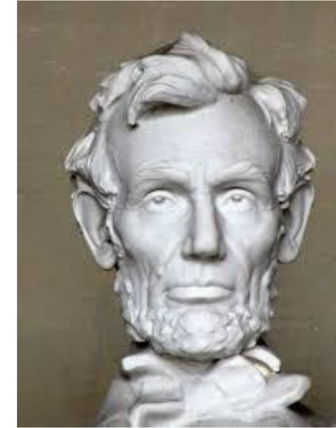


The US Health Care System and The Affordable Care Act –

The State of the States circa early 2014

Daniel Bailey, FSA, MAAA

ACUMEN ACTUARIAL LLC

AGENDA

- Introduction
- ACCESS. QUALITY. COST
  - The Past, Present, (and Future?) of the ACA:
    - History & Circumstances Leading Up to the ACA
    - More Background About the US Health System
    - Major Changes to US System for the Finance and Delivery of Health Care Resulting from the ACA
    - More About the ACA
    - Ramifications of the ACA on Various Stakeholders
- What Is Next?
- Conclusion

WHY the ACA?

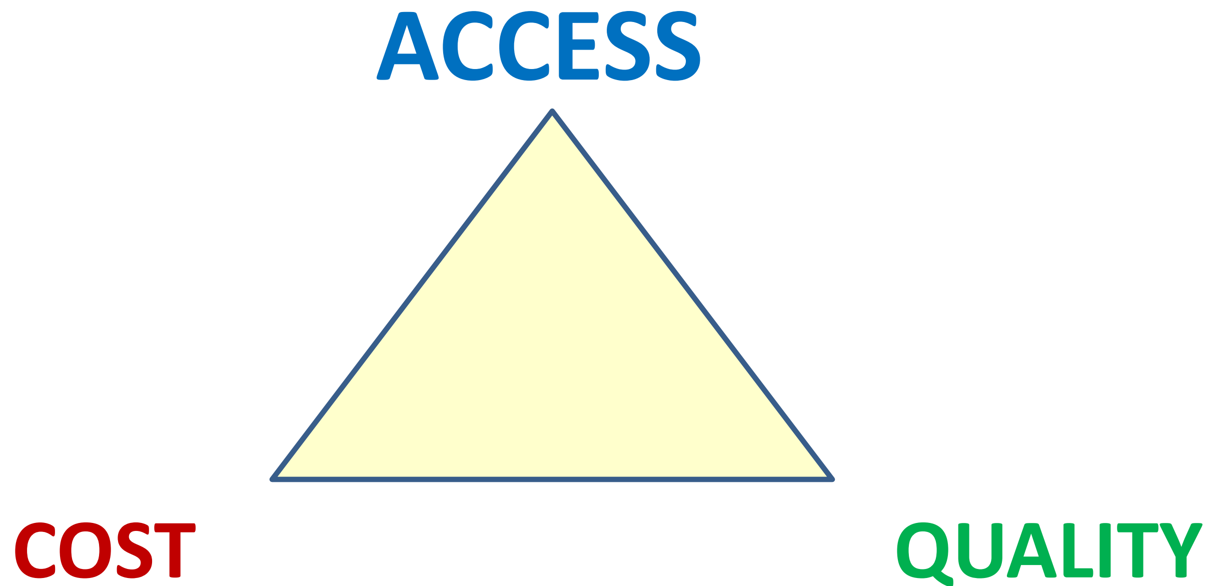
- It depends on who you ask—wide range of responses

- Businesses and markets act, and the government reacts.

Let's look at what was going on in the US system for the finance & delivery of health care in the decade (or 2) prior to the ACA.

WHY the ACA?

Consider the SYSTEM with Respect to:



ACCESS was the Primary Concern

- Access to *health **insurance***… or *health **care***?

WHO IS COVERED & WHAT DO THEY GET?

