Top 25 for the Past 25

Louisiana Department of Insurance
2017 Annual Health Care Conference
Thursday, September 7, 2017
Renaissance Baton Rouge Hotel

Donna D. Fraiche

Health Care Budgets

1960 $27.2 billion US

2004-2005 $1,095.1 million Louisiana

2004 $1,896.30 billion US

2009-2010 $1,107.8 million Louisiana

2009 $2,494.70 billion US

2015 $3.2 trillion US

2016-2017 $2,813.7 [operating budget as of 12/2016] Louisiana

US stats from CMS, La. stats from http://house.louisiana.gov/housefiscal/DOCS_TENYEAR/State%20General%20Fund%20History%20by%20Department.pdf

Health Care Spending

1991 $2,647 Louisiana

$2,672 US

2000 $4,048 Louisiana

$4,118 US

2010 $7,227 Louisiana

$7,094 US

2014 $7,815 Louisiana

$8,045 US

Health Spending Per Capita includes spending for all privately & publicly funded personal health care services & products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state (aggregate spending divided by population). Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care). Costs such as insurance program administration, research, and construction expenses are not included in this total
Kaiser Family Foundation

1940s

1946 Harry S. Truman President

Congress passed the Hospital Survey and Construction Act [aka the Hill–Burton Act] to provide federal grants and loan guarantees to communities to build or extend hospital buildings in order to improve access to the nation's people including 4.5 beds per 1000 people. Conditions for the grants included no discrimination and a commitment to the voluntary provision of charity care to the uninsured for at least 20 years. The conditions created a lien on hospital real estate

1950s

1957 Dwight D. Eisenhower President
Louisiana Commissioner of Insurance created in State Constitution, Article IV, Section 11
Rufus D. Hayes was 1st Commissioner, appointed by Earl Long, serves 1957-1964

1960s

1963 Lyndon B. Johnson sworn in after Kennedy assassination

1964 John McKeithen elected Governor of Louisiana
Dudley A. Guglielmo elected Commissioner of Insurance, serves 1964-1972

1960s

1967 Medicare/Medicaid - Part of Lyndon Johnson's "Great Society"
American Health Lawyers Association formed – dedicated to the education of health care lawyers; just celebrated its 50th Anniversary*

1969 Community Benefit Standard adopted to qualify healthcare entities as IRS charitable tax exempt entities
Result: tremendous capital expenditure, building and extensions of hospitals and Medicare provider entities [Bricks & Mortar]

*Many thanks to AHLA. Much of the slide contents is from their website

1970s

1969-74 Richard M. Nixon President

1970 Bipartisan Nixon Plan for National Healthcare fails

1972 Edwin Edwards elected Governor of Louisiana

Sherman Bernard elected Louisiana Insurance Commissioner, serves thru 1988

1973 US Supreme Court decision, *Roe v. Wade*, re privacy rights and choice to terminate pregnancy

Rehabilitation Act of 1973 provided Civil Rights protection to those with disabilities

1970s

1974 Employee Retirement Income & Security Act [ERISA] regulated operation of employee pension & health benefits for employers
Renewed failed effort to achieve national health insurance under Nixon's Plan
Gerald Ford sworn in as President after Nixon resigns

1975 National Health Planning & Development Act mandated regulatory review of cap exceeding 150K (repealed 1986)

1970s

1976 Med Device Amendments

Creation of Health Education & Welfare Agency [HEW], renamed Health & Human Services [HHS]

Subsequently created Centers for Medicare/Medicaid Services [CMS] and Inspector General for Fraud & Abuse Investigations

1977 Medicare/Medicaid Fraud & Abuse Amendments created categories of violations including felony sanctions

Jimmy Carter elected President

1980s

1980 David Treen elected Governor of Louisiana
Omnibus Budget & Reconciliation Act [OBRA] created Medicaid Waiver authority

1981 Ronald Reagan elected President

1982 *Arizona v. Maricopa County*, US Supreme Court approved a *per se* rule to MD negotiations when collectively negotiating with health plans as constituting an antitrust violation risk
Tax Equity & Fiscal Responsibility Act [TEFRA] permitted HMOs to provide contracted Medicare services

1980s

1983 Edwin Edwards elected Governor of Louisiana [again]
Prospective Payment Systems [PPS]
Inpatient care Diagnostic Related Groups [DRGs] shift from cost-based reimbursement to episodic care of diagnosis related payments

1986 Emergency Medical Treatment & Active Labor Act [EMTALA] prohibited patient dumping
Health Care Quality Improvement Act [HCQIA] granted good faith immunity for protected peer review activity
False Claims Act [FCA] Amendments incentivized whistle blowing

1980s

1987 Buddy Roemer elected Governor

HCA v. FTC, FTC challenged hospital mergers

Safe Harbors developed to allow exceptions to Anti-kickback laws

Medicare/Medicaid Patient Program Protection Act passed

Nursing home reforms

1980s

1988 Clinical Laboratory Improvement Amendments [CLIA] federal regulations for inspection & certification of labs

Medicare Catastrophe Act (Repealed) expanded Medicare coverage, inpatient hospital care & outpatient prescription drugs

NOTE: beneficiaries did not want to pay premiums for Part B services (including physicians)

Doug Green elected Louisiana Insurance Commissioner, serves thru 1991

1980s

1989 George H.W. Bush elected President

Omnibus Budget Reconciliation Act [OBRA]

-reformed MD payments with Relative Value Units [RVUs]

-enacted prohibitions on MD self-referral [STARK I]

-established Medicare geographical re-classification for payment of Medicare rates

1990s

1990 *Wilder v. Va. Hospital Ass'n*, US Supreme Court upheld right of private parties to challenge Medicaid rates that create access issues
Adequacy rule
Americans with Disabilities [ADA] enacted
Ryan White – Comprehensive AIDS Resources & Emergency Act
Medicaid Drug Rebate Program

1990s

1991 Edwin Edwards elected Governor [again]
Jim Brown elected Commissioner of Insurance, serves thru 2000
Medicaid Voluntary Contribution & Provider Specific Tax Amendment – use of provider taxes & donations using Medicaid as a funding sources with certain restrictions on States

1992 **Louisiana Health Care Commission [LHCC] launched by LA Legislature & Dept. of Insurance to address cost, quality, access & discuss the "universal healthcare" debate;**
340B Drug Discount Program

1990s

1993 Bill Clinton elected President

OBRA 1993 – Stark II extending the ban of MD self-referral to “designated health services” [DHS]

US Dept. of Justice & FTC issued Joint Statement of Antitrust Enforcement in Health Care

President Clinton proposed the Health Care Security Act for universal coverage [never passed]

1990s

1996 Murphy J. Foster elected Governor

HIPAA passed – to permit health care coverage & to regulate use and disclosure of protected health information

Welfare Reform enacted – ending AFDC and replacing with state block grants

Temporary Assistance to Needy Families [TANF]

1990s

1997 Balanced Budget Act [BBA] created State Children's Health Insurance Program [SCHIP] allowing states to extend coverage to uninsured children up to 133% of federal poverty level

Part C Medicare provisions through private managed care plans

Louisiana Hospital conversions require AG approval

AWP law requires MCOs to open networks to Rural Providers "The Rural Hospital Preservation Act" (SB 56)

Gov. Foster signed bill to transfer 260 year old Charity Hospital System to LSU

1990s

1998 Ticket to Work and Work Incentives Improvement Act allowed disabled individuals to join workforce without losing Medicaid or Medicaid eligibility

2000s

2000 J. Robert Wooley serves as Acting Insurance Commissioner from 2000-2003; elected Insurance Commissioner from 2003-2006;

2001 George W. Bush elected President

LA Legislature and LDH establish a drug formulary [SB 502]

SB 865 required LA Dept. of Insurance to conduct actuarial analyses on mandated benefit effect every 4 years

Required insurers to provide written notification to approve or deny additional hospital days

HB 2000 allowed mammograms without referral

2000s

2003 Kathleen Blanco elected Governor

Medicare Prescription Drug Improvement & Modernization Act added Part D Medicare Prescription drug benefit called Medicare Advantage

2005 Patient Safety & Quality Improvement Act of 2005 [PSQIA] voluntary reporting system to assess and resolve patient safety and quality of care issues

Hurricanes Katrina and Rita

2000s

2006 Jim Donelon elected Insurance Commissioner

In the matter of Evanston NW HC Corp - FTC antitrust enforcement challenge to hospital mergers

Creation of Task Force to review how health care was to be delivered in Louisiana

2008 Bobby Jindal elected Governor

Average Employer-Sponsored Family Plan costs $12,680

2000s

2009 Barack Obama elected President

Health Information Technology for Economic & Clinical Health Act incentivized adoption of "meaningful use" of health information & electronic health records

Fraud Enforcement & Recovery Act [FERA] expanded false claims provisions

LA enacts Electronic Record Bill to improve health outcomes and costs

2000s

2009 "Conscience Protection" bill to protect professionals who refuse to do abortions, embryonic cell research or cloning, prohibit health insurers from requiring genetic testing info

SB 242 required health insurers and HMOs to provide enrollment period

Right to Try Act gives terminally ill patients right to experimental treatments pre-FDA approval

Act 517-DHH may accept IGT from local governing bodies for enhancing healthcare for uninsured and Medicaid

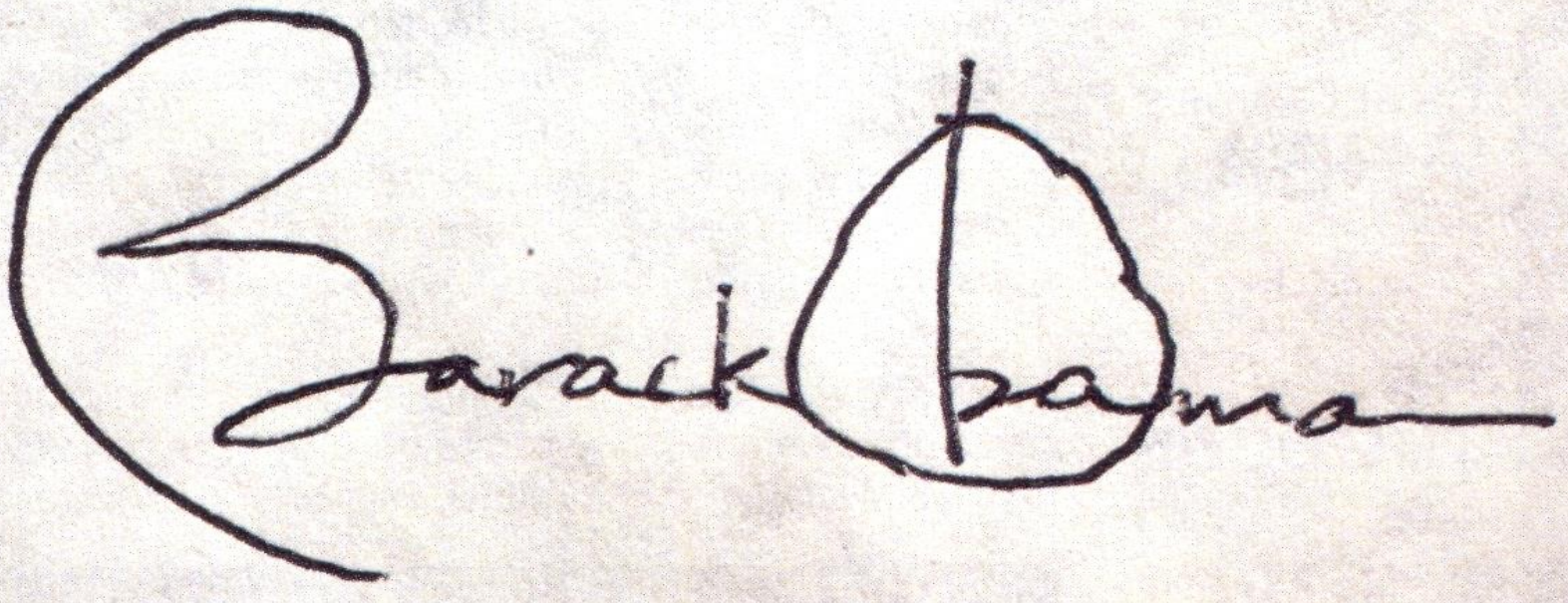
2000s

2010 Patient Protection & Affordable Health Care & Education Act of 2010 [ACA] enacted major health insurance reforms, mandated coverage, expanded Medicaid eligibility, provided subsidies for lower income individuals who were not eligible for Medicare/Medicaid

