The Unintended Consequences of the Affordable Care Act
High court upholds health care law

In a 5-4 vote, Supreme Court Chief Justice John Roberts joined the court's four liberal justices in upholding the heart of the Affordable Care Act health care law Thursday, ruling that the government may impose tax penalties on those who do not have health insurance. Looking at the decision:

**How the justices voted**

- **Chief Justice John Roberts**
  - Voted to uphold
  - *Roberts wrote the majority opinion ...*
    - "We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation’s elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions."

- **Justice Stephen Breyer**
  - Voted to uphold
  - *Ginsberg wrote an opinion with majority ...*
    - "Congress passed the minimum coverage provision as a key component of the ACA to address an economic and social problem that has plagued the Nation for decades: the large number of U.S. residents who are unable or unwilling to obtain health insurance. Whatever one thinks of the policy decision Congress made, it was Congress' prerogative to make it."

- **Justice Ruth Bader Ginsburg**
  - Voted to uphold

- **Justice Sonia Sotomayor**
  - Voted to uphold

- **Justice Elena Kagan**
  - Voted to uphold

- **Justice Anthony Kennedy**
  - Voted law down

- **Justice Antonin Scalia**
  - Voted law down

- **Justice Clarence Thomas**
  - Voted law down

- **Justice Samuel Alito**
  - Voted law down

**Four legal questions addressed**

1. Are the lawsuits premature?  
   No, hence the ruling by the court

2. Can Congress compel individuals to buy insurance (individual mandate)?  
   Yes. Chief Justice Roberts delivered the opinion of the Court with respect to this point, concluding that the individual mandate may be upheld as within Congress's power under the taxing clause of the Constitution

3. Can the rest of the law survive if a part is struck down?  
   Does not apply since all of the law was upheld

4. Can Congress force states to expand Medicaid by threatening to withhold funds?  
   The court upheld the expansion of Medicaid, but limited the federal government's ability to enforce this provision by penalizing states that refuse to go along
Details of US Supreme Court “Affordable Care Act” Decision

• 5-4 Individual mandate upheld (but as a tax, not a penalty)
• 9-0 To compel an affirmative act violates the Commerce clause
• 9-0 Individual mandate violates the “necessary and proper” clause
• 7-2 Medicaid expansion violates Congress’ spending clause power as unconstitutionally coercive of states.
• 5-4 Remedy is to limit HHS Secretary’s power to withhold existing federal Medical funds for state non-compliance with Medicaid expansion
US Supreme Court Medicaid Expansion Ruling

There has never previously been a holding prohibiting Federal financial coercion of the states, though in two cases, in 1937 and 1987 in dicta the court said there could possibly be...

“a future case in which a financial inducement offered by Congress could pass the point at which permissible pressure on states to legislate according to Congress’ policy objectives crosses the line and becomes unconstitutional coercion.”

Roberts, Breyer and Kagan found the Medicaid expansion is a “gun to the head” because of the “threatened loss of over 10% of a State’s overall budget...is economic dragooning that leaves the States with no real option but to acquiesce.”

Scalia, Kennedy, Thomas and Alito found the Medicaid expansion is unconstitutionally coercive of the states, is not severable from the rest of the law, and should invalidate the entire ACA.

Ginsburg and Sotomayor found the Medicaid expansion constitutional.
The Heart of the Affordable Care Act, 
or How We Add 30 Million People to the Healthcare System

• **Medicaid expansion:**
  – If state participates, Medicaid “version 2.0” goes to 138% of the poverty line
    • Federal government provides significant subsidy of the costs (100% through 2016, 90% thereafter)
    • But States still pay $50 billion over ten years of the additional Medicaid costs
  – If state does not participate, Medicaid stays at the current 100% of the poverty line.
  – Designed to add approximately 15 million people

• **State Health Exchange**
  – If the state participates, health exchanges provide subsidies to everyone between 139 and 400% of the poverty line (on a sliding scale)
  – Designed to add approximately 15 million people
Medicaid Expansion
Federal Poverty Level, 2013

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<th>Household Size</th>
<th>100%</th>
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<th>400%</th>
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Where the States Stand on Medicaid Expansion
25 states, DC, Expanding Medicaid—February 7, 2014

