

Modern Healthcare

Coverage Expansion, Low Cost Growth, Continued Reform Battles Highlight 2014

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Healthcare providers and insurers were busy implementing healthcare reform in 2014, millions of uninsured Americans gained coverage, and healthcare spending growth remained modest even as partisan warfare over the Patient Protection and Affordable Care Act continued in full force.

At the year's start, the huge question hanging over the ACA was whether the insurance exchanges would recover from their generally disastrous launch and Americans would be able to sign up for coverage. Those doubts were put to rest when customers flooded the repaired marketplaces during the final weeks of the sign-up period, and more than 8 million people enrolled, most with premium subsidies. The tally eventually dipped to 6.7 million through attrition. But it still surpassed the Congressional Budget Office's estimate of 6 million.

As a result, the uninsured rate from 2013 through June 2014 for people ages 18 to 64 fell more than 3 percentage points, to 17%, the Centers for Disease Control and Prevention reported in December. The drop was particularly marked in states that accepted Medicaid expansion. Arkansas and Kentucky saw the biggest declines—10.1% and 8.5% respectively, according to Gallup.

Meanwhile, CMS actuaries reported in December that U.S. healthcare spending grew more slowly than at any time in the past half-century, as Medicare squeezed outlays and Americans sought less care. The nation spent \$2.9 trillion on healthcare in 2013, an increase of only 3.6% from the prior year, with spending stuck at 17.4% of the gross domestic product. For 2014, quarterly national estimates put spending growth below 4%. Many experts say the ACA has played a role in the cost slowdown, particularly on the Medicare side.

Despite the ACA's successes, at the end of 2014 the law's future looks uncertain. Congressional Republicans remain committed to rolling back or repealing the law, and their big election victories in November, which won them control of the Senate, increase their power to chip away at the ACA in 2015. The future of Medicaid expansion also looks uncertain to bleak in many of the 23 states that have not extended coverage to low-income adults, as Republicans held or gained governorships and legislative seats.

In a more immediate threat to the reform law, three days after the election, the U.S. Supreme Court decided to hear a challenge to the legality of the premium subsidies in at least 34 states that are using the federal exchange. The King v. Burwell case, based on ambiguities in the ACA's language, raises the prospect that millions of people could lose their subsidies midway through 2015 and have to drop coverage because it's unaffordable.

"It creates a great deal of uncertainty for the future," said Robert Blendon, a veteran observer of healthcare politics at Harvard University. "A year ago, beyond whether the website worked, uncertainty was not in people's vocabulary."

Despite those uncertainties, consumer interest has been strong during the second open enrollment, which started Nov. 15, and the federal and state exchanges have functioned more smoothly. In the first month, nearly 2.5 million people selected an exchange plan, and about half were new enrollees.

HHS projected a total enrollment of 9 million to 10 million people for 2015.

For 2015, there was a 25% increase in the number of participating insurers, which offered a larger number of plans, HHS said. The heightened competition drove premiums down in many markets. But many consumers still faced higher rates if they didn't shop around. High-deductible health plans with narrow provider networks were the most common option. Those plans stirred controversy over whether their networks were adequate and their out-of-pocket costs were affordable.

"The public exchanges turned out better than many carriers expected in terms of volume and, more importantly, profitability," said Josh Weisbrod, a partner at Bain & Co.

HHS Secretary Kathleen Sebelius resigned following the botched HealthCare.gov rollout. But President Barack Obama's nominee to succeed her, Office of Management and Budget director Sylvia Mathews Burwell, easily won Senate confirmation in a bipartisan vote. Burwell installed a respected team of executives to oversee the second open enrollment, which seems to have paid off.

Beyond that, there was little bipartisan agreement on health policy. The partial exception was bipartisan House-Senate legislation to repeal and replace Medicare's sustainable growth-rate formula for physician payments. But that deal collapsed after Republicans and Democrats failed to agree on how to pay for the roughly \$140 billion cost. The end result was the 17th consecutive temporary "doc fix" to stave off massive reductions in payments to doctors.

Coverage expansions

While the healthcare reform battles burned in Washington, the coverage expansions paid dividends to healthcare providers in 2014, boosting patient volume and cutting bad debt. Publicly traded hospital chains benefited from the new environment, and investors rewarded them in the stock market. Throughout the year, these companies continued to raise their earnings projections, as the ACA provided even more revenue growth than anticipated. As of mid-December, shares of HCA, the country's largest chain by revenue, were trading nearly 55% higher than at the same point last year. Tenet Healthcare Corp. had gained more than 20%, and Universal Health Services, about 33%.

"It was a positive surprise," said Megan Neuburger, an analyst at Fitch Ratings, which upgraded the credit ratings of HCA and UHS by one notch. "We didn't expect upgrades related to the ACA."

Driven in part by healthcare reform, mergers and acquisitions continued to shape the provider sector. The big story was not the volume of activity, but the value of deals. Providers that sought partners in 2014 found a seller's market, where targets were commanding high valuations. In each of the first three quarters of the year, deal value shot up above the comparable period in 2013, according to Modern Healthcare's quarterly M&A Watch reports.

The improved operating metrics meant hospitals entered negotiations from a position of financial strength, and they could be choosier about their partners. For instance, they could demand more upfront concessions such as higher capital or clinical commitments, said Gregory Hagood, president of SOLIC Capital, a financial advisory firm.

The regions that saw the most consolidation had been the most fragmented. In the third quarter, for instance, the usually quiet Midwest emerged as a hotbed of M&A activity.

