the prevalence of treated disease; diabetes spend growth=>nearly 25 percent
• 4 percent rise in prevalence of behavioral disorders

Per capita spending growth from 2008-15
Distinctive Factors Accounting for Growth in Spending by Payer

Medicaid

- Bulk of spending growth due to enrollment increases like Medicare
- Much of the growth is tied to the rising prevalence of disease
- 2.5 percent rise in prevalence of behavioral disorders to 19 percent

Per capita spending growth from 2008-15
Distinctive Factors Accounting for Growth in Spending by Payer

Private Insurance

In contrast to Medicare and Medicaid, 85% of the growth in spending per enrollee in private health insurance can be linked to the growth in spending per case treated.

Per capita spending growth from 2008-15
THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S NATIONAL CENTER FOR
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION (NCCDPHP)

1 in 2 Adults in the US has a chronic disease & 1 in 4 Adults in the US has two or more

CHRONIC DISEASES
Leading Causes of Death, Disability, and Health Care Costs

- Heart Disease
- Cancer
- Chronic Lung Diseases
- Stroke
- Alzheimer's Disease
- Type 2 Diabetes

COUNTY MANAGEMENT & RISK CONFERENCE
APRIL 4-6, 2018 | GALVESTON | RESOURCES AND SOLUTIONS FOR COUNTIES
Percent of Chronic Diseases Caused by Lifestyle

- Cancers: 71%
- Stroke: 70%
- Heart Disease: 82%
- Diabetes (Adult Onset): 91%
Conclusion:

1. Status of ACA Repeal and Reform Efforts: in flux but ACA is still the law

2. Industry Reactions to Healthcare Reform Efforts
   mergers and acquisitions + Amazon

3. Healthcare Reform vs. Healthcare Spending
   Reform efforts need to focus on reducing amount of chronic illness.