Politics for Neurology Chairs

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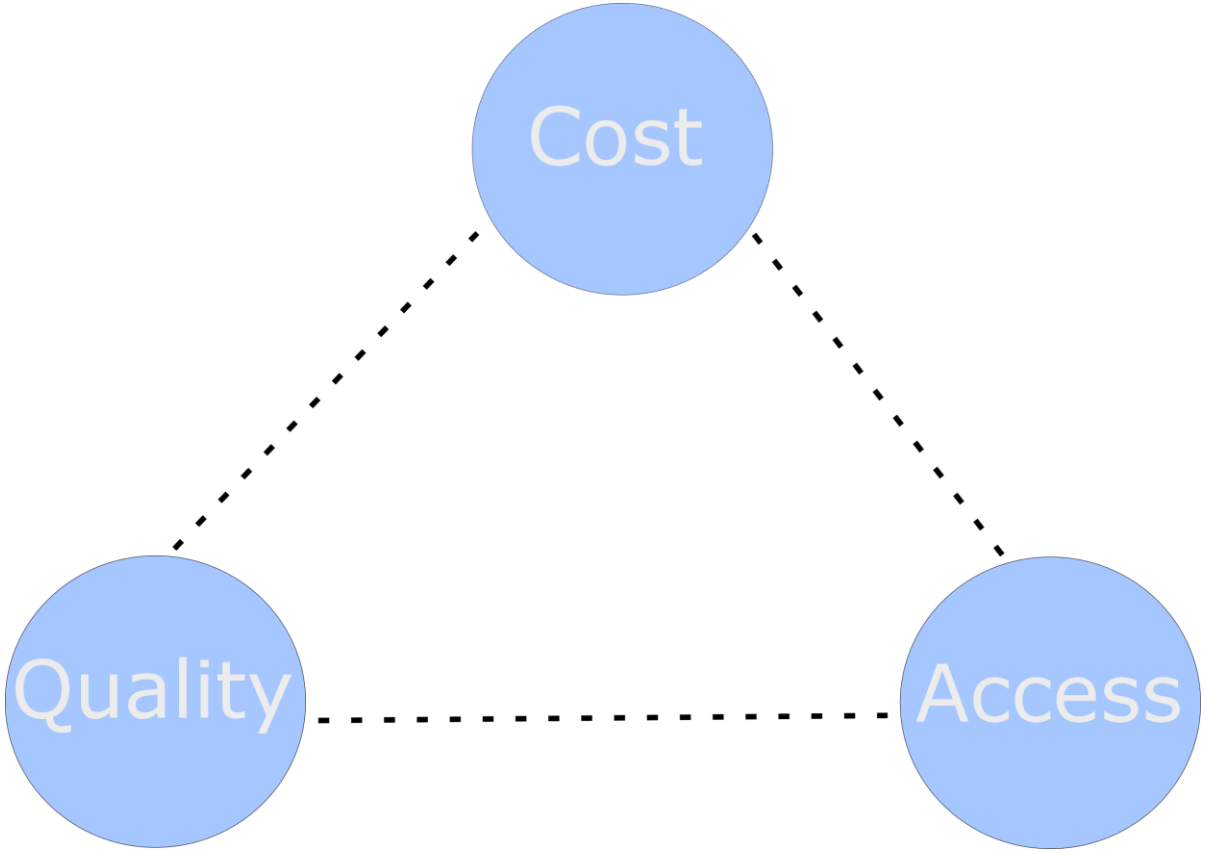
Agenda

