Health Policy 2019: Crosswinds and Opportunities

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North Dallas Chamber of Commerce Annual Health Conference

Dallas, TX

January 25, 2019

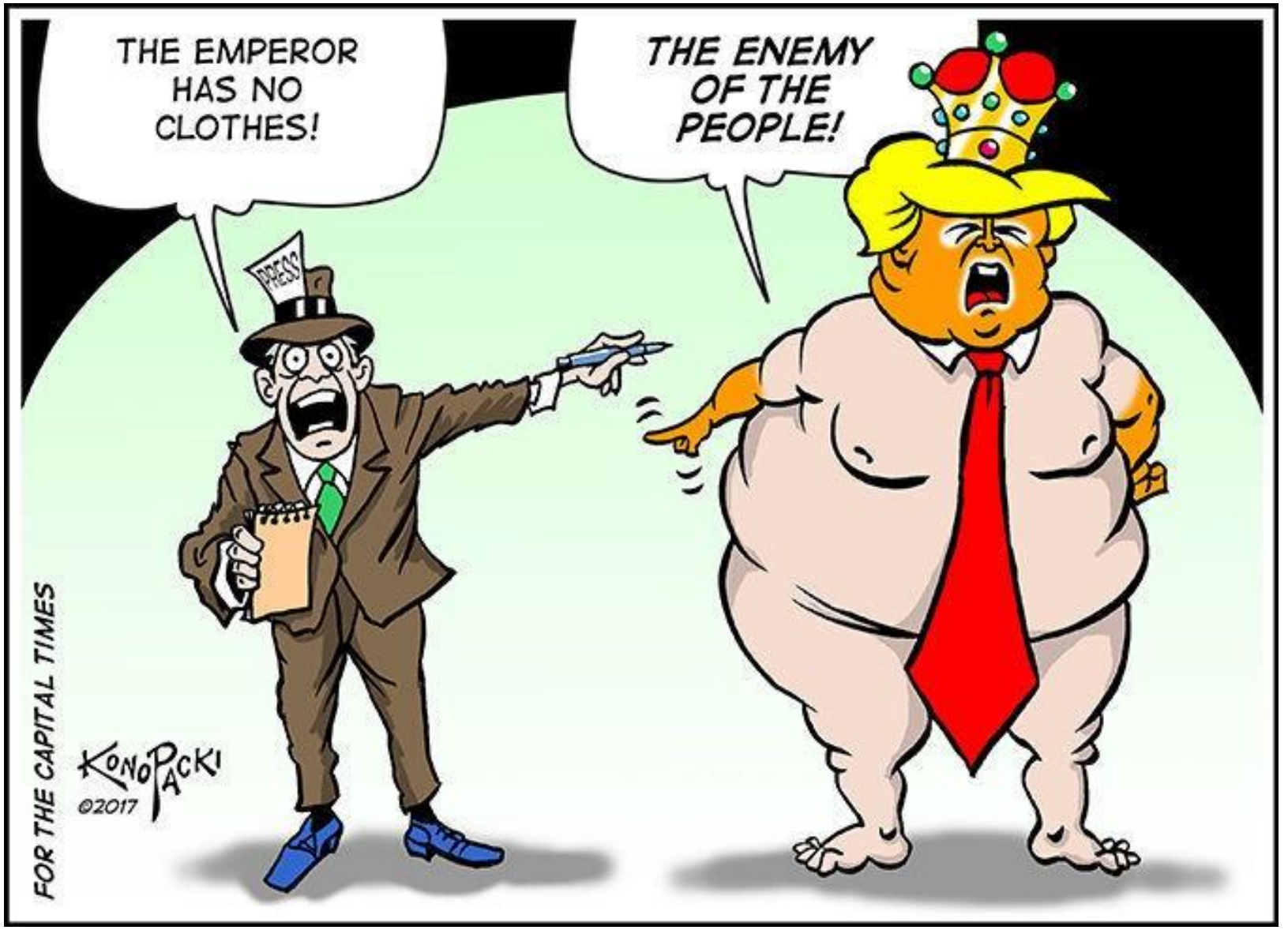
Overview

- American Communities Project → All Health Care is Local
- Federal Policy / Election 2020 backdrop
- State policy continuations and innovations
  - Coverage Expansions, work requirements, delivery reforms and marketplace management
- Cost Containment: the Old and New Frontier
- Why Social Determinants Have Become the new Buzzword
- What Communities can do about cost and social determinants together

What the Federal Government Will Argue about in 2019-20

- Everything


OVERWHELMING EVIDENCE


THE EMPEROR HAS NO CLOTHES!
THE ENEMY OF THE PEOPLE!
PRESS
FOR THE CAPITAL TIMES
KONOPACKI
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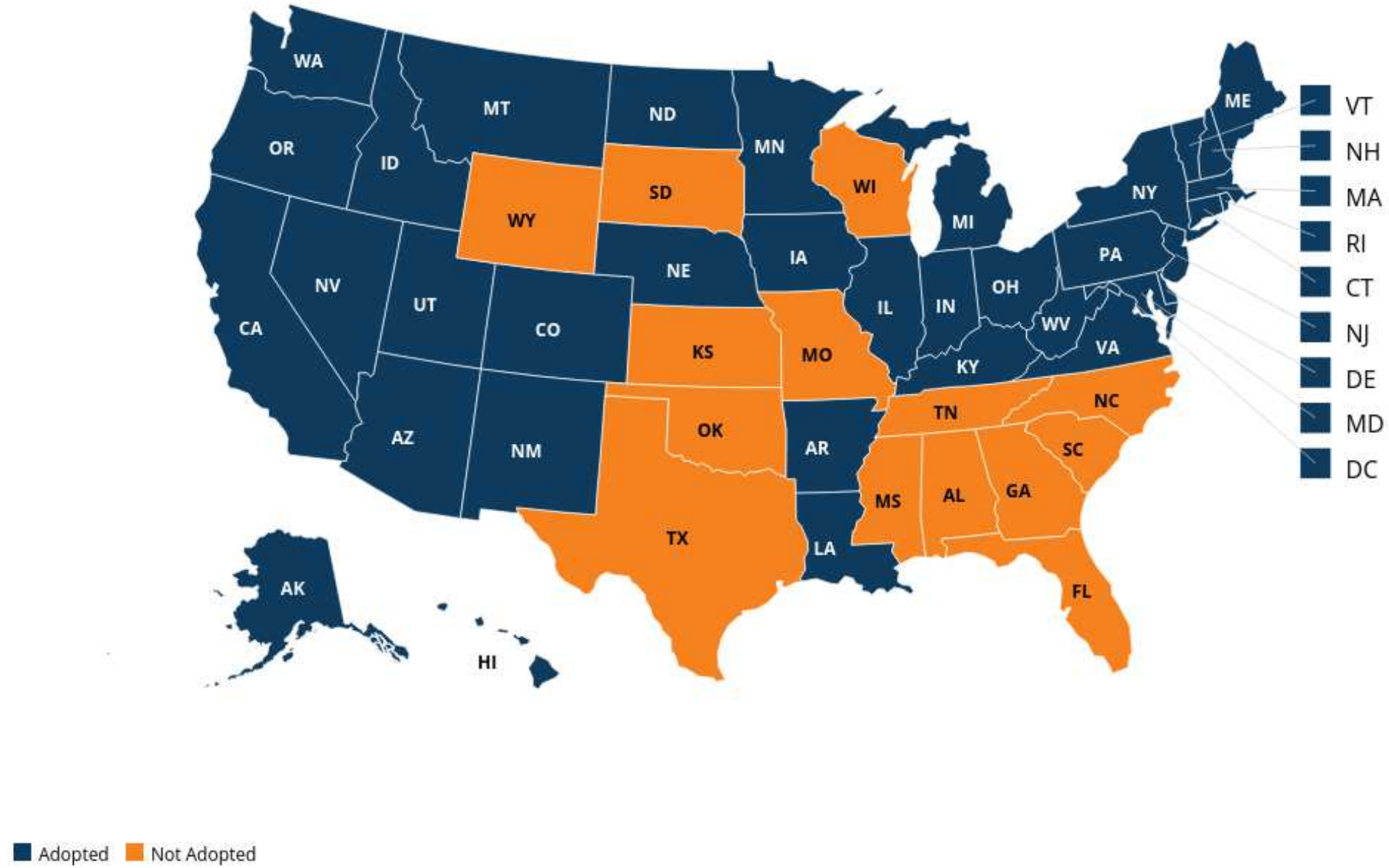
HE FOUND THAT HIS ARMS AND LEGS WERE TIGHTLY FASTENED TO THE GROUND.

