UPDATE ON THE STATUS OF HEALTHCARE DISPARITIES AND HEALTHCARE REFORM

OBAMACARE vs TRUMPCARE

Why The ACA Must Remain In Effect & Be Improved to Benefit the Public

Richard Allen Williams, MD, FACC, FAHA, FACP, DHL (Hon)

117th President, National Medical Association

Presented by

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- Clinical Professor of Medicine and Cardiology, UCLA School of Medicine
- 117th President, National Medical Association
- Author, *Textbook of Black-Related Diseases* (McGraw-Hill, 1975)
- Author, *Healthcare Disparities at the Crossroads with Healthcare Reform (Springer, 2011)*
- Author, *Blacks in Medicine (Springer, 2017)*
- Founding President and CEO, Minority Health Institute
- Founder, Association of Black Cardiologists

I HAVE NO DISCLOSURES

MEMORABLE QUOTE FROM PRESIDENT BILL CLINTON:

- “DO NOT ALLOW THE PERFECT TO BE THE ENEMY OF THE GOOD”

PURPOSE OF THE ACA

- To provide greater access to healthcare for the American people
- To lower the costs of medical care
- To increase the quality of healthcare

MAIN BENEFITS OF THE ACA THROUGH 2017

INCREASED ACCESS TO TREATMENT:

- Uninsured rate declined by 43%, from 16.0 in 2010 to 9.1 in 2017.
- As of 2017, 20 million Americans who were uninsured now have health insurance. Expanded coverage has greatly increased access to treatment.

COST CONTAINMENT:

- Reduction in personal debt occurred for persons seeking Medicaid, providing them with greater financial security.

• continued

MAIN BENEFITS OF THE ACA THROUGH 2016

MEDICARE SPENDING REDUCED

- Mean annual growth in real per-enrollee Medicare spending has been *negative*.
- Medicare is now projected to spend 20% or $160 billion **less** in 2019 alone, as predicted by the Congressional Budget Office.

QUALITY OF CARE IMPROVEMENTS:

- AHRQ estimates that the decline in hospital-acquired conditions has **prevented 84,000 deaths over 4 years.**
- 30-day readmission rates have decreased from 19.1% in 2010 to 17.8% in 2015.
- DHHS estimates that there were 565,000 fewer readmissions from 2010 to 2015.

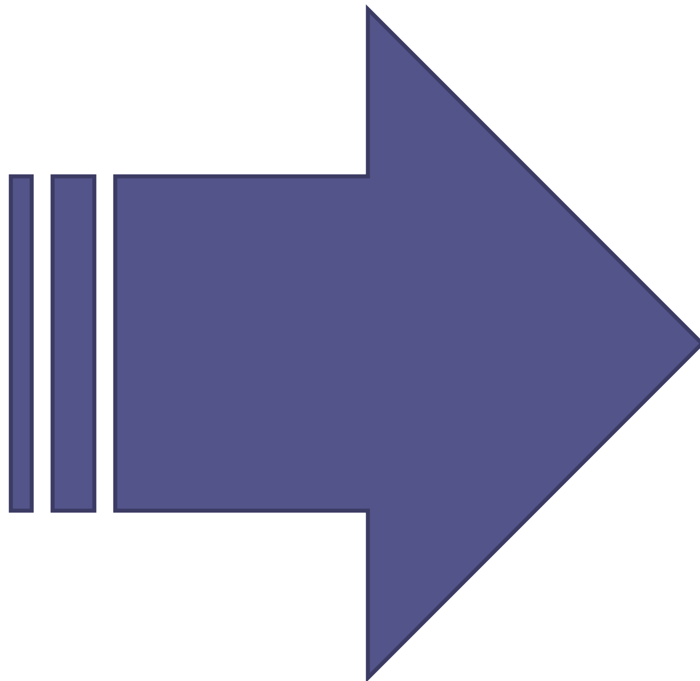
- *...continued*

MAIN BENEFITS OF THE ACA THROUGH 2017

REFORMING THE HEALTHCARE DELIVERY SYSTEM:

- Fee-for-service payment systems which focus on volume are being replaced by value-based systems focusing on prevention, wellness, and outcomes of treatment. This is one of the central features of Obamacare.