Final CEA negotiations by and between private provider (OLOL) and State (LSU)

APPROVED

MAR 2 3 2010



The Affordable Care Act (ACA)

- The Patient Protection and Affordable Care Act [PPACA] (H.R. 3200)
- The Health Care Education and Reconciliation Act (H.R. 4872)
- Totals more than 2,000 pages
- Most provisions upheld by the U.S. Supreme Court on June 29, 2012
- The PPACA was signed into law March 23, 2010.
- Amended by the Health Care & Education Affordability Reconciliation Act, which was signed into law March 30, 2010
- Provides coverage to 32 million uninsured people by 2019
- Costs an estimated $940 billion over 10 years (2010-2019)

Departments Involved

- Department of Health & Human Services / CMS
- Department of Labor
- Treasurer/Internal Revenue Service

2000s

2012 *NFIB v. Sebelius*, Supreme Court upheld ACA
1) Mandatory health coverage is a permissible exercise of Congressional power to tax
2) States can opt out of Medicaid expansion

2013 US Supreme Court sustained challenge to "reverse payments" in patent litigation – *FTC v. Actavis*

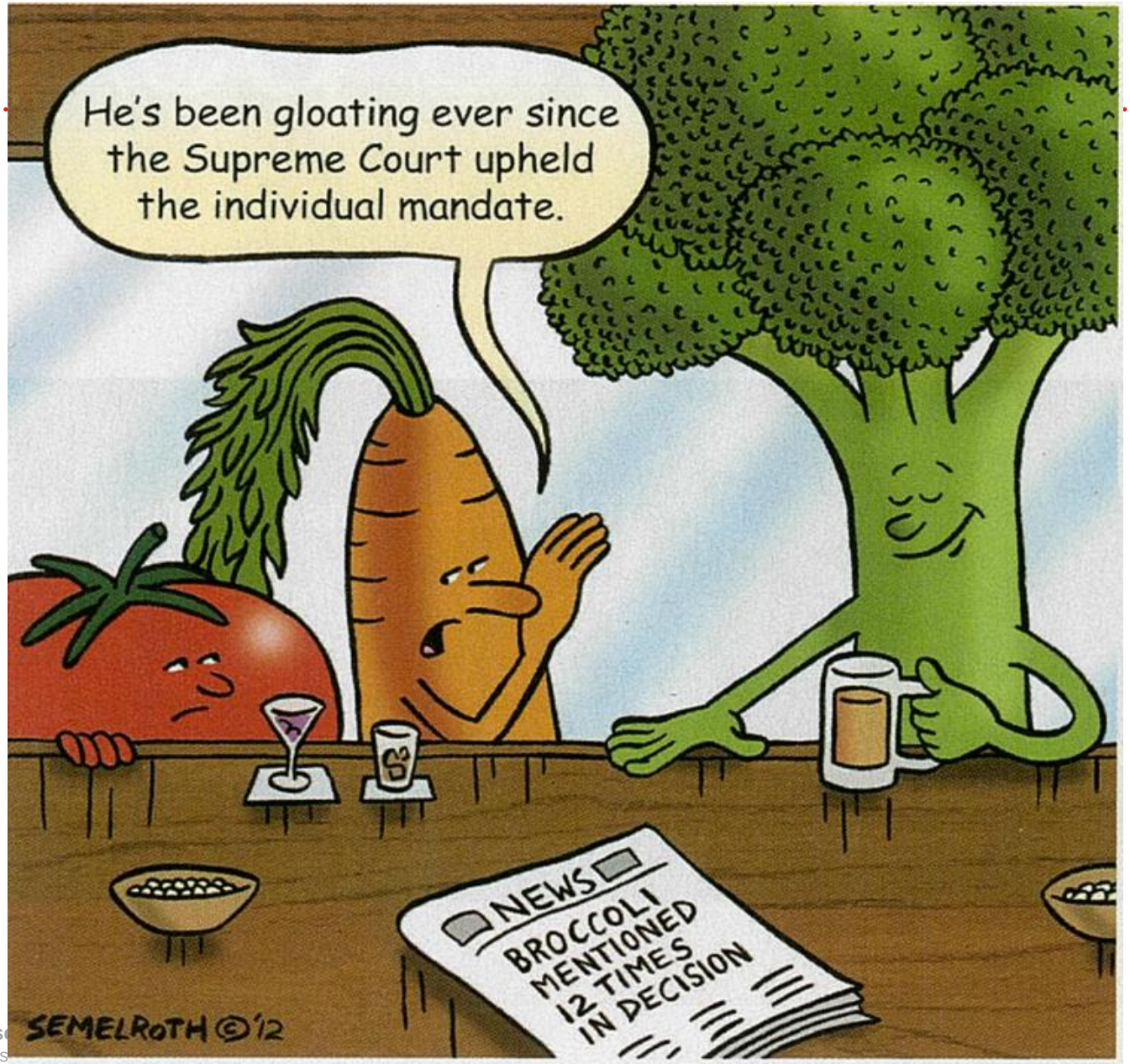
The Supreme Court – Did it Stop Health Reform?

Not exactly…..

The Supreme Court – 4 Issues

- Does the Anti-Injunction Act preclude the Court from ruling on the mandate until 2014?**
- Is the individual mandate to purchase health insurance constitutional under the Congressional authority of the Commerce Clause?
- Is the individual mandate severable from the rest of the ACA?
- Is the Medicaid (state) expansion required by the ACA unconstitutionally coercive?

**Employer & individual monetary sanction did not go into effect until Federal Tax Returns of April, 2015


He's been gloating ever since the Supreme Court upheld the individual mandate.
NEWS
BROCCOLI MENTIONED 12 TIMES IN DECISION
SEMELROTH ©'12

Coercion?

Your money or your life!

I'm thinking, I'm thinking

Or
Your money – take my wife!!

2000s

2014 IRS publishes rules implementing ACA mandating non-profit hospitals conduct community health needs assessments and develop more patient friendly billing and collection policies

Armstrong v. Exceptional Child Centers, Supreme Court rejected private parties' enforcement of Medicaid equal access provisions and adequacy rate standards

King v. Burwell, Supreme Court held that health insurance subsidies under ACA apply to both State and Federally qualified operated health exchanges

ACA survives another close call in the Supreme Court

By Lisa Schencker

2015 will be remembered as the year the U.S. Supreme Court narrowly saved the Affordable Care Act for the second time. But there were other court rulings that also will have a lingering impact on healthcare.

In their June opinion in *King v. Burwell*, Chief Justice **John Roberts** and five other justices upheld the legality of the law's insurance premium subsidies in all states, averting an insurance market meltdown.


Roberts

But healthcare providers were far less pleased with the Supreme Court's 5-4 ruling in *Armstrong v. Exceptional Child Center Inc.*, in which the court held that providers cannot sue state Medicaid agencies over low payment rates. Now it's up to the federal government to make sure the states are paying providers enough to ensure adequate patient access to care, said Nicholas Bagley, a University of Michigan law professor.

In a third significant healthcare ruling, the Supreme Court ruled in February in *North Carolina Board of Dental Examiners v. Federal Trade Commission* that state licensing boards composed of active members of the professions they regulate, such as practicing doctors and dentists, are not immune from antitrust law unless they are actively supervised by their states. That may prompt state boards to shake up their memberships, or spur states to tighten their oversight of licensing boards.

In a major antitrust ruling, the 9th U.S. Circuit Court of Appeals upheld a lower court ruling ordering St. Luke's Health System in Idaho to unwind its acquisition of a large physician practice. That sent a warning shot to providers about the antitrust risks of mergers in the name of improving care and efficiency. The appeals panel said that promising better patient outcomes wasn't enough to sidestep antitrust concerns.

"It seemed to set a pretty high barrier for merging parties to defend a merger on efficiencies," said Robert Leibenluft, a partner at Hogan Lovells and former head of the healthcare division in the FTC's Bureau of Competition.

In July, a different federal appellate court upheld a $237 million False Claims Act verdict against Tuomey Healthcare System in Sumter, S.C., based on allegations that Tuomey paid doctors above fair market value and rewarded them for referring patients to the hospital, in violation of the Stark law.

Tuomey ended up settling for $72.4 million. It was one of a string of large hospital settlements this year in Stark/False Claims Act cases involving physician compensation arrangements. The Tuomey case "has had a chilling effect throughout the industry, causing compliance officers and the lawyers who advise them to demand much more verification of fair-market value," said Peter Pavarini, co-leader of Squire Patton Boggs' healthcare practice group.

At year-end, legal observers were closely watching another ACA challenge that could reach the Supreme Court. In September, a federal district judge in Washington granted legal standing to House Republicans in a case seeking to block federal funding to reduce cost-sharing for low-income exchange-plan members. The judge is now considering that case, *House of Representatives v. Burwell*, on the merits. Experts say it could be a close case with a significant impact on the ACA. ●

Why The Big Miss?
Pre-2014 population vs. ACA post-2014 population

- 2x as likely to be obese
- 2x as likely to suffer from substance abuse
- 2.5x as likely to visit an ER
- 2.5x as likely to suffer from Hepatitis C
- 3.5x as likely to suffer from HIV
- 67% more likely to be diabetic
- 50% more likely to suffer from depression
- 50% more likely to visit an Urgent Care center
- 21% more likely to be hypertensive

Direct comparison between our 2013 120,000 person individual block and our 80,000 new 2014 customers based on behavior, disease prevalence, and costs.

Translated to 80% HIGHER claims costs in 2014!

