

# THE AFFORDABLE CARE ACT COMES OF AGE:

## Impact on California, Costs, and Coverage

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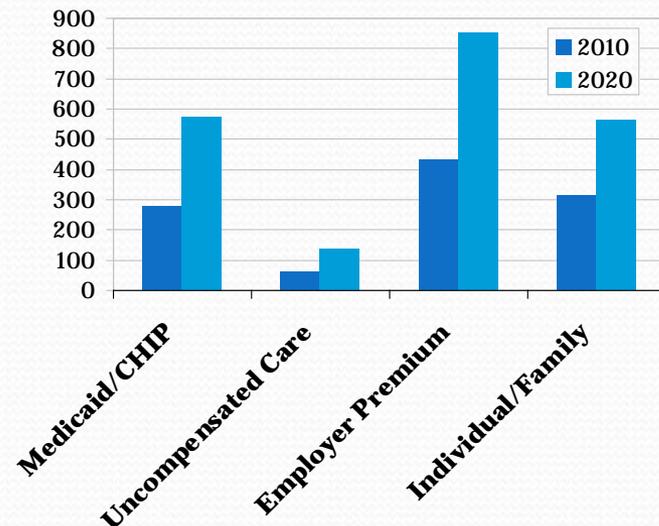
California Conference of Local Health Officers

Sacramento, October 2, 2014

# The Cost of Doing Nothing

- > In the absence of reform, in **2020**, the number of uninsured would have jumped by **57.9 - 67.6 million**, employer health spending would have increased by **67 - 98%** and uncompensated care costs would have grown by **74 - 119%**

Aggregate Health Care Spending for the Nonelderly Population (in Billions, Worst Case Scenario without Reform, 2010-2020)



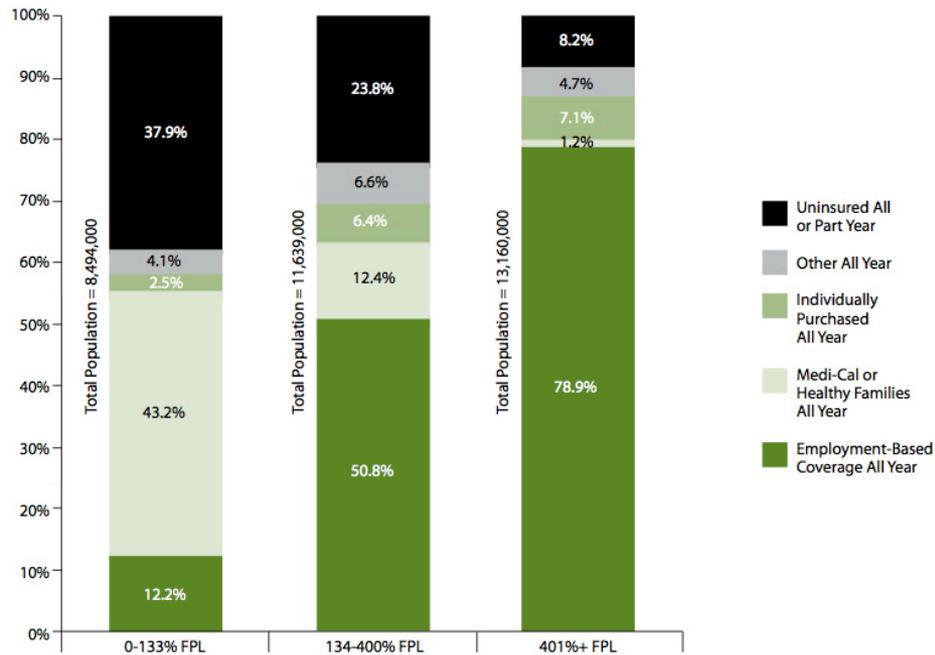
# The ACA: What Does It Do?

- Sweeping Legislation That Built on What Existed: “A bipartisan reform without bipartisan support”
- “Pillars” of Reform: Access (Exchanges, Medicaid Expansion, Employer Coverage), Delivery Reform and Cost Containment (ACOs, Agencies), Population Health
- When Fully Implemented, Expected to Cover 4 million of Roughly 7 million Uninsured Californians
- Large Medicaid Expansion Trimmed by Supreme Court Decision, G.O.P. opposition

# CA Coverage: ACA's Impact

## Exhibit 7.

Health Insurance Coverage by Federal Poverty Level Among Nonelderly Persons, Ages 0-64, California, 2009

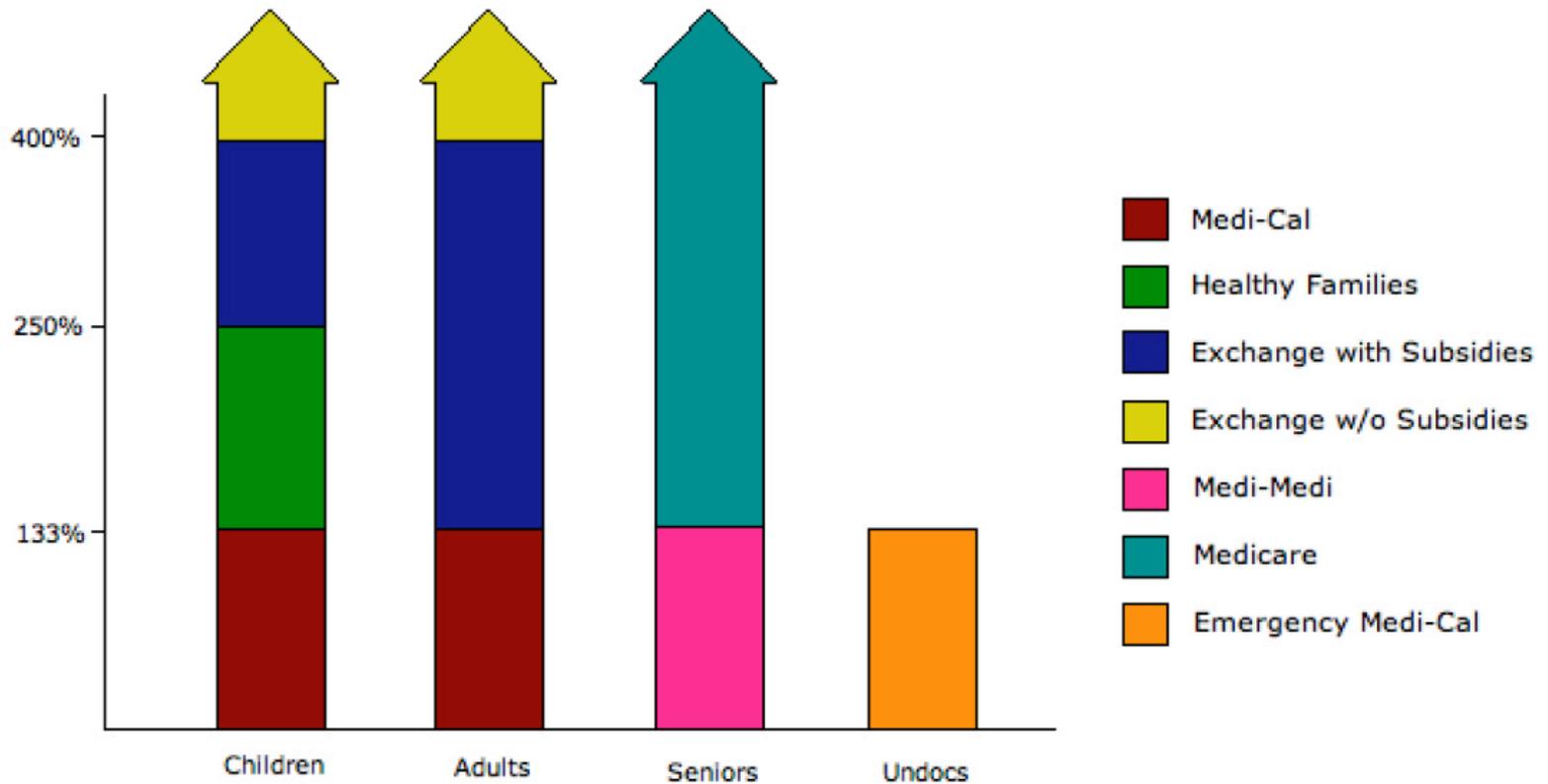


Note: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers (AIM) and the Managed Risk Medical Insurance Program (MRMIP), for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2009 California Health Interview Survey