(In round numbers—rounding & approximation used throughout)

- From 1990 to 2010, the # of Uninsured in US increased from about 30 million to 50 million (which looks like growth by 2/3)

  but the US population grew more than 20% in this 20 yr period; hence, effective increase is more like 1/3+, not 2/3)

- Some Insured are "UnderInsured"

ACCESS, slide #2—The Uninsured

- Another ~50 million elderly & disabled people have Medicare, and
- ~60 mil low income people have Medicaid (inc 10 mil Duals)—
- Hence, the Uninsured were ~1/6 of the total population, but **~1/4** of the non-Medicaid, non-Medicare ("commercial") population
- Those most disenfranchised & shut out were:

  1) the working poor who could not afford insurance but did not qualify for Medicaid, and

  2) the sick who could not buy an Individual insurance policy due to a pre-existing condition.

Access, # 3—All US Residents

- ESI -- SG
- ESI -- LG
- INDIVIDUAL
- Retiree
- TriCare
- Medicare
- Medicaid/CHIP
- Duals
- Uninsured

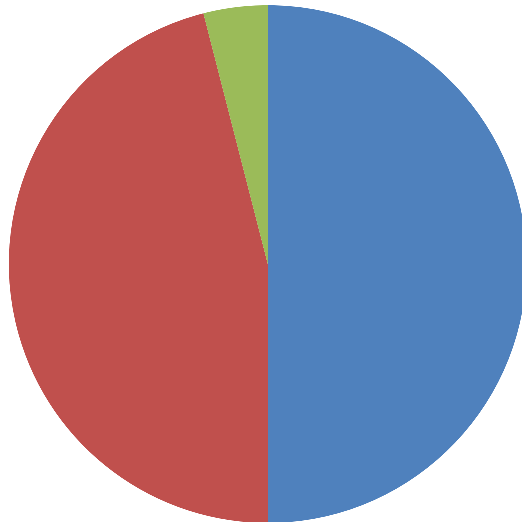
This thin green sliver here (Indiv)… is the where most of the trouble was reported

Access, # 4—"Commercial" Cvg **Only**

- Year after year, Group & Indiv health ins (medical & drug) were perennially less & less affordable
- Overview of US "Commercial" Health Coverage:

(Uninsured are not shown; neither are Gov't Programs—Medicare, Medicaid, …)

Note that roughly half is "Self-Funded"



ACCESS, # 5—Asymmetrical Information

The UnderWriting Arms Race… to the bottom:

- HMOs & Insurance Cos investment in emerging IT allowed “cherry-picking” of the more profitable “risks” (& hence avoid the less healthy individuals or small groups with pre-existing conditions whose medical costs were more likely to exceed premium)
- Insurers’ administrative cost for all this Underwriting added to the cost of premium.
- But, similar info technology now enables collection of big data for Risk Scores, Disease Mgmt, Care Coordntn, Complex Care Mgmt, Electronic Medical Records, etc…

Economic Downturn & Access

- Except for Medicaid recipients, the vast majority of US residents under 65 received health ins through some **tie to employment**—active employee (EE) or dependents
- As the unemployment rate increased during downturn beginning in 2008, the uninsured rate also increased in direct proportion.
- (The # covered by Medicaid also increased)
- UNEMP Rate went from high 4's in early 2007, to 8% on Jan 2009, and as high as 10% in Oct 2009

Economic Downturn & Access (con't.)

- **PROBLEM:** "Individual" (non-employer) coverage insured approximately 3% of all health coverage in the US, but **its problems with pre-ex and rescinded cvg were the source of most of the adverse publicity about the US health care system**. The entire system was held to blame and tainted.

  There were fewer obvious problems with group health coverage, the vast majority of which is employer-sponsored (ESI)

- **SOLUTION:** ACA 'fixed' the Individual market by providing another option for Access that is not tied to employment, Public Hlth Exchanges, which offer guaranteed issue & renewal w/out pre-ex exclusion; it needs Univ Cvg to work

ACCESS—Insurers' Point of View

- Health cost is the culprit— insurance is less **affordable** due to the cost of health care, which comprises the vast majority of hlth insurance cost.
  (We tried to control cost but encountered managed care backlash from docs & patients—not again, we're still healing…)
- Insurers wants insured groups' and individuals' premiums to be right-priced. If one insurer begins finer market segmentation by age, area, or health status, others must follow suit or lose money. The same concept applies to eligibility restrictions, pre-ex & UW rules, covered benefits & cost-sharing, …

[Translation: Don't point your fingers at us.