What the Federal Government Will Argue about in 2019-20

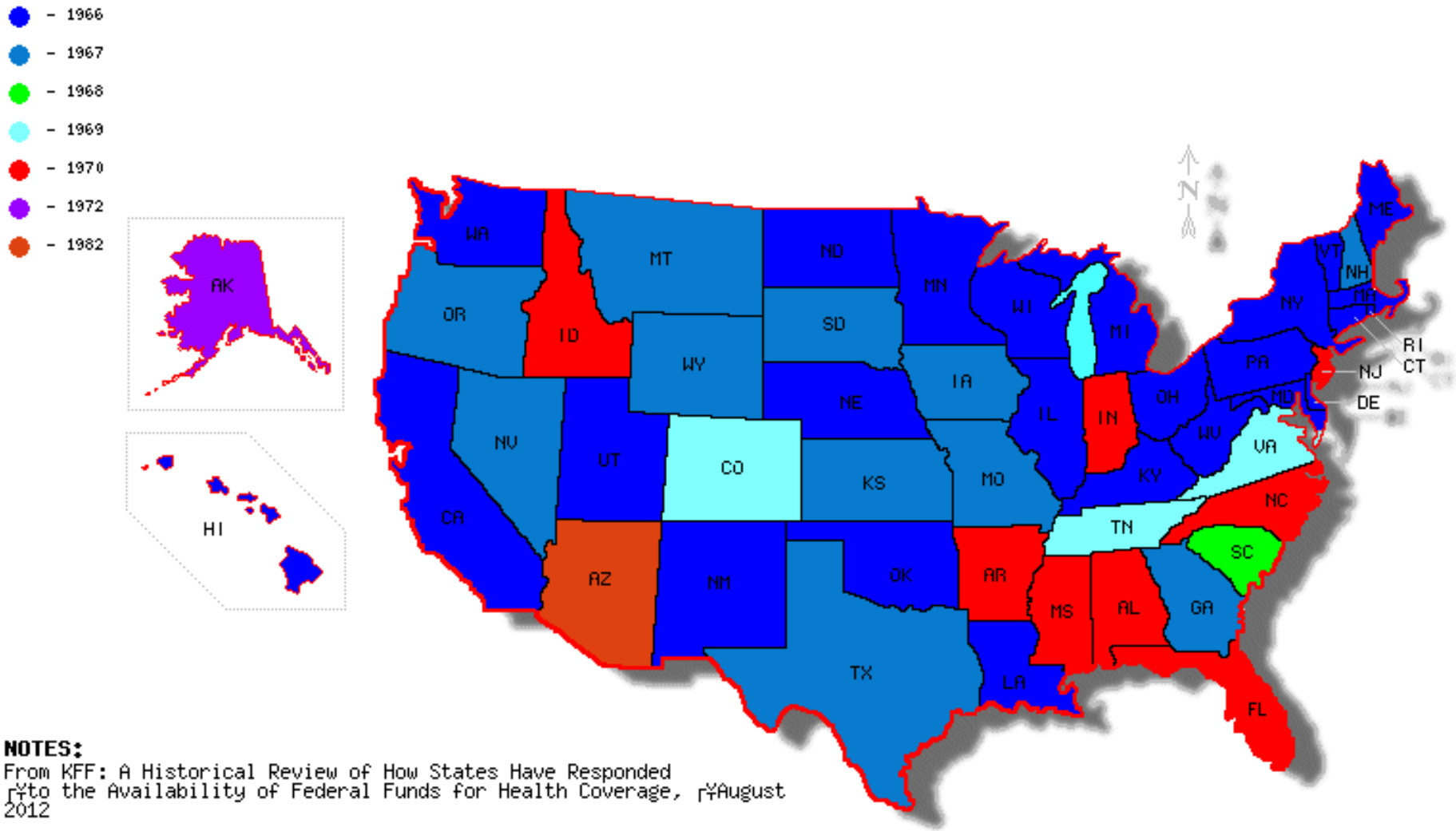
- Everything
- Medicare Drug Price Negotiation
- ACA lawsuits and fixes
- Medicare for All

Status of State Action on the Medicaid Expansion Decision



SOURCE: Kaiser Family Foundation, kff.org

When States Created Their Medicaid Programs



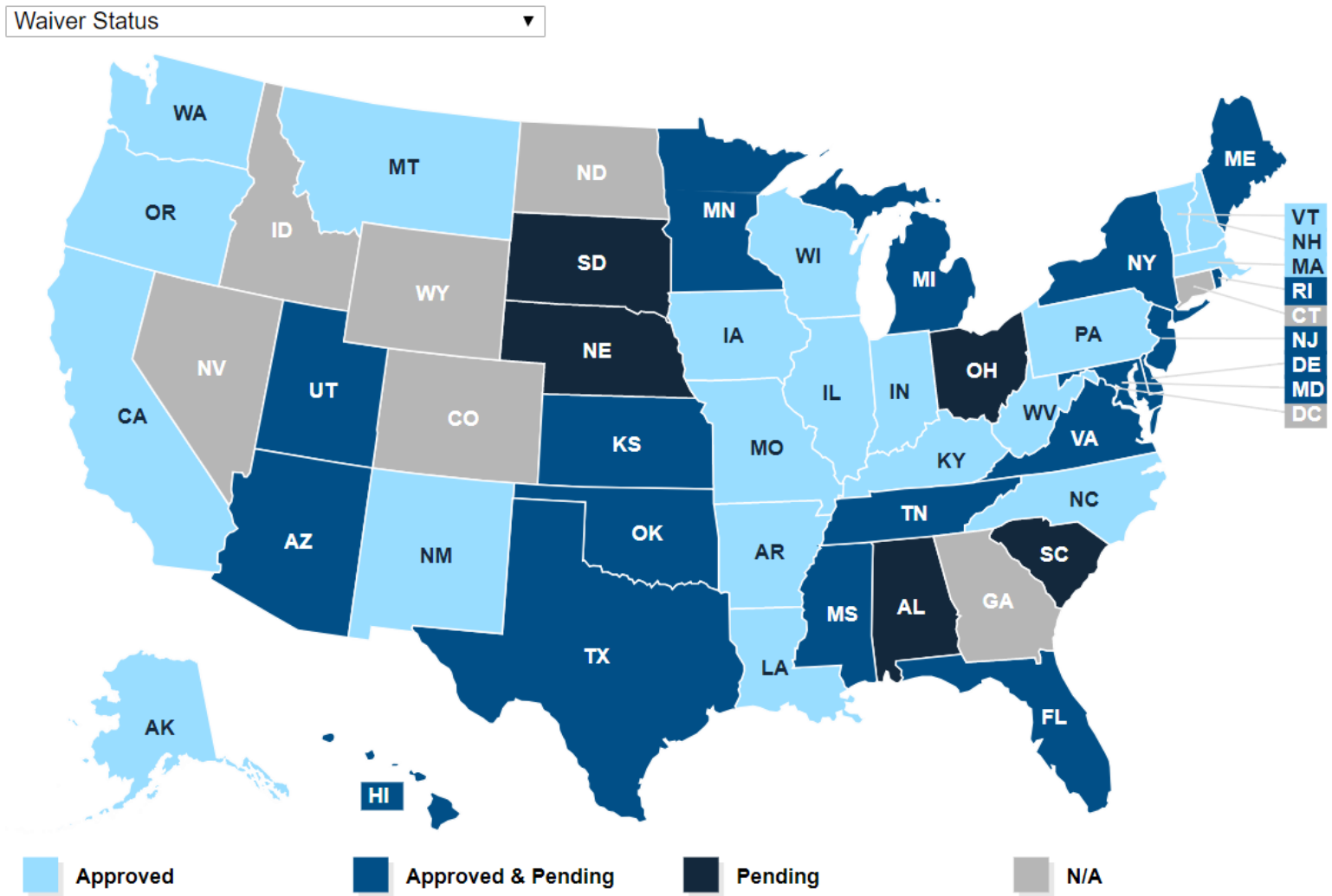
NOTES:
From KFF: A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage, August 2012