GRAPHIC EVIDENCE OF THE ACA'S BENEFITS



GOALS SET

+

GOALS MET

=

TARGETS ACHIEVED

=

JUSTIFICATION TO MOVE FORWARD

From: **United States Health Care Reform: Progress to Date and Next Steps**

JAMA. 2016;316(5):525-532. doi:10.1001/jama.2016.9797

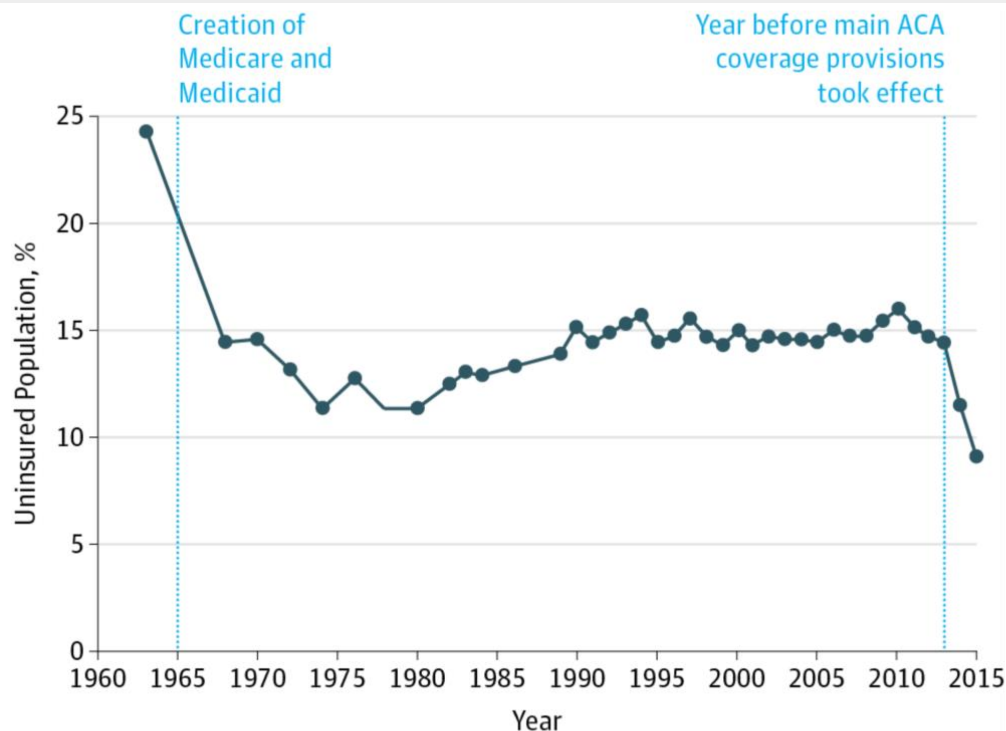


Figure Legend:

Percentage of Individuals in the United States Without Health Insurance, 1963-2015Data are derived from the National Health Interview Survey and, for years prior to 1982, supplementary information from other survey sources and administrative records. The methods used to construct a comparable series spanning the entire period build on those in Cohen et al and Cohen and are described in detail in Council of Economic Advisers 2014. For years 1989 and later, data are annual. For prior years, data are generally but not always biannual. ACA indicates Affordable Care Act.

Date of download: 8/8/2016

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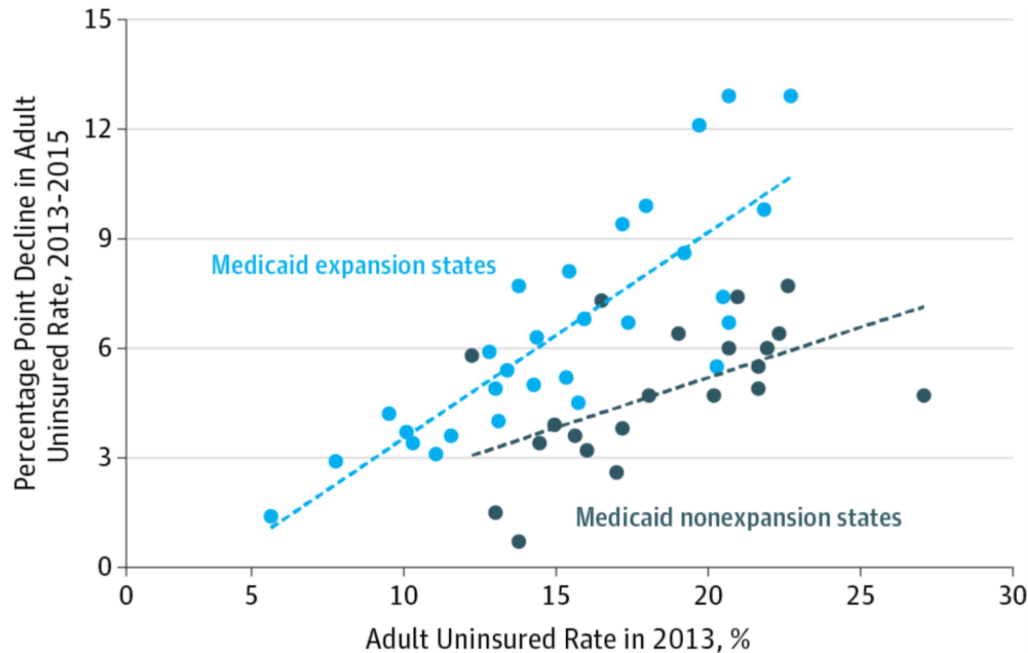

