H2C PERSPECTIVES

Why What Might Happen to the ACA is the Least of Your Worries (If You're a Healthcare Provider)

June 30, 2017

Most participants in the healthcare sector, whether they are a provider (health systems, physicians) a payor (health plans), an employer or a consumer (patients) of healthcare services, have consistently expressed concerns about the uncertainties and potential disruption of businesses or lives created by proposed changes in healthcare policy. A central promise of President Donald Trump and the Republicans during the 2016 election campaign was to quickly pass legislation that would repeal and replace the Affordable Care Act of 2010 ("ACA"). With control of the White House, the House of Representatives and the Senate, Republicans are spending significant effort to fulfill that campaign promise.

On May 4, 2017, the US House of Representatives passed The American Healthcare Act of 2017 ("AHCA"). Among the important elements of the AHCA is reducing federal Medicaid spending through block grants or per capita caps, eliminating various taxes related to the ACA, eliminating the mandate to purchase insurance, and amending insurance rules requiring coverage for individuals with pre-existing conditions and certain essential benefits that were mandated under the ACA. Underscoring the difficulties in uniting the Republicans, the AHCA almost did not get to a vote in the House. After some changes to accommodate disagreements between key Republican House members, the legislation passed by an extremely slim margin of four votes (217-213). In the end, twenty Republican Congressmen voted against the AHCA and no Democratic Congressman voted in favor. Although the AHCA was not scored by the Congressional Budget Office ("CBO") prior to its passage, subsequently the CBO estimated that enacting the AHCA would reduce the federal budget by $119 billion between 2017 and 2026 and increase the number of uninsured people by 23 million.

On June 22, 2017, the US Senate released their own bill titled the Better Care Reconciliation Act of 2017 ("BCRA"). Many of the key elements of the BCRA regarding Medicaid, mandates and insurance coverage are similar to the AHCA. On June 26, the CBO released its estimate that the BCRA would reduce the cumulative federal deficit over the 2017-2026 period by $321 billion

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and result in 22 million additional uninsured in 2026 relative to current law – slightly less than their estimate of the AHCA's impact. As of the date this is written, it is unknown if the BCRA will pass the senate as many of the Senators have indicated that they are not ready to vote for the legislation – in some cases because it does not repeal enough of the ACA and in other cases because it repeals too much of the ACA.

We believe that what happens or does not happen to the ACA is a relatively superficial matter when contrasted against underlying demographic and reimbursement trends. Instead, it is those demographic and reimbursement trends that will have a monumental effect on health plans, providers and the tax-paying population beyond anything associated with the comparatively minor issues and impact of the ACA and the legislative proposals that intend to replace it.

Impact of Policy Changes on Providers and Payors

The ACA has had its clearest and most measurable effects to date on the availability of health insurance to the American people and on their access to care. Estimates of the number of uninsured persons who have gained coverage since 2010 range from 7.0 million to 16.4 million.[1] Expanded health insurance coverage had a major impact on many of the nation's hospitals through increases in the demand for care, increased patient revenues, and lower uncompensated care costs for the uninsured.[2] This one-time "reset" that resulted in increased inpatient volumes for hospitals is masking a far deeper and more troubling issue.

Hospitals

The ACA has been a mixed blessing for healthcare providers and its possible repeal, in whole or in part, is not likely to change that. Only the flavor of those mixed blessings will change. On the positive side, more commercially-insured patients using more care under fee-for-service reimbursement was extremely helpful to health care providers. Less clear was the effect of the mass migration of previously uninsured patients into expanded Medicaid eligibility. On one hand, getting paid something instead of nothing was better than the alternative. On the other hand, getting paid at rates less than the cost to deliver care for a population that is now encouraged to utilize services was not good at all. And for all providers, the increased administrative and bureaucratic burden of getting paid whether by commercial health plans or the government is not something that is likely to change with or without the ACA.

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We expect that if the ACA is repealed or significantly modified, most healthcare providers, with some exceptions, will survive that event without overly serious consequences. The Federation of American Hospitals and the American Hospital Association commissioned a report prior to the release of either Bill estimating the potential loss of revenue to all US hospitals associated with repeal of Medicaid expansion, premium tax credits, cost-sharing subsidies and penalties. The Report states that such repeal, without replacement, could result in a $399.8 billion reduction in hospital revenues over the period 2018 through 2026 (average $40 billion per year) due to the fact that individuals would lose coverage or opt for other types of coverage. To put this in perspective, annual revenues for all U.S. hospitals are at or in excess of $1 trillion. An