Source: diymaps.net (c)

Section 1115 Medicaid Waivers: Approved and Pending as of December 21, 2018

(back to top)

Use the drop-down menu to sort the map by waiver topic.



Source: Kaiser Family Foundation, State Health Facts, *Approved Section 1115 Medicaid Waivers* and *Pending Section 1115 Medicaid Waivers*, *December 21, 2018*.

North Carolina and “Healthy Opportunities”

- Transition from FFS to Managed Care
- Integrate physical and behavioral health plus pharmacy care
- “Whole Person Care” includes upstream services for SDoH/Healthy Opportunities pilot

- => Medicaid MCOs can spend $ on housing, food, transportation, social services

State run average:
$426

Federal run average:
$477

Houston, TX
$393

Outliers:

Omaha, NE
$821

Cedar Rapids, IA
$724

Cheyenne, WY
$796

Table 1: Monthly Unsubsidized Bronze, Benchmark, and Gold Premiums for a 40 Year Old Non-Smoker

State	Major City	Lowest Cost Bronze Before Tax Credit			2nd Lowest Cost Silver Before Tax Credit			Lowest Cost Gold Before Tax Credit		
		2018	2019	% Change from 2018	2018	2019	% Change from 2018	2018	2019	% Change from 2018
Alabama	Birmingham	$372	$327	-12%	$546	$525	-4%	$612	$616	1%
Alaska	Anchorage	$526	$461	-12%	$709	$696	-2%	$759	$655	-14%
Arizona	Phoenix	$405	$333	-18%	$513	$426	-17%	$621	$574	-8%
Arkansas	Little Rock	$309	$320	4%	$378	$381	1%	$424	$469	11%
California	Los Angeles	$247	$281	14%	$360	$376	4%	$398	$405	2%
Colorado	Denver	$338	$336	-1%	$413	$466	13%	$459	$480	5%
Connecticut	Hartford	$306	$297	-3%	$484	$428	-12%	$545	$542	-1%
Delaware	Wilmington	$473	$449	-5%	$591	$685	16%	$706	$672	-5%
DC	Washington	$271	$316	17%	$324	$393	21%	$385	$426	11%
Florida	Miami	$297	$332	12%	$442	$447	1%	$456	$476	4%
Georgia	Atlanta	$371	$316	-15%	$421	$440	5%	$465	$497	7%
Hawaii	Honolulu	$336	$361	7%	$456	$503	10%	$449	$469	4%
Idaho	Boise	$290	$282	-3%	$463	$479	3%	$464	$480	3%
Illinois	Chicago	$305	$328	8%	$411	$384	-7%	$488	$442	-9%
Indiana	Indianapolis	$323	$350	8%	$366	$377	3%	$501	$498	-1%
Iowa	Cedar Rapids	$570	$429	-25%	$702	$724	3%	$781	$528	-32%
Kansas	Wichita	$344	$375	9%	$484	$529	9%	$445	$485	9%
Kentucky	Louisville	$282	$274	-3%	$397	$370	-7%	$446	$506	13%
Louisiana	New Orleans	$363	$336	-7%	$409	$384	-6%	$509	$484	-5%
Maine	Portland	$337	$335	-1%	$513	$485	-5%	$570	$582	2%
Maryland	Baltimore	$314	$298	-5%	$456	$419	-8%	$449	$408	-9%

Small Group ESI Average: 2017

$535

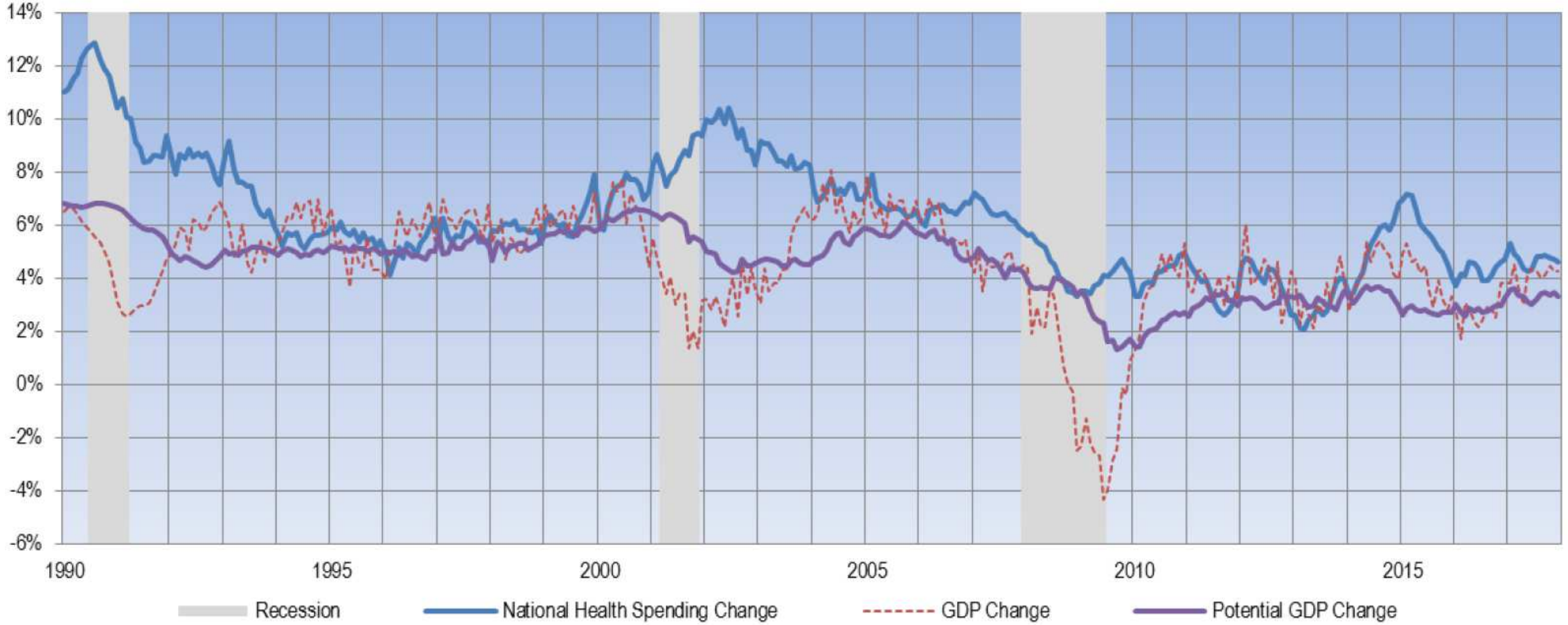
https://www.kff.org/health-costs/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/

