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U.S. Healthcare to be Trumped UP!

Prof. J. Warren Salmon, PhD
******@***gmail.com

Professor of Health Policy & Administration (Retired) - University of Illinois at Chicago USA
Professor in and Head of the Department of Pharmacy Administration - College of Pharmacy
Professor of Public Policy Analysis - College of Urban Planning and Public Affairs at UIC

LinkedIn

(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.

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 order 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 ACA repeal will not get much support given the vast corporate interests of the medical-industrial complex (Salmon 1990;1994; Relman 1980) and given the law's complexity embedded into the healthcare system. Even with Hillary Clinton in the White House, the healthcare system was destined for a major political economic crisis, with imploding health insurance exchanges (HIEs) and provider scale-backs amidst premium raises up to 70% in some places (Kaiser 2016); today many counties have only one insurance carrier. Though the ACA enhanced revenues and profit levels for many providers and suppliers, the gravy train appeared insufficient for the firms which pulled out of the HIEs (O'Donnell 2016). 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).

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Table 1.

$3.2. Trillion for the Medical Industrial Complex

Phenomenal inappropriate services, “drug misadventuring,” rampant administrative overhead, and waste, plus huge profit margins for corporate health providers can be indirectly attributed to the medical industrial complex. No other nation of the world has such a large corporate for-profit presence in their national health system (Salmon, 1990, 1994)

The entities included in the “old supply side MIC” are:

pharmaceutical biotechnology, medical diagnostics, and biomedical research and development; medical, dental, and optical hardware or services; construction of facilities; real estate investment trusts for health facility holdings; provision of legal, accounting and consulting services; computer and information technology; among other products to assist providers in caring for patients. Entities in the medical industrial complex have historically been the motor force of cost rises, now about 6% annually (overall GNP creeps along at 2.2% lately).

In 1980, the New England Journal of Medicine editor Arnold Relman (1980) decried the “new medical industrial complex”:

Investor-owned hospital and nursing home chains, home care, dialysis centers, health maintenance organizations (HMOs), and now pharmacy benefit managers (PBMs), accountable care organizations (ACOs), and drug store retail clinics. All of these segments have reaped bountiful returns on their investments by stiffly competing against traditional “not-for-profits” and public providers, who are left to primarily serve the uninsured and less profitable population groups.

The ACA did not bring affordability or universal coverage. Having an insurance card is not access to care, as many newly insured people have yet to secure a primary care physician relationship to get needed treatment. 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 (Haefer ??). 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 and preserving aspects (Pollack et al. 2017).

The Republican Party will seek to trim benefits, force greater cost-sharing, and roll back protective regulations in new legislation (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 by Congress (Ellison 2016); this is Trump territory! Hopefully, the CMS will not punish the 32 States that reaped huge financial benefits by enrolling many of their uninsured. 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 hard and long through a minefield of regulatory changes beyond financing, and craft the complicated legislative language that acknowledges not just the opposition's criticisms, but the expected heavy disruption to the entire healthcare system—a reality already happening with the prolonged uncertainty! 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.

Two sets of hearings on Price offered little on how he would protect the vulnerable or replace the ACA. His history is rolling back coverage in trillions of dollars to the uninsured, Medicare and Medicaid beneficiaries. 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 Meritbased 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; surely, all such initiatives have increased practices’ costs. 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 bought a medical device manufacturer stock (Zimmer-Biomet), then introduced legislation that directly benefited the company so the stock price soared (Raju 2017). His 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 a few of his colleagues also want to better protect doctors from malpractice claims, which maintain “too-high” premiums leading him to seek federal tort reform. It is instructive to note that Price has railed against a "stifling and oppressive federal government" that interferes with the ability of patients and doctors to make medical decisions. 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 subsidize 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.

The management of the Health Insurance Exchanges remains again technically, as well as 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. 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 & 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 (e.g., 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 behavior 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). Valuebased 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 favored 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 (REF). 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.

J. Warren Salmon, Ph.D. was Professor of Health Policy and Administration, School of Public Health at the University of Illinois at Chicago (UIC). He was formerly a Professor in and Head of the Department of Pharmacy Administration, College of Pharmacy; and Professor of Public Policy Analysis, College of Urban Planning and Public Affairs at UIC. Professor Salmon's research has focused on the corporatisation of medicine and pharmacy, managed care pharmacy, urban health care delivery, comparative health care systems, global pharmaceutical industry developments, and alternative and complimentary medicines. He edited six books and is collaborating with Stephen Thompson on Healthcare Corporatization: The Loss of Physician Hegemony & the Medical Malpractice Crisis (Springer, forthcoming).

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