Figure Legend:

Decline in Adult Uninsured Rate From 2013 to 2015 vs 2013 Uninsured Rate by StateData are derived from the Gallup-Healthways Well-Being Index as reported by Witters and reflect uninsured rates for individuals 18 years or older. Dashed lines reflect the result of an ordinary least squares regression relating the change in the uninsured rate from 2013 to 2015 to the level of the uninsured rate in 2013, run separately for each group of states. The 29 states in which expanded coverage took effect before the end of 2015 were categorized as Medicaid expansion states, and the remaining 21 states were categorized as Medicaid nonexpansion states.

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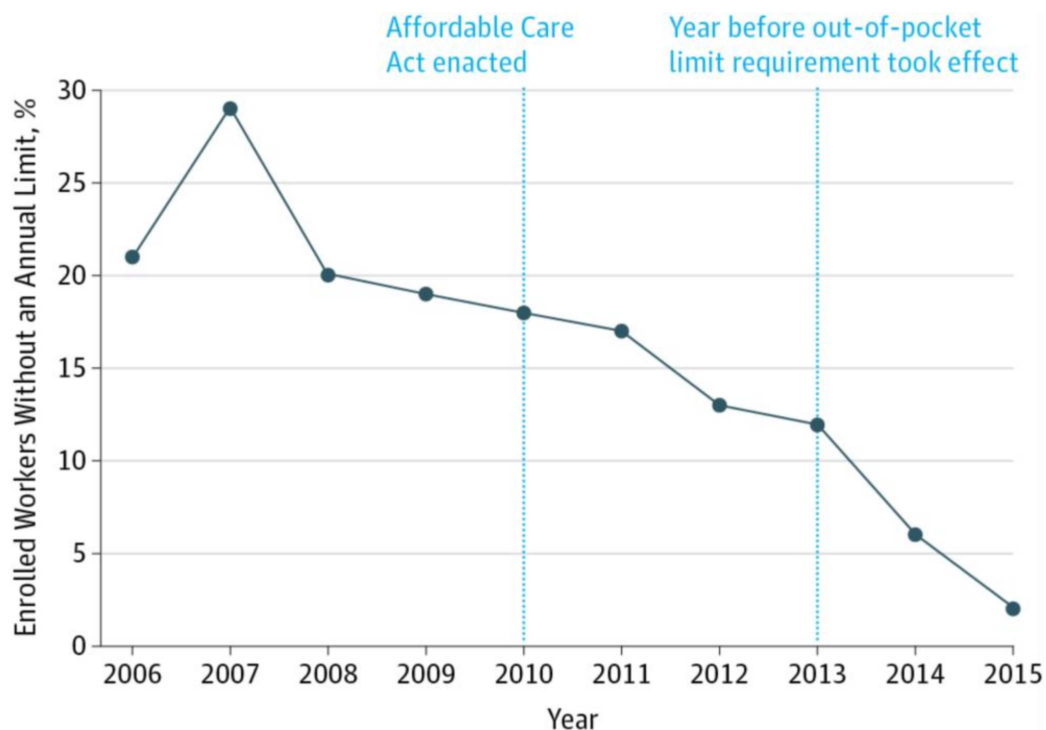

Figure Legend:

Percentage of Workers With Employer-Based Single Coverage Without an Annual Limit on Out-of-pocket SpendingData from the Kaiser Family Foundation/Health Research and Education Trust Employer Health Benefits Survey.