The early impact of the ACA: % Uninsured Low-Income Adults

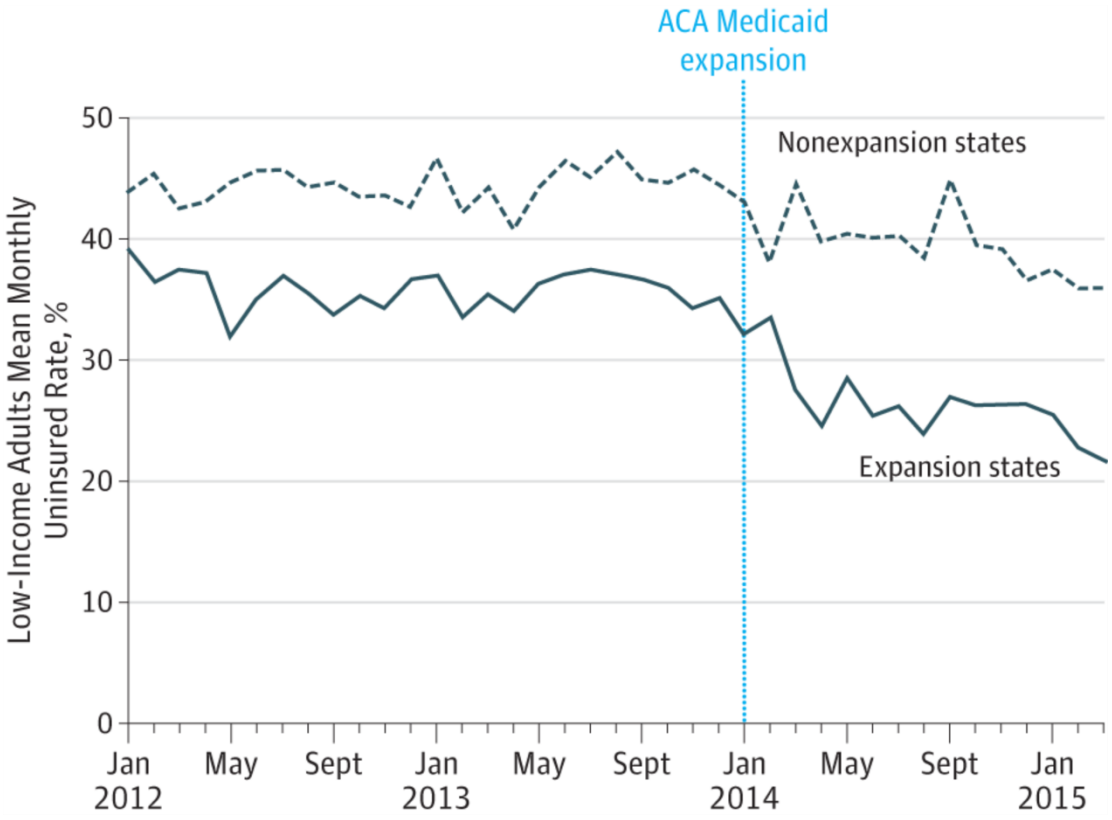


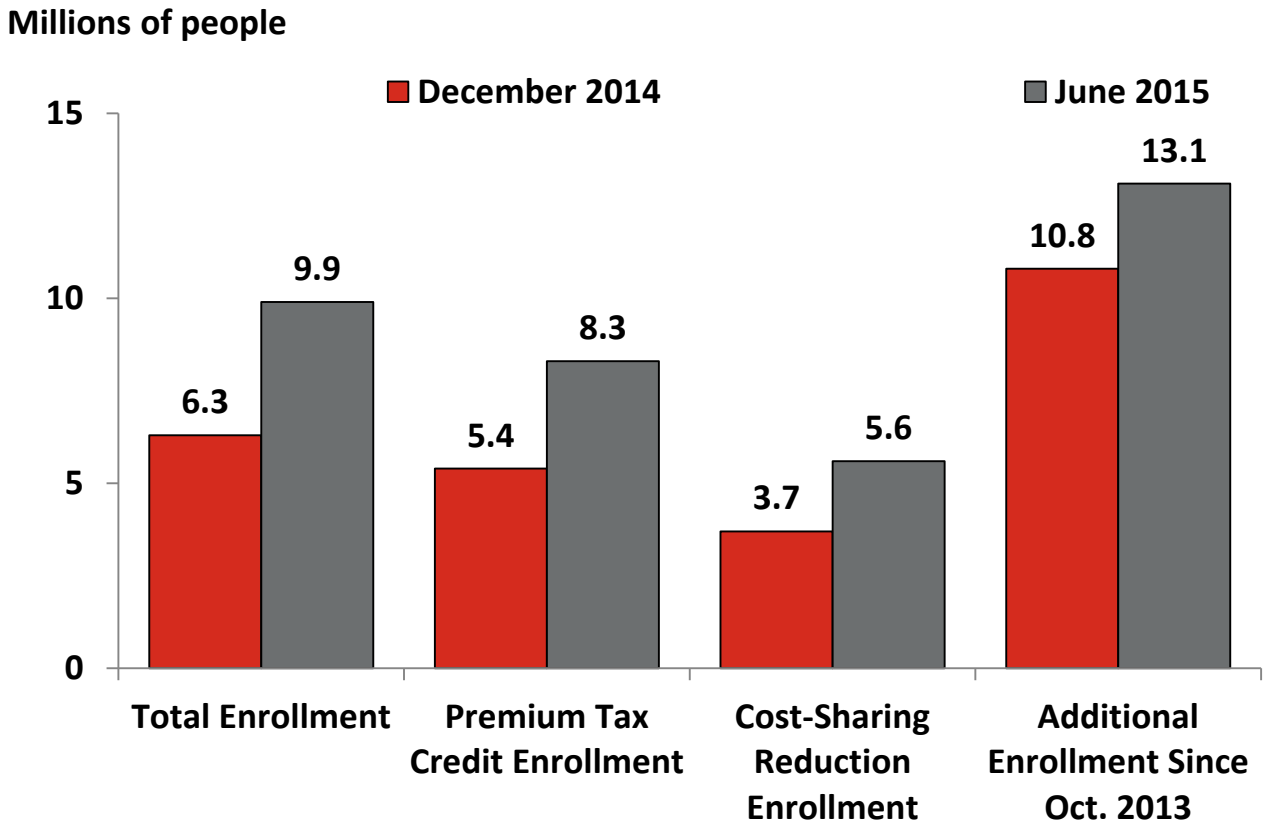
Figure Legend:

Uninsured Rates for Low-Income Adults in Medicaid Expansion vs Nonexpansion States. Dotted vertical line indicates the beginning of the Affordable Care Act's (ACA's) Medicaid expansion on January 1, 2014.

From: **Sommers et al. 2015. Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act**

JAMA. 2015;314(4):366-374. doi:10.1001/jama.2015.8421

Enrollment in Marketplace Plans & Medicaid Climbed to 23 Million; Majority Had Premium & Cost-Sharing Reduction Subsidies



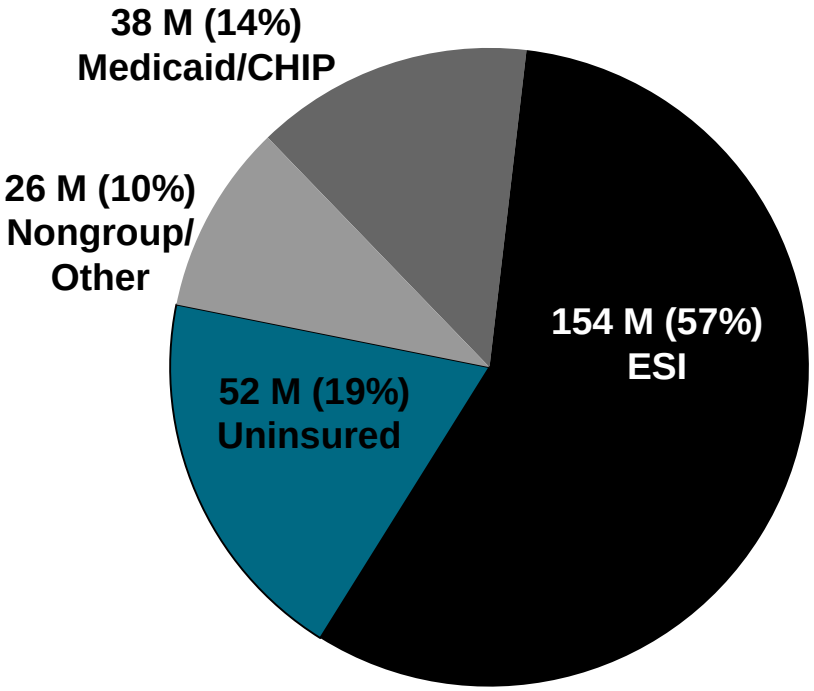
Health Insurance Marketplaces

Source: Centers for Medicare and Medicaid Services, February, August, and September 2015.

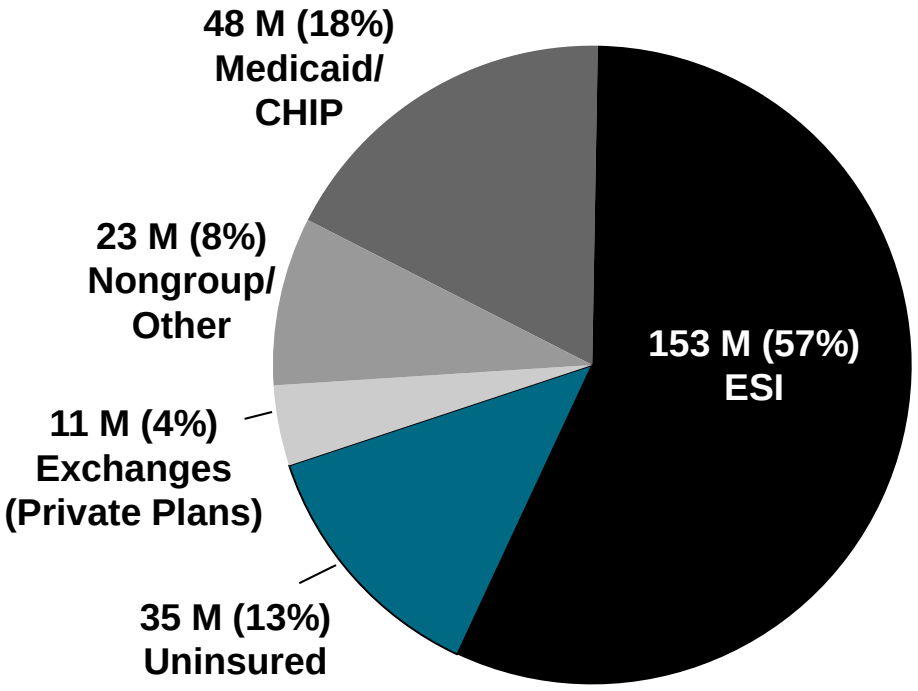
The Individual Mandate & the Establishment of Health Insurance Exchanges

- Small employers could purchase health insurance beginning in 2014 through the health insurance exchanges or “marketplaces” established in each state
- If a state government doesn’t establish an exchange, DHHS will
- The amount of the tax is the greater of 2 amounts
  - a flat dollar amount
  - a percentage of income
- Flat dollar amounts for adults:
  - 2014 -- $95
  - 2015 -- $325
  - 2016 -- $695

Source of Insurance Coverage Without and Under Affordable Care Act, 2015



Without the Affordable Care Act



Under the Affordable Care Act

Among 270 million people under age 65

* Employees whose employers provide coverage through the exchange are shown as covered by their employers. Note: ESI is employer-sponsored insurance; "Other" includes Medicare.
Source: Congressional Budget Office, Updated Budget Projections: 2015 to 2025, March 2015, https://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-UpdatedBudgetProjections.pdf

What Happened to Health Care Costs in America in the Obama Years

- High-Deductible Plans now standard
  - Basic coverage
  - More preventative screenings and contraception at no extra charge to customers
  - High deductibles [of at least $1,000] were a minority
    - 2008 - 18% of covered workers
    - 2006 – 10% of covered workers
  - High deductibles with employer sponsored plans at small firms:
    - 2008 -- 35%
    - 2006 – 16%
  - High deductibles in 2016
    - 51% of covered workers
    - 65% of workers in small firms

CONSUMER-DIRECTED HEALTH PLANS (CDHP)

Individuals decide what care they receive

Consumer Directed or Driven Health Plans

- Defined as: Third Tier health plans that allow members to use Health Savings Accounts (HSAs) to pay for routine healthcare
- 2011 = 11%
- 2017 = up to 36%
- High Deductible Plans (HDHP) – protects catastrophic medical expense (prefunded account)

What Happened to Health Care Costs in America in the Obama Years

- Prescription Drug Spending Soared
  - 2015
    - $457 billion total spending
    - 16.7% of all health care service spending

Daraprim $13.50 to $750 per tablet [5,556% increase]

Exorbitant drug price hikes are becoming more common - The Denver Post

BUSINESS

Exorbitant drug price hikes are becoming more common

How pharmaceuticals can spike prices and the impact

By Linda A. Johnson
The Associated Press

POSTED: 09/27/2015 12:01:00 AM MDT

ADD A COMMENT (HTTP://WWW.DENVERPOST.COM/BUSINESS/CI_28879430/EXORBITANT-DRUG-PRICE-HIKES-ARE-BECOMING-MORE-COMMON#DISQUS_THREAD)

TRENTON, N.J. — Hillary Clinton was among the patients and politicians who voiced outrage last week after it became public that the price of a 62-year-old drug used to treat a life-threatening infection had been raised by more than 5,000 percent. But exorbitant drug price hikes like that have happened increasingly over the past few years. They could become even more common because of decreasing competition in the pharmaceutical industry, among other factors.