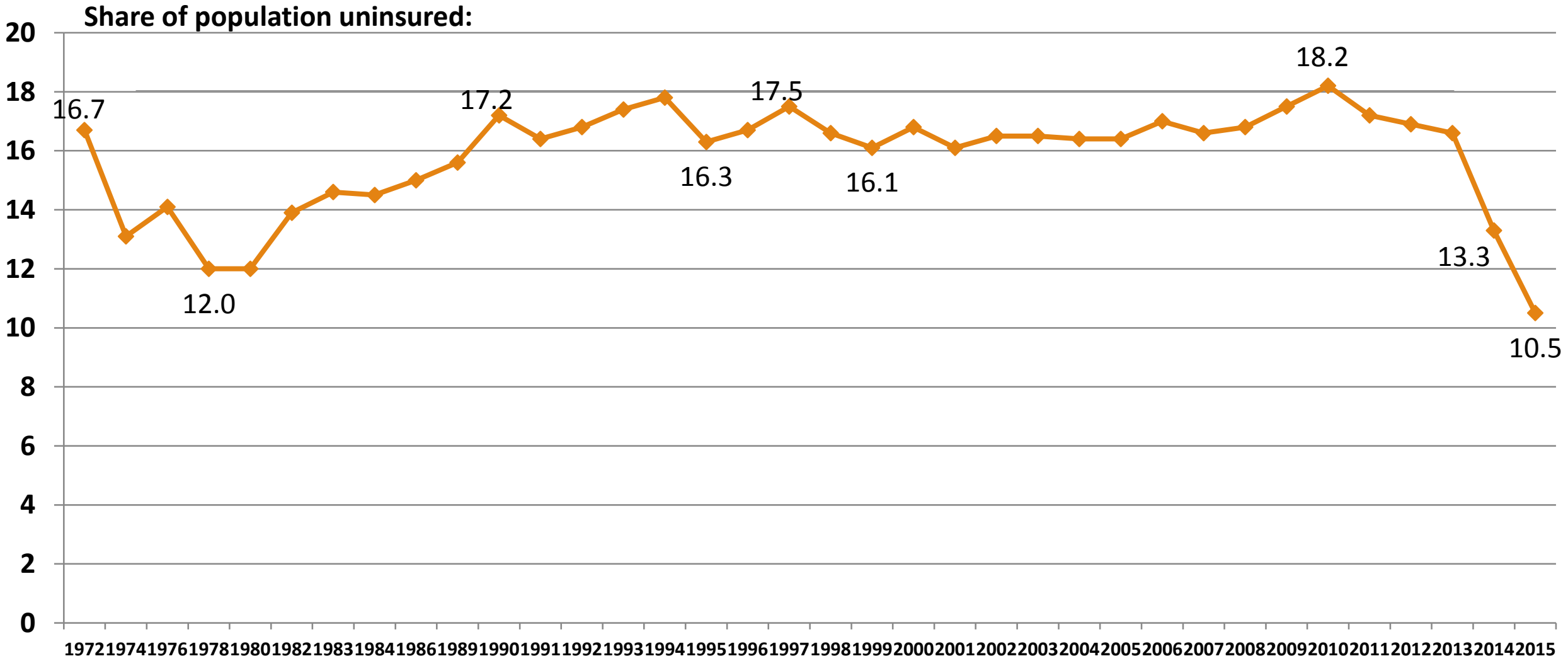
- Progress on Access, Cost, and Quality
- Pathology
- Whither the Affordable Care Act?
- Options to achieve universal coverage