Which Policies Came First: Cost Reduction, Access Expansion, or Quality Improvement ?

- First health policies in US?
  - Virginia (1639), Mass (1649), NJ and NY (1665) ***regulated physician FEES***
  - 1760 NYC banned unlicensed medical practice
  - By 1830, all but PA, NC, and VA had licensing boards

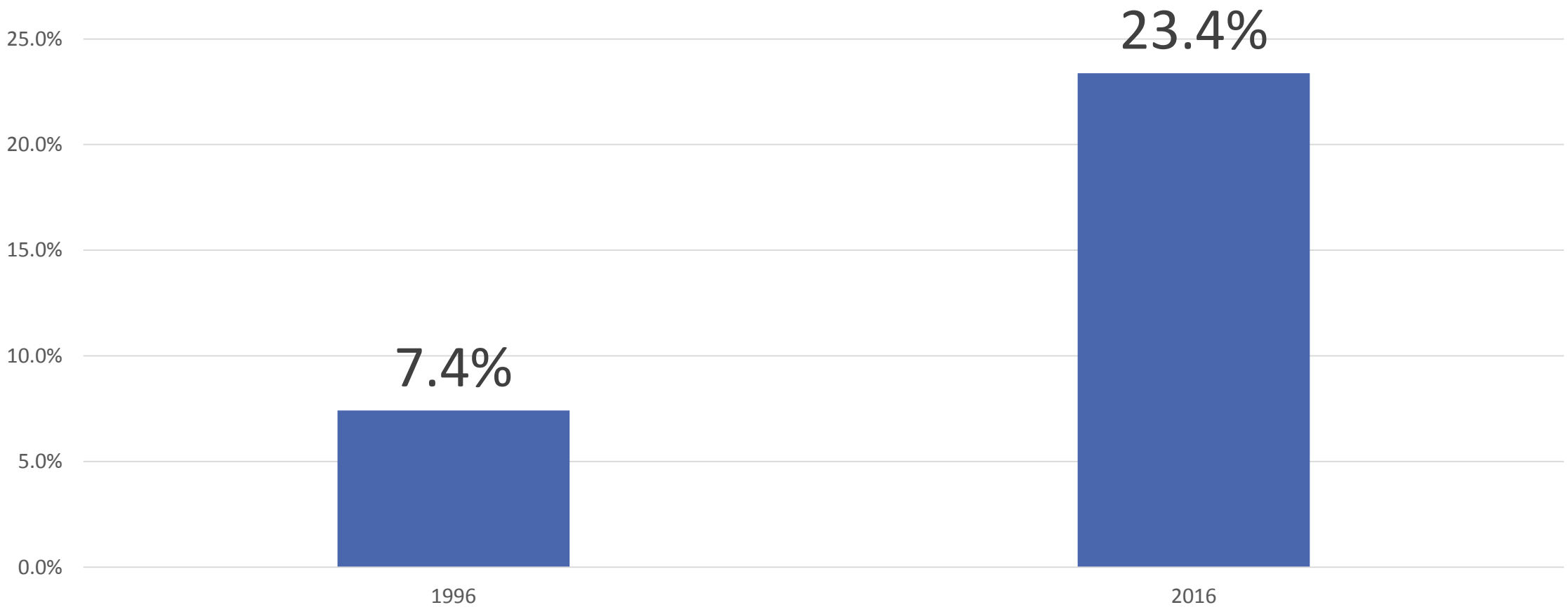
TIME SERIES TRACKER

Exhibit 7. Year-over-Year Percentage Change in Spending and GDP



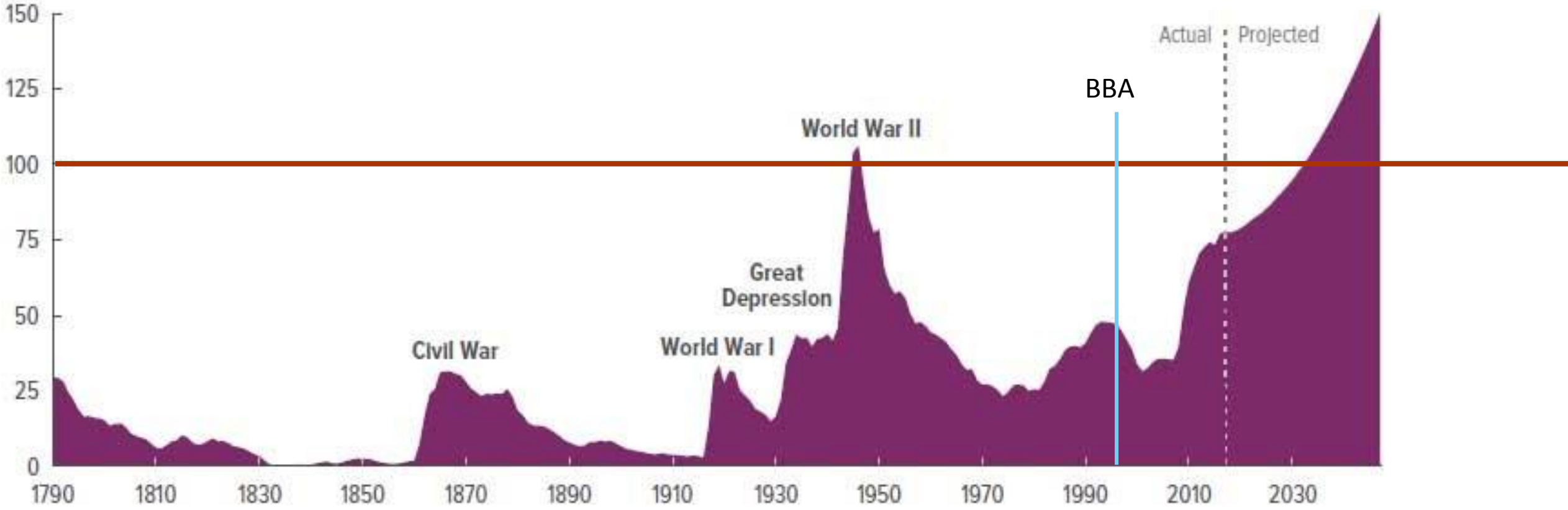
Source: Altarum monthly national health spending estimates. Monthly GDP is from Macroeconomic Advisers and Altarum estimates.
Note: Lightly shaded bars denote recession periods.