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[1]*Source: NEJM*
[2]*Source: Kaiser Family Foundation*

impact equal to 4% of total annual hospital revenues is not small, but this is probably significantly overstated as both Senate and House proposals contemplate replacement rather than repeal.[1] Moody's also released a sector comment in March 2017, stating that legislation to repeal parts of the ACA is a "credit negative" for hospitals. However, based on Moody's preliminary median report released in May 2017, unrestricted cash and investment at a sample size of 150 hospitals increased from $397 million in 2014 to $477 million in 2016, an increase of 20%, and over the same time period operating cash flow increased from $64 million to $76 million, an increase of 19%.[2]

States

Certain segments of the population and many safety net hospitals, however, will have a much more difficult time dealing with changes to the ACA. Safety-net hospitals, characterized by disproportionate government reimbursement and very high levels of unreimbursed care, found the ACA enormously helpful, especially in states that expanded Medicaid eligibility. The dynamic of increased utilization at below-cost reimbursement versus lower utilization and more unreimbursed care remains a challenge. Some states, such as California, have attempted to address this issue by imposing a tax (termed the "Hospital Quality Assurance Fee Program") on relatively well-to-do hospitals and redirecting the proceeds, along with additional federal matching funds, to safety-net hospitals. State programs like this will likely remain in place, albeit with enhanced challenges, whatever happens to the ACA.

The repeal and replace legislation currently under consideration proposes either imposing Medicaid per capita spending levels or providing block grants to States, which, according to the CBO will result in reduced federal Medicaid spending by $772 million to $834 million over the next decade relative to spending under the ACA. This aspect of the House and Senate proposals highlights the major battle being waged between the federal and state governments about who will pay and who will be stuck having to make the hard, unpopular choices that tend to spell peril for elected officials. Reduced federal funding for Medicaid puts elected state officials between the rock and a hard place of either raising taxes on one important constituency to pay for the needs of another, or increasing costs and reducing service to that other constituency to avoid increasing taxes on the first.

Health Plans

For health plans, the ACA was not a welcome event. The requirements to provide essential benefits to people with pre-existing conditions, rating restrictions (the ability to make large differentiations in rates depending on individuals' medical conditions or probability of care utilization), medical loss ratio (MLR) floors (the requirement to refund premiums if medical costs turn out to be too low), premium taxes, and other burdens made life more difficult for health plans.

The excursion by many health plans into the Exchanges was predictably painful as it turned out, to almost no one's surprise, that individuals signing up with the benefit of government subsidization used a good deal of healthcare services with less beneficial impact from younger insured members than expected. Many health plans suffered significant losses selling individual insurance plans on statewide and federal exchanges due to inadequate experience for assessment/rating of patient populations or deterioration in the patient risk pool. What came as an additional surprise to some health plans was the un-funding of risk corridors meant to protect health plans from exactly that event. Now many health plans have abandoned the Exchanges or, if remaining, increased prices enormously in response to the cost to serve those populations.

Whether the ACA is in place or is repealed in whole or in part will matter almost not at all to the major health plans. Most of these health plans adapted to the new environment by increasing premiums and providing less attractive benefits. As a result, just about all the large health plans are doing fine post-ACA with Anthem, Aetna and United all maintaining strong levels of operating income and stock prices having increased an average of 125% since the end of December 2013 versus the S&P 500's 32% increase over the same period.

[1]*Sources: Dobson DaVanzo & Associates LLC; CMS*
[2]*Source: Moody's*

So, What Matters if Not the ACA?

A major portion of the ACA dealt with health insurance coverage and did very little to address, perhaps even exacerbating, a much more important and fundamental issue that is affecting – and which will begin to affect more seriously – health plans, providers, employers and every citizen of the U.S. particularly those who work for a living and pay taxes whether they are aware of the extent of that taxation or not.

The issue is this: significantly increasing health care utilization will result from an increasingly aged, Medicare-insured population. That Medicare-insured population, according to MEDPAC's March, 2017 Report to Congress on Medicare Payment Policy, pays providers increasingly less than those providers' cost to deliver care resulting in increasingly negative margins on that business.

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In California, for example, average net Medicare revenue per adjusted discharge is half of what is paid by private insurers in a pattern that is consistent MSDRG-to-MSDRG. This trend is going to create very serious problems for the U.S. economy in general and healthcare providers specifically.

Utilization of Healthcare Services

Age Cohort	Inpatient Utilization per 1,000 (a)		Physician Office Visits per 1,000 (b)	% of Total Population	
	Discharges	*Days*		*2015*	*2035*
under 65	93	410	268	85.1%	81.2%
65-74	253	1,317	532	8.6%	10.6%
75+	*avg.* 464	*avg.* 2,614	670	*sum* 6.3%	*sum* 11.4%
75-84	*403*	*2,267*	*N/A*	*4.3%*	*8.1%*
85+	*571*	*3,217*	*N/A*	*2.0%*	*3.3%*

(a) Source: National Hospital Discharge Survey, I.C. Department of Health and Human Services
(b) Source: National Ambulatory Medical Care Survey, U.S. Department of Health and Human Services
(c) Source: California Office of Statewide Health Planning and Development

H2C's analysis of U.S. Census population forecasts by age cohort contrasted with U.S. Department of Health and Human Services inpatient utilization rate data (and, independently, California Office of Statewide Health Planning and Development inpatient data), indicate that without reductions in such utilization rates, total inpatient days will increase by 50% over the next 20 years purely as a result of demographic changes.