Notes: Based on literature review as of 2/7/14. All policies subject to change without notice.
HHS has announced that states can obtain a waiver to use federal funds to shift Medicaid-eligible residents into private health plans. The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

EXPANDING COVERAGE
FOR LOW-INCOME RESIDENTS

- Expanding Coverage .......... 26
- Considering Expansion .......... 4
- Not Expanding Coverage at This Time .......... 21

Learn more about ACA implementation at advisory.com/daily-briefing
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Medicaid Expansion and Hospitals

• Expectation of ACA as drafted was the all states would participate, and expansion of coverage would end the EMTALA hospital provided free care. So ACA deleted a hospital subsidy for EMTALA care.

• For those 24 states not participating in the Medicaid expansion, their hospitals are taking serious financial hits.
  
  – Four hospitals in Georgia have shut down, allegedly at least in part because of the loss of funding due to ACA payment cuts for emergency services.
  
  • Source: http://dailycaller.com/2014/02/18/fourth-georgia-hospital-closes-due-to-obamacare-payment-cuts/
Percent of overall enrollments in Medicaid

- Washington: 85%
- Hawaii: 80%
- Kentucky: 79%
- Maryland: 79%
- Connecticut: 61%
- California: 58%
- Colorado: 58%
- New York: 55%
- District of Columbia: 43%

Source: State reports
State Health Insurance Exchanges
Status of State Health Insurance Exchanges

17 State Exchanges, 25 Federal Exchanges, 8 State Partnership w/Federal Exchanges
State Health Insurance Exchanges

• If a state refuses to establish an Exchange, the Feds will do it for them:

  – “SEC. 1321. (c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.

    (1) IN GENERAL – If a State...will not have any required Exchange operational by January 1, 2014...the Secretary (of HHS) shall...establish and operate such Exchange within the State.”
State Health Insurance Exchanges – The Legislative Glitch

• According to plain language of the “ACA” statute, only state run exchanges may pay subsidies:

  – “The premium assistance amount...(is) equal to the lesser of...the monthly premiums for such month for one or more qualified health plans offered in the individual market...through an Exchange established by the state under (sec.) 1311.” (emphasis added)

• HHS and the IRS called this a “glitch”, the “result of bad draftsmanship”, a “scrivener’s error.”

• However, detailed research in the Congressional Record* suggests the Democrats left out federal subsidies as an incentive for states to set up exchanges.

*See Health Matrix journal article by Jonathan Adler and Michael Cannon.
Unintended Consequences

• For states that opt out of Medicaid expansion and the State Health Insurance Exchange, starting in 2014, and if the U.S. Supreme Court ultimately upholds the ACA provision that Federally run exchanges cannot pay benefits, the key part of ACA, expanding coverage to the uninsured, will essential fail in those states:

  – States that opt into Medicaid expansion and State Health Insurance Exchange will become “magnate” states for the low-income people.
Legal Challenges to ACA
Continued Legal Challenges to the Affordable Care Act

• More than 60 legal challenges are pending against ACA:

  – Halbig v. Sebelius – brought by the Cato Institute
  – Pruitt v. Sebelius – brought by the Oklahoma Attorney General
    • Challenges the ability of the Federal government to pay subsidies in states where
      the Federal government runs the exchange.

  – Sebelius v. Hobby Lobby - raising 1st amendment religious liberty
    issues regarding providing of contraceptive care in employees’ health
    insurance
    • Supreme Court arguments scheduled for March 25, 2014
Continued Legal Challenges to the Affordable Care Act

Origination Clause Challenge:

“All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may propose or concur with Amendments as on other Bills.”