Access Quality Cost triangle



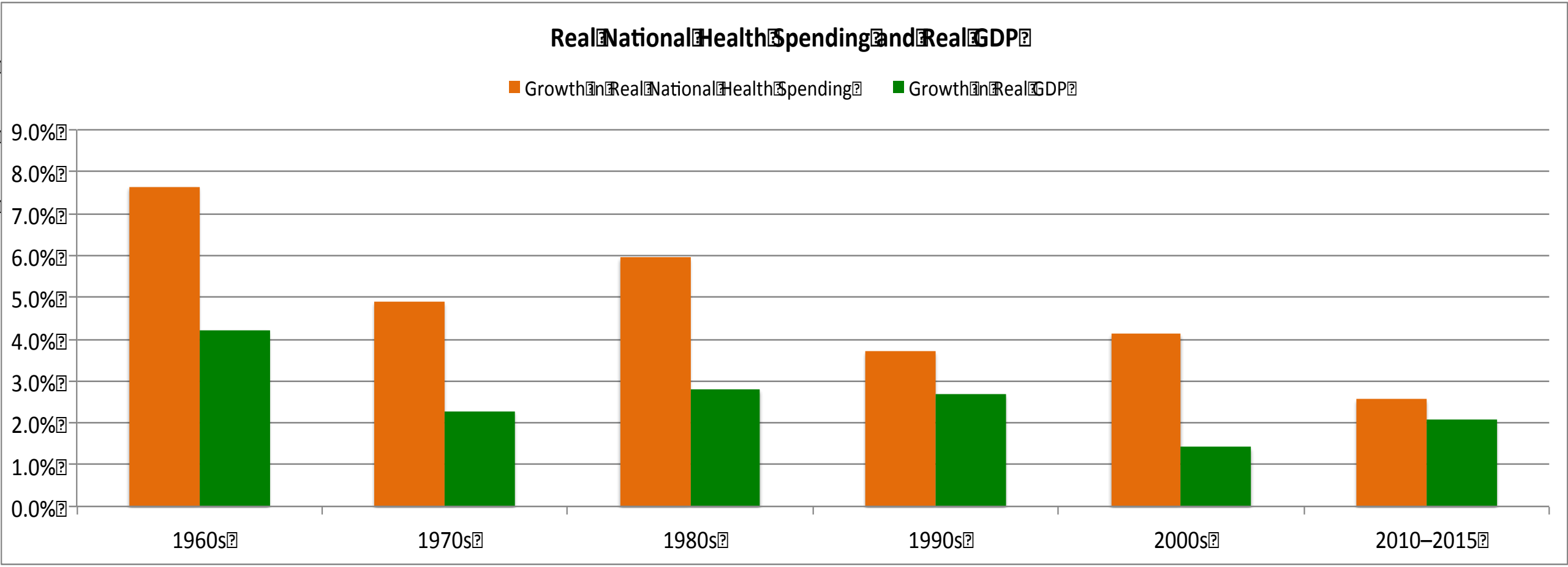
PROGRESS

Uninsured Rate Among the Nonelderly Population, 1972-2015



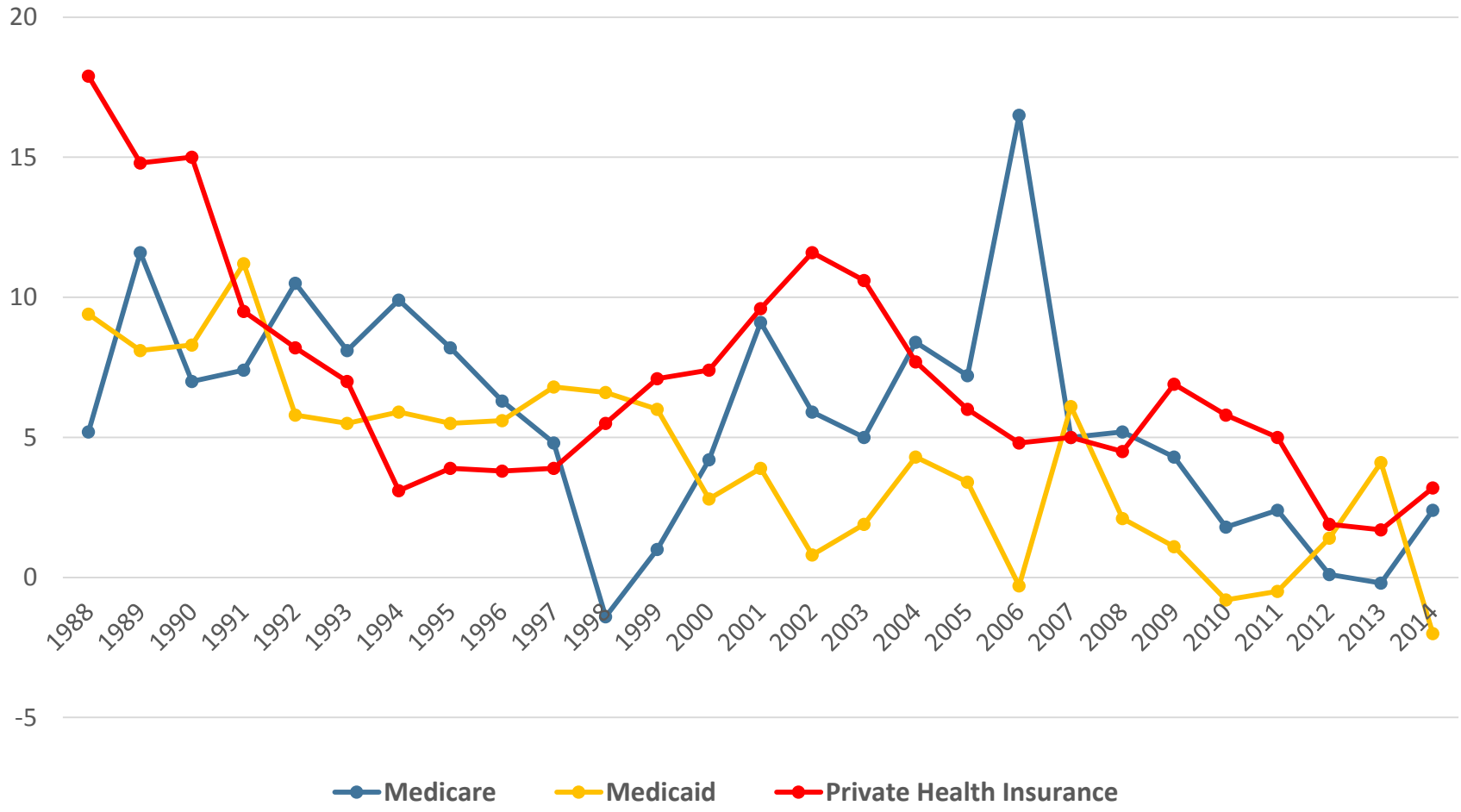
Source: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf.