Our Major Problem:
Family Premium / Family Income



Federal Debt Held by the Public

Percentage of Gross Domestic Product



Source: Congressional Budget Office. For details about the sources of data used for past debt held by the public, see Congressional Budget Office, *Historical Data on Federal Debt Held by the Public* (July 2010), www.cbo.gov/publication/21728.

Pathways to Health Cost Reduction

- Reduce utilization
- Reduce prices
- Make patients pay more
- Eat better and exercise more
- Get smarter about advanced illness care
- Get smarter about social determinants of health

Figure 1

Social Determinants of Health (Healthy Opportunities)

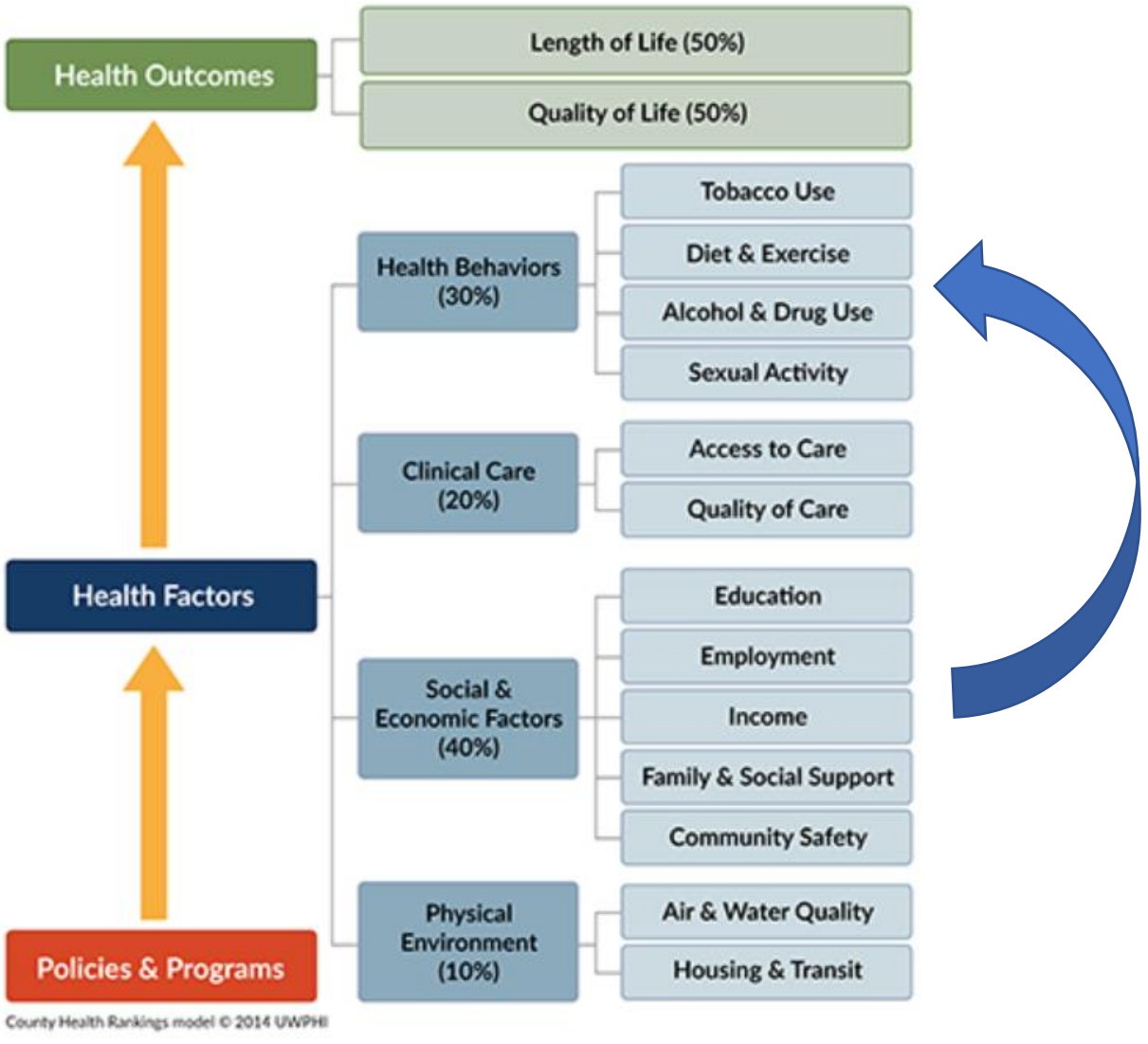
Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

Source: County Health Rankings http://www.countyhealthrankings.org/what-is-health



Behavior conditioned by social, economic, and physical context

Hard-headed Economist's View

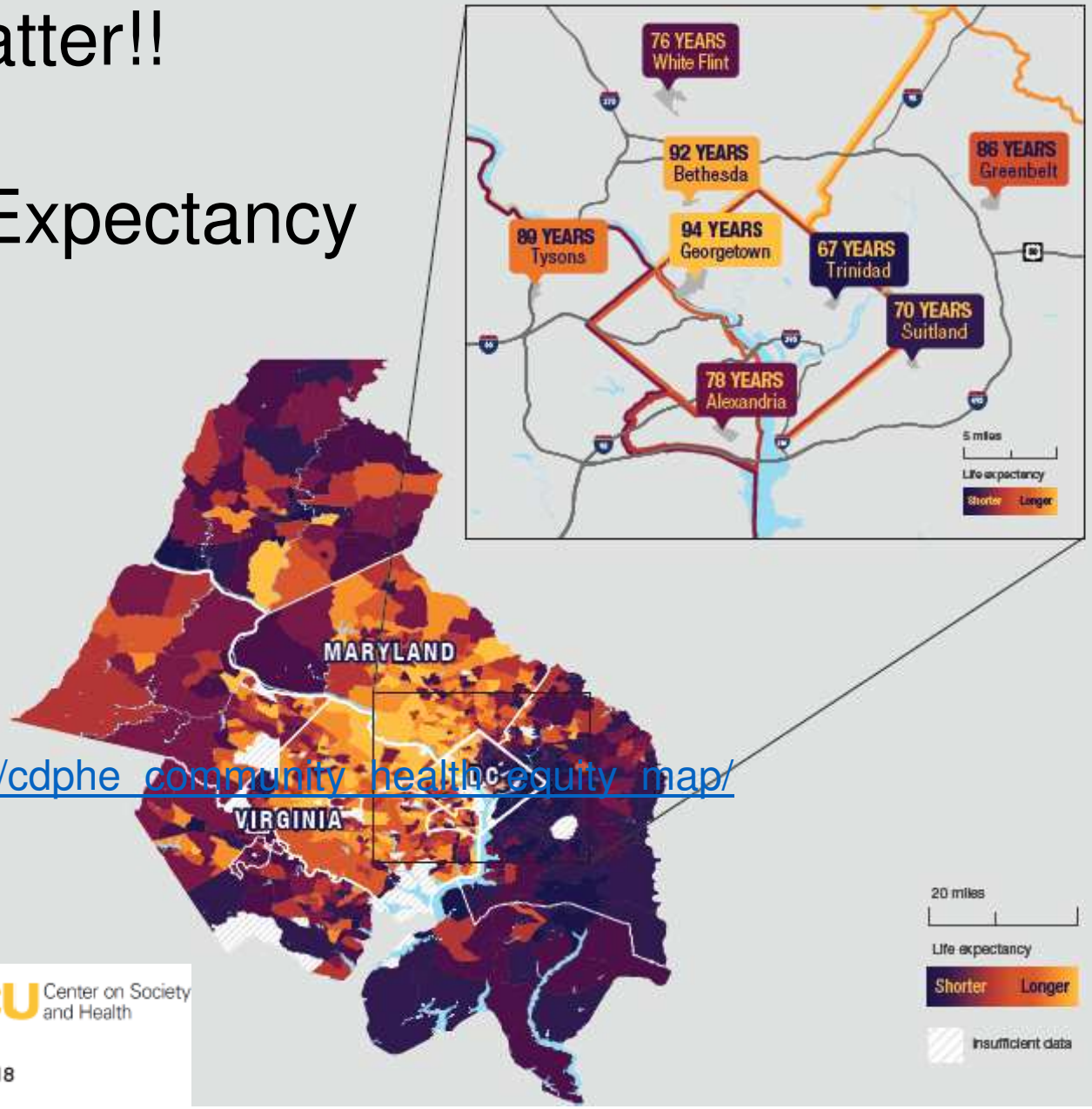
- Health is a product of choices – current and past – made subject to constraints, e.g., income, education, insurance, knowledge/expectations of future, physical and social environment (i.e., SDoH or Healthy Opportunities).