Three separate challenges working their way through the courts:
- Association of American Physicians & Surgeons v. Sebelius
- Sissel v. U.S. Dept. of Health and Human Services
- Pacific Legal Foundation case
Continued Legal Challenges to the Affordable Care Act

• Coons v. Geithner – challenges the constitutionality of the Independent Payment Advisory Board as a violation of the separation of powers doctrine.
Unintended Labor Union Consequences of the “Cadillac Tax”

• Effective in 2018, the “Cadillac Tax” is 40% of the value of an employer-provided health plan that exceeds:
  – $10,200 for individuals
  – $27,500 for families

• In 2018, this tax hits 16% of employer-paid plans

Unintended consequences:
  – Because of healthcare cost inflation, by 2029, the tax hits 75% of all plans
  – Union plans are especially hard hit, leading to increasing union opposition to the Affordable Care Act
The Mandates

Individual Mandate
Employer Mandate
Individual Mandate

• 2014 – Penalty is $95 per adult; $47.50 per child; up to $285 per family or 1% of family income, whichever is greater

• 2015 – Penalty is $325 per adult; $162.50 per child; up to $975 per family or 2% of family income, whichever is greater

• 2016+ - Penalty is $695 per adult; $347.50 per child; up to $2,085 per family or 2.5% of family income, whichever is greater
Fix the Individual Mandate?
NO –According to the Supreme Court

Chief Justice Roberts listed several factors that transformed the individual mandate from a penalty into a tax for constitutional purposes:

“...for most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more. It may often be a reasonable financial decision to make the payment rather than purchase insurance ...”

“...the payment is collected solely by the IRS through the normal means of taxation—except that the Service is not allowed to use those means most suggestive of a punitive sanction, such as criminal prosecution.”
Individual Mandate Delays

There are 14 categories of exemptions to the individual mandate:

“14. You experienced another hardship in obtaining health insurance.”

The HHS exemption application form says:

“Please submit documentation if possible.”
Employer Mandate

- Penalty for not providing insurance is $2,000 per employee
- Additional penalty of $3,000 per employee if
  - Employee secures coverage through a health insurance exchange, and
  - Receives a subsidy
- Applies to all employers with 50 or more full time or FTE employees (full time is 30 hours per week).
- Penalty is per employee minus the first 30 employees.
  - Example: a 50 employee firm with no health insurance would pay penalties of:
    - $2,000 \times (50 - 30) = $40,000 penalties
Unintended Consequences

The employer mandate makes it extremely expensive to go over 50 employees

Small employers have an increased incentive to:
- Reduce staff through attrition or layoffs
- Cease hiring new employees
- Replace full time employees with part time (under 32 hours per week)
- Outsource

- ACA may be a factor in the persistently higher than expected unemployment, underemployment and part-time jobs
Employer Mandate Delayed - Again

Original Effective Date per Statute – January 1, 2014

July, 2013 - delayed for one year till January 1, 2015, allegedly because Treasury Department computer systems not ready to track every employer in the U.S.

February, 2014 – delayed again.
   For 50-99 employee firms, delayed until 2016.
   For 100+ employee firms, no fines if coverage provided to at least 75% of the workforce
Employer Mandate Delayed - Again

Likely administration rationale:

$11,000 per year per employee – average employer cost for Healthcare insurance
$2,000 per year per employee – ACA fine
42.1 million Americans work in firms of 100 employees or fewer*

If employer mandate had been applicable on January 1, 2015, millions of employees might have lost their coverage and been forced into the ACA Exchanges just before the November, 2014 elections

*Source. U.S. Census, 2008, latest year for which numbers are available
38 Delays to Date to Various Provisions of Affordable Care Act
Adverse Selection
• ACA requires one of four levels of coverage, known as:

• Bronze Plan – covers 60% of actuarially anticipated healthcare costs
• Silver Plan – covers 70% of actuarially anticipated healthcare costs
• Gold Plan – covers 80% of actuarially anticipated healthcare costs
• Platinum Plan – covers 90% of actuarially anticipated healthcare costs

• But...currently individual and small employer plans cover between: 46%-47% of actuarially anticipated healthcare costs
What kind of health plan do people pick?

Source: State reports
• To go from 46% of actuarially costs to 60% = 30%
• Plus: Surcharge to cover costs of state health exchange 5%
• Plus: Rate increase for healthcare inflation and potential adverse selection >5%

Total health insurance rate increase as of 1/1/2014: 44%+
• IRS calculates that the bronze plan for a family of four to five will be a minimum of $20,000 per year for 2014

• Average individual plan cost is $4,500 to $6,000 for 2014

• Average individual deductible
  Bronze Plan: $4,545
  Silver Plan: $2,567
Adverse Selection Issue

Key ACA provisions:

– **Guaranteed issue** – precludes insurance companies from denying or dropping coverage because of preexisting conditions.