Health spending growth has slowed, and was close to being on pace with economic growth from 2010-2015



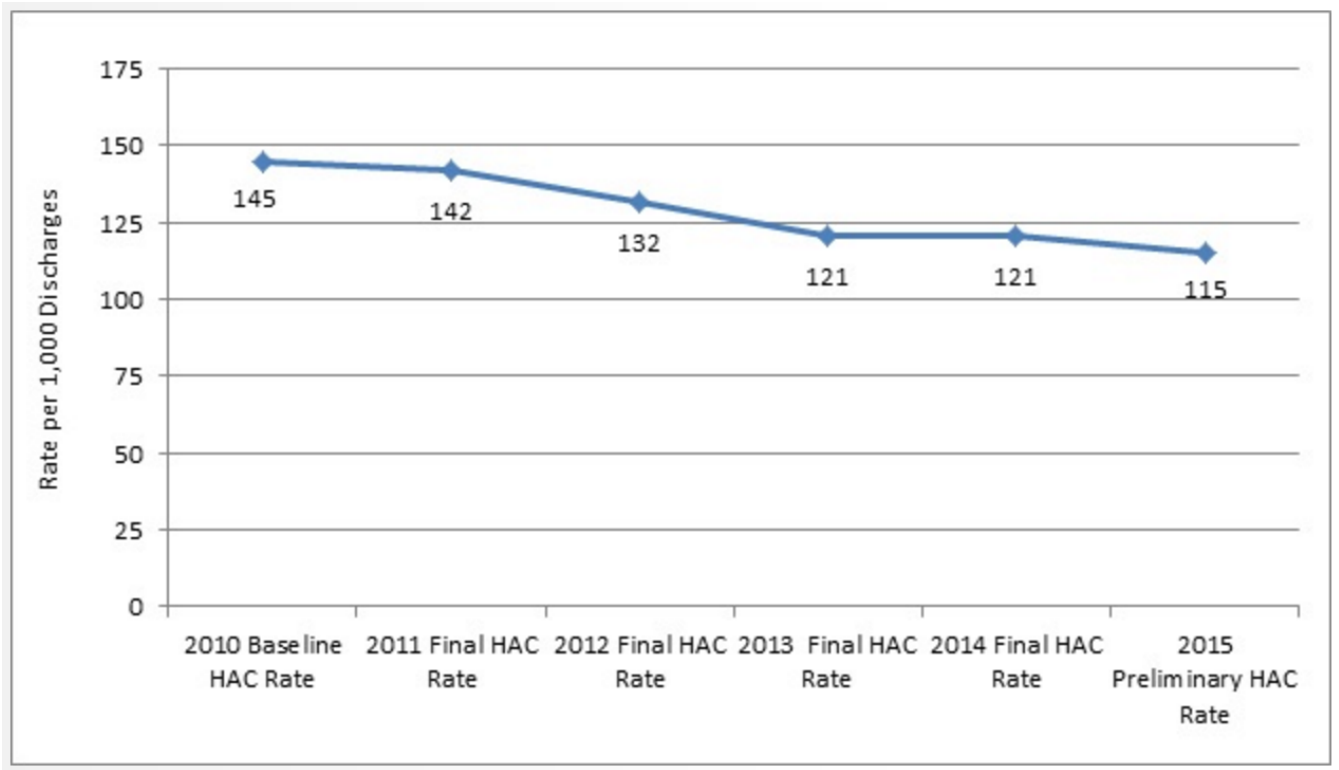
Source: Author's analysis of National Health Accounts and price data from the Bureau of Labor Statistics

Annual change in expenditures per insured person for private insurance, Medicare, and Medicaid, 1988-2014



Source: CMS National Health Accounts, Table 21

Adverse Events per 1000 Hospitalizations, 2010 to 2015



Source: AHRQ National Scorecard Estimates from Medicare Patient Safety Monitoring System, National Healthcare Safety Network, and Healthcare Cost and Utilization Project.