# Future of Coverage



# Covered California

- An Exchange or “Insurance Store” with Standardized Products, Information, and Subsidies (up to 400% of FPL or \$92,000 for family of four in California)
- CA First in the Nation to Create Health Benefit Exchange after Passage of the ACA/Design of ACA Resembled Unsuccessful CA Health Reform efforts of 2005-2008
- Key Features: Standardized Benefits, Active Purchaser, Market Reforms, Pragmatic Relationship with Health Industry
- Individual and Small Business (SHOP) Exchanges
- “Big Four” Insurers Participated w/ Regional Carriers

# Covered California: Year One

- Almost 1.4 million Californians Signed Up on Individual Exchange, >1.2 million with subsidies
- Decent Levels of Enrollment among Latinos, Asian-Americans after Slow Start: African-Americans Signed Up at Lower Rate
- California Website (CalHEERS) Worked Reasonably Well Despite Hiccups and Glitches
- Year 2 Premiums Up Modestly Across the Board and Down in Some Regions
- SHOP (Small Business Marketplace) Started Slowly ~13,000 enrollees

# Covered California: Year One

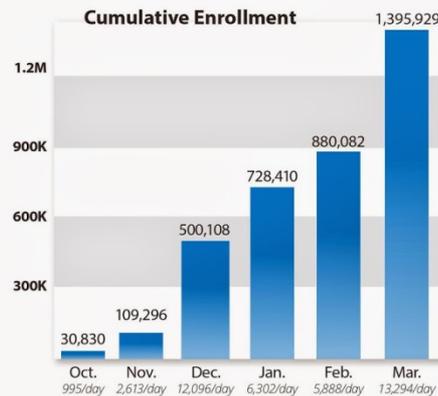
## Covered California Enrollment Statistics April 17, 2014



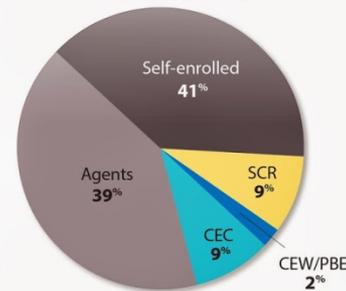
**Covered California**  
Enrollment  
Individuals Who Selected Plans

**1,395,929**

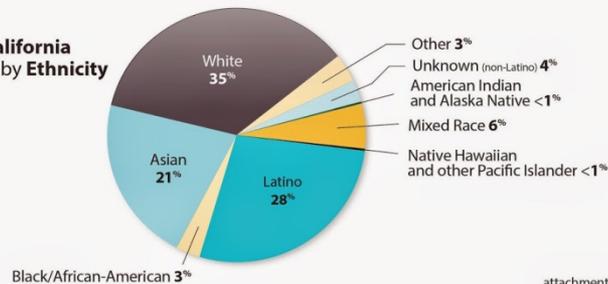
Subsidy eligible 1,222,320  
Not subsidy eligible 173,609



### Enrollment Pathway



### Covered California Enrollment by Ethnicity



# Medi-Cal Expansion

- 3 million Uninsured Californians Eligible For but not Enrolled in Medi-Cal, 2.1 million Newly Eligible under ACA. Substantially Young, Working-Age Men and Single Adults
- Over 1.9 million Californians newly enrolled in Medi-Cal through March 2014
- 650,000 Transferred Over from CA's unique Low-Income Health Program (LIHP): "Bridge to Reform"
- LA, Orange, SD, San Mateo Counties in 3 year care coordination project for 1.1 CA dual eligibles: \$678 M savings projected.
- County-level backlog of 350K Medi-Cal apps remains

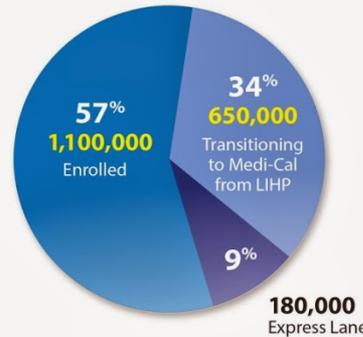
## Medi-Cal Enrollment Statistics March 31, 2014



### Medi-Cal Enrollment\*

**1,930,000**

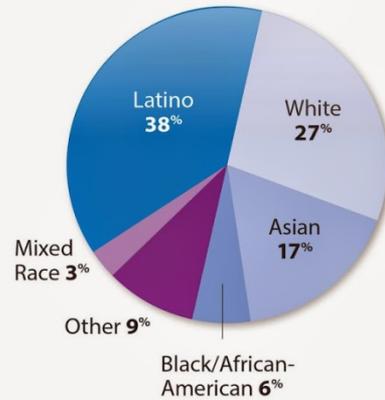
|                         |         |
|-------------------------|---------|
| Transitioning from LIHP | 650,000 |
| Express Lane            | 180,000 |



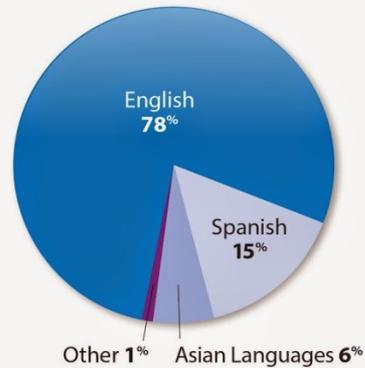
Likely eligible\* — **800,000**

\*Number reflects new Medi-Cal applicants and some ongoing caseload eligibility activity that is conducted via the state's marketplace.