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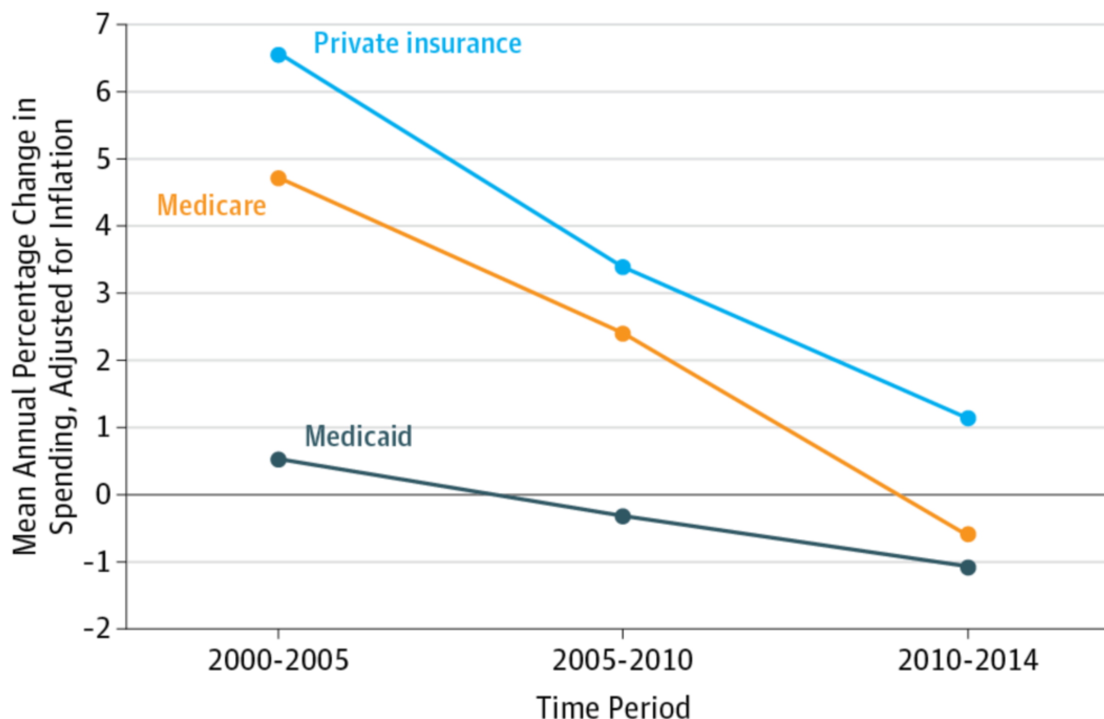

Figure Legend:

Rate of Change in Real per-Enrollee Spending by PayerData are derived from the National Health Expenditure Accounts. Inflation adjustments use the Gross Domestic Product Price Index reported in the National Income and Product Accounts. The mean growth rate for Medicare spending reported for 2005 through 2010 omits growth from 2005 to 2006 to exclude the effect of the creation of Medicare Part D.

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The JAMA Network

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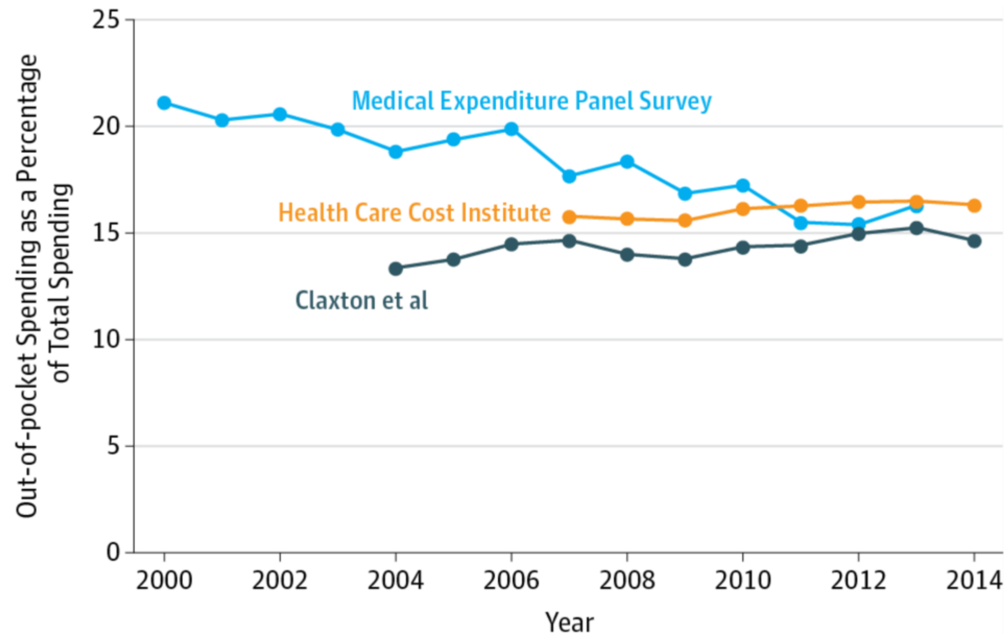

Figure Legend:

Out-of-pocket Spending as a Percentage of Total Health Care Spending for Individuals Enrolled in Employer-Based Coverage Data for the series labeled Medical Expenditure Panel Survey (MEPS) were derived from MEPS Household Component and reflect the ratio of out-of-pocket expenditures to total expenditures for nonelderly individuals reporting full-year employer coverage. Data for the series labeled Health Care Cost Institute (HCCI) were derived from the analysis of the HCCI claims database reported in Herrera et al, HCCI 2015, and HCCI 2015; to capture data revisions, the most recent value reported for each year was used. Data for the series labeled Claxton et al were derived from the analyses of the Trueven Marketscan claims database reported by Claxton et al 2016.