Improvements in Patient Safety 2010 - 2015

21% reduction in HACs

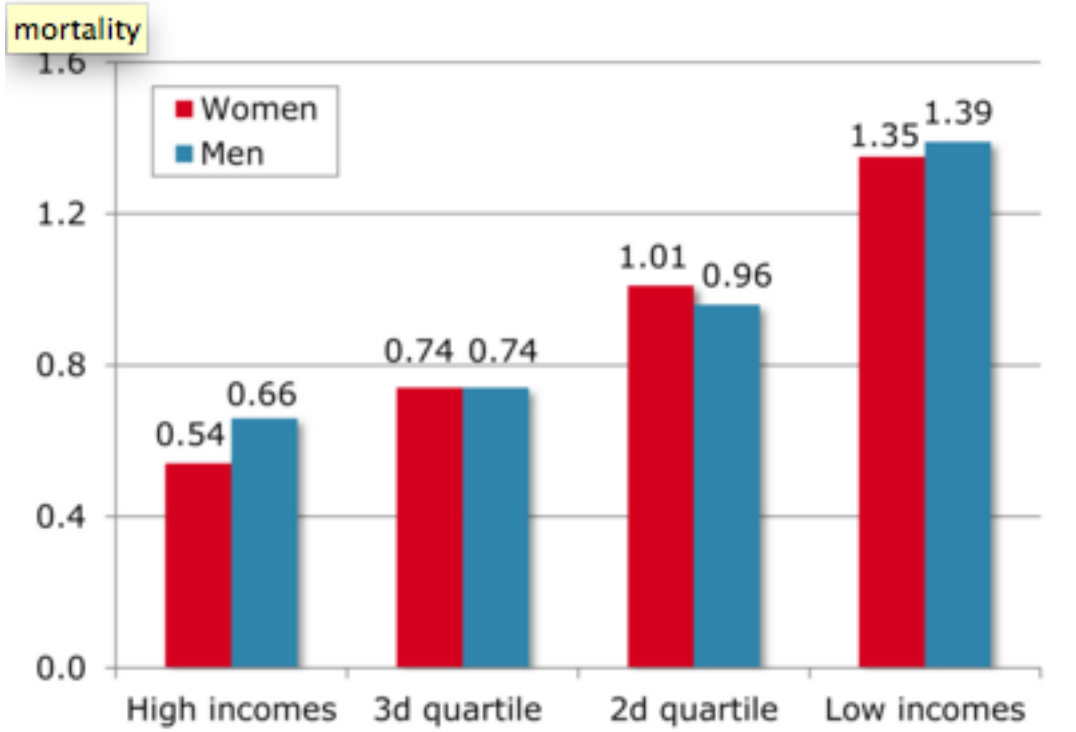
124,000 lives saved

3.1 million patient harms avoided

$28.2 billion in savings

PATHOLOGY

Death Rates Rise as Incomes Fall*



Source: Brookings Institution.
* Annual death rates shown between 1992 and 2010 for individuals ages 50-74. The rates equal the mortality rate of each income group divided by the mortality rate for the entire age 50-74 population. If the rate exceeds 1, people in that income group are more likely to die than the overall population.

Access Pathologies

Continuation of a fragmented system with tens of millions of people uninsured and many inequities

High deductibles and out of pocket costs, creating access barriers for low-income people