– **Community rating** – requires insurers to set premiums solely on the basis of:
  
  • Age
  • Smoker status
  • Geographic area
  • Cannot charge higher premiums to the sick or those susceptible to sickness

– **Gender Neutral** – no difference in premiums between men and women

– **300% Range** – difference between lowest and highest premium cannot be more than 300%. Actual range is closer to 700%.
Adverse Selection Issue

- In health insurance, to avoid adverse selection, 70% of a risk pool required.
  - 70% of 15M – 10.5M enrollees to comfortably avoid adverse selection

- The provision allowing young adults up to age 26 to remain on parents’ health insurance took 3M “young invincibles” out of the potential exchange pool
Uninsured Aren’t Buying

• Half of uninsured adults have looked for insurance online...
  ...but only 10% have actually bought it

  --Source: Urban Institute survey, December, 2013
  http://hrms.urban.org/briefs/early-market-experiences.html

• Just 25% of people who bought insurance on the Exchanges were previously uninsured. Biggest factor: they believe they can’t afford it.

  – Source: McKinsey & Co study, March, 2014,
    http://healthcare.mckinsey.com/individual-market-enrollment-updated-view
Affordable Care Act Enrollment Data

As of March 31, 2014 End of Enrollment Period

• 48M uninsured. ACA goal: insurance 30M, 15M through the Medicaid expansion and 15 through the Health Insurance Exchanges.

• Estimated additional Medicaid enrollees 3M

• Administration estimated Health Insurance Exchange enrollees* 8.0M
  o 20% don’t pay the first month
  o 3-5% don’t pay the second month
  o Exchange enrollees after cancellations for non-payment 6.1M

• Percentage of Exchange enrollees who are uninsured
  o (remainder previous had insurance but lost it through ACA related cancellations)
    Urban Institute – 10%;  McKinsey – 25%;  1.5M

Total Previously Uninsureds Now Covered Through ACA 4.5M

*Rand Study puts the total Health Insurance Exchange enrollees at 3.9M
http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf
Affordable Care Act Cancellations

Policyholders cancelled as out-of-compliance with ACA mandates: 9.3M

Source: AP study, Dec 26, 2013 = 4.7M cancelled
Fox news took AP’s work and continued updating
As of March 6, 2014 = 6.3M cancelled
(no data from 11 states with contain 24% of population)
Extrapolating those 11 states into the data suggests 9.3M total
Patient Population

3.23 million ACA enrollees for whom age info available as of Feb 1, 2014
Source: Dept of Health & Human Services

**18-34 “young Invincibles”**
- 6%

**35-44**
- 25%

**45-54**
- 16%

**58-64**
- 22%

**58-64 are only 12% of population**

**Must be 40%+ to avoid adverse selection**
Percent of young adults signing up for Obamacare

- District of Columbia: 46%
- Arkansas: 39%
- Kentucky: 34%
- California: 29%
- US average: 28%
- Colorado: 26%
- Washington: 25%

Source: Federal, state reports
How Sick Are the Exchange Enrollees?
Express Scripts study, April 11, 2014

Pharmacy use provides quickest look at the health of the new Exchange enrollees. Express Scripts study involves 423,000 lives and 650,000 pharmacy claims from January 1, 2014 through February 28, 2014

- Overall use of pharmacy was 35% higher in Exchange plans.
- More than 6 of every 1,000 prescriptions in Exchange plans were to treat HIV. Four times higher than commercial health plans.
- Proportion of pain medication was 35% higher in Exchange plans
- Proportion of anti-seizure medications was 27% higher in Exchange plans
- Proportion of antidepressants was 14% higher in Exchange plans
- Proportion of contraceptives was 31% lower in Exchange plans

ACA Risk Corridor Program

• Caps big individual claims costs for insurers:
  – 2014-2016: 80% of costs between $45,000 and $250,000 are paid by the government
ACA Risk Corridor Program

- For the years 2014, 2015 and 2016:
- 50% of the costs between 103% and 108% of the health plan’s targeted amount reimbursed
- Over 108%, Feds pay health plan 2.5% of target and 80% of claims costs over 108% with no upside limit

- Targeted amount = premiums less administrative costs
ACA Risk Corridor Program

• If health plans claims costs come in below targeted amount, they pay the excess to the Feds using the same formula in reverse.