### Medi-Cal Enrollment by Ethnicity



### Medi-Cal Enrollment by Language



# The Good News is that the Bad News is Wrong...

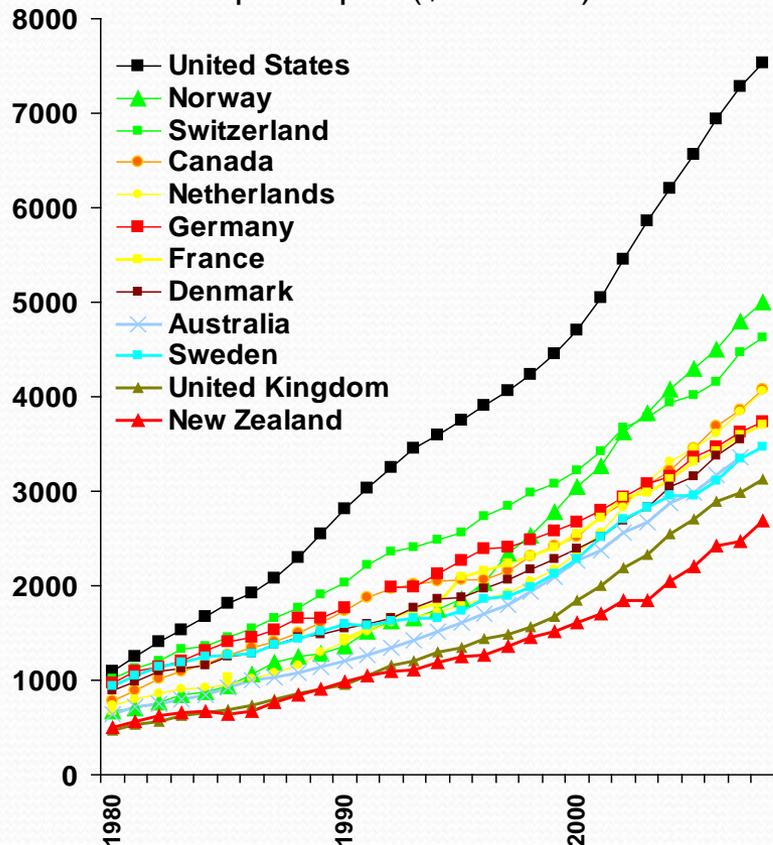
- Overall signups exceeded target after disastrous start: 7.3 million Americans enrolled in individual market as of 8/2014, with >90% having paid premiums
- Few if Any Premium Spikes in 2<sup>nd</sup> Year: Premium increases Modest (around 4% in CA): 25% More Insurers Signed Up in Year 2.
- Modest Impact at Best on Employer Coverage (Jury is Still Out)
- Young Signed Up in Adequate (though not ideal) numbers: 29% of those in Covered CA are 18-34 range
- Not a “budget buster” (at least not this year)

# But Enormous Challenges Remain...

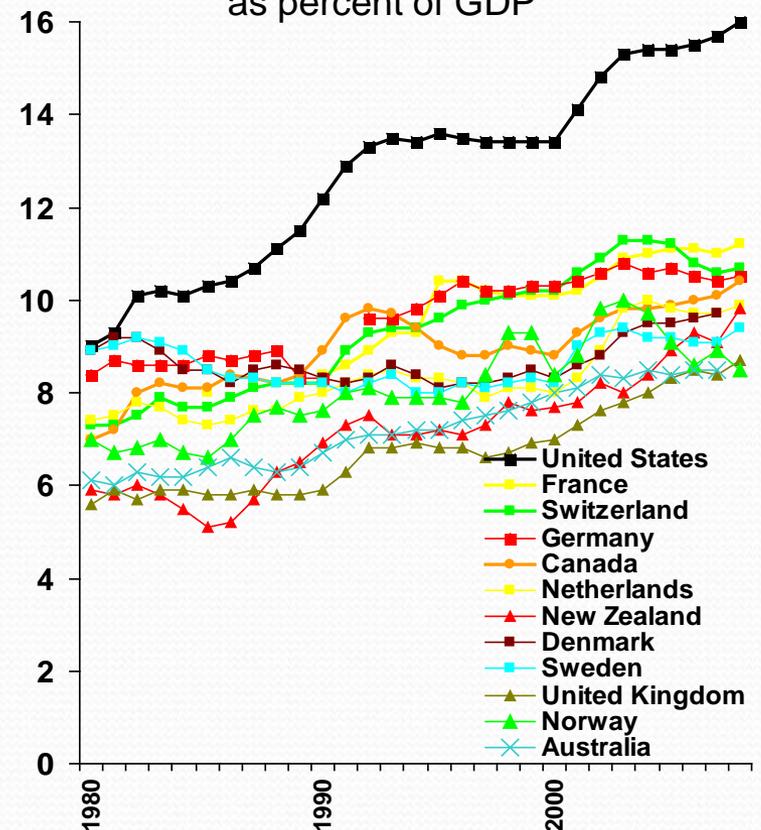
- Year Two Auto-Enrollment May Snare Enrollees in Less Affordable Plans
- Harder to Reach Long-Term Uninsured
- Halbig Lawsuit may still Derail ACA
- Politics: Most Elements of ACA (except the individual mandate) are Popular, but “Obamacare” is not.
- A Policy Success but Political Disaster: Website Failure, Communication Problems
- “Insurance is a Grudge Purchase”: Jon Kingsdale
- 51 Different Marketplaces Mean Vastly Differing Year-to-Year Experiences across U.S.

# International Comparison of Spending on Health, 1980–2008

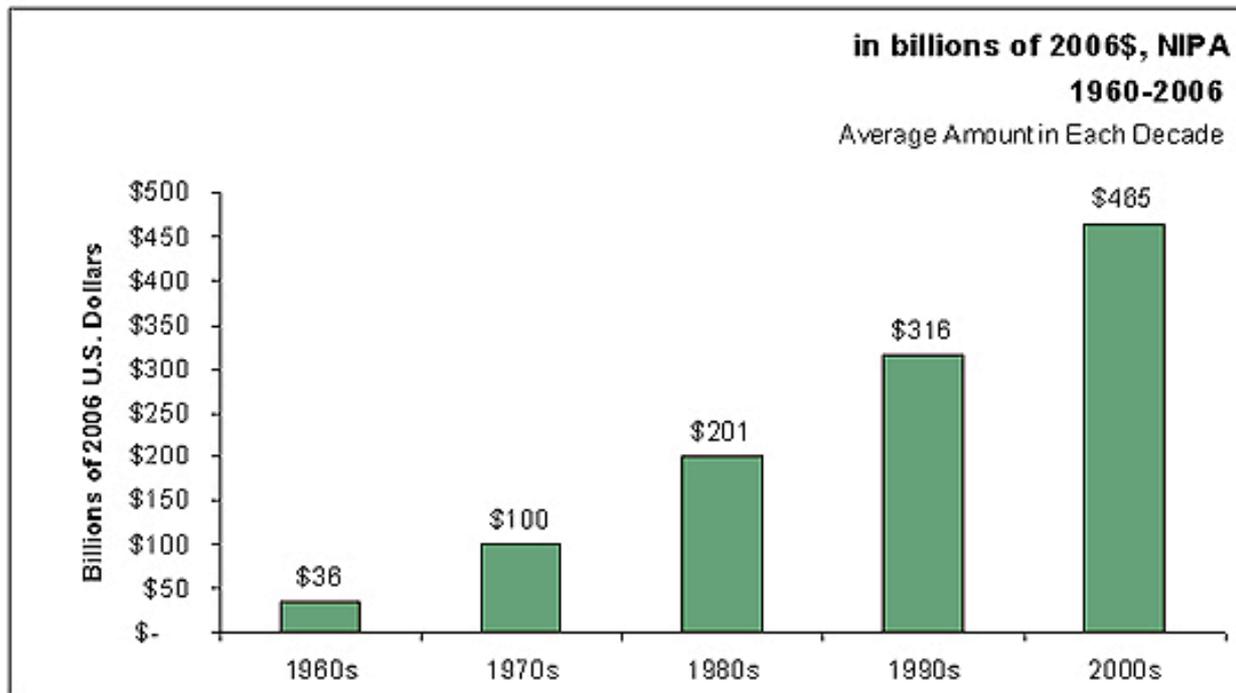
Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP



# National Employer Costs for Private Group Health Benefits



Source: U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts, 1960-2006, Tables 6.11B, 6.11C, & 6.11D.