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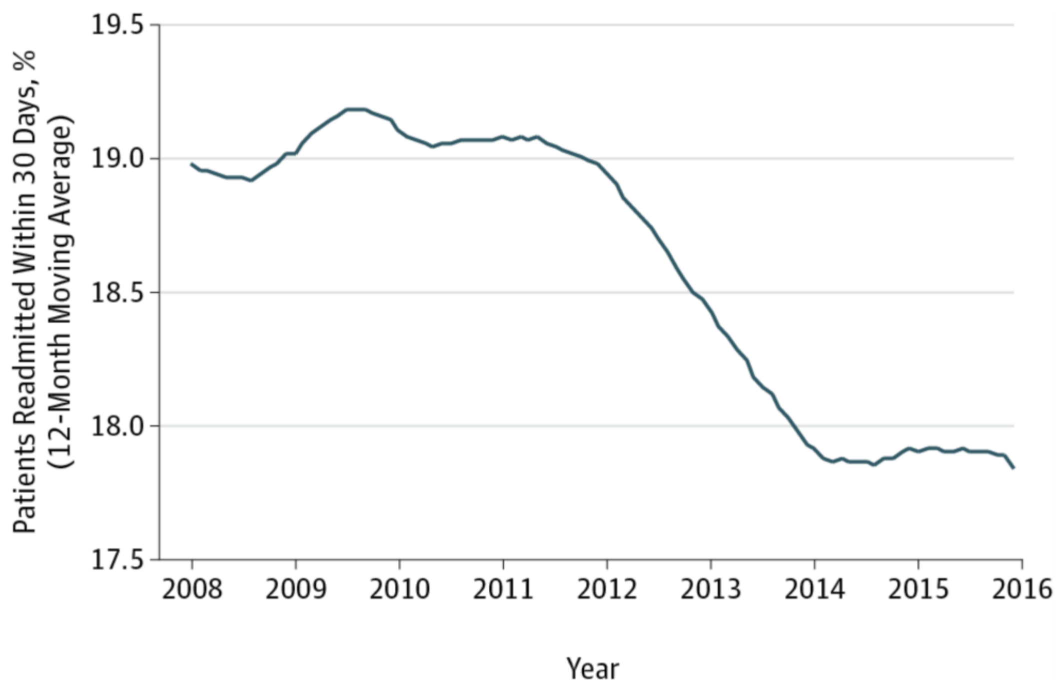

Figure Legend:

Medicare 30-Day, All-Condition Hospital Readmission RateData were provided by the Centers for Medicare & Medicaid Services (written communication; March 2016). The plotted series reflects a 12-month moving average of the hospital readmission rates reported for discharges occurring in each month.

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MAIN DEFICIENCIES OF HEALTHCARE REFORM

- Insurance premiums are increasing.
  - In California, premiums are expected to rise 13.2% in 2017.
  - Covered California premiums rose just 4.2% in 2015 and 4.0% in 2016.
  - Rising costs of medical care such as drug costs are blamed.
  - Adverse tiering of drug prices is an example.
  - Blue Shield’s rates are going up more than 19%;
  - Anthem’s rates will jump 16%.
  - This will make insurance coverage less affordable for the public.

MAIN DEFICIENCIES OF HEALTHCARE REFORM

- Covered California (CC) officials say that more competition among insurers will bring the premiums down.
- CC negotiations with insurers were expected to keep premiums down.
- It was thought that negotiations through the Exchanges would keep prices in check.
- However, the ACA law contains few controls over overall costs.
- 38 states operate such exchanges on their own.

- NOW.....

  Some people are feeling that they will not be able to afford health insurance as the premiums rise, especially if subsidies are removed.

Revenue Projections of Participating Insurance Carriers

- Gloom and Doom exists with some carriers, based on actual and projected losses in the insurance marketplaces.
- Several insurers have exited the market (examples: HealthNet, Aetna) with others threatening to follow (example: Anthem), citing lack of a functioning risk corridor and risk adjustment that is beneficial to them. However, others such as Molina are prospering. So what's the difference?