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Reimbursement aside, healthcare providers' costs are likely to continue escalating at rates significantly in excess of the U.S. GDP inflation rate. This will also cause major headaches for commercial health plans who will have to react to providers' increasing pressure to shift more and more costs on to them. "Cost-shifting" is now at least $13 billion a year for hospital-based services in California alone and perhaps $300 billion across the entire U.S. economy based on H2C's analyses. Cost-shifting by providers will continue the pattern of high single- and double-digit commercial premium rate increases and reduced benefits imposed on employers and workers until... What then?

That is the question that will ultimately dwarf whatever one might worry about with respect to the ACA.

What is happening now, similar to what is happening in Congress, is an increasingly difficult, challenging and acrimonious fight among health plans, providers, employers and the tax-paying commercially-insured public to push costs onto someone else. This fight will, without any doubt, seriously intensify over the coming decade.

To be sure, there are genuine attempts being made by all parties to help contain healthcare delivery costs. Health plans and governments are attempting to place a greater share of healthcare delivery cost risk onto providers through incentives and alternative reimbursement mechanisms such as capitation, pay-for-performance, value-based reimbursement and bundled payments. This makes sense because the only agents in the entire healthcare universe, besides the patients themselves, who can actually "control" medical costs are providers.

Similarly, governments are attempting to encourage care coordination by expanding the use of health plans for Managed Medicare and Managed Medicaid over traditional fee-for-service arrangements. Bundled payment reimbursement is another way to encourage care coordination over a single event. Governments are also attempting to link and coordinate Medicare and Medicaid reimbursement for high-utilizing dual-eligible populations. However, there has been considerable political and provider resistance to more extensive movement in this direction. Politically, patient advocates want to preserve choice and maximize service. Cost is not their issue – patient "protection" is. Many providers like fee-for-service reimbursement and, the more of it, the better. Coordinating care in the manner practiced by managed health plans is intended, by definition, to reduce the frequency of encounters and address necessary encounters in the lowest cost venue possible while maintaining acceptable quality.

For their part, providers are creating "clinically integrated networks" ("CIN") by which it is hoped that investment (often very significant) among providers in common IT and EHR systems with robust data analytics will lead to better care coordination and management which will result in higher quality care, improved utilization and lower costs. This has so far met with limited success. The issue for providers is that CINs are, from a health plan and consumer perspective, narrow networks. Narrow networks compete on cost because it is a defined (narrow) network that health plans (provider-sponsored or not) are increasingly selling to employers, employees and individuals. Choice of provider is typically the most important part in a consumer's decision to purchase a health plan product if such a choice has little or no cost consequences. There is evidence that this preference becomes increasingly elastic on average if the consumer is required to share in more of the monthly premium and bear the burden of higher out-of-pocket costs. This elasticity of behavior appears to be greater for those whose use of health care services is limited, but less so for those who expect to need care regularly or imminently. Another issue for providers is that CINs rarely offer sufficient network coverage and thus require health plan sponsorship to support network adequacy. Health plans, in turn, can force competition among CINs. Thus, for providers, any effort in this direction hinges on both operational success *and* the ability to make significant market share gains at the expense of other providers. On top of that, they need to accomplish this, in most cases, through a health plan intermediary whose interests are not necessarily aligned.

Patients are also being encouraged to reduce costs by both coercion and incentive. Coercion includes reducing costs by limiting choice (narrow networks, HMOs) and/or by increasing the proportion of costs for which they are liable ("cost sharing").

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Various incentive arrangements are being tried, many tied to encouraging lifestyle modifications, but the reality today is that few really work in a meaningful way. All current evidence appears to point to greater success when potentially high-utilizing populations (who are generally older, poorer and less educated) are frequently monitored, engaged, and frankly pestered – all of which is founded on the low-tech approach of personal engagement, frequently with social services rather than medical personnel.

All these approaches, but for health plan sponsored narrow networks which tier according to cost, focus on patient utilization management as the key to generating cost reductions. Herein lies a major fallacy. First, compared to unit costs (e.g. cost per event), utilization rate reductions have less impact on overall cost. Second, only some populations are amenable to expectations of significant utilization reductions or venue redirection. Commercial utilization rates cannot be reduced much because they are already comparatively low. The utilization rates of Special-Needs Populations (SNPs), which include mainly seniors with multiple chronic conditions and dual-eligibles, can probably be reduced considerably if incentives to do so were more widely implemented and if social services were combined and funded along with medical services as part of a comprehensive approach.