Counter-argument: Incrsng hlth costs => insrrs' profitable growth]

ACCESS, pre-ACA breaking point

RESULT—an imperfect storm—

- **Reduced financial security**

  Lack of health ins and personal hlth-cost crises became a significant & publicized cause of personal bankruptcy

- **Reduced health security**
  - Those without health ins coverage receive less health care, especially non-emergency care.

Gov't intervention was seen as necessary

On the other hand, several years of increasing member cost-sharing (copays & deductibles) and improvements in cost-transparency helped people better understand the high cost of health care.

Not Really The Perfect Storm

but enough to cause the federal government to react

QUALITY

QUALITY

How To Assess Quality?

I want it all, perfect, now, for free!

The New Consumer Credo

- And *what do we mean by quality*? Quality of insurance cvg? Of health care? Is it minimum acceptable quality? Or can it identify the best providers & practices?

- The World Health Organization (WHO) uses various outcomes metrics to evaluate and compare results among nations—the US lags other OECD nations with respect to certain indicators, such as life expectancy, healthy births, physical fitness of residents, etc.

Quality

- Other Quality Measures:
  - NCQA
  - HEDIS
  - STARS
  - Market Share, Brand recognition
  - Potential Year of Life Lost, QALYs, …
- It is difficult enough to evaluate quality in any one nation; fair international comparisons are more difficult yet.
- **In many respects, health care in the US is outstanding, even the best in the world—no one wants to lose that!**

QUALITY—depends on the beholder

- It seems intuitive that better quality costs more, but spending more does not assure quality. Some physicians report that too much diagnosis is counter-productive; over-diagnosis leads to over-treatment – unnecessary treatment causing medical harm
- Effective high-quality care is more cost-efficient—right service, right provider, right setting, right time
- Outcomes Research & Best Practices—not an easy task—CQI
- <u>Fragmentary fee-for-service care can add to cost & may diminish quality</u>—hence the need for coordinated care. Internists & family practice docs & other PCPs in Group or Staff model HMOs have been doing more of this somewhat for years, esp. those in multispecialty settings with collocated medical services.

COST

COST

WHO PAYS & HOW MUCH?

(& what do they get?)

- **The cost of health care is the crux of our access and affordability problem in US**
- But it is the complex interplay of forces between payers, providers, and patients that has led to our current expensive situation—and this is where the analysis gets difficult. There are many causes and effects to untangle

COST (nominal dollars—not time-value adjusted)