The issue was brought to light after a Sept. 20 New York Times article on drug-price increases.

The story featured Turing Pharmaceuticals, a startup that paid Impax Laboratories $55 million in August for rights to Daraprim. It's the only approved treatment for a rare parasitic infection called toxoplasmosis that mainly strikes pregnant women, cancer patients and AIDS patients.

Turing's CEO, former hedge fund manager Martin Shkreli, soon raised Daraprim's price from $13.50 to $750 per pill.

Late Tuesday after the public outcry, Shkreli said he would reduce the price of Daraprim. But rising drug prices are likely to remain an issue for the industry. Here are some questions and answers on the subject:

Q: How can these price spikes happen?

A: Companies generally can charge what they want for approved drugs because the U.S. government doesn't regulate medicine prices. The powerful pharmaceutical lobby has repeatedly fended off proposals that would cut into profits, from setting up price controls to allowing Medicare to negotiate discounts on drugs it buys for beneficiaries. That means the primary check on medicine prices is large buyers — insurance companies, big hospital chains and group purchasing organizations that negotiate sizable discounts off the manufacturer's wholesale price. That happens when several companies make the same generic drug or similar brand-name drugs. When there's no competition, big buyers and payers can't rein in prices.

Q: What's triggering the latest price spikes?

A: For many generic drugs, industry consolidation has left only one or two companies making a particular medicine. That has led to lengthy shortages for an increasing number of crucial medicines, driving up prices, particularly for drugs for infections, blood pressure and seizures. Even without shortages, prices have jumped tenfold or more for generics only made by one or two companies. The Turing case highlights a recent trend in which a drugmaker buys a smaller one or just its rights to an old brand-name drug, intending to sharply increase the price, said Dr. Peter B. Bach, director of the Center for Health Policy and Outcomes at Memorial Sloan Kettering Cancer Center.

Q: What's the impact?

A: The higher prices initially mainly hit people paying out of pocket, said Rob Frankil, owner of Sellersville Pharmacy in southeastern Pennsylvania, who testified last fall at a congressional hearing about big increases in generic drug prices. Over time, the spikes affect the whole health system. "We pay for it in the end," through rising insurance premiums and deductibles, said Frankil, who regularly sees patients who are sticker-shocked by an increase, decide to go without their medication, ration it or switch to a cheaper, less-effective drug.

- Soaring cost of brand name pharmaceuticals, single-source drugs has eroded. MPAC – Medicare Payment Advisory Commission
- Part D Medicare up 47% from 2006 to 2013
- Reasons – Biologics entering market place [big R&D recapture]
- Medicare subsidizes 80% as reinsurance [catastrophic]
- 248% increase in reinsurance payments

2000s

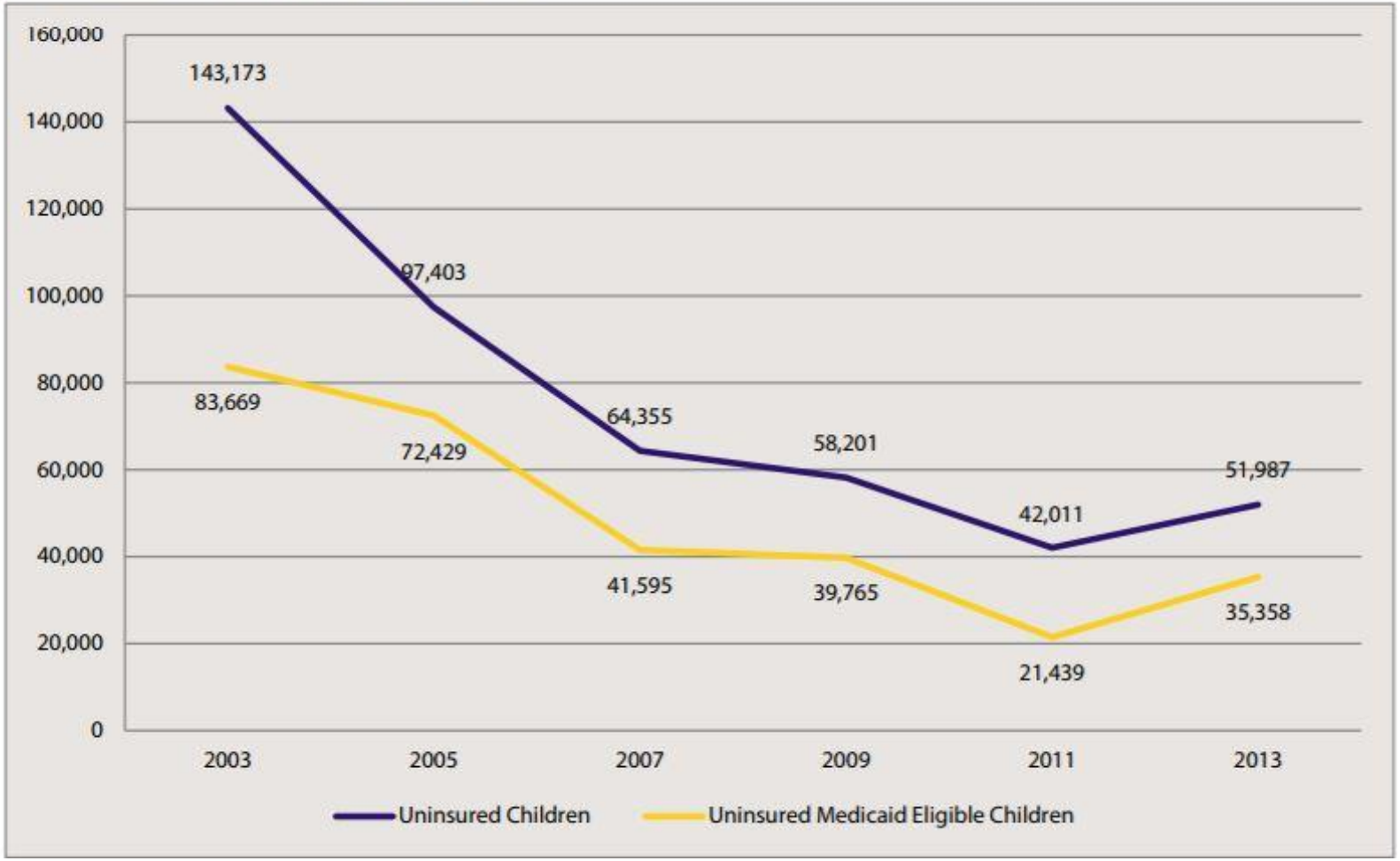
2015 John Bel Edwards elected Governor

Cyber Security Act of 2015 (CSIA) to improve cyber security including health care data & internet operated insurance exchanges

21st Century Cures Act funded NIH disease research and drug and medical device approval process

The Uninsured in Louisiana

Figure 1: Uninsured Children (U19), 2003-2013



The Uninsured in Louisiana

Figure 5: Uninsured Nonelderly Adults (19-64, 2003-2013)

Louisiana's Uninsured Rate Falls to 12.5%; Leaders Cite Medicaid Expansion

http://www.theadvocate.com/baton_rouge/news/politics/article_11018d78-ee3e-11e6-abef-03ea15db5d1d.html

Louisiana's uninsured rate falls to 12.5 percent; leaders cite Medicaid expansion

BY ELIZABETH CRISP | ECRISP@THEADVOCATE.COM FEB 8, 2017 - 3:15 PM

Travis Spradling Buy Now

Advocate staff photo by TRAVIS SPRADLING – Gov. John Bel Edwards signs the first executive order of his new administration at the State Capitol, No. JBE 16-01, which provides for Medicaid expansion in the state of Louisiana.

Elizabeth Crisp

Louisiana is one of 10 states that have seen the steepest decreases in the rate of uninsured residents over the past four years, according to survey findings released Wednesday.

The 2016 Gallup-Healthways Well-Being Index found that Louisiana's uninsured rate fell to 12.5 percent last year — down from 21.7 percent in 2013.

The survey's researchers note that all 10 states that saw their uninsured rates drop have expanded Medicaid through the federal Affordable Care Act.

Louisiana's Medicaid expansion took effect July 1, following an executive order that Gov. John Bel Edwards signed shortly after taking office in January 2016.

The Gallup survey was conducted throughout 2016, so half of it was prior to the expansion taking effect and half post-expansion in Louisiana. Nearly 400,000 people are currently enrolled under the expanded criteria, according to the Louisiana Department of Health.

"Medicaid expansion is working, and in the process, Louisiana is saving more than $184 million," Edwards said. "This is great news for the more than 394,000 working poor people of Louisiana who've been denied health coverage and are now getting the care they need. We're saving lives in Louisiana and these numbers are proof of that."

Louisiana's Medicaid expansion enrollment tops 400K people

BY ELIZABETH CRISP | ECRISP@THEADVOCATE.COM FEB 16, 2017 - 1:45 PM (5)

Travis Spradling

Buy Now

Advocate staff photo by TRAVIS SPRADLING – Gov. John Bel Edwards signs the first executive order of his new administration at the State Capitol, No. JBE 16-01, which provides for Medicaid expansion in the state of Louisiana.

Elizabeth Crisp

Louisiana's Medicaid expansion enrollment has topped 400,000, as the future of the federal health care law that provides for the program remains unclear.

The Louisiana Department of Health announced on Thursday that enrollment is at 400,635 new enrollees.

The state had earlier placed its goal at about 375,000 enrollees by June 30. Because enrollment has outpaced the modest expectations set, it's now on track to reach nearly 450,000 in that time.

Louisiana's Medicaid expansion enrollment tops 400K people

- Gallup Report found the uninsured rate fell by nearly half from 21.7% in 2013 to 12.5% in 2016
- Most recent LA Health Insurance Survey, which placed 1 in 5 adults here without coverage just before expansion took effect, suggests that much of that decline came **after** expansion began July 1
- According to stats from LDH, more than 58,700 adults have now received at lease 1 preventative or primary care service after enrolling in the expansion. 67 women have been newly diagnosed with breast cancer

Figure 8: Percentage of Population Enrolled in Medicaid by Parish

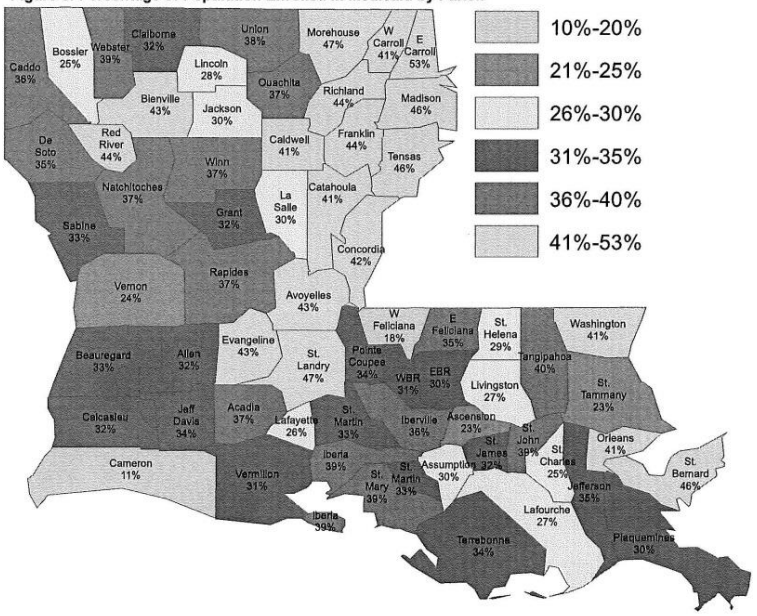


Table 9 presents total population, enrollees, percentage of population enrolled, recipients, payments and payments per recipient by region during SFY 2014/15. The Greater New Orleans Area and Northeast Louisiana both had 37 percent of their population enrolled in Medicaid, the highest numbers in the state. The Capital Area and Northshore had the smallest percentage of population enrolled in Medicaid at 29 percent. The Greater New Orleans Area had the highest payments paid on behalf of their recipients at about $1.2 billion, while Southwest Louisiana had the least amount paid on behalf of their recipients at about $401 million. South Central Louisiana had the lowest average rate of payments per recipient at $4,003, while the highest ratio was in Central Louisiana with $6,225 per recipient. Figure 9 shows more detail in the payments per recipient by parish. Tables 10 through 12 break down regional payments, enrollees and recipients by race and gender.