Note: Amounts shown are averages of annual figures for each time period.

## While Health Care Spending is Vital to the Economy...

- ◆ An Engine of Job Growth (1.7 million + jobs added from 2000-2010)
- ◆ Medical Spending Shown to Yield Improvements to Health
- ◆ Wealthy Countries Naturally Shift Consumption to Health Care
- ◆ Health Care “Cities” Replaced Steel with Health Spending: Jacksonville, Pittsburgh, Cleveland, Minneapolis, etc.



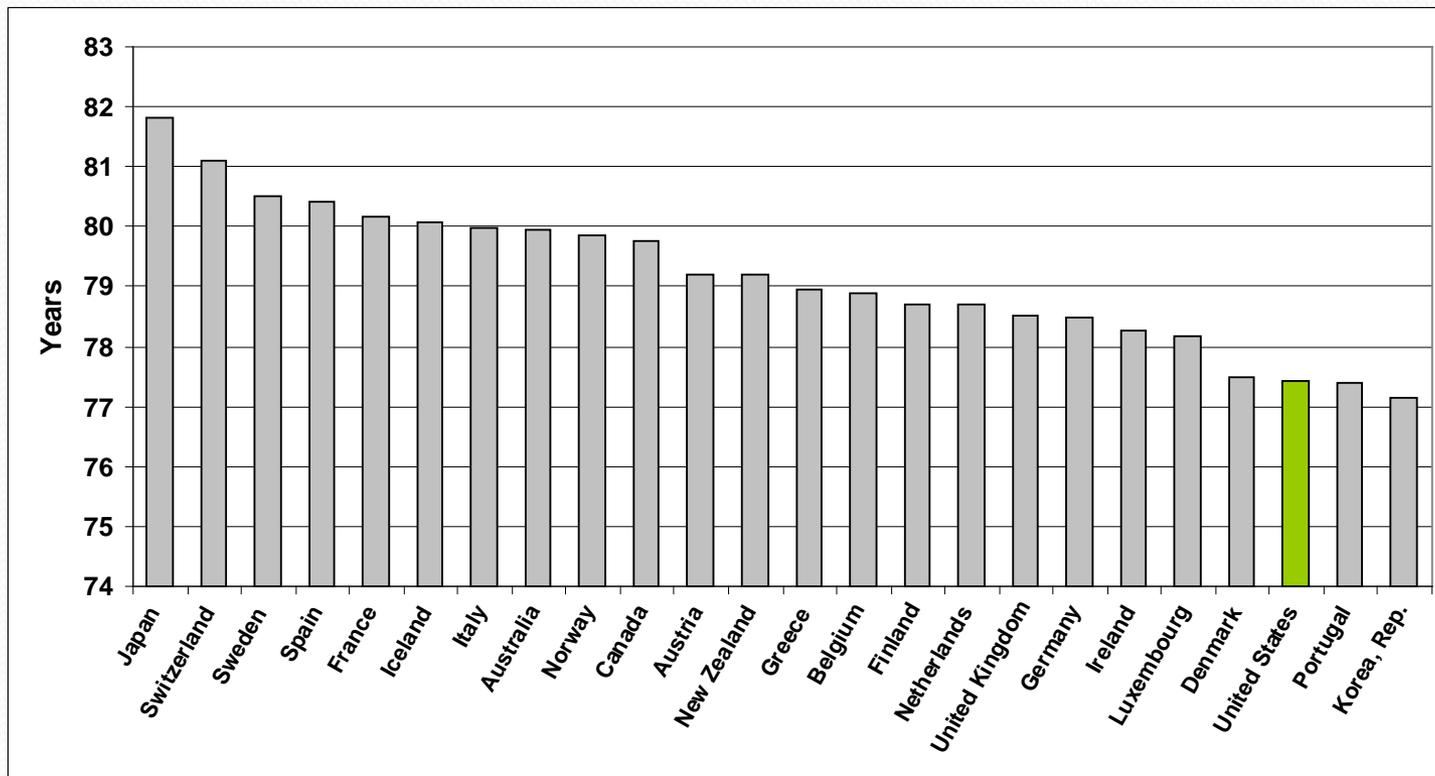
# Rising Health Costs: Why We Should Care

- ◆ Reflects Waste in Current System: We Can Do More With Less: Volume not Value
- ◆ Makes Health Care Increasingly Unaffordable, Including for Insured Americans
- ◆ Hurts Competitiveness of U.S. Business
- ◆ Crowds Out Investment in Other Key Areas (Education; Defense; Infrastructure)
- ◆ Key Driver of Federal Deficits

# Why the US Spends More on Health Care

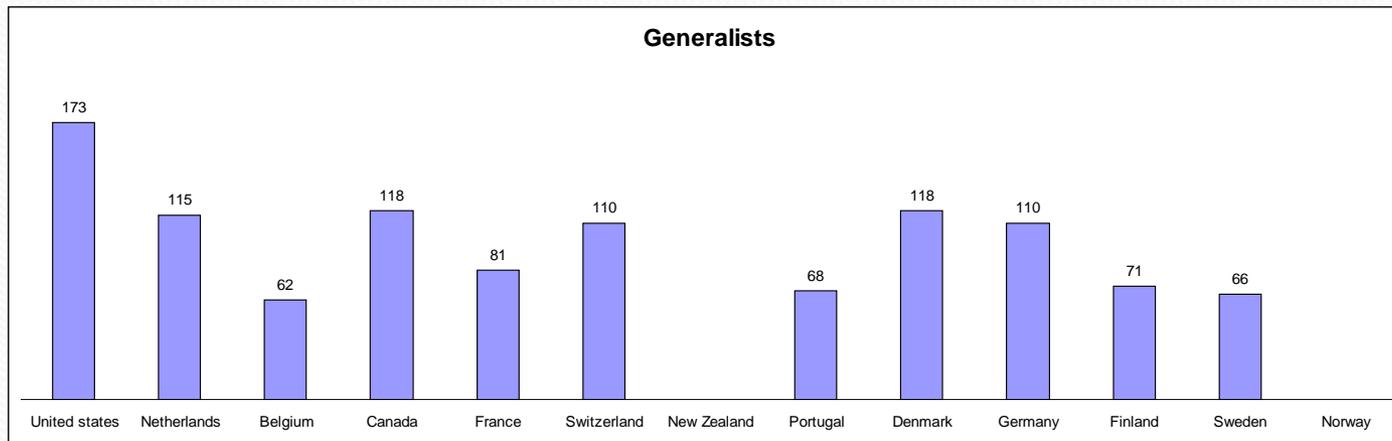
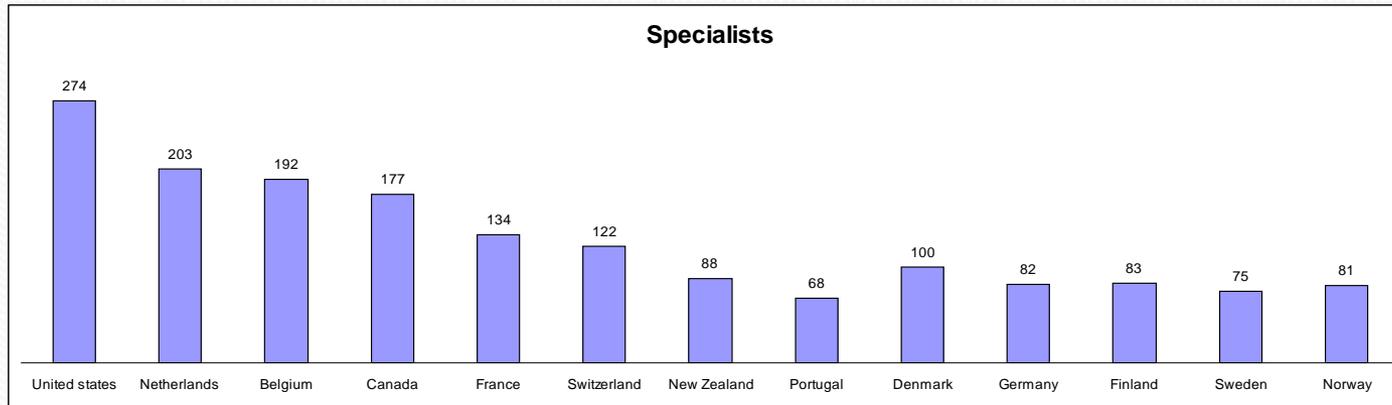
- ◆ Higher Prices for Medical Services
- ◆ Early Adoption/ Fast Growth of New Medical Technologies
- ◆ Powerful Suppliers/ Weak, Fragmented (and Insatiable) Demand
- ◆ Outsized Administration Costs
- ◆ Payment for Episodes of Care, Not Outcomes: "No Code for Health"
- ◆ Fee-for-Service Payments drive up the Costs of Treating Chronic Illnesses (>70 percent of U.S. medical costs)
- ◆ Specialist-oriented System prompted in part by U.S. Medical Education process; early-career physician debt

