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HEALTHCARE EXECUTIVE ALLIANCE
SPECIAL SUPPLEMENT

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U.S. Healthcare to be Trumped UP!

(even more so than under Obamacare)

Now approaching 20% of gross domestic product (GDP), healthcare is a crucial economic concern, while it remains politically tenuous. Americans are troubled as to what lies ahead under Trump, matched by despair as the Republicans seek to dismantle most of Obama's healthcare achievements. U.S. healthcare faces major uncertainties in the near future. What happens this year and next will define the nature of the next decades' health system.

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The End of Affordable Care?

As his first act as President, Trump signed an Executive Order to prohibit federal agencies from actions related to the Affordable Care Act (ACA), known as Obamacare (Associated Press 2017). This ends the individual mandate for purchasing insurance, and gives States greater flexibility in implementation. Trump's promise to "repeal and replace Obamacare" must now pass Congress (Meyer 2016). However, total repeal will not get much support given the corporate interests of the medical-industrial complex (Salmon 1990;1994; Relman 1980) (Table 1 - see supplement online) and the law's complexity embedded into the healthcare system.

Even with a Democrat in the White House, the healthcare system was destined for a major crisis, with imploding health insurance exchanges (HIEs) and provider scale-backs amidst premium raises up to 70% in some places (Kaiser 2016); many counties have only one insurance carrier. The numbers struggling to pay medical bills and avoid bankruptcy did come down, but the out-of-pocket burden on consumers became politically painful. Physicians expanded their practices, hospitals found new revenues for their previously self-pay patients, insurance firms reaped added profits, and a plethora of private consulting firms cropped up to assist in implementation. States that accepted the Medicaid expansion benefited greatly in reducing their uninsured cohorts, which safety-net hospitals and community health centres appreciated (Kaiser Health 2017). Republican governors now worry about repeal because of the fiscal whammy their budgets may have to endure (and the provider uproar) if they cannot replace lost federal revenues (Beaumont 2017).

The ACA did not bring affordability or universal coverage. Many newly insured people have yet to secure a primary care physician relationship. Almost 9 million post-election signups for coverage reflect popular anxiety over what is to come (Schencker 2016a; Tracer 2017). Ten percent are still uninsured, and the Centers for Medicare and Medicaid Services (CMS)'s favouring of primary care physicians in value-based payment and forcing specialists into mandated bundled reimbursements has driven much doctor ire. It's reported that 359,000 physicians are under alternative payments mechanisms beginning in 2017 (Haefner 2017). While a minority of physicians favour repeal (40% in one informal survey; 15.1% in a survey published in the NEJM); most identify some merit in the law (Pollack et al. 2017).

The Republican Party will seek to trim benefits, force greater cost-sharing, and roll back protective regulations (Edney et al. 2016). A *New York Times* piece "Where Trump won, many want to keep healthcare" should trigger pause to Trump's populist image (Goodnough 2016). Eighty rural hospitals closed last year, with more dangling on bankruptcy if reimbursements are lowered and patients are dis-enrolled (Ellison 2016); this is Trump territory! Physicians serving folks who lose coverage will face an ethical dilemma over discontinuing care without any or diminished reimbursement.

Repeal will affect coverage for 156 million employees (ie, children on parents' insurance, pre-existing conditions, mental health and disability benefits, preventive medicine guarantees, etc.) (Schencker 2016b). Trump and Congress must work through a minefield of regulatory changes beyond financing, and craft the complicated legislative language that acknowledges not only criticisms, but the expected heavy disruption to the entire healthcare system. The Republican agenda must speak to access, benefit design, consumer choice, and specifics on flexibility for the States. State governments (the majority Republican-controlled) are not eager for reduced Medicaid funding under block grants (Sommers and Epstein 2017); nor will consumers be easily satisfied since the public remains split on favouring the ACA.

Key Health Appointments

Key among Trump's appointments is the now-confirmed Health and Human Services Secretary, Representative

Tom Price of Georgia—one of the foremost critics of Obamacare. Seema Verma will be nominated to head the Centers for Medicare and Medicaid Services (CMS), while the FDA commissioner, NIH director and CDC director are still to be named.