• ACA limits Risk Corridor Program to $25 billion over three years, $12B in 2014.
If Adverse Selection Occurs, When Will It Happen?


- Period Too Short For Meaningful Data
- Full Year of Data
- Full Year of Data

End of Enrollment Period

Data Cut Off for 2015 Rates

Data Cut Off for 2016 Rates

2016 Rates Announced

Data Cut Off for 2017 Rates

2017 Rates Announced

March 31, 2014

Early Summer 2014

Early Summer 2015

November 2015

Early Summer 2016

Nov, 2014 Mid-Term Elections

Adverse Selection Hits Rates?

Nov, 2016 Presidential Election

Adverse Selection Hits Rates!
The ACA Website Disaster
State Health Insurance Exchanges

• The Affordable Care Act requires each state to build a State Health Exchange

• Each State Health Insurance Exchange has the following tasks under ACA:
  – Dispense health insurance subsidies
  – Regulate insurers; regulate coverage; enforce price controls
  – Verify who is eligible by income and residency
  – Police compliance with the individual mandate
  – Report scofflaws to the IRS
  – Penalize businesses that do not insure their employees
State Health Exchanges

• **The IT Challenge**
  – Federal Data Services Hub
    • Contract to build the data hub was only released in late 2012 to IT firm QSSI (a subsidiary of United Healthcare) to build data hub.
    • Connects with:
      – IRS – for income and employment status
      – Social Security – for identity
      – Homeland Security – for citizenship status
      – Justice Department – for criminal history
      – HHS – for enrollment in entitlement programs and certain medical claims data
      – State Government Systems – for residency
      – State Medicaid Systems
  – Exchange software being built by CGI Group on an $88M government contract.
The Obamacare Hub - Transfer of Data and Dollars

"the largest consolidation of personal data in the history of the republic." USA Today

Step 1
Person or employer enters private data into Exchange (government web portal).

Step 2
State's website portal sends entered data to Federal Data Services Hub and other state data sources (Medicaid, Revenue, Health, etc.) and requests data from state data sources and the Hub.

Step 3
Step 4
To transfer and validate person's or employer's data, the Hub connects with the federal government and then transfers data back to the state Exchange.

The Exchange (website portal), using data from state sources and the Hub, approves or does not approve individual or Employer for coverage, including access to premium subsidies.

For individuals eligible for taxpayer-funded federal premium subsidies or Medicaid, the U.S. Department of Treasury will transfer the funds directly to the health plan chosen by the individual. NOTE: If health plans are overspent due to inaccurate estimates of income or employment status, the IRS will seek repayment from the individual in what is known as a "clawback."


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Why the ACA Website Disaster Occurred

1. No Experienced IT System Integrator
   55 separate IT contractors
   CMS, with no experience, took on the roll of system integrator—and failed
Why the ACA Website Disaster Occurred

2. Code was Kept Secret
   Open source code is the industry “best practice.” Secret code is stultifying, eliminates peer review. None of the best minds from Silicon Valley would work under those deadening conditions.
Why the ACA Website Disaster Occurred

3. Government Contracting Rules

A complex, arcane process, requires companies to devote years of research to master the process. Most government IT contractors come from a relatively narrow group of companies who work for the government repeatedly.

“I realized I could figure out how to develop these very complex, very next generation software programs or I could figure out how to contract with the government...so I chose to do the thing that was innovative.”
Why the ACA Website Disaster Occurred

4. Poor Choice of Contractors

GCI, contractor to build the website, was fired in 2012 by the Canadian province of Ontario for failing to build a similar website under a $46M contract.

GCI was fired by government in early 2014, replaced by Accenture, who successfully developed the California health exchange website “Covered California”

QSSI is contractor to build the federal data hub. Their EVP, Anthony Welters, was among the largest Obama contributors and “bundlers, and according to the White House visitors’ log, has visited Obama 12 times by the end of 2012.