Cost Pathologies

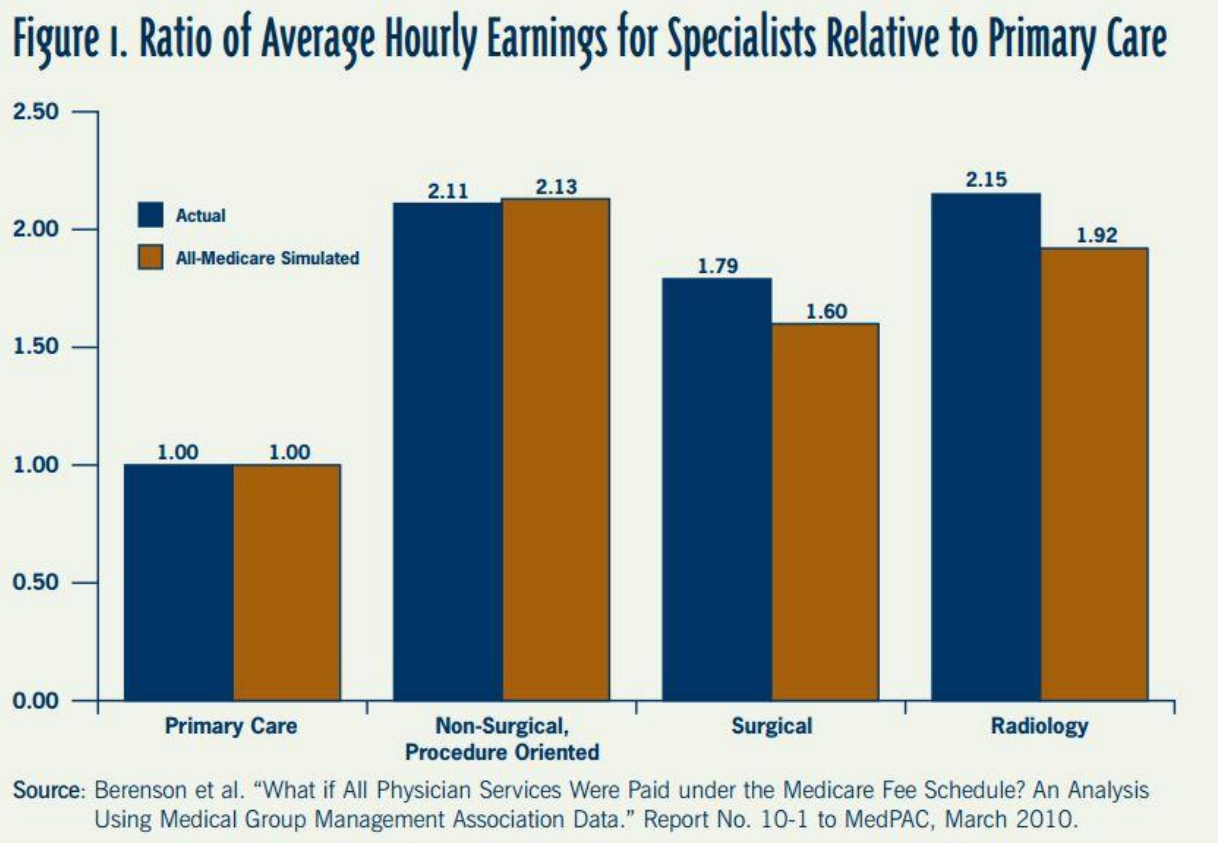
Primary care still undervalued

Still primarily Fee-for-Service, rewarding volume

High administrative costs

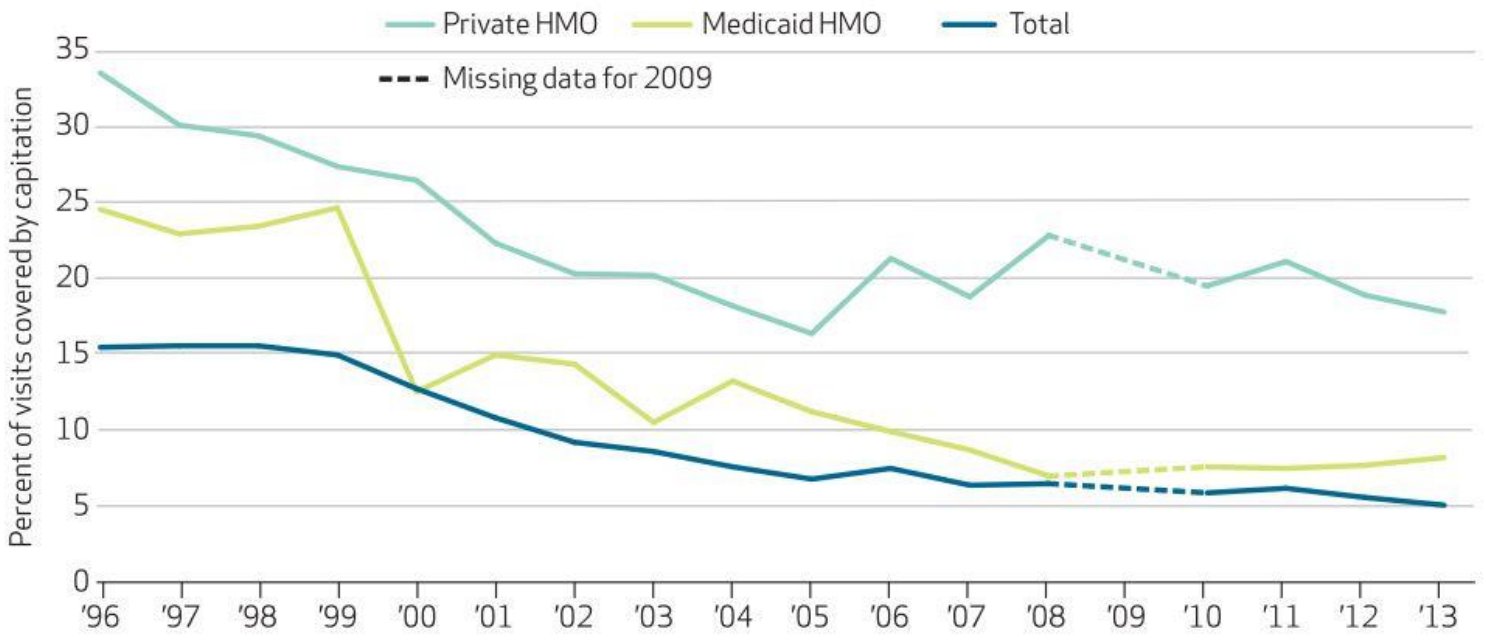
High prices

Ratio of Average Hourly Earnings for Specialists Relative to Primary Care



http://www.nihcm.org/pdf/NIHCM-EV-Berenson_FINAL.pdf

Percentage of US office-based physician visits covered under capitation arrangements



SOURCE Authors' analysis of data from the Medical Expenditure Panel Surveys, 1996–2013. **NOTES** Office visits among the US community-dwelling population. Actual data from 2009 were omitted because of incomplete follow-up with capitated providers in that year. For purposes of continuity in the exhibit, the value for 2009 was interpolated as halfway between the values for 2008 and 2010. HMO is health maintenance organization.