Still, higher patient volume put pressure on balance sheets. With greater staffing and supply needs and many newly insured patients with delayed medical needs, health systems' costs rose almost as fast as revenue. A

Modern Healthcare analysis of fiscal 2014 financial results for 59 health systems found that operating expenses increased an average of 6.2% while revenue increased 6.7%.

"You definitely hear it from a lot of hospitals that costs are rising faster than revenue," said Lisa Schneider, managing director at Russell Investments. As a result, she added, health systems need their investment portfolios to make up the shortfall and generate greater returns.

The impact of insurance expansion for providers was uneven, however. In states that expanded Medicaid eligibility to adults with incomes up to 138% of the federal poverty level, bad debt decreased by a median rate of 5.6%, Moody's Investors Service found. But in states that did not accept the ACA's Medicaid expansion because of the opposition of Republican governors or lawmakers, bad debt jumped 6.8%.

Millions in coverage gap

Nationally, nearly 4 million low-income uninsured adults fall into the coverage gap resulting from state decisions not to expand Medicaid, according to the Kaiser Family Foundation. "If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require medical care, potentially serious financial consequences," Rachel Garfield of the Kaiser Commission on Medicaid and the Uninsured wrote in a report.

Nevertheless, hospital leaders were encouraged that 2014 brought more states into the Medicaid expansion fold. Michigan, New Hampshire and Pennsylvania launched expansions this year, bringing the total number of expansion states to 27, plus the District of Columbia.

Up until the November elections, the political outlook looked promising for other holdout states to expand Medicaid, including Florida, Georgia, Kansas, Maine and Wisconsin. But GOP election victories in those states greatly dimmed their likelihood of enacting expansion. Still, under pressure from hospitals in their states, Republican governors in Indiana, Tennessee, Utah and Wyoming continued discussions with the CMS over their alternative expansion plans. Tennessee Gov. Bill Haslam issued a proposal in December that would require hospitals to contribute toward the state's eventual 10% share of the cost for its expansion population. Experts say the CMS is likely to be more flexible in accepting conservative models featuring beneficiary contributions, given increased GOP political power following the election.

Accountable care, bundled payment

There is widespread agreement that the U.S. healthcare system needs to shift from a payment model that rewards volume to one that incentivizes quality and value. This year saw continued moves in that direction. Medicare added more hospitals and physician groups to its growing Medicare accountable care organization program, increasing the number of contracts to nearly 350 from 220 in 2013. Private-sector agreements between employers, insurers and providers also proliferated, featuring shared savings and losses based on providers meeting their cost and quality targets.

But the CMS reported mixed results in its Medicare ACO experiments. This fall, the CMS published results for the first 220 ACOs showing that three-quarters failed to save enough to earn bonuses during their first year. Savings totaled \$817 million, with providers keeping \$445 million. The financial risks of such contracts prompted four more Pioneer ACOs to leave the program, reducing the number to 19 from 32 at the start.

In May, two of the nation's largest not-for-profit health systems said they would form a new clinically integrated network with reach across most of Michigan. Trinity Health and Ascension Health said their Together Health Network would enter into accountable care and bundled-payment contracts. And in September, Anthem Blue

Cross and seven Los Angeles-area hospitals announced a joint-venture HMO called Anthem Blue Cross Vivity that will market health plans that operate under a global budget.

Medicare penalties

On the quality of care front, Medicare's growing penalties for hospitals experiencing higher rates of preventable 30-day readmissions became a hot issue for hospital leaders and quality experts in 2014. Hospitals serving a disproportionate share of lower-income patients were more likely to be hit with penalties under the Hospital Readmission Reduction Program, despite launching programs to keep patients with chronic conditions from having to return. In 2015, 2,610 U.S. hospitals will have payments cut, and the maximum penalty will be 3%. Hospital leaders say concern over the fines prompted improvement efforts, such as better discharge processes and tighter coordination with post-acute-care providers. But executives of safety-net facilities argued they had little control over the socio-economic conditions in poor neighborhoods that often drive readmissions. Safety leaders who previously opposed risk-adjusting the readmissions data for socio-economic factors now worry the penalties could hurt financially strapped hospitals serving the poor.

Meanwhile, federal officials reported in December that about 1.3 million fewer patients were harmed in U.S. hospitals between 2010 and 2013. That represents a cumulative 17% reduction, preventing about 50,000 deaths. The estimated three-year cost savings from harm reductions was nearly \$12 billion. They said the improvements resulted from widespread efforts to reduce adverse drug events, hospital-acquired infections and other preventable events, particularly through the public-private Partnership for Patients initiative.

But some prominent quality experts said hospital-safety improvements have been limited.

Information technology

In health IT, the two big issues in 2014 centered on federal policy goals and the healthcare industry's inability to attain them—meaningful use of electronic health records and the conversion to the ICD-10 diagnostic and procedural coding system.

In December, the CMS announced that more than half of physicians and other eligible professionals failed to meet the Stage 1 meaningful-use targets in a timely fashion and would incur Medicare reimbursement cuts in 2015. The agency also announced that it was adding more wiggle room to the program so providers might avoid further payment cuts for noncompliance with Stage 2 meaningful use.

On ICD-10, Congress in March ordered HHS to push back the launch date at least one year beyond the scheduled Oct. 1, 2014 date. The CMS then re-set it for Oct. 1, 2015. But that date also may be in jeopardy, with physician organizations lobbying to impose another delay and House Republicans calling for hearings on national readiness for the new system.

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