# Life Expectancy at Birth in Developed Countries



**Source:** World Development Indicators (2004).

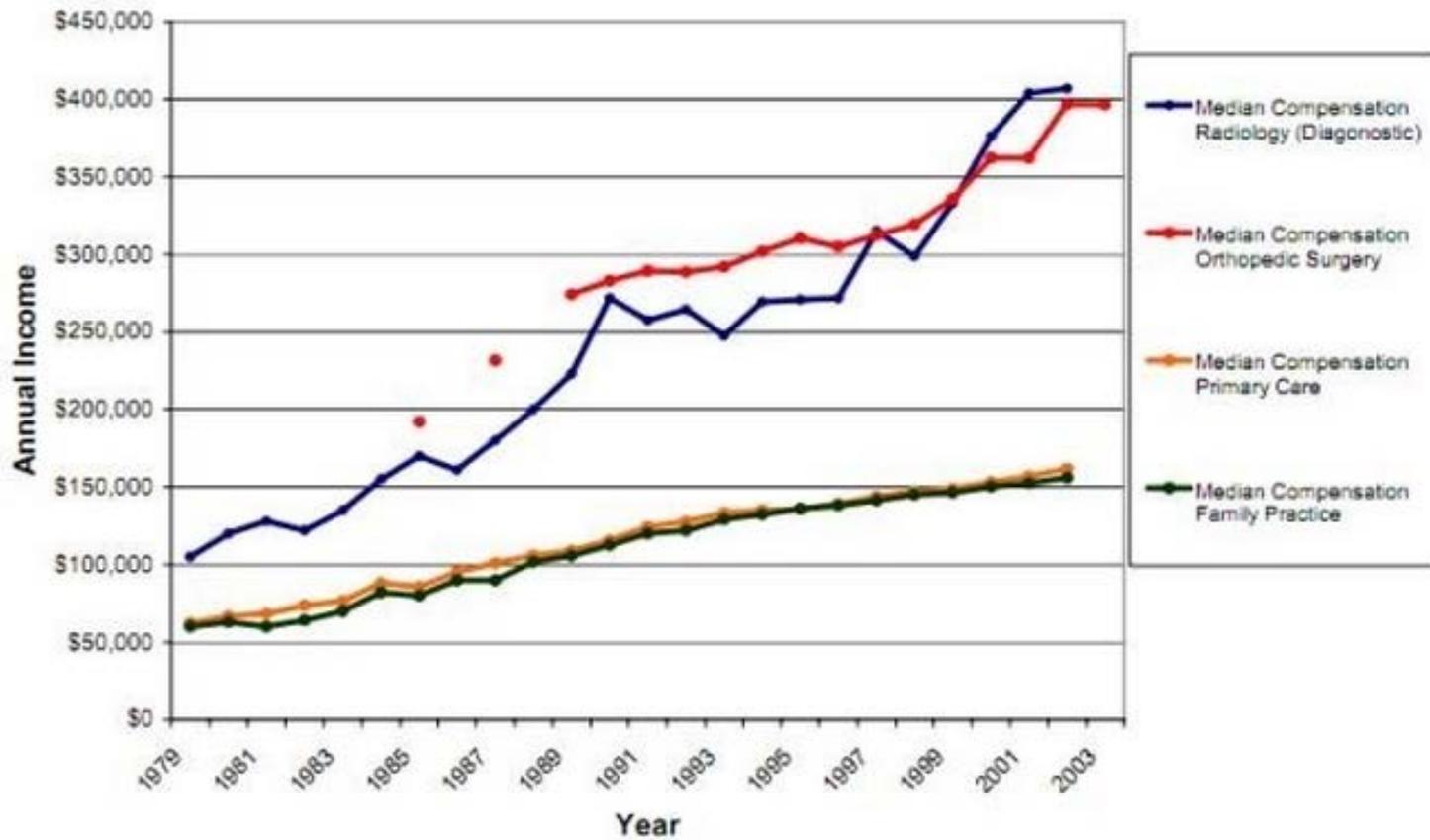
# Physician Salaries Worldwide



Note: \$ thousand per year PPP, 2003 Source: OECD; MGI analysis

# Primary Care Compensation

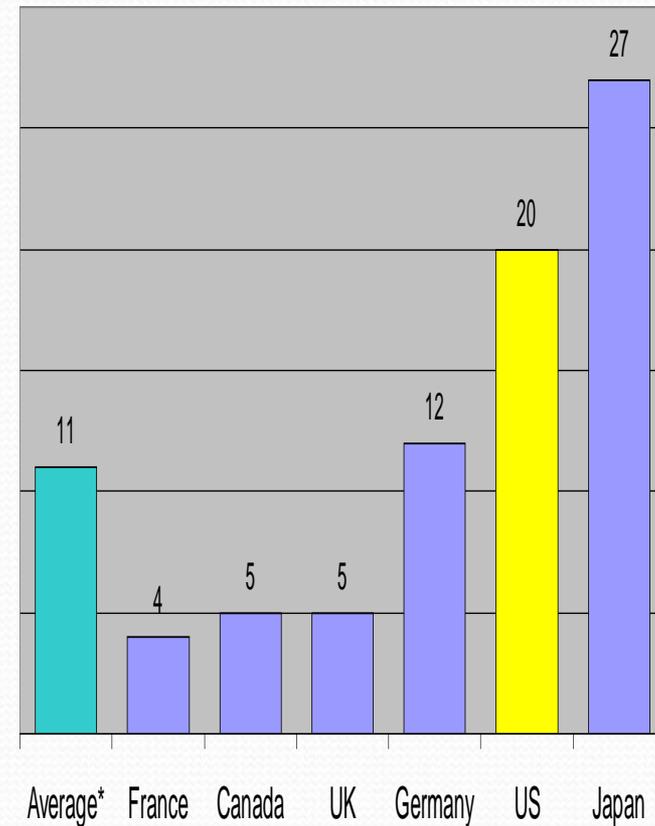
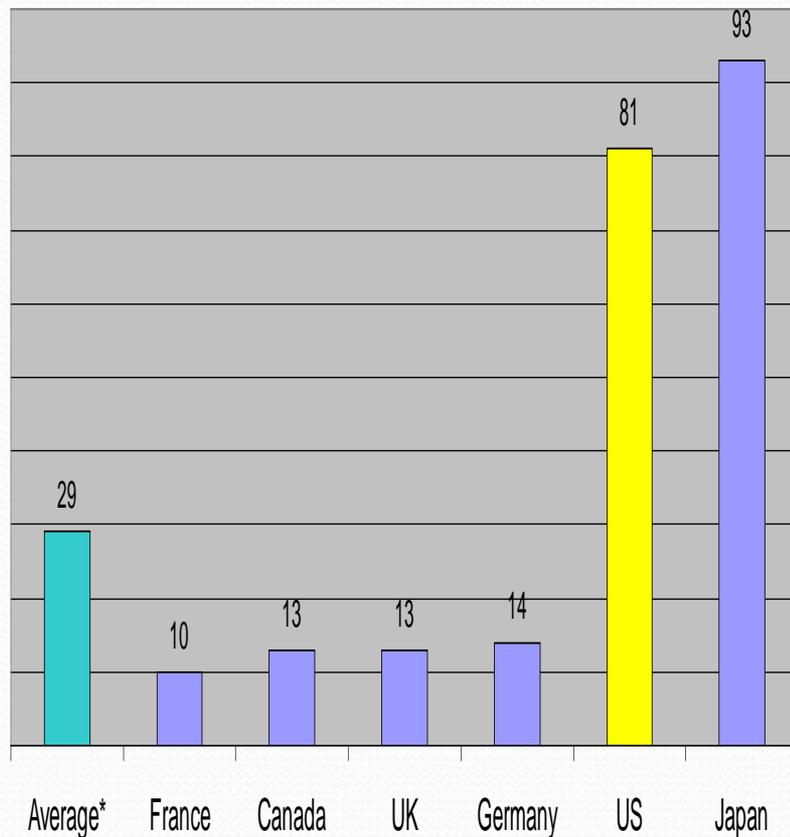
Figure 10. Progress of the Physician Payment Gap