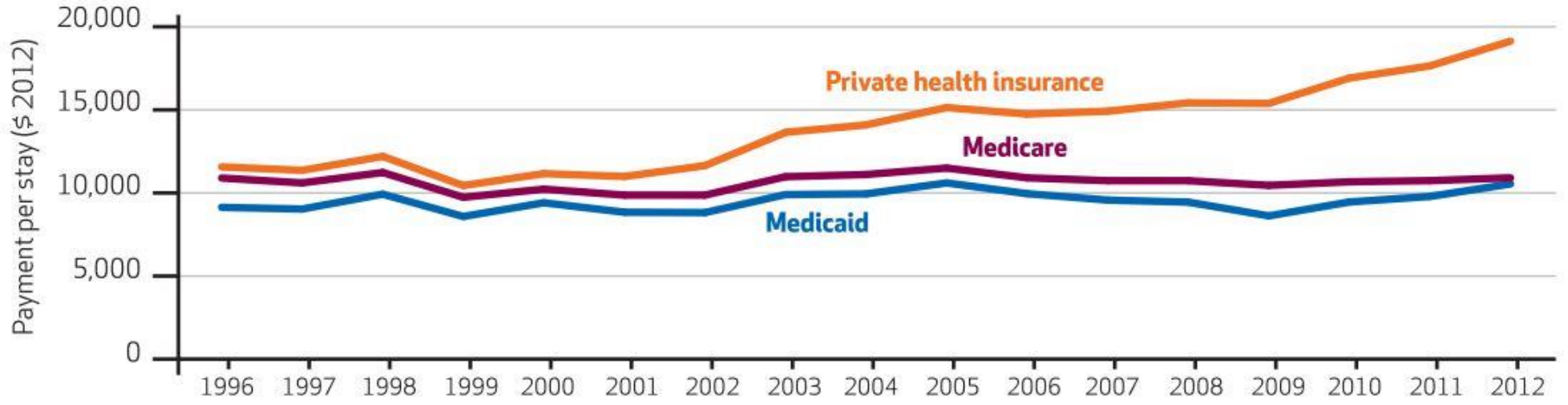
http://content.healthaffairs.org/content/35/3/411.full.pdf+html

Costs of Health Care Administration in the United States and Canada, 1999

Table 1. Costs of Health Care Administration in the United States and Canada, 1999.

Cost Category	Spending per Capita (U.S. $)	
	United States	Canada
Insurance overhead	259	47
Employers' costs to manage health benefits	57	8
Hospital administration	315	103
Nursing home administration	62	29
Administrative costs of practitioners	324	107
Home care administration	42	13
Total	1,059	307

Average Standardized Payment Rates Per Inpatient Hospital Stay, By Primary Payer, 1996-2012