Hearings on Price offered little on how he would replace the ACA. Price was an orthopaedic surgeon for 20 years, which may have charged him up against Obama's bureaucrats; CMS actions became unappreciated by a large segment of the medical profession over implementation of the Medicare Access and CHIP Reauthorization (MACRA) Act of 2015 and and the Merit-based Incentive Payment System (MIPS). Besides electronic health records, an alphabet soup of MU, ICD-10, QPP, APMs, and other quality and cost requirements have been felt to be fencing in physicians. Private corporate providers and insurance firms have followed suit to restrict physician autonomy, which has fostered what is thought to be growing physician burnout (Salmon and Thompson 2017).

As to ethics, Price's portfolio holds substantial insurance, pharmaceutical, and corporate hospital chain stocks. The *Wall Street Journal* reported that he traded $300,000 in shares in numerous healthcare companies while pursuing legislation that could impact them (Grimaldi and Hackman 2016). Price announced that he would divest from 43 firms if confirmed, and maintained that his broker made trades without his direct knowledge, leading Democratic Senator Al Franken, to comment that he found Price's response "begs credulity."

Price and colleagues also want to better protect doctors from malpractice claims, which maintain "too-high" premiums leading him to seek federal tort reform. He wants the federal government to supplant States with required medical tribunals to decide malpractice disputes and not leave it up to the State civil courts. He favours caps on compensation to patients who have been harmed so that "costs can be reduced."

The real issue is how to better address medical mistakes and errors, which are the real cost drivers resulting from use of risky technologies and the burgeoning bureaucratic sanctions squeezing doctors these days (Salmon and Thompson 2017). Defensive medicine (excess services doctors order to supposedly avoid malpractice) can also be cost-problematic, both of which Price may try to champion against (Teller 2017).

Price has been unspecific on addressing "the most vulnerable" of the American population, who are generally socially and economically unfortunate and who suffer from greater pain from chronic diseases. CMS has not had the best track record in developing and funding "risk corridors" of patient groups who turned out to be the sickest, heavy utilisers. This policy dilemma must be adroitly addressed to guarantee financial stability for insurers to keep them in the federal programme. Doing away with the mandate relieves insurance providers from enrolling the younger, healthier cohorts whose premiums subsidise those who suffer from expensive diseases. Under Obama, there was a budget shortfall for risk corridors, so providers and insurance companies rose up in arms seeking bailouts.

Management of the Health Insurance Exchanges remains again technically and politically, problematic. Some State exchanges may no longer be viable, and the consumer cooperatives formed under the ACA have faced closures and huge financial downfalls also.

> "WHATEVER THE FLAWS [OF THE ACA] THE NEW TRUMP ADMINISTRATION IS TRYING TO PULL OFF A CON BY OFFERING AMERICANS COVERAGE THAT IS LIKELY TO BE SO MUCH WORSE THAT IT BARELY DESERVES THE NAME INSURANCE (THE REPUBLICAN HEALTH CARE CON 2017)"

Mergers and acquisitions (M&As) across the entire insurance, pharmaceutical, pharmacy benefit managers, drugstore chains, as well as a host of hospital systems and other entities in the medical-industrial complex are predicted to surge to increase the scale of operations to compete in a challenging healthcare system. This will lead to greater political influence well beyond what physicians and the nonprofit segment can muster. This M&A set of dynamics is key within the policymaking process that lies ahead for the next four years under Republican rule and continues to challenge the medical profession (Salmon and Thompson 2017).

In witnessing the Congressional agenda on access, benefit design, consumer choice, financing, and flexibility for the States, one might speculate that benefits under the ACA may be lessened, consumer cost-sharing may go up, and "choices" that confront the poor, less literate, high users, and the sickest among us, will become challenging. One fears unplanned results in a haphazard delayed strategy, which may ultimately fail for improving our overall population health.

Looks like Repeal and "Repair" now

The conservative belief that "intense competition" in the medical marketplace will bring down costs and stimulate innovation in benefit design and delivery systems has yet to be proven. Price prefers relying on individual tax relief for insurance purchases and high-deductible Health Savings Accounts that primarily work best for younger, middle class, healthy individuals, not the sick (Kodjak 2016). However, aiming for a much more simplified consumer-friendly form of health coverage could be a beneficial reform over the present. Mounting administrative obfuscation for choosing

a health plan and a suitable benefit package in American healthcare requires a well-informed, educated populace with the key criteria being more clinical than financial (Aruru and Salmon 2015). Only a few ACOs are beginning to examine the social determinants of health that may truly enable for some cost reductions.