- Are choices more important than constraints? Philosophers and politicians will always differ

- Odds can be overcome, but, Odds can also be Changed

And Odds Matter!!

“ZIPCODE” → Life Expectancy



http://www.cohealthmaps.dphe.state.co.us/cdphe_community_health_equity_map/

Steven Woolf, MD, MPH
Derek Chapman, PhD
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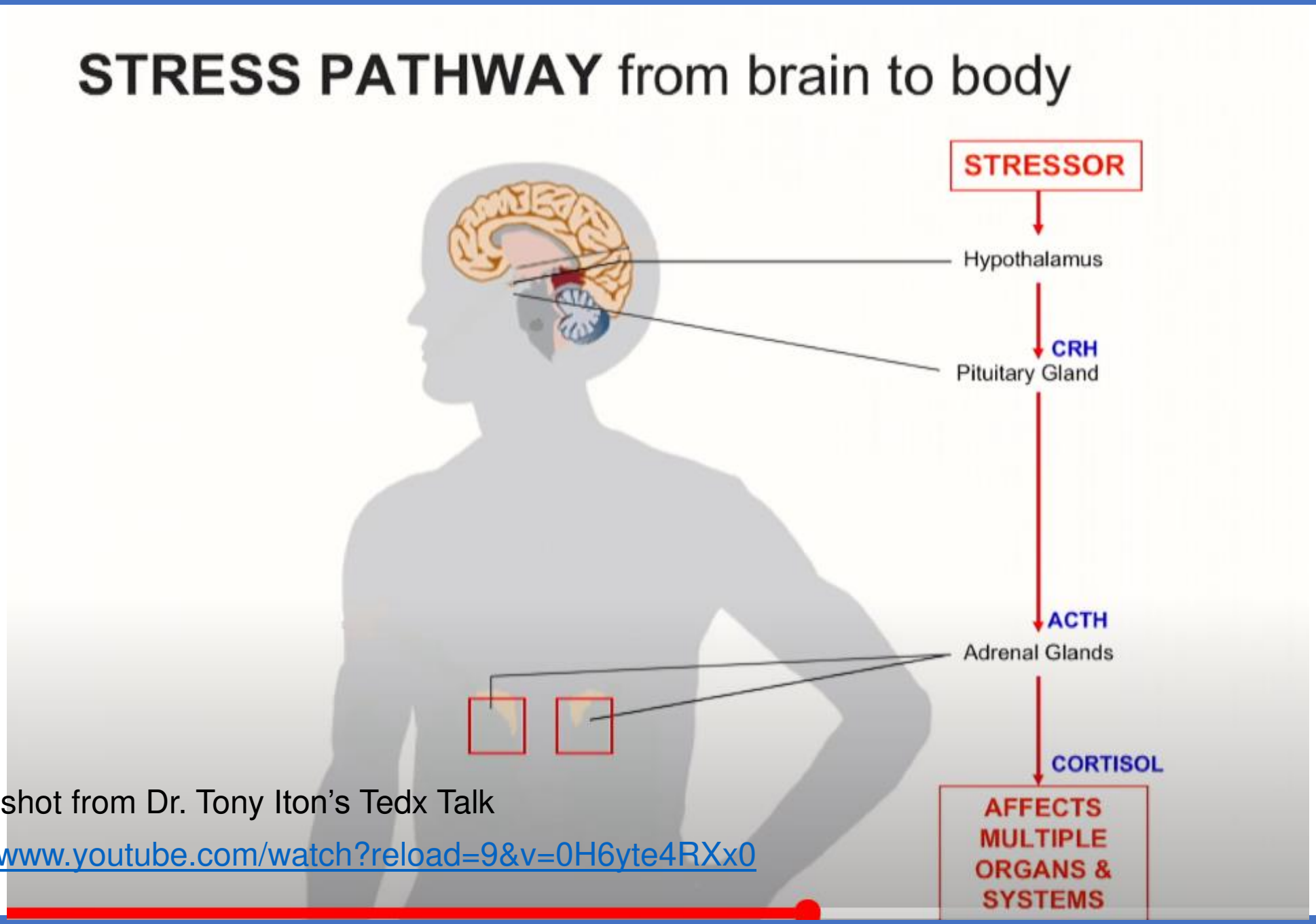
David Wheeler, PhD
Lauren Snellings, MPH, CHES
Jong Hyung Lee, MS

VCU Center on Society and Health

October 2018



Screenshot from Dr. Tony Iton's Tedx Talk

https://www.youtube.com/watch?reload=9&v=0H6yte4RXx0


EMERGENCY
AMBULANCE


Intervention
Hope and helpline.
CARELINE
Prevention
BUILDING COMMUNITY
It takes a village.
Resilience
BUILDING RESILIENCE
Discovering passions.