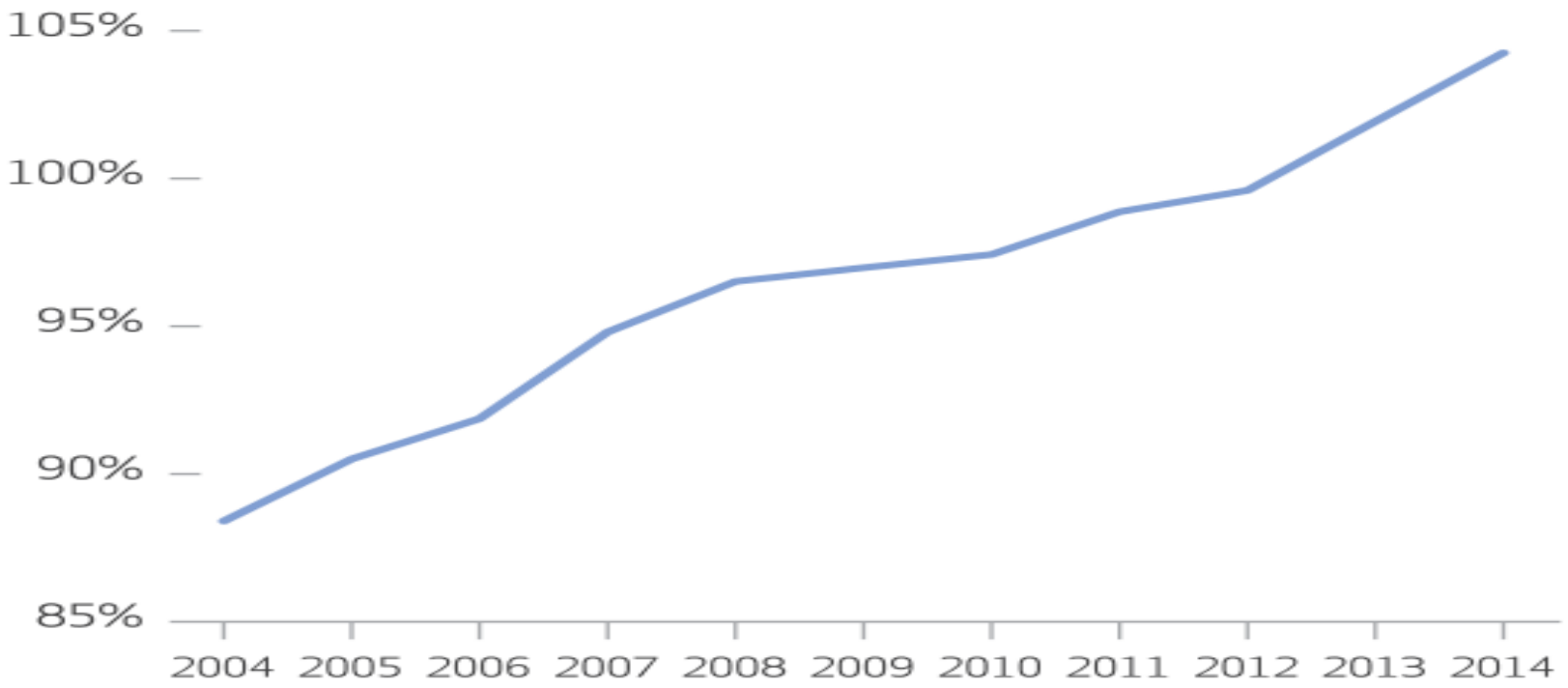


SOURCE Authors' analysis of data for 1996–2012 from the Medical Expenditure Panel Survey. **NOTES** The average payment rates were computed as if each primary payer paid for all nonmaternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays. Estimates and standard errors can be found in online Appendix F and Appendix Table F.1 (see Note 9 in text).

http://content.healthaffairs.org/content/34/12/2147.full.pdf+html

EXHIBIT 1

Average risk score of Medicare Advantage enrollees as a percentage of the average risk score for fee-for-service Medicare enrollees, 2004–14



SOURCE Centers for Medicare and Medicaid Services, personal communication, January 8, 2016. **NOTE** All estimates used the version of the CMS Hierarchical Condition Category (CMS-HCC) model that was phased in starting in 2014 and excluded diagnoses that were not included in earlier versions of the model.

Quality Pathologies

Underinvestment in public health

Imperative to ‘pay for value’ when we have very limited ability to measure it (and underinvestment in developing measures)

Lack of care coordination, particularly for patients with chronic care needs

Insufficient attention to patient preferences, and insufficient involvement of patients in decision making

Insufficient attention to and rewards for safety and process improvement

Electronic Health Records not yet interoperable; valuable information often not available to clinicians and patients

Trump's Assault on the ACA

Even an HHS fully committed to making the Federal Marketplaces work had many troubles

HHS appears to be committed to undermining the market for individual insurance:

- Announced discontinuation of Cost Sharing Reduction (CSR) payments
- Shortened open enrollment (OE) from 12 weeks to 6
- Shutting down the web site during OE for maintenance at strategic times
- Slashed an already inadequate marketing budget from $100 M to $10 M, and cut support for navigators by 60%
- May direct the IRS to not enforce the 'individual mandate'
- Is continually telling people that the ACA is on the verge of collapse, and discouraging enrollment
- Is attempting to encourage 'association' plans, further undermining the individual market
- HHS hiring freeze is diminishing the capacity to get anything done

Expected consequences of the assault on the non-group insurance market

Higher premiums for non-group insurance

Fewer people purchasing non-group coverage

- Healthy people more likely to drop coverage than the sick, further increasing premiums

Increase in federal government expenditure as a result of discontinuation of CSR payments

States, like CA, that operate their own marketplaces will largely be able to insulate themselves from the assault (although non-enforcement of the individual mandate will hurt a bit)

We should expect health insurers to push back hard, but not clear that Congress will be willing to act, or that the Administration will care

When premiums go up in 2018, and again in 2019, will people blame Trump, or believe his claim that the ACA was imploding?

Medicaid policy

Medicaid is a federal-state partnership, in which the federal government pays a share (averaging around 60%) of what each state spends, as long as state spending conforms to a set of federal rules

In the ‘repeal and replace’ bill that passed the House, financing was converted to a ‘per capita cap’, in which federal payments to each state would be capped at the status quo level of per capita spending, and would grow at the rate of the Medical Care CPI

Senate came close to passing a similar bill

Republicans in Congress have not given up on transforming Medicaid from a defined benefit to a defined contribution system

Medicare Policy

Speaker Paul Ryan has long wanted to transform Medicare from a defined benefit to a defined contribution system

Speaker Ryan has not been able to generate much traction for this proposal yet

Seems likely that Medicare spending will increase more quickly under Republican control than under Democratic control, but many uncertainties

Secretary Price slowed, and partially reversed, CMS efforts to move towards bundled payments; unclear what the next Secretary might do

MACRA and MIPS in for turbulent times

Summary

- Progress
  - 20 million fewer people uninsured
  - Cost growth closer to GDP growth than any time over the past 50 years
    Medicare spending per beneficiary growing especially slowly
  - Some momentum towards increasing the value of primary care, and attention to population health
- Pathology
  - 28 million still uninsured; many other underinsured
  - High prices for many goods and services; volume still rewarded financially
  - Insufficient rewards for quality and safety
- An uncertain future, with clear expectation of moving backwards on access, and high likelihood of moving backwards on cost; less clear what effect there will be on quality/delivery system reform