The Affordable Care Act
And Health Care Reform
“A Work In Progress”

Kim D. Slocum
President
KDS Consulting, LLC
May 16, 2013
"This is a really big [bleeping] deal!"
Seventy Thousand Pages Of Subsequent Regulation—And Still Counting
Three Years Post-Passage, Still Much We Do Not Know
Average Health Care Spending Per Capita, 1980–2010
Adjusted For Differences In Cost Of Living

Dollars ($US)

- US ($8,233)
- NOR ($5,388)
- SWIZ ($5,270)
- NETH ($5,056)
- DEN ($4,464)
- CAN ($4,445)
- GER ($4,338)
- FR ($3,974)
- SWE ($3,758)
- AUS ($3,670) *
- UK ($3,433)
- JPN ($3,035) *
- NZ ($3,022)

* 2009

Source: OECD Health Data 2012.
The U.S. Spends More on Health Care Than Any Other Nation

Here’s What the U.S. Could Do Today If It Spent Only as Much on Health Care Over the Past 30 Years as the Second-Highest-Spending Country

Average Health Care Spending Per Person

The cumulative difference in health spending between 1980–2010 is nearly $15.5 trillion

With $15.5 trillion we could:

- Transform our $11.6 trillion federal debt into a $3.9 trillion surplus
- Send 175,401,721 students to a four-year college
- Cover an area the size of South Carolina with solar panels
- Buy everyone in the world 4 iPads

Source: 2012 OECD Health Data.
The Federal Government Has A Health Care Problem, Not A Debt Problem

HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE DEBT

Health Care Spending

Social Security

Discretionary Spending (Defense and Nondefense)

Other Mandatory Programs

% of GDP

Source: Congressional Budget Office (August 2011)

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In 2012, Nearly Half Of Adults (19-64) Were Uninsured During The Year Or Were Underinsured

- Insured all year, not underinsured: 54% (100 million)
- Uninsured during the year: 30% (55 million)
- Insured all year, underinsured: 16% (30 million)

184 million adults ages 19–64

SOURCE: THE COMMONWEALTH FUND
US Health Care’s Long Term Futures

OUT-OF-POCKET COSTS INCREASE DRAMATICALLY
Red meat (not just skin) in the game

OR

PRICE CONTROLS BECOME COMMON
“All payer” rate setting—global budgets, outright caps

OR

WE “BEND THE CURVE”
Improved coordination, measurement, and evaluation of care plus reimbursement reform
ACA—Perception And Reality

- **Perception**—ACA deals only with improving access to health insurance coverage.
- **Reality**—ACA also uses provisions related to insurance coverage to exert leverage on health care spending growth (for at least a part of the market).
Two Routes To Coverage Expansion

- Public exchange
  - With subsidy (up to 400% FPL)
  - Without subsidy (above 400% FPL)
- Medicaid
  - From 100%-138% FPL
  - Potentially 14 million new enrollees over ten years
  - Pressure on states from hospital industry and large employers with low-wage workforces
- Most health plans participating in exchanges also anticipating Medicaid participation minimize “churn” and maximize continuity of care
Note: Some states’ governors are accepting federal government’s aid in setting up state exchanges, however they are facing resistance from their state legislatures in places such as Arizona, Florida, and Ohio to expand Medicaid. Additionally, Maine’s governor has now entered talks with the Obama administration to accept money for Medicaid expansion. 
Health Insurance Exchange Participation—State Level

What the States are Saying - March 13, 2013
Type of Insurance Exchange

Note: As of 3/13/13 all policies subject to change. The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

Learn more about the Medicaid expansion at advisory.com/MedicaidMap

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Federal Subsidies Will Likely Be Extensive—And Expensive

- Premium support (to 400% of FPL) and out-of-pocket cost sharing (to 250% of FPL)
- 100% of Medicaid expansion costs for first three years, 90% thereafter
- As much as $300 billion in new spending per year
- Administration has major commitment to success of law, and significant financial stake as well
Constraints On Private Insurers Working With Exchanges

- “Actuarial Value” (60%-90%)
- “Essential Health Benefits”
- Limitations on:
  - Medical underwriting
  - Recissions
  - Age banding of premiums
  - Cost shifting to consumers
  - Annual premium increases
- Plans must move from “picking risk to manage” to “managing risk that picks them” (managed care must manage care)
Large Employers—
Between A Rock And A Hard Place

- 60% minimum Actuarial Value
- ACA requirement
- 2018 “Cadillac Tax”
Large Employers Face A Significant Choice

Today
“Nip & Tuck”
Annual trend mitigation from buy-downs & other cost shifting tools

Shift Risk
Defined Contribution “Exit Strategy”

Manage Risk
More involvement with delivery system—pressure on pricing & utilization
Commercial Rate Compression Is A Near Certainty

Percentage of Hospitals Receiving Inpatient Commercial Payment Rates That Are Above and Below the Expected Medicare Rate

- 11% of Hospitals Above 2x Medicare Payment
- 26% Above 1.5x Medicare Payment
- 55% Above Medicare Payment
- 8% Below Medicare Payment

The greater the commercial payment rate, the greater the potential risk.
Base: All Provider Systems
Are you preparing your cost structure to break even on Medicare, over the next five years?

