Remedies

Industry experts discuss prescriptions for adapting to the Affordable Care Act.

Moderated by **Joe Vanden Plas**
Photographed by **Bill Fritsch**

It seems that controversy surrounding the Affordable Care Act never ends. Critics contend the law is increasingly unstable, but supporters point to increased access to medical insurance coverage, moderating cost of care (if not insurance), and improved financial performance by Wisconsin health systems.

For the 2016 plan year, individual insurers raised premiums, in some cases by double figures, and modified their products. ACA critics cite the experience of insurers like UnitedHealth Group, which in 2015 lost $475 million on the federal insurance exchanges and projects an even higher loss in 2016. With no appetite in Congress to bail out struggling insurers, the company is warning investors it may exit the exchanges in 2017.

In 2015 at least, younger and healthier people were not enrolling in the necessary numbers and UnitedHealth's risk pool therefore skews older and more expensive. This year, individual insurers hope younger, healthier people sign up in higher numbers.

On the flip side, the ACA appears to be helping integrated health systems in Wisconsin increase their efficiency and profitability.

In this industry roundtable, we examine the law's impact on local health systems and the various roles providers, insurers, employers, and employees can play in controlling costs.

Panelists

Opposite, left to right:
Cheryl DeMars, CEO, The Alliance
John Healy, partner and senior account executive, M3 Insurance
Arthur Nizza, president and CEO, UnityPoint Health–Meriter

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VANDEN PLAS: With the local market in mind, and based on your actual 2016 plan year experience and what you anticipate for 2017, is the cost/premium dynamic different for insurers that are part of an integrated health system than it is for a UnitedHealth Group?

NIZZA: If you look at it as an integrated system, you have to look at the forces that pressure either the insurance side, which is for consumers who are looking for a more competitive premium, but you also have to look at how pressures on the provider would affect their insurance-integrated partner. And what you see there are the same pressures, mostly from the federal government, in trying to move the cost of health care lower. Overall, what we see either on the insurance side or on the provider side of our integrated system is really a concerted effort by consumers, whether it's the largest consumer, being the government, or other consumer groups to try to lower the overall cost of health care.

"The compliance issues employers have would probably be one of the top three problems they have because they're not getting a lot of guidance from the government on exactly how to do this." — John Healy

HEALY: M3 is not an insurance company. We're an insurance agency so we help them with strategies that control cost. If you want to call Dean Health Plan an integrated system, they consider themselves an ACO and have for a number of years. They can be very competitive when it comes to other local insurers, whether they are Group Health Cooperative or Unity. Group Health Cooperative aside, because they simply rent the networks of the local providers, I would say they all think being part of an integrated system helps control costs.

VANDEN PLAS: What key feature of that kind of system really helps drive efficiency?

HEALY: Doctors will try their best because they get compensated, sometimes, based on what kind of care they provide — to whom and when. The right care at the right time would control costs if it's done right.

VANDEN PLAS: Cheryl, how about companies that self-insure? What's the picture like for them?

DEMARS: The question that you're asking is what are the effects of the Affordable Care Act on cost in the near term? It's a mixed bag. For self-funded employers, they were already doing a lot of what the Affordable Care Act was trying to accomplish by providing minimum essential benefits and doing so at an affordable cost. The impacts for our members now have to do with reporting requirements, so things like counting full-time employees and determining who was eligible for benefits, or who had benefits for some or all of the year? Those sound like simple questions but because of the definitions and the other requirements, it's at least, right now until systems are put in place, pretty onerous.

HEALY: There recently was a two-month delay on what the government expected from employers from a reporting standpoint, but Cheryl makes a great point. Fully insured or self-insured, it doesn't really matter. The compliance issues employers have would probably be one of the top three problems they have because they're not getting a lot of guidance from the government on exactly how to do this.

They're given a lot of forms. They're given a lot of information but we routinely get questions from our clients about what to do. Even though they may have sat through several webinars on the subject or seen several pieces of information from different providers, they still don't know what to do. That's why I think the government put a two-month delay on that reporting.

NIZZA: The only thing I would also add is just the peculiar demographics of Dane County and some of the surrounding

counties. You have a situation here where — there are certainly exceptions — you have fairly well-insured populations. I understand Wisconsin didn't expand Medicaid through the federal government but did expand Medicaid or BadgerCare here up to a different level of the poverty line. From an integrated systems point of view, what we have seen is probably a neutering effect where there is some small percentage of less non-insured patients.

In other words, our number of patients that don't have insurance at all has decreased, but the ACA also partly funded that through some excise taxes and some regular taxes but also by lowering the market basket increases to providers. So at the end of the day, those two have probably created a washout effect in terms of whether you're really seeing an influx of revenue into the system versus reduced reimbursement from some of the bigger payers.

"The reality is we're not going to all stay whole and shouldn't if we really want to change health care and health, and that's okay."

— Cheryl DeMars

PREMIUM ON MODERATION

VANDEN PLAS: Does anybody think the premium rate picture here is going to be that much different in 2017 than it is in 2016?