TRUMPCARE REPEAL AND REPLACE PLAN

- Removes most subsidies, putting insurance out of reach for middle-class and poor people
- Removes mandate to purchase insurance which will devastate the Exchanges
- Replaces Medicaid Expansion with block grants
- (Cap and Scrap)
- Provides Health Savings Accounts (HCAs) for low-income people
- Provides tax credits which will only benefit the wealthy
- Charges higher premiums to older, sicker patients

TRUMPCARE (CONT'D)

- Slices Medicaid spending by $ 800 billion
- Puts a cap on Medicaid growth, limiting it to the growth rate of the Consumer Price Index (CPI)
- Shifts the <u>financial risk</u> to states
- Limits the benefits that "able-bodied" people can obtain
- Attempts to control costs but does nothing to increase value or quality of coverage
- Eliminates the 10 Essential Health Benefits guaranteed by Obamacare

TRUMPCARE (CONT'D)

- Allows states to implement eligibility requirements that mandate Medicaid beneficiaries to work in order to receive benefits
- Ignores the special long-term care needs of some patients
- Drastically reduces funding for substance abuse programs
- Eliminates Planned Parenthood and other community-based programs
- Cuts spending for medical research (NIH, CDC)

TRUMPCARE (CONT'D)

- Repeals the Individual Mandate which requires people to purchase health insurance or pay penalties
- Eliminates subsidies that help people to purchase coverage in the insurance markets (makes insurance affordable)
- Threatens to remove cost-sharing subsidies for insurers (this alone will destabilize the insurance marketplace, necessitating insurers to raise "silver plan" premiums by an unaffordable 19%)

PREDICTED RESULT OF TRUMPCARE

- Congressional Budget Office (CBO) estimates that 14 million people will lose their health insurance coverage in the next year and 22 million will lose it in the next decade if Trump's plan passes.
- In addition, huge financial losses will occur due to higher premiums and decreased revenue.
- All of the gains accrued under the ACA will be reversed and the health and lives of millions of poor citizens will be jeopardized.

RECENT DEVELOPMENTS

- The Graham-Cassidy Bill will be presented to the Senate Health Committee on Sept. 26, 2017
- It is the newest attempt to repeal and replace the ACA, and the most Draconian
- If it passes Congress, 30 million people will lose health insurance coverage, Medicaid will be destroyed, and the states will gain control of the healthcare destiny of 100 million citizens
- Subsidies, the individual mandate, and the right to purchase insurance despite prior conditions wiii be lost

EXPECTED FALLOUT FOR BLACKS AND HISPANICS

- LOSS OF INSURANCE (5 million Hispanics, 4 million blacks)
- LOSS OF HEALTH (decreased access)
- LOSS OF MONEY (higher premiums, more out-of-pocket payments)
- LOSS OF LIFE

Benefits of ACA Coverage by Race and Ethnicity

- Black non-Hispanics have benefited the most under Obamacare. Uninsured rate for blacks declined 11.8 percentage points, a 52.7% decrease from baseline. The absolute number of insured increased by 3 million for blacks.
- For Hispanics, the uninsured rate declined by 11 percentage points from baseline, a 27% decrease.
- For White non-Hispanics, the decline was 7.3%, a reduction in uninsured coverage of 50.7% from baseline.
- Obviously, blacks stand to lose the most if the ACA is repealed and/or replaced.

HOW TO FIX OBAMACARE

- First, Do No Harm
- Modify the risk pool by adding younger, healthy enrollees
- Cut and Paste, don't Discard and Waste
- Retain allowance for children to remain on parents' insurance coverage up to age 26
- Retain feature allowing coverage despite prior medical conditions

How to Fix Obamacare (Cont'd)

- Bipartisan efforts are essential and focus should be on Revise and Re-Size rather than Repeal and Replace
- Congress must immediately appropriate funds to reimburse insurers for cost-sharing reductions
- "Risk corridors" should be established for insurers
- A permanent reinsurance program is needed (I call it "Reassurance")(Works like Medicare Part D)
- Modify the Medicaid Drug Rebate Program

How to Fix Obamacare (Cont'd)

- The ACA premium subsidies are too low and should be increased, not eliminated, so that insurance coverage is truly affordable. The income cutoff of 400% of FPL should be raised
- (Holahan and Blumberg, Urban Institute)
- Trump signed an Executive Order on Day 1 eliminating outreach, education, and marketing of the ACA. This should be reversed by Congress to increase enrollment in the Exchanges.

How to Fix Obamacare (Cont’d)

- Limit non-insurance purchase penalties to 2 years rather than eliminating the Individual Mandate altogether
- Eliminate the Employer Mandate. Not needed
- Retain (and even expand) Essential Health Benefits(EHBs) including free mental health and substance abuse treatment, mammograms, maternity care, and prescription drugs.
- Allow a limited amount of tax cuts
- Pay Risk Corridor money to insurers ($22 billion)

How to Fix Obamacare (Cont'd)

- Separate Medicaid from Insurance Issues (disaggregate)
- If all else fails….SUE THE BASTARDS!! Examples: Molina Healthcare in CA sued for Risk Corridor money and received a $52 million judgment this month in Federal Court. 26 other cases are pending.
- Communities of color should sue for denial of access to healthcare. Examples: Recent lawsuits by the Mexican American Legal Defense Fund (MALDEF) and the Civil Rights Education and Enforcement Center

IN CONCLUSION

- President Trump has attempted to destroy Obamacare at the expense of the American people and particularly people of color. Although his efforts to repeal and replace the ACA are temporarily stalled, he will not give up.
- He has created an atmosphere of despair regarding the future of Healthcare by focusing on Wealthcare. His attitude may be interpreted as “TrumpDon’tCare”.