# Scanner Capacity: US Vs. Other OECD Countries (Scanners per million)

CT Scanners

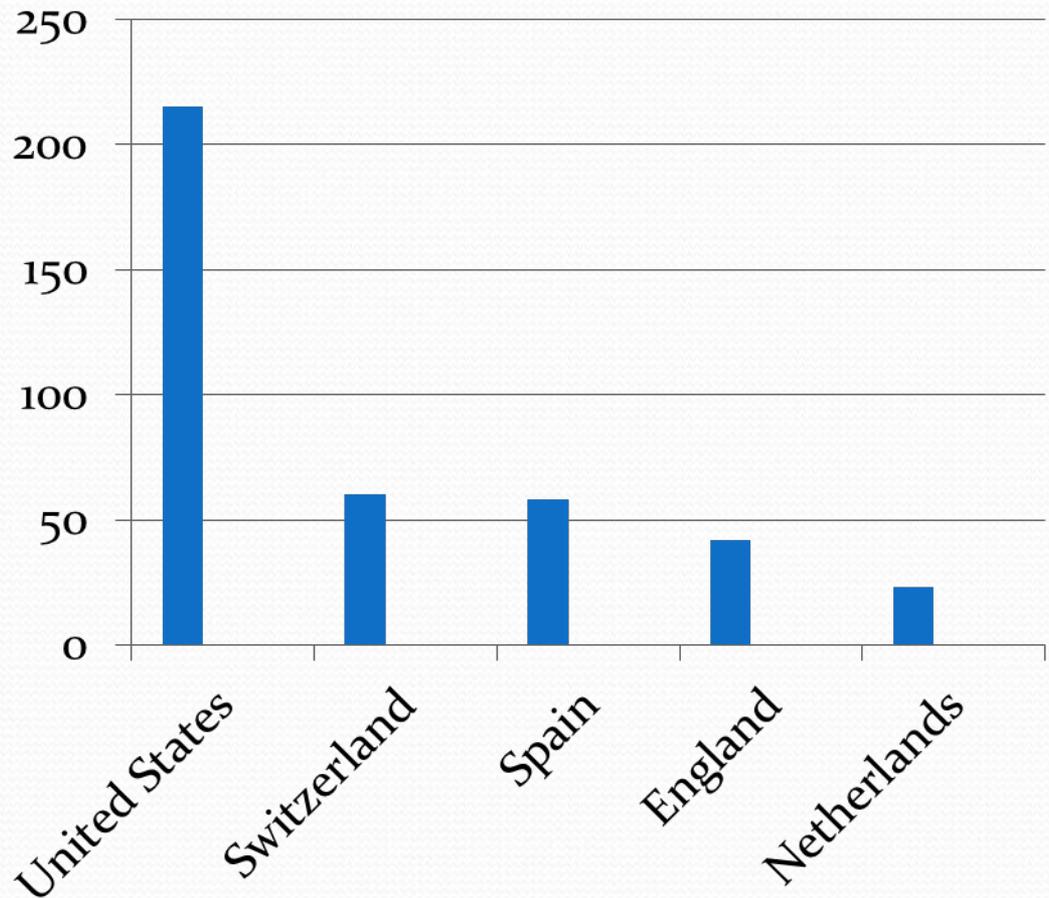
MRI Scanners



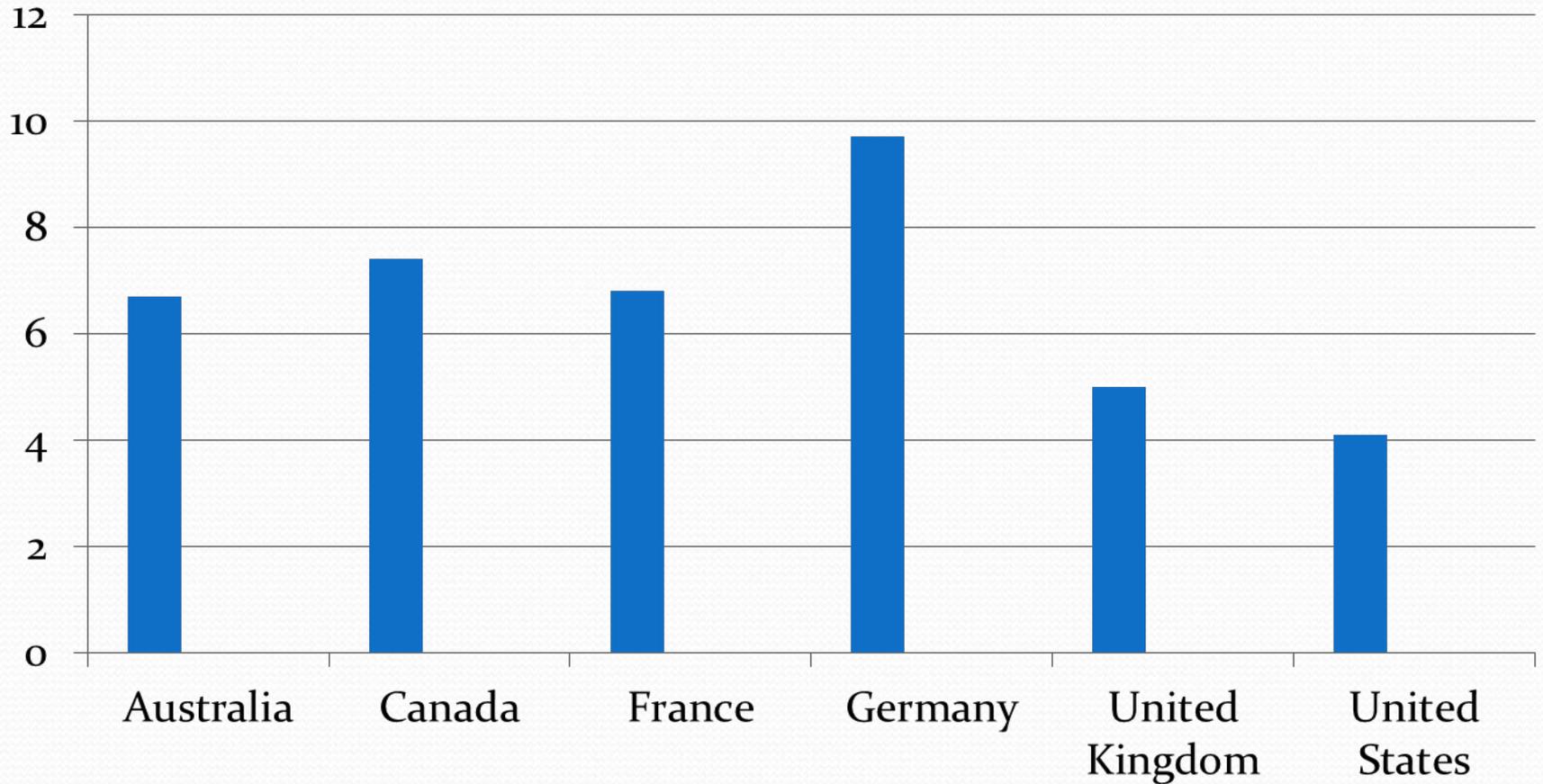
\* Excludes United States Source: OECD; Frost and Sullivan; MGI analysis

# Drug Prices are Higher in the U.S.

- While higher US prices stimulate innovation, they strain the pocketbook of consumers whether paying full price or through co-payments.
- What price is appropriate for a breakthrough drug like Sovaldi for hepatitis C, which Gilead Sciences sells for about \$1000 a pill or 84K for an average course of treatment?