Table 9: Population, Enrollees, Recipients and Payments by Region

Region	Payments[1] ($)	2014 Population[2]	Medicaid Enrollees[3]	Enrollees/Population Ratio	Enrollees/Population Rank	Medicaid Recipients[3]	$ per Recipient
1 - Greater New Orleans Area	1,199,982,287	887,892	327,975	37%	2	299,297	$4,009
2 - Capital Area	906,173,092	679,108	195,219	29%	9	192,080	4,718
3 - South Central Louisiana	500,589,659	405,672	126,950	31%	7	125,054	4,003
4 - Acadiana	914,981,064	602,383	194,426	32%	5	192,279	4,759
5 - Southwest Louisiana	401,685,523	297,271	93,031	31%	6	91,944	4,369
6 - Central Louisiana	655,835,090	308,348	106,228	34%	3	105,351	6,225
7 - Northwest Louisiana	848,837,954	547,473	179,887	33%	4	176,681	4,804
8 - Northeast Louisiana	659,426,247	355,995	131,758	37%	1	128,314	5,139
9 - Northshore Area	676,744,797	565,534	163,192	29%	8	159,546	4,242
State Total	**$6,764,255,713**	**4,649,676**	**1,485,012**	**32%**		**1,434,738**	**$4,715**

[1] Payments are based on recipient region payments.
[2] Population estimates are based on the beginning of the SFY. U.S. Census Bureau, Population Division. (December 2014) Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014. Retrieved from http://www.census.gov/popest/data/counties/totals/2014/index.html.
[3] Individual region enrollee and recipient counts may not sum to the total state count due to movement between regions during the SFY; the state figures are unduplicated for entire state, while numbers are unduplicated within the region.

2000s

2016 Donald Trump elected

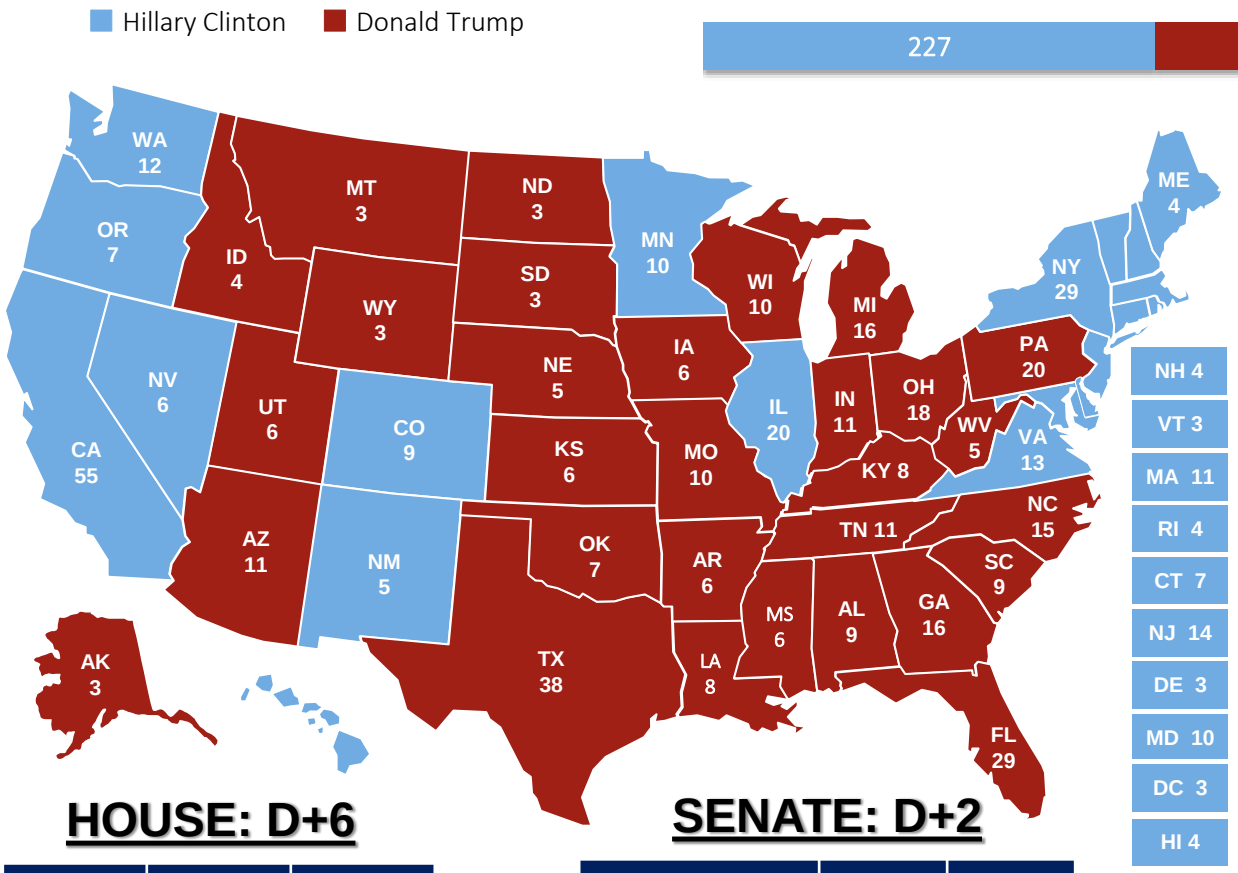
Average employer-sponsored family plan cost $18,142 [up 50% over 8 years]

Premiums up 20% from 2011 to 2016

What Happened to Health Care Costs in America in the Obama Years

- More people are covered
  - Uninsured rate spiked to an all-time high of 18% in 2012
  - By the 1st Quarter of 2016 the rate had fallen to 11%
  - During the 1st Quarter of 2016 only 8.6% of Americans lacked health insurance, compared with 9.2% the year before

2016 Election



Hillary Clinton (D)
Running Mate: Tim Kaine
Popular Vote: 48.0%
States Carried: 20 + DC

Donald Trump (R)
Running Mate: Mike Pence
Popular Vote: 46.0%
States Carried: 30 + ME-2

HOUSE: D+6

	114th	115th
GOP	247	241
DEM	188	194

SENATE: D+2

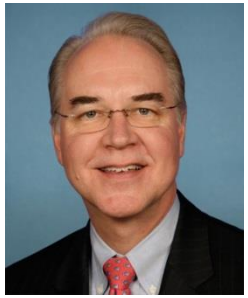
	114th	115th
GOP	54	52
DEM / IND	46	48

GOVERNORS: D+1

	2016	2017
GOP	31	30
DEM	18	19
IND	1	1

Trump Administration Leadership

Secretary of Health and Human Services nominee



Rep. Tom Price, MD (R-GA)

Administrator of the Centers for Medicare and Medicaid Services nominee

Seema Verma

Director of the White House Domestic Policy Council

Andrew Bremberg

Health Care Advisor at the White House Domestic Policy Council

Katy Talento

Day One ACA Executive Order

Eliminate any "fiscal burden on any State" or any "cost, fee, tax, penalty or regulatory burden" on individuals and providers

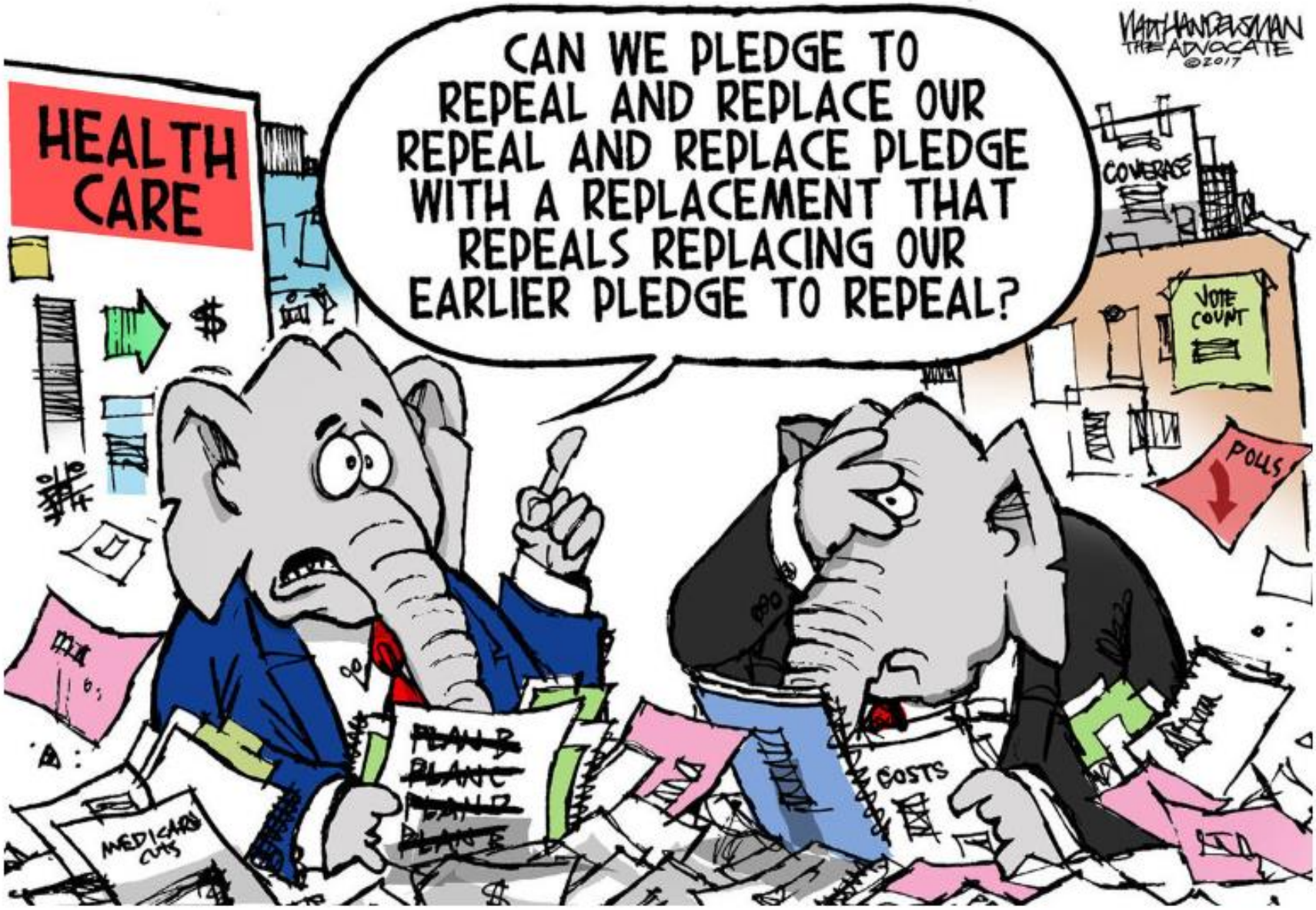
- While the order does not specify the suspension of any particular part of the law, it could result in the weakening of the "individual mandate." Although the mandate cannot be eliminated entirely through executive order, the hardship exemption could be expanded and the IRS could cease harsh enforcement of the mandate. In addition, the order could settle some ACA-related lawsuits, such as those filed by employers seeking relief from having to cover contraceptives for female employees on religious grounds.