- However, we have “the audacity of Hope” and the blessings of God on our side. We need to act strongly in conjunction with the Congressional Black Caucus, from the centers of our communities at the grass roots level to the Halls of Congress to beat back Trump’s deadly plan of destruction. This is truly a Civil Rights battle.
- We must vow never to give in and not only to continue the struggle but to fight smartly and to say to ourselves, “AND STILL I RISE”

SINGLE PAYER HEALTH INSURANCE: IS IT A VIABLE OPTION?

- Defined as " a healthcare system financed by taxes that covers the costs of essential healthcare for all residents, with costs covered by a single public system"

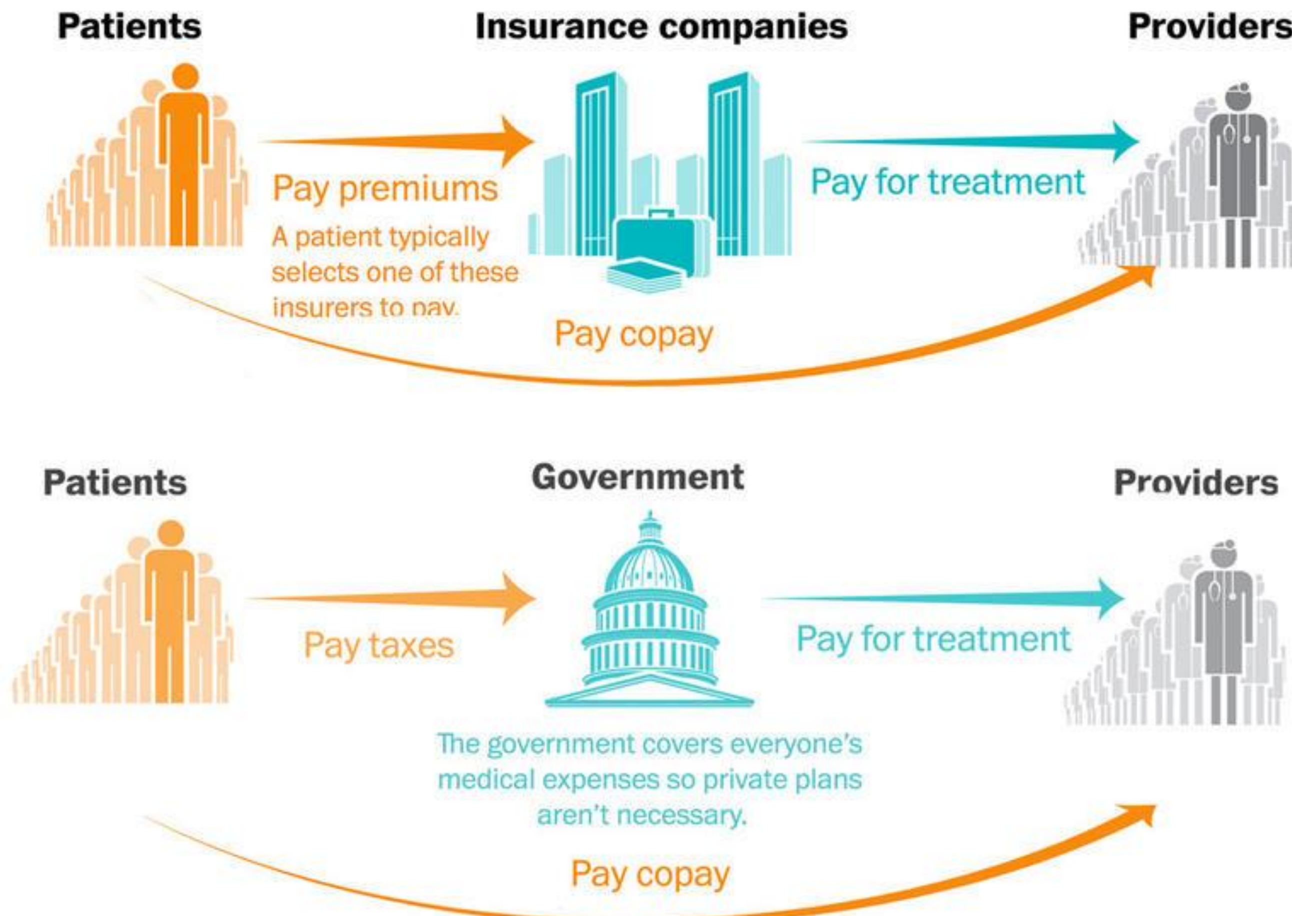
- "Medicare for All" is a system in which a single public or quasi-public agency organizes healthcare financing, but the delivery of care remains largely in private hands….all residents of the U.S. would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive healthcare, dental, vision, prescription drug and medical supply costs (Physicians for a National Health Program)