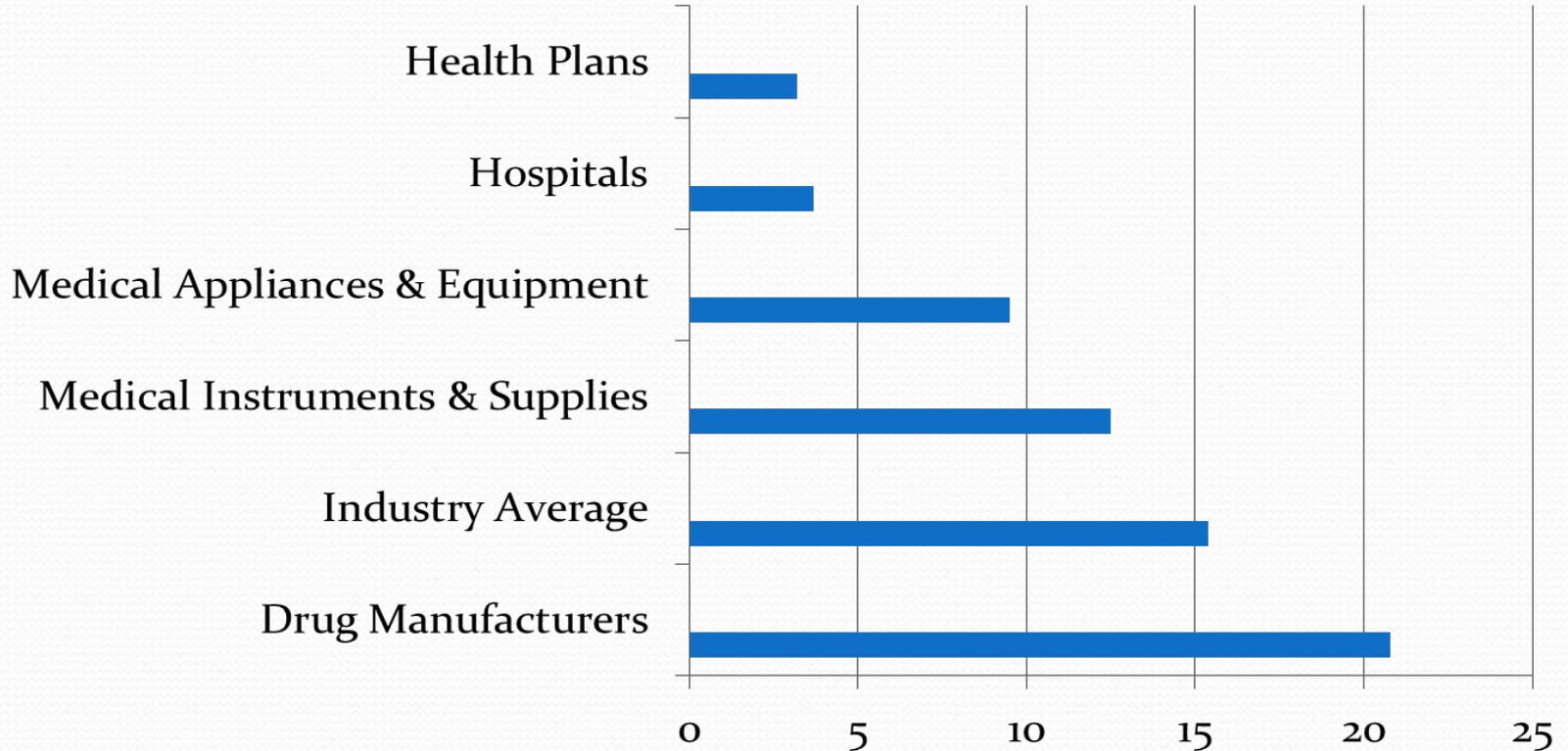


# Annual Physician Visits



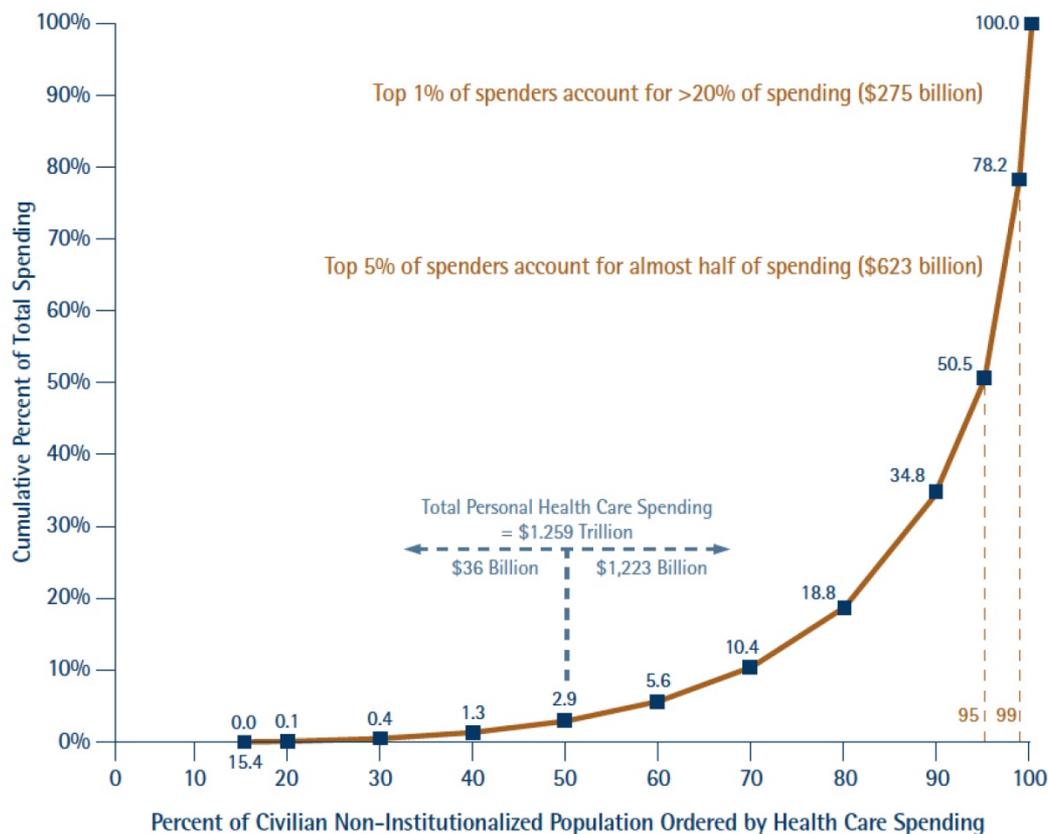
# Health Sector Profit Margins

(Insurers Aren't the Main Culprit in Rising Health Costs)

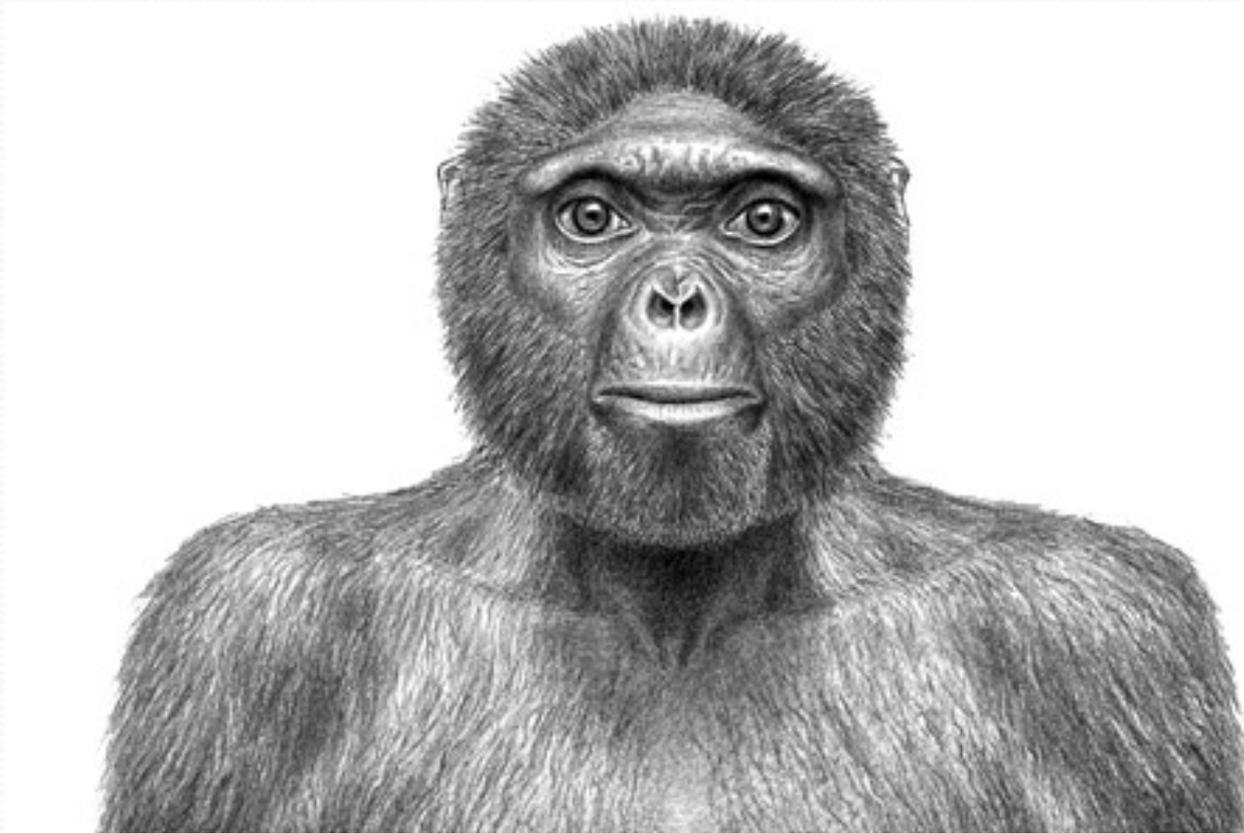


# Distribution of U.S. Health Care Spending: Half of All Spending Goes Toward 5 Percent of the Population

FIGURE 1. CUMULATIVE DISTRIBUTION OF PERSONAL HEALTH CARE SPENDING, 2009



# Cost Containment: The “Missing Link In the Affordable Care Act”?



# Reducing Health Care Prices

- Changing Payment Rates for Medicare Advantage
- “Cadillac Tax” (Changes to Tax Exclusion)—40 percent excise tax on most expensive insurance plans (2018)
- Reduction in Annual Increase in Hospital Payments
- Reduced DSH Payments
- Competitive Bidding for DME (durable medical equipment) Mandated by 2016
- Dozens of Smaller Experiments
- New Organizations (IPAB, CMMI, PCORI) Established to Study Outcomes, Create Cost-control Backstops

# Reducing Use of Health Services

- Changing Payment from Fee-for-Service: Accountable Care Organizations and Bundled Payment
- In effect, Nudging Physicians and Hospitals Toward Integrated Care Models/ Kaiser Permanente
- ACA authorized Medicare to adopt ACO and Created 3 kinds of ACOs– Networks of Physicians, Hospitals, and other Providers, that take clinical and financial responsibility for patients
- Many Other Experiments, Including Penalties for Hospitals with High Readmission Rates, High Rate of Hospital-Acquired Conditions

# Prevention and Health Promotion

- \$15 billion Prevention and Public Health Fund, reduced by \$5 billion
- Community Transformation Grants
- 550 New Community Health Centers Opened as a result of ACA/ CA has received almost \$900 million including Support for 92 new centers
- Workplace Wellness and Menu Labeling provisions
- Preventive screenings covered w/o co-pays/ deductibles
- Community Health Assessments/ local health depts.
- ACA's underrated contribution to population health

# A Small Dike Against Health Spending Tide?

- Growth of U.S. Health Spending for Past Three Years the Lowest in Decades
- Direct or Indirect Role of the ACA?
- Recession-induced or More Permanent Trend?
- Impacts Not Only Health Care Debates But Deficit Assumptions, Policies
- Stay Tuned...
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