Many observers fear that Medicare and Medicaid will also become vulnerable under Price (Dickson 2017). Medicaid has the vast majority of the 20 million newly enrolled under the ACA. The discussion of "essential benefits" and federal optional additions to Medicaid are absolutely key to watch in the policymaking process and what will be the actual "replace" with Price in charge (Radelat 2017).

Planned Parenthood funding is gone with the Republican Congress so women's health remains in danger, one impetus to stimulate the millions participating in the women's march after the Inauguration. The recent Congressional budget, which Trump's Office of Management and Budget nominee, Mick Mulvaney, supports, cuts entitlements (Fleming 2017). Medicare is being slashed $449 billion and Medicaid by $1 trillion over the years to come. Trump campaigned on no cuts to these programmes.

Under Obama, the CMS—with their private insurance company cohorts and the corporate provider sector—moved to squeeze doctors' decision making through requiring and monitoring electronic health records and implementation of the dreaded MACRA and incentives and penalties in payments in MIIPS and the rest of the alphabet soup of other quality and cost control mechanisms (eg, MU, ICD-10, PQRS, VBM, QPP, CQMs, etc.). All of these reviled as well as befuddled the medical profession, take time and add costs to practices, while cuts to reimbursement are on the horizon without compliance. Yet corporate health providers have clearly recognised that controlling doctor behaviour is crucial to enhance their profit levels (White et al. 1994). If a Trump administration yields to demands of the medical-industrial complex for maintaining their revenue streams, it is going to be quite difficult for Price to champion the cause of the practitioners (Salmon and Thompson 2017). Already, Trump's Executive Order rattled the insurance industry to decry ending the mandate and consumer penalties for no signup (Meyer 2017).

It is uncertain whether the trend toward value-based care will continue (Japsen 2017; Jopson 2017). Value-based reimbursement has had strong backing for its cost control intentions (MacDonald 2017). Accountable care organizations (ACOs), which the ACA instituted, propelled hospital systems to steadily implement coordinated care. However, different perspectives remain in the ACO's details (Salmon 2015; 2016a; 2016b).

Medicaid block grants, which might mandate managed care arrangements, have long been favoured by Republicans. States may be able to make their own decisions about what to do with the money, which might include scaling back benefits to the poor and disabled, cutting mandatory benefits (eg, mental health, substance abuse, etc.), eliminating added subsidies for safety net providers, instituting consumer copayments, and disenrolling clients who use emergency rooms too often, neglect medical regimens, or other strictures). Such would be possible with reworking the numerous federal mandates, adjustments, and waivers, which have historically been part of this programme favoured by the more liberal States. While Republican governors and legislatures (the majority of the States), would appreciate the discretionary authorities, they fear substantial shifts in funds over time, which would cause them to defund and discharge recipients. Currently, State budgets aren't accounting for any repeal (Quinn 2017).

Conclusion

Summarising the shifting sands around the complex U.S. healthcare system since the election is an elusive exercise. It remains to be seen if the next hundred days—a benchmark for new administrations in D.C. —will be not much more than a trajectory of further uncertainties amidst intense conflicts. Consensus building within the Trump Administration, as well as between Trump and Congress, at this stage appears rocky (DeBonis 2017). The temperamental, combative, and unapologetic demeanour of Trump from the campaign trail and on Twitter has led some commentators to ponder when he will start acting "Presidential." Trump's populist obsession (Costa and Goldstein 2017) may lead him to try to keep his promise of "insurance for everybody", though Congress will likely water that down fiscally. Trump has evidently noted the ACA retains favour as greater numbers of Americans realise serious qualms about any Republican replacement. Forty-five percent think the ACA law was a good idea, the highest mark since polls began in April 2009 (Radnofsky 2017).

Many smiles and sadness over what is now transpiring in government accompany an outright astonishment for the need for serious health reform for our nation. Professionals must raise their voices to provoke an intelligent and detailed debate to bring better healthcare to all Americans. ■

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REFERENCES

For full references and supplementary table, please email edito@healthmanagement.org or visit the website https://iii.hm/8b2