US National Health Care Expenditures

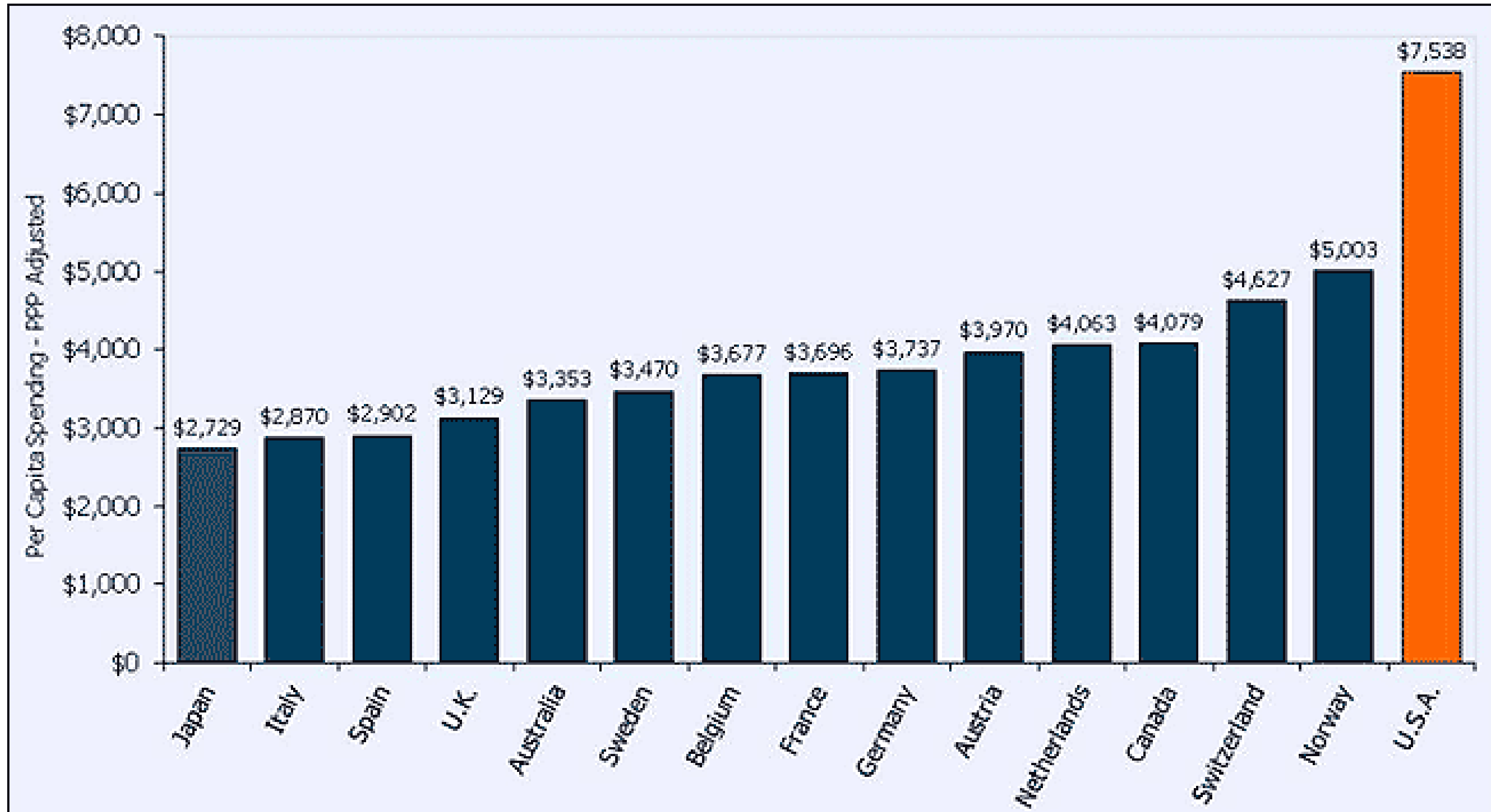
Year	Per Capita	Total ($ bil)	GDP ($ tril)	% GDP	US Pop (mil)
1960	$140	$27	$0.526	5.1%	186
1970	$340	$73	$1.038	7.0%	210
1980	$1,050	$247	$2.790	8.9%	230
1990	$2,690	$700	$5.800	12.1%	254
2000	$4,880	$1,377	$9.950	13.8%	282
2010	$8,420	$2,600	$14.500	17.9%	309
TREND over					
last 50 yrs	8.5%	9.6%	6.9%	2.5%	1.0%
last 40 yrs	8.4%	9.3%	6.8%	2.4%	1.0%
last 30 yrs	7.2%	8.2%	5.6%	2.4%	1.0%
last 20 yrs	5.9%	6.8%	4.7%	2.0%	1.0%
last 10 yrs	5.6%	6.6%	3.8%	2.6%	0.9%

PER CAPITA COST

- Is higher in US than virtually all other nations
- Per capita health care cost increases roughly twice as fast as CPI. The key "trend" driver is:
  - **Advances in Medical Technology**—New medical goods and services, new diagnostics such as MRI, CT, & PET scans, robotic surg & minimally-invasive procs, new chemo, other advances in pharmaceuticals. It comes at great expense… but has enormous benefit.
- **We live longer (on average), and enjoy more productive, higher quality lives**

(This seems like something to be grateful for. No ?!?)