HEALY: We're not necessarily forecasting this but the larger employers are going to be faced with similar levels of increases simply because they're experience rated. If their population is healthy, obviously, if they're self-insured, and they have a healthy population, they don't get gigantic increases.

DEMARS: For self-funded employers, it's not so much about what premium increases are like but what their own experience is. The trend we're seeing is pretty flat among employers who are taking proactive steps to keep their employees healthy and manage their cost.

VANDEN PLAS: This is a longer-term question. When will moderating care costs translate into moderating insurance premiums?

DEMARS: That question really is one of the reasons why employers self-fund. When an employer self-funds, they're paying the cost of the care their employees use directly, and if they're doing things to help their employees maintain or improve their health and are practicing value-based purchasing strategies to control the costs, the benefits fall directly to their bottom line without getting mixed up in the underwriting process of an insurance company.

NIZZA: The evidence is such that what you're starting to see is a moderating of health care costs. Now I'm not saying it's at a level that anybody's comfortable with or that the increases are still something that our entire economy can bear in the long term, but you have started to see, through largely governmental programs and the push by the government toward value-based programs and readmission penalties, just a bending of the increase of the [cost] curve.

It's not that health care costs are going down, and it's not that health care costs aren't increasing, but the rate of increase has actually started to taper. The entire governmental philosophy of moving programs like Medicare from volume-based payments to value-based payments will continue to moderate the cost of health care, which will have to translate into premiums at some point.

HEALY: Your original question was when and I don't know that there's any way to really say that right now. For the large employer, outside of the compliance-related issues of the ACA, they're not really seeing their costs go up or down. They're increasing simply because the health care trend itself is continuing to go up. It's increasing by less than it was prior to the ACA. I don't know that the ACA really has had that kind of an affect on costs. I haven't seen that with our customers.

Cadillac Caution

If the delay of the so-called Cadillac tax on expensive medical insurance plans has convinced business executives to breathe a sigh of relief, they better not breathe too deeply. The excise tax was pushed back to 2020 from 2018, but the advice of our roundtable panel cautions against taking a pause in making changes to health benefits in order to avoid the tax.

The best course, argues Cheryl DeMars, is to stay the course, assuming that course includes working to improve the health of your workforce and transition to value-based purchasing strategies.

"Those are the things that ultimately are within an employer's control and will help them manage the excise tax," she states. "They're long-term strategies."

Under the ACA, an employer or a health insurer that offers an annual health insurance plan that costs more than $10,200 for an individual or more than $27,500 for a family would pay a 40% excise tax on the amount exceeding either of those cost thresholds. In subsequent years, the thresholds would be adjusted based on medical inflation.

John Healy says M3 has told clients they must manage their health plans as if the excise tax will hit them because the way it's structured, it eventually will.

"We've counseled our clients to make plan changes as if the law will be part of the landscape," he states. "Don't wait too long because if you wait too long you're going to have to make draconian changes to your plan."

The biggest misnomer, DeMars notes, is the tax will only impact the richest plans. "It doesn't just apply to things that would be considered excessive," she notes."

The strategies that employers are working on, things like wellness programs and workplace-based clinics that are designed to control costs, get factored into that amount."

DEMARS: There are a few theories that I've heard for why costs are moderating. One is the prevalence of high-deductible health plans is creating more caution on the part of consumers, especially about discretionary use of health care services. Preventive services are covered at 100% but those things that are discretionary are getting put off when it's your own money. Sometimes during big changes in health care, like when HMOs first came on the scene, there's a chilling effect on the cost in the market, but if we're not addressing the underlying drivers, that's going to disappear.

ROLE PLAYING

VANDEN PLAS: How would each of you explain the role of insurance providers, patients, and employers in reducing fundamental health care costs, and how does this role differ by region or market fundamentals?

NIZZA: It harkens to something that I was talking about before. The only way to really, fundamentally reduce health care costs, not just change the differential equation of how fast the costs are increasing, is to come up with some type of a program in which the insurance, the providers, the patients, and the employers really have completely aligned incentives. There's a movement toward some of that, but I'd say we haven't figured out the secret sauce yet in terms of being able to put together a program that knits everyone together so that everyone is either gaining or losing equally in that equation.

There are many programs that are meant to get us there — the whole bundle payment, value-based payment. Medicare has a plan to move Medicare payments within probably three or four years to a full 50% of value-based payments with higher percentages in outlying years. That will do something to clearly incent providers and other parts of the health care system to manage those costs, but it's

not going to be enough. Not everybody's on Medicare, and there are many other parts of the system — insurers, providers, patients, and employers — that need to be fundamentally in the game.

VANDEN PLAS: How does this differ by region and market?