QSSI sold to United Healthcare in 2012. They have been paid $150M to date for their ACA work.
Why the ACA Website Disaster Occurred

5. Inadequate Testing – Testing should have started a year prior to launch, at the latest, not two weeks prior.

Four stages of testing:

   Alpha, Beta, Detail and Destruction/Break testing

Healthcare.gov website was launched while still in Alpha test.

6. Procrastination in Awarding Contracts

   ACA enacted in March, 2010
   Contracted awarded starting in 2011
   Site requirements completed in March, 2013
Why the ACA Website Disaster Occurred

7. Scope Creep
   Administration kept changing the requirements throughout the process. One change, to keep applicants from seeing the price until after they registered, was allegedly done two weeks before October 1 launch.

8. Poor Management
   Government contractors tell of a process so cumbersome it took weeks to resolve elementary questions, such as whether users should provide Social Security numbers.
   - CMS used database software from a company called MarkLogic, which manages data differently from systems from IBM, Microsoft and Oracle, thereby creating significant compatibility problems.
   - White House constantly demanded oversight—”nothing was decided without a conversation there…”
   - Over 3 years, five managers held the position of head of development of healthcare.gov
9. Poor Legislative Design.

Perhaps the ultimate responsibility should lie with the drafters of the legislation, who designed a law without consideration of the process and problems of implementation.

The amazingly complex structure of the law creating a daunting IT task.
Why the ACA Website Disaster Occurred

10. Too Big to Fail
Other companies have built similarly large projects of the size and scope of ACA, but always slowly,

starting small

building the software in increments

rolling out the finished project gradually

ACA did not allow a gradual rollout, but instead required a “big bang”, where a massive system had to work on the first try.
Why the ACA Website Disaster Occurred

11. Failure to Manage the Quality of the Software

Lines of Code for Large Software Projects:
   - Facebook – 20M lines
   - Microsoft Windows – 50M lines
   - Affordable Care Act – 500M lines

Average programmer writes six lines of code per day
   (many days it is zero because programmer is testing, debugging, rewriting or documenting)
Why the ACA Website Disaster Occurred

1,000 programmers, working for the three year period since ACA was enacted would have written 66M lines of code.

Open source code projects average .69 bugs per 1,000 lines

(this is a closed source project, so it is probably much worse)

ACA team admitted in November, 2013 that they had a “punch list” of 600 open items. At .69 bugs per 1,000 lines, they probably had closer to 21,000 bugs.

John Xenakis, experienced programmer: “Healthcare.gov will not be fully functional at any time in the foreseeable future, if ever.”
Why the ACA Website Disaster Occurred

Current “to do list” includes:

• Problems with the government sending enrollment transactions to insurers—the 834s—still have error rates much too high for volume processing

• Government cannot to an automated enrollment reconciliation with insurers, sorting out who is and who is not insured—*because the system still hasn’t been built.*

• Government cannot pay insurers—instead they are sending estimated bills to the Feds—*because the system still hasn’t been built.*

• Government cannot add or delete people from the systems for issues like a newborn or a divorce—*because the system still hasn’t been built.*

• Government cannot handle appeals when people their eligibility or subsidy calculation is wrong—*because the system still hasn’t been built.*

• Government cannot cancel people off of Healthcare.gov—*because the system still hasn’t been built*

Current Status of the ACA Website

Total Website Development costs as of 3/31/14: $677M
Additional repair costs to be paid to Accenture in 2014: $121M

“Back-end” had to be operational by March, 2014 or
“disaster would ensue and the whole law could be jeopardized...”

Then the goal slipped to summer of 2014:
Now, completion by summer appears to be a question mark.

Government is now taking bids for a new contractor to “overall” Healthcare.gov for 2015 under:

“...aggressive time constraints...” and that can “transition a large-scale systems development project of 400 to 500 employees in three months.”

In addition to the back-end systems, security is still a mess. Security consultant David Kennedy stated that it took him just four minutes to access 70,000 enrollees’ records, without actually hacking the site.
April 25, 2014: The Oregon Health Insurance Exchange gave up, and announced that it will switch to the federal website.