THE UNITED NATIONAL HEALTH CARE ACT OF 2009 (HR 676) WAS THE ORIGIN OF SINGLE PAYER IN AMERICA

THREE COMPONENTS OF A HEALTHCARE SYSTEM

- PATIENTS
- PAYERS
- PROVIDERS

HOW THE MONEY FLOWS



ARE SINGLE PAYER AND UNIVERSAL HEALTHCARE THE SAME?

U.S. IS THE ONLY HIGHLY DEVELOPED COUNTRY WITHOUT UNIVERSAL HEALTHCARE

- 51 OTHER COUNTRIES IN THE WORLD HAVE IT, FROM NORWAY TO KUWAIT

HOW DOES SINGLE PAYER WORK?

- First year: Medicare eligibility lowered to age 55
- Second year: Age lowered to 45
- Third year: Age lowered to 35
- Fourth year: Universal Medicare would be expanded to everyone

COMPARISON BETWEEN SINGLE PAYER AND OBAMACARE

A Superior Health Care System

	Single-Payer Bill (H.R. 676) vs.	Affordable Care Act
Universal Coverage	Yes. Everyone is covered automatically at birth.	No. About 30 million will still be uninsured in 2022 and tens of millions will remain underinsured.
Full Range of Benefits	Yes. Coverage for all medically necessary services.	No. Insurers continue to strip down policies and increase patients' co-payments and deductibles.
Savings	Yes. Redirects $400 billion in administrative waste to care; no net increase in health spending.	No. Increases health spending by about $1.1 trillion over 10 years. Adds further layers of administrative bloat to our health system through the introduction of state-based exchanges.
Cost Control/ Sustainability	Yes. Large-scale cost controls (negotiated fee schedule with physicians, bulk purchasing of drugs, hospital budgeting, capital planning, etc.) ensure that benefits are sustainable over the long term.	No. Preserves a fragmented system incapable of controlling costs. Gains in coverage are erased by rising out-of-pocket expenses, bureaucratic waste and profiteering by private insurers and Big Pharma.
Choice of Doctor and Hospital	Yes. Patients will be allowed free choice of their doctor and hospital.	No. Insurance companies continue to deny and limit care and to maintain restrictive networks.
Progressive Financing	Yes. Premiums and out-of-pocket costs are replaced with progressive income and wealth taxes. 95 percent of Americans will pay less for care than they do now.	No. Continues the unfair financing of health care whereby costs are disproportionately paid by middle- and lower-income Americans and those families facing acute or chronic illness.

SOURCE: http://www.pnhp.org/facts/what-is-single-payer

Be Good, America.

PROS AND CONS OF SINGLE PAYER

- PROS:
- 1. Everyone including children would have health insurance
- 2. No insurance companies to deal with
- 3. Although there would be some cost to patients, the out-of-pocket cost would be low
- 4. Cannot be denied because of pre-existing conditions
- 5. No loss of coverage if job or economics change

- CONS:
- 1. Higher taxes
- 2. Leaner insurance (only "essential" needs covered). Purchase of supplemental insurance may be necessary
- 3. Individuals not in the work force or disabled may not be covered
- 4. Increased demand for care will result in longer wait times, leading to rationing of care
- 5. Cost=$1.38 to 2.8 trillion dollars per year!!

WHO LIKES SINGLE PAYER?

- 53% of Americans favor it
- A majority of medical professionals
- A majority of healthcare organizations (AMA, etc.)
- Congressional Democrats

WHO DISLIKES SINGLE PAYER?

- Pharmaceutical industry
- Device manufacturers
- Equipment makers
- Insurance companies
- President Donald Trump

WHAT IS THE OUTLOOK FOR SINGLE PAYER?

- In 2017, states were able to exercise a waiver to set up their own healthcare solutions as long as they comply with the law (the ACA)
- In June 2017, the Health California Act (SB 562) was passed by the State Senate. It has been placed on hold by Speaker Rendon for logistical reasons after being sent to the State Assembly
- If SB 562 passes, Single Payer will become healthcare law in California

HOW CAN OUR HEALTHCARE PROBLEMS BE RESOLVED?

IN CONCLUSION

Disclaimer: The Image depicted below is for humorous purposes only. It is in the public domain on the Internet. There is no intent to harm the President or to draw conclusions about the state of his mental health.

Q&A