NIZZA: The way it differs by region and market is the dynamics, frankly, that exist in terms of everything that we've been talking about. What percentage of the market is self-insured? Clearly, there are different dynamics at work within a self-insured marketplace in terms of what costs affect them and how they engage a group of providers to reduce costs. In markets where you have integrated delivery systems, the dynamics are a little bit different. We talk today about having three or four systems within Madison, within Dane County, but if you scratch below the surface a little bit, each of the systems relies either more heavily or less heavily on other systems within the same region to create the other required parts of the health care delivery system.

"It's not that health care costs are going down, and it's not that health care costs aren't increasing, but the rate of increase has actually started to taper." — Arthur Nizza

We depend heavily, for example, on the University of Wisconsin to fill out our network as UnityPoint Health–Meriter, and we have collaborations with Dean and St. Mary's in terms of several product lines that we're aligned on. So I think it varies. In a self-insured marketplace, where you have providers that are not integrated delivery systems, it's maybe a little bit harder. In a marketplace where you have providers that are integrated delivery systems and a mix of self-insurance and full indemnity, there are just different dynamics.

HEALY: Most employers have started to really understand the health of their employees is what really dictates their cost. So while there are all these various stakeholders that certainly play a big part in it, my personal belief in talking to our clients is that they're starting to really get the fact that they need to do more around wellness. They need to do more to create an environment that fosters good health on all levels for their employees, and the dependents of their employees, so they can control the claim cost. If the claims aren't there, their costs are going to moderate.

As a society, we tend to say, 'Well, I'll let them take care of it for me.' As long as that dynamic continues, and people aren't willing to take personal responsibility, I don't see much changing with health care. It's going to continue to increase. Maybe it increases at a slightly slower pace but it still increases. Wellness is a huge component, as well as onsite clinics, of the future of health care.

DEMARS: Just to follow up, John, there's a broader benefit that employers recognize, as well. The health of their employees certainly does drive their health care cost but it also impacts their business results.

HEALY: Productivity.

DEMARS: Employee health is inextricably linked to the health of their business, and that connection is increasingly important and recognized. Art, I also agree with your point about the need for alignment of these various interests. We aren't on the same page right now across these various entities, and I'm in too many conversations where we talk about creating fundamental change and then there's a side conversation about how do I stay whole? The reality is we're not going to all stay whole and shouldn't if we really want to change health care and health, and that's okay. We just need to figure out what the tradeoffs are and be courageous enough to make them.

As to the role of purchasers — employers — they have three key roles. As a purchaser, they're buying health care on behalf of their employees and have an opportunity and an obligation to do so based on value. If they can focus on not just the cost but also the quality and the value they're getting, we can create a market that rewards those who are stepping up to do a better job.

They also have a role to play as employers that maintain a culture. You have employees for eight hours a day. There's a lot you can do during that time to make it easier for people to make good decisions for their health and harder or more expensive to choose differently.

The business community also has a role to play as a community leader to advocate for and promote healthier communities.

NIZZA: One point Cheryl mentioned that I can't emphasize enough is the role of the business leaders in understanding health care because it's one of the few areas in which they're guaranteed to be consumers some point in their life. Everybody's going to touch the health care system somehow. They're also consumers for their businesses and yet I've had very candid conversations with business leaders, both in my previous position on the East Coast and in Madison, in which the concept of value, and what does it actually mean to factor in value when you're making a health care decision, is really alien.

Everyone naturally gravitates toward price points and it's understandable. Price matters and it's easy to figure out because it's a common denominator. You can look at the price for that versus other things you're buying and, at some level, that's an equation you can do. At some level, it's not.

DEMARS: To get there, we're going to need greater transparency about the results that are being delivered, as well as the costs. We've been working at this for a long time. We're farther than we were but we're not where we need to be. It's not surprising to me that the business community doesn't understand necessarily what value looks like in health care because it's not as tangible or readily discernable as it is for many of the other things that they buy. That's the education and the conversation we need to have. IB

What If the ACA Is Repealed?

As they've done in the past, Congressional Republicans recently voted to repeal the Affordable Care Act, but this time it passed both houses of Congress, it was put on President Obama's desk, and he promptly vetoed it. While repeal fell short, Republicans demonstrated that if current majorities are maintained in 2016, all that's needed to repeal the ACA is for a Republican to be elected president.

So what happens if the law is repealed? We put the question to our roundtable panelists.

In John Healy's view, it's somewhat obvious that it would depend on what the ACA is replaced with, but he doubts the law would be scrapped in its entirety because more people have access to medical insurance. "There's somewhere over 12 million people that enrolled in Healthcare.gov," he notes. "Some people say that's not 12 million new people, but several million people have gotten health care that didn't have it before."

Cheryl DeMars doubts that many would advocate for the status quo, but if there's a do-over she wants lawmakers to simultaneously expand access (eliminating preexisting conditions and lifetime limits) and do more to address underlying cost drivers. "We're all for expanding access but we wish it had expanded access plus done more to create a more efficient delivery system for people to access," she says. "Things like focusing on appropriateness of care, that's a big one."

Arthur Nizza says the ACA accomplished two things that Republicans, Democrats, and independents are aligned on. The first is increasing access to health care and the second is moderating the cost of care.