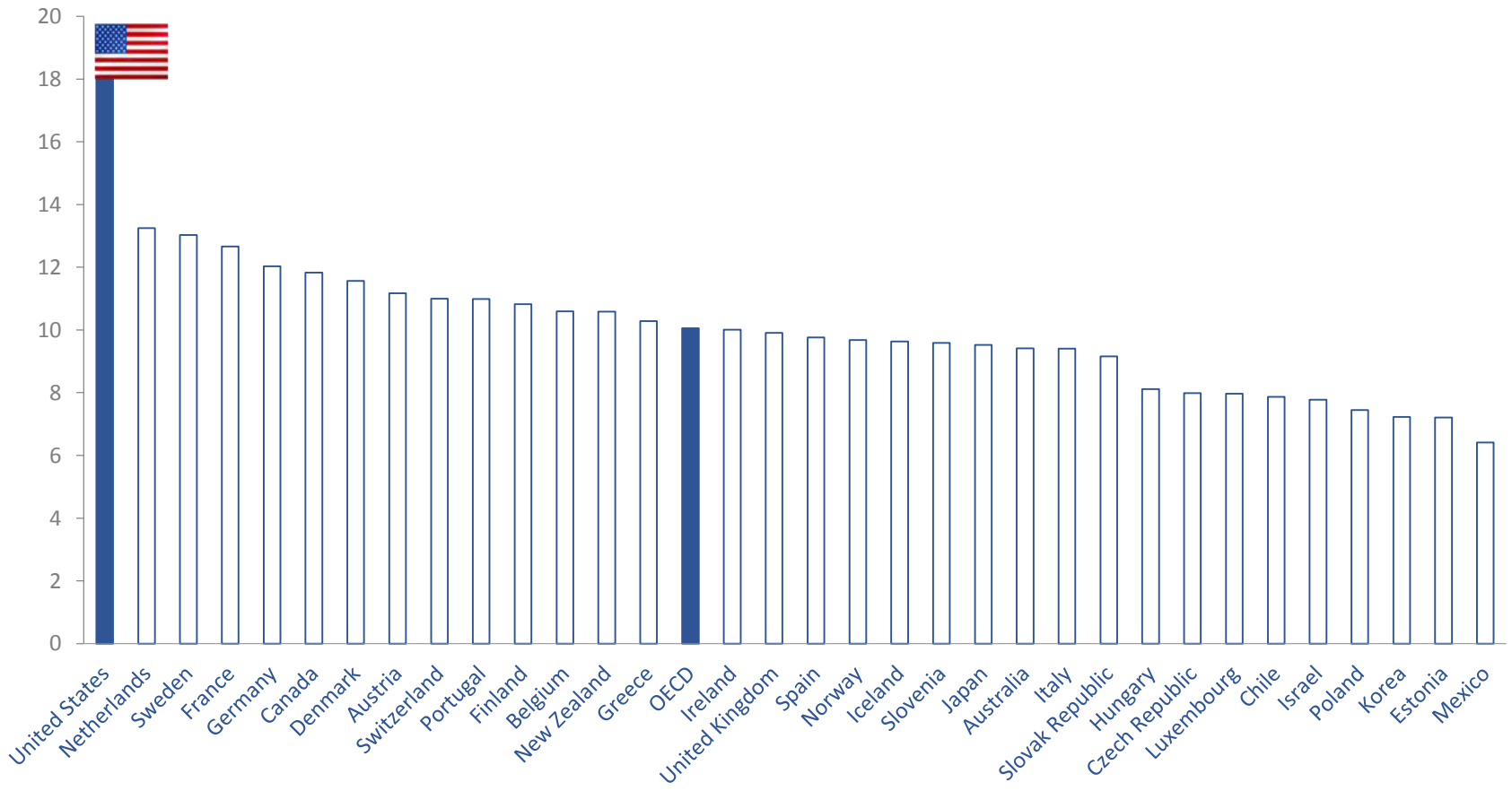

Jobs
for you


Family & Social
Services Administration
learn more
"PEOPLE HELPING PEOPLE HELP THEMSELVES"


Addiction
Treatment
and Steps of Care

Health Expenditures as a % of GDP

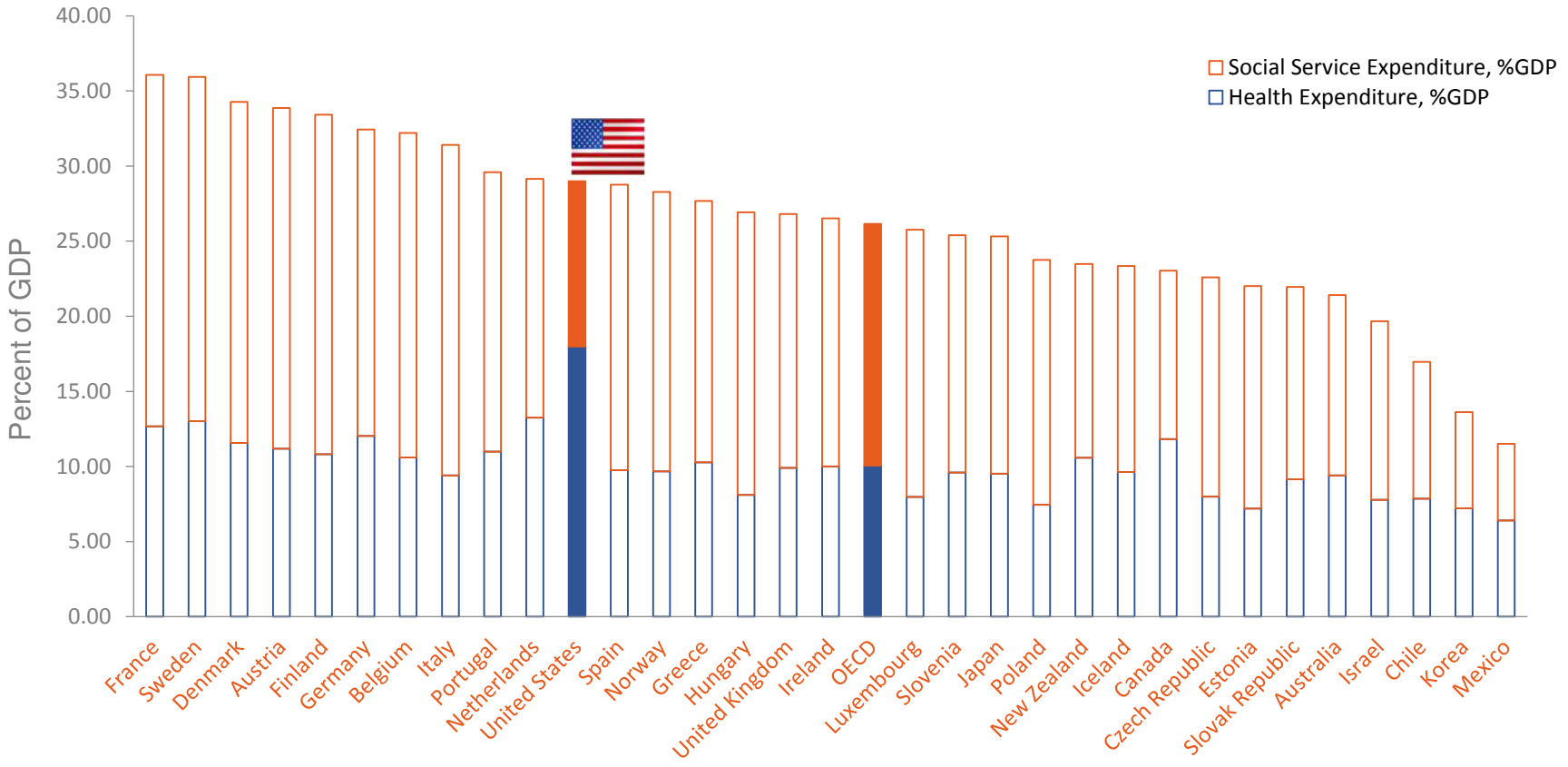
(Slide borrowed from Lauren A. Taylor)



*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.

Total Expenditures as a %GDP

(Slide borrowed from Lauren A. Taylor)



*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.

POPULATION HEALTH

By Elizabeth H. Bradley, Maureen Canavan, Erika Rogan, Kristina Talbert-Slagle, Chima Ndumele, Lauren Taylor, and Leslie A. Curry

Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09

ABSTRACT Although spending rates on health care and social services vary substantially across the states, little is known about the possible association between variation in state-level health outcomes and the allocation of state spending between health care and social services. To estimate that association, we used state-level repeated measures multivariable modeling for the period 2000–09, with region and time fixed effects adjusted for total spending and state demographic and economic characteristics and with one- and two-year lags. We found that states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes. Our study suggests that broadening the debate beyond what should be spent on health care to include what should be invested in health—not only in health care but also in social services and public health—is warranted.