This effort could, for example, be supported by wider use of capitation. But attempts to accomplish this are sometimes also derailed because providers like the fee-for-service revenues generated by high-utilizers. Finally, providers face a fundamental dilemma which is that even if they can contract on a basis where they can profit by managing utilization (capitation for instance), they will have succeeded in reducing the use of an infrastructure (their own) that requires activity to maintain profitability. Therefore, they would also need to gain market share at the same time. And to do that, they need to be low cost. In short, cost is everything and yet few providers find the ability to face this inconvenient truth.

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Solutions?

If the ACA is only of superficial importance when compared to the economic consequences of rapidly increasing governmentally-reimbursed utilization described previously, then what can each of the participants in the healthcare industry do to address these deeper issues? Here we will focus on providers because, stated simply, the problem with health care today is cost, specifically provider costs, and more specifically hospital costs. So, what is it that might force or encourage providers, most of whom are not-for-profits with deep community responsibilities and connections and large fixed costs which present practical limitations on their scope of response, to address this?

As shown previously, most health systems, aside from rural and safety net hospitals, have strong operating and financial metrics. Many have seen volumes increase as a result of more commercially-insured patients and expanded Medicaid coverage resulting from the ACA. Additionally, demographic aging will soon result in increasing Medicare volumes. Most regard this as good news and have been able to cost-shift effectively and increasingly. Some health systems have seen increased competitive pressures from better positioned hospitals and health systems which is resulting in financial pressure. Several health systems are investing in population health strategies and have started up or acquired health plans. Others are willing to take on a moderate amount of value-based risk through Medicare Shared Savings Plan ACOs. Cost management – especially captive physician expenses and specialty pharmaceuticals are a universal challenge for health systems. However, even though most hospitals believe that they will have to take on more risk and provide more value as time goes on, as the system is currently structured,

there is often little incentive for hospitals to move a significant portion of their reimbursement from fee-for-service to value.

What will be required for fundamental change to the system is pressure and pain. Those feeling the pressure and pain right now, and increasingly, are employers and the commercially-insured. But at what point is that pain sufficient to drive action? And what action? We believe there are at least three possibilities each of which would affect healthcare providers in completely different ways.

The first possibility is that the commercially-insured and their employers find a way to be served by providers who decide not to accept government reimbursement. In theory, this approach would mitigate the significant effect of cost-shifting which has contributed to rapidly escalating commercially-insured rates and, thus, health insurance premiums. The issue with this is two-fold. First, it is unclear whether an adequate network of providers necessary to satisfy employers' and the commercially-insured's network requirements could be built without those providers relying on government-insured patients. Second, it would be difficult for not-for-profit providers to adopt this approach without calling into question their mission and tax-exempt status. The danger for not-for-profit providers, however, is that if this solution could be implemented, it would force intense price competition for their most profitable book of business. It could also put a cap on providers' ability to cost-shift and result in growing operating losses as commercial business migrates elsewhere.

The second possibility is that congress enacts legislation that requires coordination of Medicaid and Medicare medical care and social services delivery under contracts with health plans, and eliminates the ability of all beneficiaries, or a defined subset of those beneficiaries, to opt out. This would be both revolutionary and highly effective at coordinating care and controlling costs. The result would likely be dramatically reduced inpatient utilization and reduced utilization of other medical services in favor of investment in social services. However, this would also be very difficult to accomplish politically because it might reduce patient choice and could be seen as adversely affecting providers.

The third possibility hinges on the growing realization that healthcare cost escalation is not necessarily driven by health plans but is instead a reflection of health plans passing provider cost increases onto consumers. It also hinges on acknowledgement that health care does not respond to the competitive forces that exist in other industries because of lack of price transparency, lack of objective quality assessments or metrics meaningful to consumers, lack of information or understanding related to highly-complex situations, and finally, the frequent presence of duress embedded in the decision-making process when purchasing healthcare services. In this scenario, employers and individuals, working through Congress, could seek legislation to control healthcare provider costs in a manner similar to that employed with energy utilities. While this scenario may seem far-fetched to some, it may eventually emerge as most likely because of its precedence and because many players in the healthcare industry would likely favor this "solution" (unions, politicians and a significant number of hospitals.) However, it would not, without other reforms, likely reduce costs very much. Instead, it would create new opportunities for governments to redistribute costs in ways that would be politically determined.

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In the end, there is no good outcome for most hospitals and health systems unless they take a proactive approach. That approach must be operational and it must be political. In both cases, it requires that hospitals and health systems have a much clearer view of their cost structures and where, how much and why they make or lose money on service lines according to payor category. It also requires a connection between hospitals' and health systems' financial planning and strategy functions which, for many, are almost completely separate undertakings. Only with that connection can a clear view be achieved, a clear business strategy be developed, and coherent execution happen.

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