- After spending over $250M, of which $134M went to Oracle, the website failed to enroll a single individual (small numbers of Oregonians have succeeded in enrolling using paper applications)
- State switched to feds because of cost:
  - Another $78M to fix “Cover Oregon”
  - $4M to $6M to switch to the federal website
- Maryland also failed to develop a workable website, and announced that it will be the software license form the Connecticut website
- State exchanges have also experienced problems in Massachusetts, Minnesota and Hawaii
Other Website Disasters

“According to the research firm the Standish Group, 94% of all large federal information technology projects over the past 10 years were unsuccessful—more than half were delayed,
over budget,
or didn’t meet user expectations,
and 41.4% failed completely.”
Other Website Disasters

UK Electronic Medical Record for National Health Service – Wasted $11 billion over 10 years before giving up the project

The liberal “Guardian” newspaper:

“The government is an inept purchaser of private services: indecisive, ponderous, overambitious and wasteful. Mass centralization does not reduce costs, but kills flexibility.”
“The back end of this brobdingnagian gobbler has to communicate with hundreds of databases run by dozens of government agencies and dozens or hundreds of private companies, many of which have several different IT fiefdoms each determined not to let anyone do anything the others’ way. Every communication is a transaction, every communication has to work right, and the entire dance of incompatible and uncooperative systems has to work with the precision of a ballerina on a balance sheet...

I can’t, in good conscience, wish them the heart attacks, panic attacks, strokes, mental breakdowns, cirrhotic livers, and divorces that this is going to cost if they are really determined to fix it.”

--njcommuter, 10/25/2013, at hot.com/greenroom/archives/2013/10/24
Future Predictions & Effects on Healthcare Providers
Scenario 1: Affordable Care Act Survives
(Achieves Enrollment Objectives, Avoids Adverse Selection, Is Not Overturned by Supreme Court, and Democrats Control the White House in 2017)

• Physician Shortages – Longer Waits/Restricted Access
• Increases in:
  – Concierge Physicians
  – Nurse practitioners/Physician assistants growth
• Hospitals continue acquiring physician practices
  – Independent physicians a dying breed?
  – Or hospitals loss money, begin divesting employed physicians?
• If CMS revises ACO model, it might become the dominant healthcare delivery model for Medicare
• Industry consolidation continues = fewer, larger buyers of healthcare, mostly self-insured or in captives
Scenario 2: Compromise in 2017

(ACA Muddles Through for 2 ½ Years
Election of 2016 Creates a Climate for Bipartisan Compromise)

• There is a precedent: All major social programs (social security, Medicare, Medicaid) when through years revisions and modifications

• What form the compromises would take is anyone’s guess
Scenario 3: Republican President in 2017

• If a Republican President and Congress in 2017 – ACA repealed
• If a Republican President and Democrats control at least one chamber of Congress – President refuses to enforce key provisions, ACA mostly dies.
Scenario 4: Private Health Exchanges

Trend toward Private Insurance Exchanges

- Many run by Hewitt (an Aon subsidiary) or Mercer (a Marsh subsidiary)
- Recent Companies Switching: Walgreens, Sears, Darden Restaurants

Transfers risk of inflation to employee
Higher deductibles/copays transfers responsibility of cost control to employee
Employees given wider choices of plans

Think of it as “Defined Contribution health benefits”, similar to Defined Contribution retirement benefits

ACA might cover 4-5M people through the Health Insurance Exchanges
Private employers currently cover 155M – 170M people

*ACA, if it survives, could become irrelevant. Private exchanges will drive healthcare.*
Accountable Care Organizations (ACOs)
Accountable Care Organizations

ACOs – Accountable Care Organizations

- “The Mayo Clinic” model*
- Often called “HMO version 2.0” or a “mini-HMO”

An integration of a:

- defined patient population (5,000 minimum),
- a defined set of local hospitals,
- medical groups,
- ancillary providers

*Administration cited six healthcare systems as models: The Mayo Clinic, The Cleveland Clinic, Geisner Clinic, Kaiser Permanente, Dartmouth-Hitchcock Clinic and Intermountain Healthcare
Three Types of ACOs