The high cost of health care remains a pressing concern for state policy makers and taxpayers. During the period 1999–2009, health care costs increased faster than inflation,[1] and in many states Medicaid inflation-adjusted spending has had a compound annual growth rate of more than 5 percent since 2000.[2] Such increased spending may reflect greater insurance coverage and access to health care for the population. Nevertheless, greater investments in health care without equivalent economic and tax revenue growth may result in fewer resources for state-funded social services, such as housing, nutrition, and income support programs—which themselves may influence health outcomes in states.

The potential for social services to be crowded out to some degree by rising health care costs is of particular concern given health policy makers' growing interest in the role of social determinants in influencing the health of individuals and populations. Extensive evidence demonstrates a clear relationship between a variety of social determinants and health outcomes.[3,4] Poor environmental conditions, low incomes, and inadequate education have consistently been associated with poorer health in a diverse set of populations. Taken together, social, behavioral, and environmental factors are estimated to contribute to more than 70 percent of some types of cancer cases, 80 percent of cases of heart disease, and 90 percent of cases of stroke.[3,5] Furthermore, several studies have aimed to

760 HEALTH AFFAIRS MAY 2016 35:5

METHOD: Multivariable regression using state-level repeated measures data from 2000-2009 with regional and time fixed effects.

FINDING: The lagged ratio of social to health spending was significantly associated with better health outcomes: adults who were obese; had asthma; reported fourteen or more mentally unhealthy days or fourteen or more days of activity limitations in the past thirty days and had lower mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes.

(Slide borrowed from Lauren A. Taylor)

Examples from around the country

- Hospital systems (Baylor Scott White (DSRIPs), Intermountain)
- Commercial health plans
- ACA-related: (Re-admission penalties, CHNAs, AHCs, SIM)
- Post-ACA regulatory: Medicaid MCOs and Medicare MA plans, waivers
- Local coalitions (Austin, Waco, DFW, KC, Cleveland, Atlanta, CACHI, Wilmington DE, Cincinnati, Springfield MO, Grand Junction, CO, Annapolis, MD, Indianapolis)

By Len M. Nichols and Lauren A. Taylor

DOI: 10.1377/hlthaff.2018.0039
HEALTH AFFAIRS 37,
NO. 8 (2018): 1223–1230

POLICY INSIGHT

Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities

https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039

Overview

- Fundamental Insights
- Logic of VCG model how it could work in SDoH context
- Example
- Implementation Steps and Challenges

Fundamental Insights

- SDoH investments have public good-like properties => free rider problems
  - Non-rivalrous
  - Non-excludable
- E. Ostrom clarified the boundaries among public, private, club/toll, and common pool are more like continua than bright lines
- Economics profession worked out a functional solution to the free-rider problem in the 1970s, Vickrey-Clarke-Groves (VCG), which works under certain conditions
  - “trusted broker”
  - functional local stakeholder coalition
- Those conditions are likely to be present in many communities grappling with SDoH deficits today

VCG logic

- Given a trusted broker and a stakeholder collaborative agreeing on a particular SDoH project to undertake:
- The broker accepts and sums the confidential WTP or bids, $V = \sum v_i$
- If $V > C$ (total cost), then project is worth doing (has collective ROI)
- Simpleminded cost allocation would have all pay $c_i = C/N$
- Trusted broker assigns prices; $p_i = c_i + t_i$ so that each $p_i < v_i$ (has individual ROI)
- $t_i \geq 0$ if $v_i > c_i$ and $t_i < 0$ if $v_i \leq c_i$
- If stakeholder strategically bids low, they risk $V^* < C$ => they would lose $v_i - p_i$

=> SO it is in each stakeholder's self interest to bid accurately, reveal true WTP

VCG Simple Example

- Suppose 3 players, $v_1 = 110$, $v_2 = 40$, $v_3 = 50$, then $V = 200$
- If $C = 180$, project worth doing, BUT if we made each $p = c_i$, two out of three would oppose the project
- Player 1 (maybe a health plan) imposes an "externality" on players 2 and 3 (maybe hospitals), and he must pay $t_1 > 0$ for that, and players 2 + 3 must be compensated for bearing it, so t_2 and $t_3 < 0$
- Broker could assign taxes and prices such that:
- $p_1 = 60 + 32 = 92$, $p_2 = 60 - 21 = 39$, $p_3 = 60 - 11 = 49$, so total collected = 180, and each $p_i < v_i$

VCG Real World Example using NEMT

- Cost and benefit estimates, updated with M-CPI from 2005 NAS report, with updated prevalence estimates from Paul Hughes-Cromwick (of Altarum)
- Assume community of 300,000: estimate of transportation- challenged population = 7,000 (2.3%)
  - There are 162 MSAs in US with 300,000 or more residents
- Net Savings estimates of $2,200 per client per year
- Cost of transport = $750 per client per year
- Note: Providers LOSE margin when insured patients' utilization goes down (we assumed 20% of gross revenue decline)

VCG Real World Example using NEMT

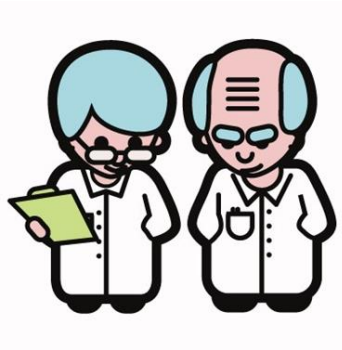
Community of 300,000, average prevalence of transportation challenged, cost and savings updated from NAS report

Stake-holder	Market Share of Target patients	Gross value of invest-ment	Loss from reduced care	Net Value, bid to trusted broker	Cost share	Tax or side payment	Net price
Medicaid	50%	7,700	0	7,700	1,312.5	500	1,812.5
Medicare	20%	3,080	0	3,080	1,312.5	200	1,512.5
Private insurer	10%	1,540	0	1,540	1,312.5	100	1,412.5
Providers/ uninsured	20%	3,080	2,464	616	1,312.5	-800	512.5
TOTALS	100%	15,400	2,464	12,320	5,250	0	5,250

Key Roles in VCG Implementation

Technical Assistants (TAs): Researchers, Evaluators, numbers ppl
(Len and Lauren + Altarum)

Trusted Broker (TB): to be decided by local stakeholders



Stakeholders: health delivery and payor organizations, maybe local governmental units as well

Vendors: Organizations that can deliver SDoH interventions and results

Key Ingredients for Success

- Local stakeholder coalition agrees with WAAITT
- Neutral convening “trusted broker” can be found or created
- Data must be shared and self-interest in solution must be calculated
- Recognition (that probably) no cavalry is coming to finance solutions

12 Step Process

Setup

- TAs identify key stakeholders
- TAs and stakeholders identify TB
- TB convenes stakeholders

Select Intervention

- TB, TAs, and stakeholders review evidence on salient SDoH deficits
- TAs produce projections of ROI for one or more interventions
- Stakeholders select intervention

Bid

- With TA help, TB solicits bids
- With TA help, TB assigns Ps to each stakeholder

Implement

- TB and stakeholders select and contract with a vendor
- Vendors implement
- TB oversees implementation

Reconcile and Rebid

- TAs help TB and stakeholders reconcile data and facilitate rebidding for year 2

Challenges and Risks

- Selecting sites and assembling a consortium of funders
- Local trust insufficient to overcome free-rider/under-bidding behavior