Give states more flexibility

- The order might allow federal officials to be more receptive to state requests for Medicaid waivers, which allow states to design alternative coverage models. For example, waivers that allow insurers to charge higher premiums or co-payments than are now allowed, or that allow insurers to offer less generous, cheaper packages of benefits could be in the offing.

Encourage the interstate sale of health insurance

- The order instructs agencies to work to create a system that allows the sale of health insurance across state lines, an idea that Republicans have been proposing as the centerpiece of an alternative to the ACA.


MATT HANDELSMAN
THE ADVOCATE
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CAN WE PLEDGE TO REPEAL AND REPLACE OUR REPEAL AND REPLACE PLEDGE WITH A REPLACEMENT THAT REPEALS REPLACING OUR EARLIER PLEDGE TO REPEAL?
HEALTH CARE
$
COVERAGE
VOTE COUNT
POLLS
PLAN B
PLAN C
PLAN D
PLAN E
MEDICAID CUTS
COSTS

ACA Repeal - Legislative

- What can Congress do through Budget Reconciliation?
  - Repeal taxes and spending provisions that implicate significant federal budgetary provisions
  - Cannot repeal regulatory provisions with incidental impact on budget
  - Cannot include replacement provisions that do not implicate the budget or add to deficit

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RELATED CONTENT

Governors' market stabilization proposal may clash with new GOP repeal bid

Parliamentarian's rulings jeopardize Senate GOP repeal bill

GOP senators likely to pass ACA repeal bill because failure is not an option

Senate parliamentarian's ruling dims odds for new ACA repeal bill

By Harris Meyer | September 1, 2017

A brewing Senate Republican effort to pass a new bill repealing and replacing the Affordable Care Act suffered a serious setback Friday when the Senate parliamentarian ruled that congressional authorization to pass such a bill with just 51 votes ends Sept. 30.

That means Senate Majority Leader Mitch McConnell would face the tough task of rounding up at least 50 votes—plus Vice President Mike Pence's vote—before the end of this month to pass a repeal-and-replace bill, which they were unable to do in July. Then, Senate Republicans would have to reach agreement with House Republicans, who passed their own bill. The two chambers would have to pass identical bills by the end of the month.

Republican Sens. Bill Cassidy of Louisiana, Lindsey Graham of South Carolina and Dean Heller of Nevada are working to build support among GOP lawmakers and governors for a plan to replace the ACA framework with a program of healthcare block grants to the states. Their plan, the details of which have not been released, would restructure Medicaid and likely reduce funding.

No Senate Democrats are expected to support their bill.

Experts said parliamentarian Elizabeth MacDonough's ruling that the fiscal 2017 budget reconciliation instruction for healthcare legislation expires on Sept. 30 significantly dims prospects for such legislation this year. The House and Senate

- Senate parliamentarian Elizabeth MacDonough ruled the fiscal 2017 budget reconciliation instruction for healthcare legislation expires on Sept. 30
- That means Senate would have to round up at least 50 votes—+VP Pence's vote—before the end of this month to pass a repeal-and-replace bill
- Then, Senate Republicans would have to reach agreement with House Republicans, who passed their own bill
- The 2 chambers would have to pass identical bills by the end of the month

Repeal ACA Effects

- Reversal in Coverage
  - Uninsured would increase by 22 million people by 2026
    - Pre-ACA between 40-50 million uninsured
    - After ACA dropped to 28 million uninsured
    - After repeal back up to 50 million
  - Public Health Crisis
  - Reduced Medicare/Medicaid and DSH funds to hospitals

American Hospital Association

Special Bulletin

Thursday, May 4, 2017

House Passes Legislation to Repeal Parts of the Affordable Care Act

The U.S. House of Representatives has voted 217-213 to pass the American Health Care Act (AHCA), legislation to repeal and replace parts of the Affordable Care Act (ACA).

The bill would make significant changes to the Medicaid program, including repealing the ACA's Medicaid expansion and cutting nearly $840 billion from the program. An amendment by Rep. Tom MacArthur (R-NJ) would allow states to waive certain insurance rules and consumer protections required under the ACA, specifically those related to essential health benefits and community rating, thereby impacting pre-existing conditions. An additional amendment by Rep. Fred Upton (R-MI) would establish an $8 billion pool to support individuals with pre-existing conditions. For a summary of the bill, please see our special web resource.

In a statement today, AHA President and CEO Rick Pollack said:

> America's hospitals and health systems are deeply disappointed in the House passage of the AHCA because it will jeopardize health coverage for millions of Americans.
>
> Despite last-minute changes, the proposal eliminates essential protections for older and sicker patients, including those with pre-existing conditions, such as cancer patients and the chronically ill. It does little to help the 24 million Americans who would be left without coverage following repeal and makes deep cuts to Medicaid, which provides essential services for the disabled, poor and elderly people in this country.

KEY CHANGES IN JULY 20 REVISED BETTER CARE RECONCILIATION ACT (BCRA) DISCUSSION DRAFT

PROVISION	ORIGINAL BCRA OVERVIEW – 6/26/17	KEY CHANGES, REVISED BCRA – 7/20/17
Premium Tax Credits	**Age and Income-Based Tax Credits:** • Starting in 2020, refundable premium tax credits in the individual market: – Available to individuals 350 percent of FPL and below. – Based on a new benchmark plan (median-premium 58 percent AV plan). – Individuals' premium contributions tied to income and age, with older ages required to contribute more than younger ages. – Cannot be used towards any insurance that covers abortion, with exceptions. – Limits based on immigration status.	**Age and Income-Based Tax Credits:** No change from June 26 BCRA. **Catastrophic Coverage** • Starting 2019, allows anyone to enroll in a catastrophic plan (removing ACA's age and hardship restrictions). • Extends premium tax credit eligibility to catastrophic plans (previously not allowed under ACA). • Includes enrollees in catastrophic plans as part of the individual market and small-group market's single risk pools. **Health Savings Account (HSA) for Plan Premiums** • Starting 2018, allows individuals to use HSA funds to pay premiums for a high-deductible health plan. • HSA funds would only apply for non-employer plans and non-tax deductible plans, and only for amounts that exceed premium tax credits.
Cost-Sharing Reductions (CSRs)	Provides authorization and appropriations for CSRs through 2019, and eliminates them beginning in 2020.	No change from June 26 BCRA.
Individual and Employer Mandates	Eliminates penalties for the individual and employer mandates, effective retroactively starting in 2016.	No change from June 26 BCRA.
Continuous Coverage Penalty	Starting 2019, requires health insurers to impose a 6-month waiting period on individuals who cannot demonstrate 12 months of continuous coverage when applying for coverage.	No change from June 26 BCRA.
Market Stability Funding	**$112 Billion Total Funding** • Provides $112 billion total to support individual market stabilization across two programs, as outlined below. • **Short-Term Assistance to Address Coverage and Access Disruption Program**: $70 billion to CMS to fund arrangements with health insurance issuers to address coverage and access disruption, as follows: – $15 billion per year for 2018 – 2019; and – $10 billion per year for 2020 – 2021. • **Long-Term State Stability and Innovation Program**: $62 billion to the states for premium stabilization and incentives for individual market participation, as follows: – $8 billion for 2019; – $14 billion per year for 2020 – 2021; – $6 billion per year for 2022 – 2023; – $3 billion per year for 2024 – 2025; and – $4 billion for 2026. • States would be required to begin matching federal contributions at a gradually increasing rate for 2022 – 2026.	**$182 Billion Total Funding** • Provides an additional $70 billion to support individual market stabilization, increasing the total from $112 billion to $182 billion. • **Short-Term Assistance to Address Coverage and Access Disruption Program**: No change from June 26 BCRA. • **Long-Term State Stability and Innovation Program**: Funding increases by an additional $70 billion, from $62 billion to $132 billion, distributed per year as follows: – $8 billion for 2019; – $14 billion for 2020; – $14 billion for 2021; – $19.2 billion for 2022; – $19.2 billion for 2023; – $19.2 billion for 2024; – $19.2 billion for 2025; and – $19.2 billion for 2026. • No change in state matching federal contributions from June 26 BCRA. • For particularly high cost states (such as Alaska), reserves 1 percent of total funding ($1.82 billion) for both programs to subsidize insurance in states where premiums are at least 75 percent higher than the national average.

KEY CHANGES IN JULY 20 REVISED BETTER CARE RECONCILIATION ACT (BCRA) DISCUSSION DRAFT

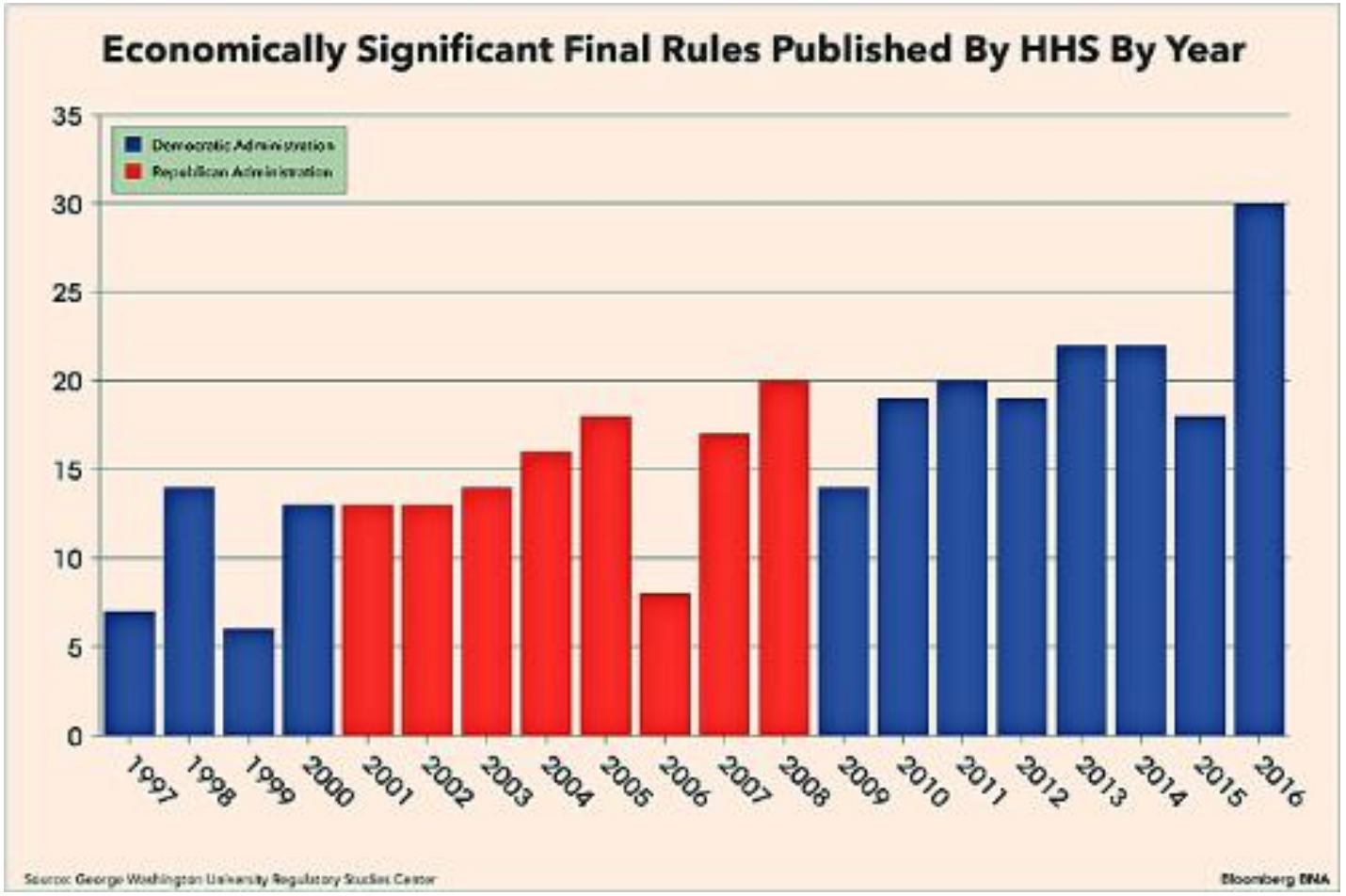
PROVISION	ORIGINAL BCRA OVERVIEW – 6/26/17	KEY CHANGES, REVISED BCRA – 7/20/17
ACA Market Rules	**Broader ACA Section 1332 Waivers** • Appropriates $2 billion for FY 2017-2019 to help states apply and implement the ACA's Section 1332 waivers. • Significantly amends Section 1332 waivers by removing existing conditions for coverage, affordability, comprehensiveness, and federal-deficit neutrality, and instead only requires that the state's plan would not increase the federal deficit. • States would be able to waive numerous ACA requirements under Section 1332 waivers, including the requirements for Essential Health Benefits (EHBs). **Repeals Certain ACA Market Rules** • Starting in 2019, replaces the ACA's 3:1 age-rating rule with a default 5:1 age-rating ratio and allows states the option of setting their own age rating ratio. • Starting in 2019, requires states to determine the Medical-Loss Ratio (MLR) for insurers.	**Broader ACA Section 1332 Waivers**: No change from June 26 BCRA. **Repeals Certain ACA Market Rules**: No change from June 26 BCRA.
ACA Taxes and Fees	• Repeals most ACA taxes and fees, with varying effective dates in 2017 and 2018. • Repeals the Additional Medicare Tax, effective 2023. • Delays the Cadillac Tax from taking effect until 2026.	• Does not repeal the Net Investment Income Tax, Additional Medicare Tax, and the remuneration tax on executive compensation for health insurance. • No change in the repeal/delay of other ACA taxes and fees from June 26 BCRA.
Medicaid Expansion	**Gradual Expansion Reduction** • Retroactively limits the federal match for newly eligible enrollees to current expansion states only, as of March 1, 2017. • States would still be allowed to expand Medicaid through 2019 at the regular federal match rate. • For states that implemented the Medicaid expansion as of March 1, 2017, the bill would maintain the current federal match for newly eligible enrollees (90 percent) through 2020. The federal match to these states for Medicaid expansion funding would phase down to 85 percent in 2021, 80 percent in 2022, 75 percent in 2023, and then drop to the state's regular federal match by 2024.	**Gradual Expansion Reduction**: No change from June 26 BCRA.