• Medicare ACOs – rules laid out by ObamaCare, administered by CMS

• Medicaid ACOs – some states moving Medicaid to ACO format:
  – Massachusetts
  – New Jersey
  – Oregon (called CCOs - “coordinated-care organizations”)
  – Colorado – called Accountable Care Collaborative program
  – Minnesota – called Accountable Health Model, applies to Medicare, Medicaid and private insurance

• Private ACOs – contacts between health insurers and providers
ACO Quality and Cost Savings
Risks and Rewards

Meet quality standards and cut costs = share 60% of the savings

Fail to meet the quality standards = no savings shared (even if you cut costs)

Meet the quality standards but fail to cut costs = share 60% of the losses
Pioneer ACOs – Results After Year One
Early Returns - How 32 accountable-care organizations (ACOs) in the Pioneer program faired during the first year

32 Pioneer ACOs caring for 669,000 Medicare patients. All met quality criteria.

18 Lowered Medicare costs for their patients compared with a historic benchmark

14 increased average Medicare costs for their patients at least somewhat compared with historic benchmark

13 saved enough to split $76 million in savings with Medicare

5 had savings insufficient to split with Medicare, continuing in program

7 switched to a different ACO program that carries less financial risk

2 dropped out of Medicare ACO program

5 remaining in Pioneer program
ACO Growth

Working Together
Number of accountable-care organizations (ACOs), quarterly

Source: Leavitt Partners
The Wall Street Journal
Reasons for Pioneer ACO Defections and Stalling of ACO Growth

ACO’s ability to manage patient care is limited. Patients can see other doctors or hospitals who are not part of the Pioneer program.

Medicare has lagged in providing Pioneer ACOs the claims data they need to track spending on their assigned patients.

Tapped out market for trailblazers. All the innovators are already in the market.

No proven model to follow. Most providers, while not opposed to accepting risk, are waiting until they see a viable pathway to follow.
The Oregon Experiment
The Oregon Experiment


• In 2008, Oregon had funds to increase Medicaid enrollment by 10,000, but a 90,000 waiting list
• 10,000 Medicaid recipients were selected by lottery
• Result: Two similar groups of poor, one with insurance and one without, that could be compared.
## The Oregon Experiment

<table>
<thead>
<tr>
<th></th>
<th>Insured</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician office visits</td>
<td>8.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Prescription drugs used</td>
<td>2.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Had a “usual place of care”</td>
<td>70%</td>
<td>46%</td>
</tr>
<tr>
<td>Received “all needed care”</td>
<td>72%</td>
<td>61%</td>
</tr>
<tr>
<td>Received screening for cholesterol</td>
<td>42%</td>
<td>27%</td>
</tr>
<tr>
<td>Women over 50 having mammograms</td>
<td>59%</td>
<td>29%</td>
</tr>
<tr>
<td>Men over 50 getting PSA test for prostate cancer</td>
<td>41%</td>
<td>21%</td>
</tr>
<tr>
<td>Out of pocket costs</td>
<td>$337</td>
<td>$553</td>
</tr>
<tr>
<td>Average annual healthcare spending</td>
<td>$4,429</td>
<td>$3,257</td>
</tr>
</tbody>
</table>
The Oregon Experiment

Study screened for high blood pressure, high cholesterol, diabetes, risk of future heart attack and risk of future stroke

Conclusion: There were no major detected differences between the uninsured and Medicaid recipients.

While there was more treatment for diabetes, there was no difference between the two groups on the key indicator for diabetes.

The only major gain was psychological. Depression dropped from 30% to 21%, perhaps because of less fear of large medical bills.
The historian Barbara Tuchman wrote:

“You cannot extrapolate any series in which the human element intrudes. History, that is, the human narrative, never follows and will never follow the scientific curve. Human beings are an adaptive lot. Observers often miss the countervailing forces that work to undo trends of all kinds.”
Kimber J. Lantry
Executive Vice President
AXIS Healthcare
4040 Civic Center Drive, Suite 200
San Rafael, CA  94903
(415) 262-6871 Office
(415) 250-6132 Cell
kimber.lantry@axiscapital.com