Base: All Provider Systems: In order to be able to make money on Medicare, please indicate which of the following your hospital will have to do.
“Narrow Networks” Of Providers Needed To Maintain Plan Affordability

Another Big Step in Reshaping Health Care

February 28, 2013

Hospitals and health insurers are locking horns over how much health-care providers will get paid under new insurance plans that will be sold as the federal health law is rolled out.

The results will play a major role in determining how much insurers will ultimately charge consumers for these policies, which will be offered to individuals through so-called exchanges in each state.

The upshot: Many plans sold on the exchanges will include smaller choices of health-care providers in an effort to bring down premiums.
The “New Normal” Delivery System

• “Accountable” organizations (e.g. ACOs/PCMHs)
• Fewer, larger players as hospital merge/affiliate and acquire physician practices
• New alliances as health plans create partnerships with new provider organizations to provide “wrap-around” services
• More “at risk” outcomes-based payment models—provider decision making based on expected clinical results
Markets Will Develop At Different Rates

SOURCE: Sg2 Analysis (2012)
“You’re Only As Good As Your Numbers”
Aggregate Data Vital For ACOs

- Managing shared information across multiple providers
- Coordinate patient care from several affiliated sites
- Analyze trends and document outcomes in “prospective payment” world
- Quality improvement (vs. measurement) requires evidence-based active outreach to providers

Although it will be a while before true population level health management is possible, the required framework is under construction

“It is not enough just to possess information systems or extract the important data. The ability of an organization to leverage the technology to perform sophisticated data mining and analysis in real time for continuous care improvement is critical for long-term organizational sustainability.”

-Hospitals And Health Care Systems Of The Future (AHA—Sept. 2011)
The Business Model For Dominant Providers Will Change

- **Vendor**
  - "Own the Encounter"

- **Orchestrator**
  - "Own the Disease"

- **Owner**
  - "Own the Population"

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**Scope of Services**
- Comprehensive
- Focused

**Risk/Revenue Mix**
- Fee for Service
- Accountable Payment

**System of CARE**

**Change**

- Integrated Health Enterprise
There Will Be Varied Sustainable Niches

SCOPE OF OPERATIONS

Fee for Service
- Contracted Providers
- Narrow

Major Regional Players

At-Risk Models
- Population Health Managers
- Broad

SOURCE: KaufmanHall
Trading Partners Coming Together In New Ways

- Hospitals
- Physician Groups
- Health Plans
- Alternate Site Providers
- Other Actors (including Private Equity)

- 69% of Hospitals own Medical Group
- 34% of doctors owned by health systems

- DaVita Healthcare Partners
- Optum-Monarch
- Wellpoint-CareMore
- Vanguard
- Humana Concentra
- Dignity Health
- Penn Allegheny
- Blackstone
- Highmark-West

34% of doctors owned by health systems
Where We Stand

- Estimated 400+ such organizations in development (and counting)—about half participating in Federal ACO program
- More physicians becoming employees of hospitals
- Over thirty private sector insurance contracts involved some form of shared savings or shared risk
- “Bus has left the station…”
- **BUT…**
  - Lots of moving parts must come together quickly ("anatomy" vs. "physiology")
  - “When one door closes, another opens, but it can be hell in the hallway” (Hospital CEO)
Which Line Is Real?

Projected Medicare Spending as a Share of GDP, 2013–2085

Source: Medicare Trustees (2012); Social Security Trustees (2012); CEA calculations.
Why ESRD Matters

- ESRD <1% of Medicare beneficiaries, but 5% of Medicare spending (~$30 billion—6.9%)
- Over $65,000 per ESRD beneficiary (vs. ~$11,000 for all Medicare beneficiaries)
- “…An ounce of prevention”

SOURCE: MedPAC Data Book
Furthermore...Most Of ACA Challenges Either Have Affected, Or Are Affecting Dialysis

- Revisiting provider business models
- Bundled payments
- Role of expensive specialty Rx products
- Consolidation/economies of scale
- Health care IT & information exchange
Predictions

- Your financial fate likely tied to more strategic Medicare/Medicaid reforms
- What level of urgency does Congress/White House perceive?
- In short-term (~3 years) big structural changes unlikely (especially for Medicare)
- Most cost reductions will come from reductions in provider payments (implicit or explicit)
Hospitals/Dialysis Centers/Medical Groups As Employers

- Avoid chasing “shiny objects”
  - Cost shifting to employees
    - Consumer Directed Health Care, popular but flawed concept
    - Embrace “value-based” benefit design instead—make it easy to do the right thing
  - Wellness/preventions programs as cost trend mitigation strategy
- “Eat your own cooking”
  - If involved with accountable-type organizations, try out interventions on your own population first
  - “Private-label” insurance program
Summing Up…

- The ACA represents an attempt at delivering a “soft landing” for the US health care system.
- Much we still do not know, but in implementation the law will try to address both coverage and cost issues.
  - Health plans, employers and Federal government will all exert pressure on providers.
  - Delivery system is responding, but it may be a while before we can determine success or failure—transition will continue to be bumpy.
- Dialysis/ESRD represents a microcosm of many ACA implementation issues.
- As large employers, there are steps you can take to exploit your unique position as both payer and provider.
In Closing...

“"You can always count on Americans to do the right thing - after they've tried everything else."” --Winston Churchill

...Thank You