KEY CHANGES IN JULY 20 REVISED BETTER CARE RECONCILIATION ACT (BCRA) DISCUSSION DRAFT		
PROVISION	ORIGINAL BCRA OVERVIEW – 6/26/17	KEY CHANGES, REVISED BCRA – 7/20/17
Medicaid Block Grant Option	**Five Year Block Grant, CPI-U Growth Rate** • States may choose a block grant option for non-elderly, nondisabled, non-expansion adults for a period of 5 FYs, beginning in FY 2020. If states do not extend the block grant option at the end of the 5-year period, they would revert to the per capita cap financing system. • The total block grant amount for the initial FY would match the baseline per capita allotment, increased in subsequent FYs by CPI-U. • States can rollover unused block grant funds into the next FY as long as they continue with the block grant option. • As part of the "targeted benefit package" states must provide mental health services and substance use disorder services. • States may impose cost sharing, not to exceed 5 percent of the family's annual income. • If prescription drugs are included in the block grant benefits option, they must be subject to the Medicaid rebate program.	**Five Year Block Grant, CPI-U Growth Rate**: No change from June 26 BCRA. • Allows states to use the block grant option to cover the Medicaid expansion population (in addition to non-elderly and nondisabled adults).
Medicaid DSH Allotments	**Increases DSH Allotments for Non-Expansion States Only** • For non-expansion states, repeals the ACA's DSH payment reductions, which were set to go into effect between FY 2017-2024. • In addition, increases the DSH allotment for FY 2020 for certain non-expansion states with FY 2016 per capita DSH allotments below the national average. • Starting Q2 2024, DSH allotments shall be determined as if there had been no increase in FY 2020. • No change for expansion states in the ACA's DSH payment reductions for FY 2017-2024.	**Increases DSH Allotments for Non-Expansion States Only**: No change from June 26 BCRA. • Changes payment calculation for DSH allotment increases for FY 2020 for non-expansion states from per Medicaid enrollee to per uninsured. • Defines "expansion state" as a state that has expanded Medicaid as of January 1, 2021.

KEY CHANGES IN JULY 20 REVISED BETTER CARE RECONCILIATION ACT (BCRA) DISCUSSION DRAFT

PROVISION	ORIGINAL BCRA OVERVIEW – 6/26/17	KEY CHANGES, REVISED BCRA – 7/20/17
Other Medicaid Changes	**Work Requirements** • Beginning October 1, 2017, allows states to impose work requirements on non-elderly, non-disabled, non-pregnant Medicaid beneficiaries without children under age 6 and provides a 3 percent administrative federal match for implementation. **Medicaid and CHIP Quality Bonus Program** • Establishes new Medicaid and CHIP Quality Performance Bonus Payments for FYs 2023-2026. States can qualify for an additional percentage to their Federal Matching Assistance Percentage (FMAP) by spending less than expected in medical expenditures while also satisfying certain quality measures.	**Work Requirements**: No change from June 26 BCRA. **Medicaid and CHIP Quality Bonus Program**: No change from June 26 BCRA. **Home and Community-Based Services** • From January 1, 2020 to December 31, 2023, establishes a new $8 billion demonstration project for states to provide payments for home and community-based services for aged, blind, and disabled populations. States would apply to receive funding from HHS, with priority given to the 15 states with the lowest population density. **Public Health Emergencies** • From January 1, 2020 to December 31, 2024, the HHS Secretary may exclude state spending on declared public health emergencies, such as Zika, from the Medicaid per capita cap or block grant calculations. The aggregate amount excluded cannot exceed $3 billion.
Planned Parenthood	Prohibits federal funding for one year from bill's enactment.	No change from June 26 BCRA.
Misc. Provisions	**Public Health and Prevention Fund** • Repeals Prevention and Public Health Fund starting in 2018. **Opioid Crisis Funding** • Appropriates $2 billion for FY 2018 to provide grants to states to support substance use disorder treatment and recovery support services for individuals with mental and substance use disorders. **BCRA Implementation** • Appropriates $500 million for HHS to implement the law.	**Public Health and Prevention Fund** • Repeals Prevention and Public Health Fund starting in 2019. **Opioid Crisis Funding** • Provides $45 billion over FY 2018-2026 for state grants towards substance use disorder treatment and recovery services. **BCRA Implementation**: No change from June 26 BCRA.
CBO Estimate (Relative to Current Law)	• Reduce the federal deficit by $321 billion over 2017-2026. • Results in 22 million more uninsured individuals by 2026.	• Reduce the federal deficit by $420 billion over 2017-2026. • Results in 22 million more uninsured individuals by 2026.

The Cost of Regulations



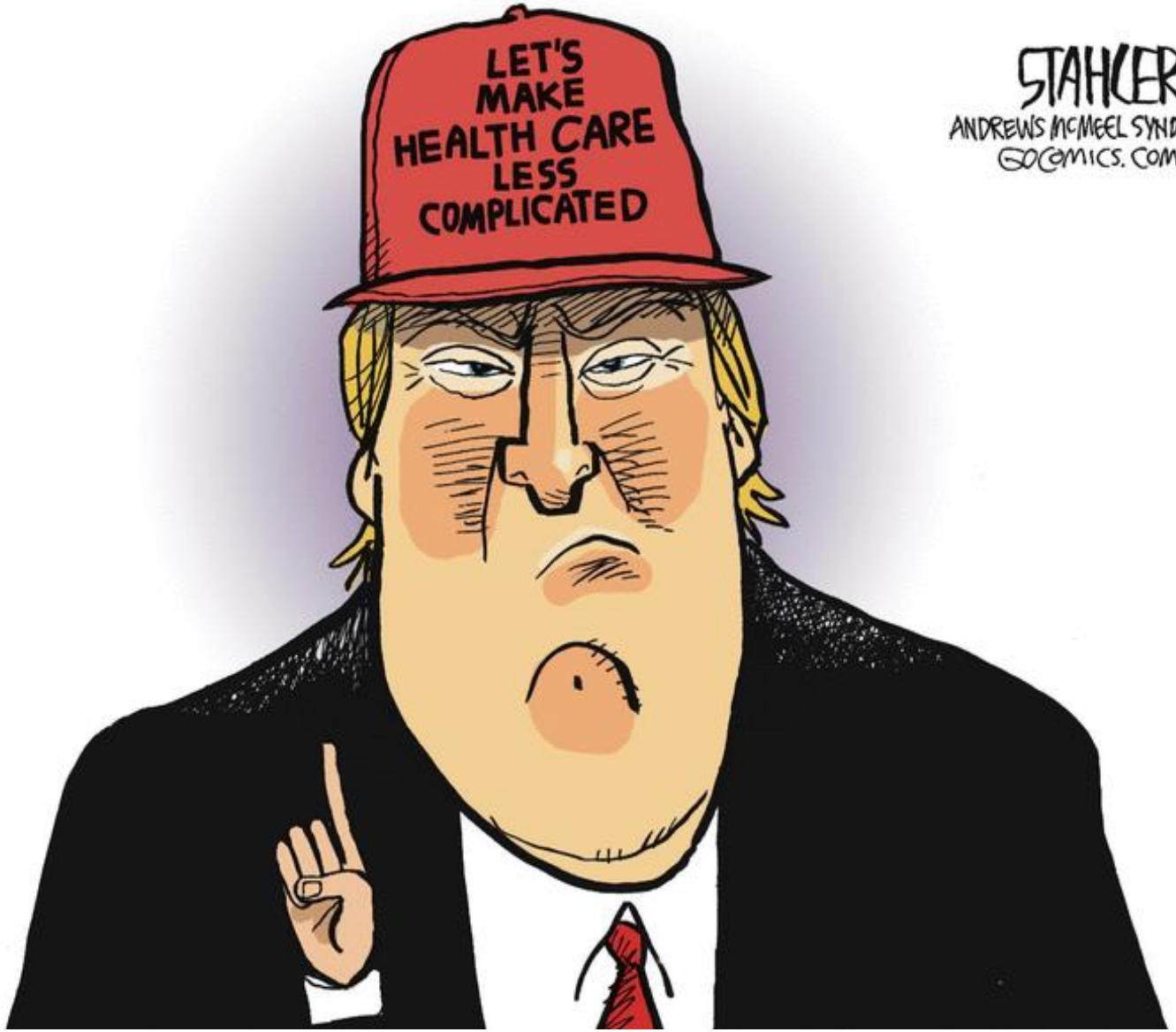
Four Takeaways from the CBO

1. **Millions of Americans will lose coverage**
   - According to a Congressional Budget Office (CBO) analysis of the AHCA, a total of 14 million Americans will lose coverage in the next year. Of those, 6 million would elect not to purchase insurance in the individual marketplace, 5 million would lose coverage from Medicaid, and 2 million would lose employer-based coverage (all figures rounded). The CBO also projects that by 2020, 21 million Americans would be without coverage and by 2026 that number would rise to 24 million.
2. **Medicaid program will be cut**
   - According to CBO, shifting Medicaid to a capped, per-capita program would not keep up with rising medical costs. This would result in a $880 billion cut from the program over 10 years. By 2026, the federal government would spend 25% less on Medicaid and cover 14 million fewer people than under current law.
3. **Subsidies shift to the younger and wealthier**
   - The AHCA would shift government subsidies away from older, sicker and more rural households. The ACA's subsidies were tied to income and the local cost of care. The AHCA ties the subsidies to age and to income, which makes the bill more favorable for the young and healthy.
4. **Dramatic premium changes come in the next two to three years**
   - The CBO report says premiums are likely to spike 15-20% in 2018 and 2019 and then settle due to the $100 billion Patient and State Stability Fund that states can use to stabilize their markets. From repeal until 2020, the individual market would cover 6-9 million fewer people each year.

"Nobody knew health care could be so complicated."

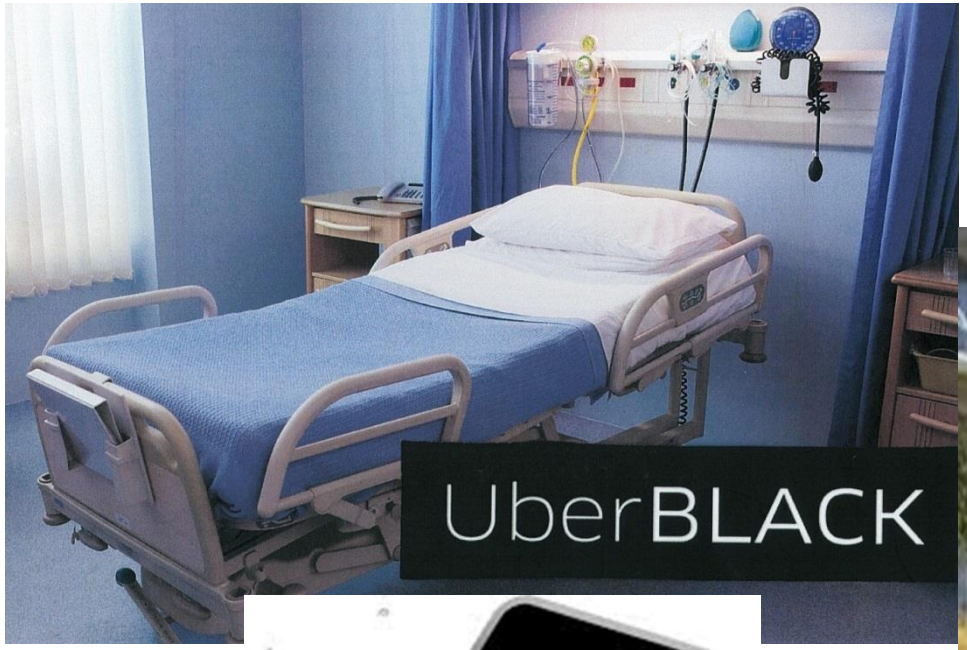
Is the AHCA Coming Back?

- "We are going to restart negotiations (on healthcare), not retrench or put up dividing lines." (Paul Ryan 3/28)
- "I think we are closer today to repealing Obamacare than ever before, certainly closer than when we delayed the AHCA vote! (Steve Scalise 3/28)
- "This Freedom Caucus would vote against the 10 Commandments! I'm out! (Ted Poe, 3/27)



Bernie Sanders' reaction when asked about Trump saying "Nobody knew that health care could be so complicated."

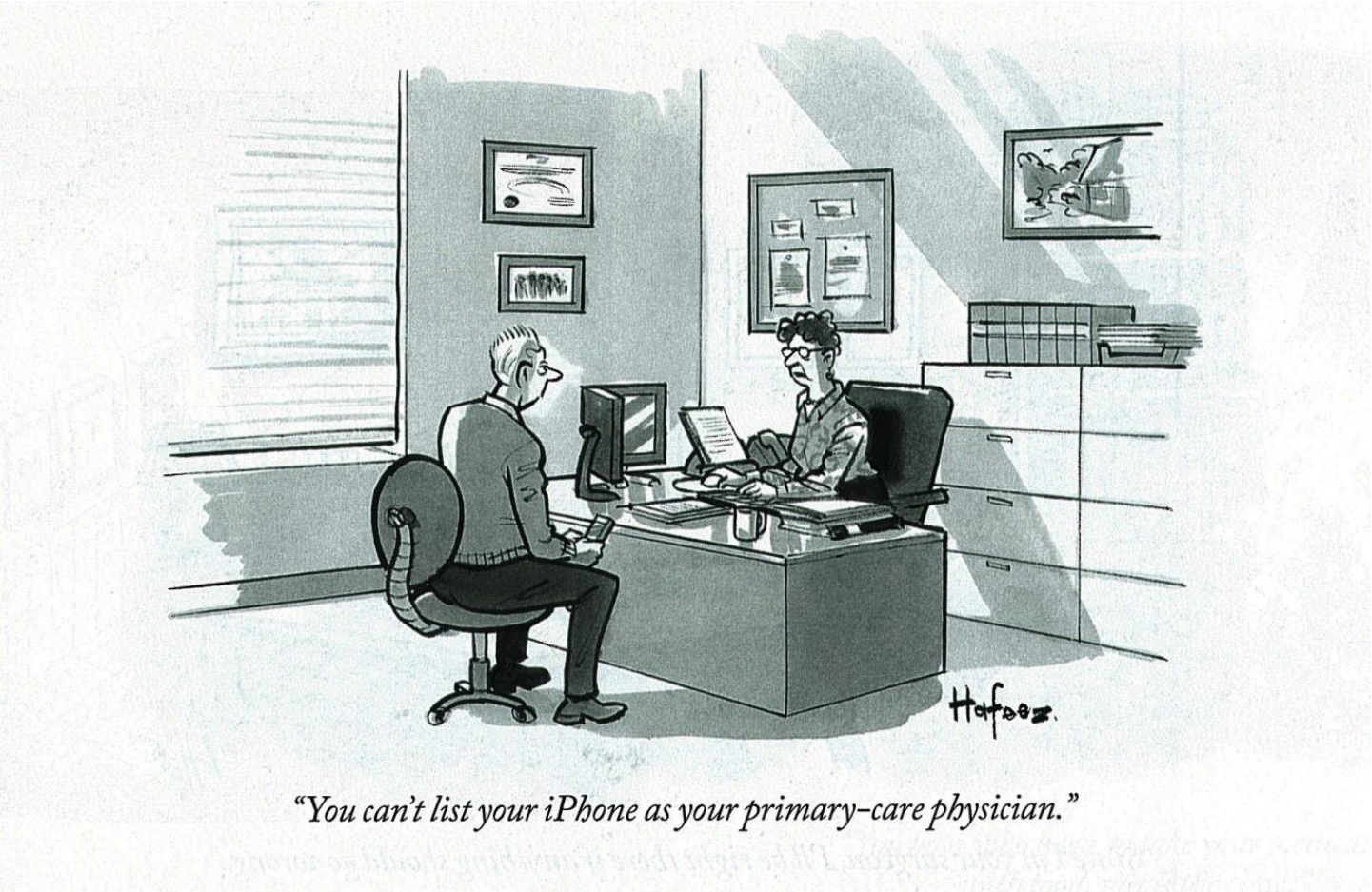
Where We're Going



Health Care Long Term?

- Smart homes…bedside acute care?
- Driverless cars…ambulances?
- 911…from your wrist and on it's own?
  - Simultaneous alert to your MD…with charts?
- Implanted chips to dose prescriptions?
- DNA sequencing – genome vs. symptoms
- Stem Cell Therapy -- mainstream

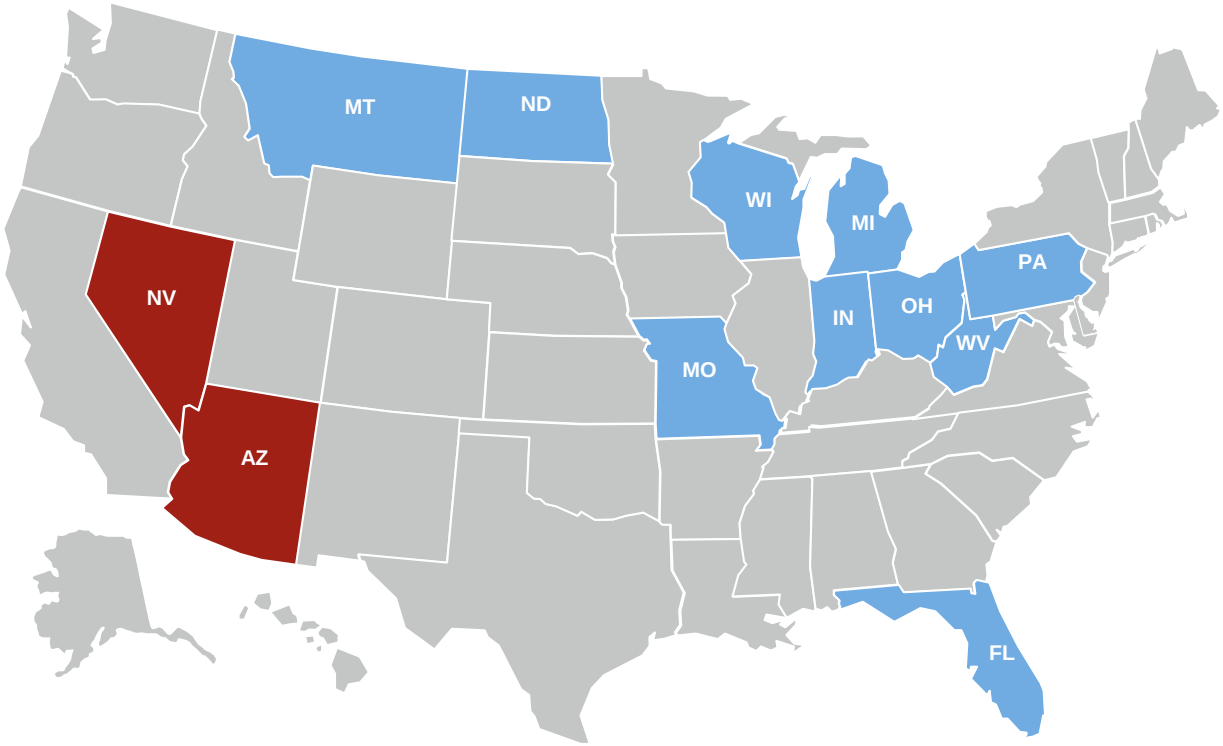
- Enhanced Telemedicine with World-Renowned Specialists
  - but not licensed in the State or location of the patient
- Uber Health
  - encounter where the patient is located with immediacy
- 3D Imaging
- 3D Printers/Biometric Scaffolds



"You can't list your iPhone as your primary-care physician."

2018 Senatorial Elections

10 of 25 Democratic Senators up for re-election in 2018 are from states carried by President Trump; only 2 Republican seats are potentially at issue



Democratic held

Tammy Baldwin (D-WI)
Sherrod Brown (D-OH)
Bob Casey (D-PA)
Joe Donnelly (D-IN)
Heidi Heitkamp (D-ND)
Joe Manchin (D-WV)
Claire McCaskill (D-MO)
Bill Nelson (D-FL)
Debbie Stabenow (D-MI)
Jon Tester (D-MT)

Republican held

Jeff Flake (R-AZ)
Dean Heller (R-NV)

"You're Fired."

Donald Trump

Donna D. Fraiche represents providers/consumers in challenges against State Medicaid cuts affecting rates and access. She served as co-counsel to the American Hospital Association in connection with *Amici* Briefs before the Supreme Court.

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THANK YOU!

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