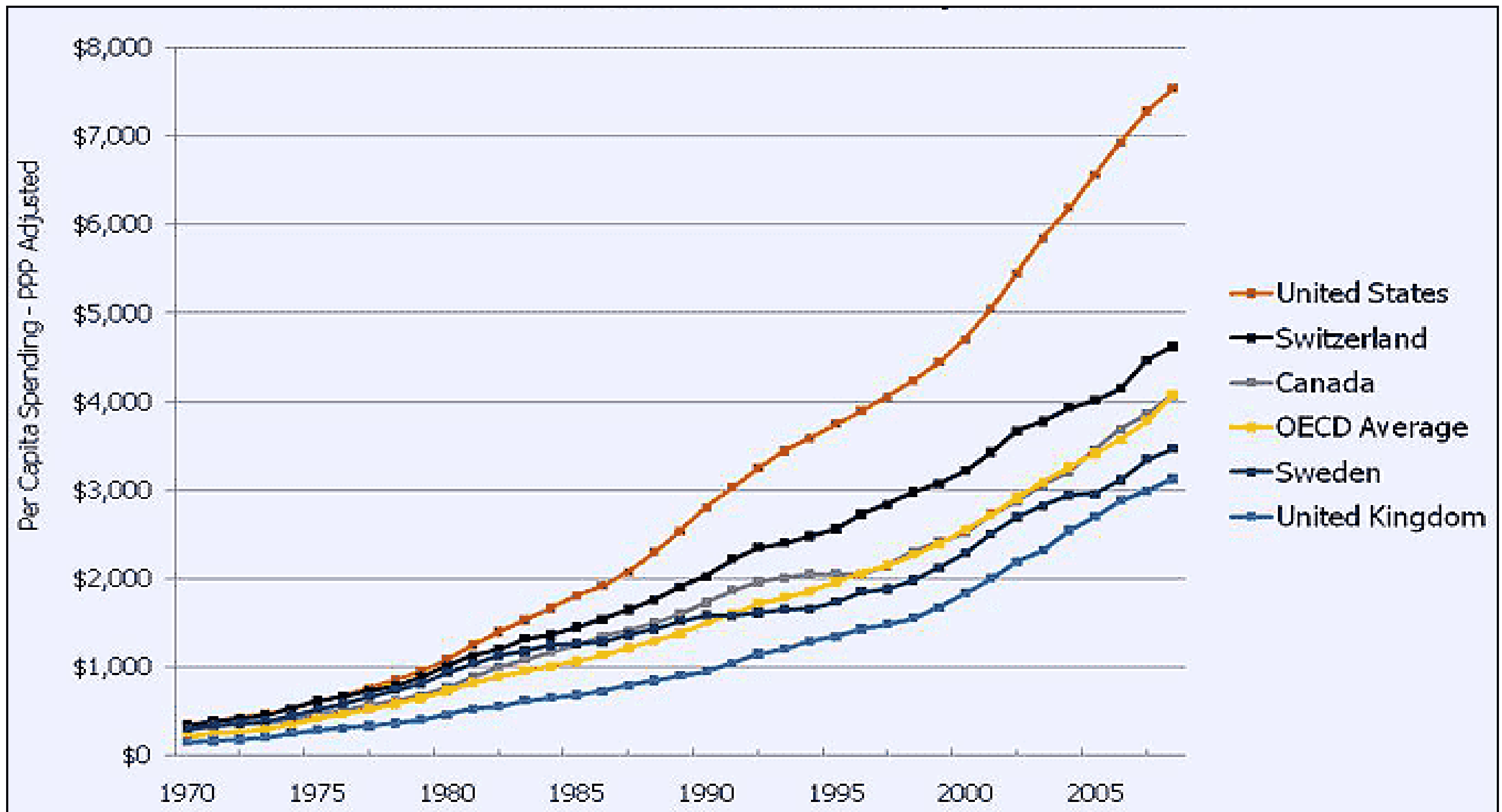
Per Capita NHE; US is Outlier



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).

Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. (Purchasing power parity)

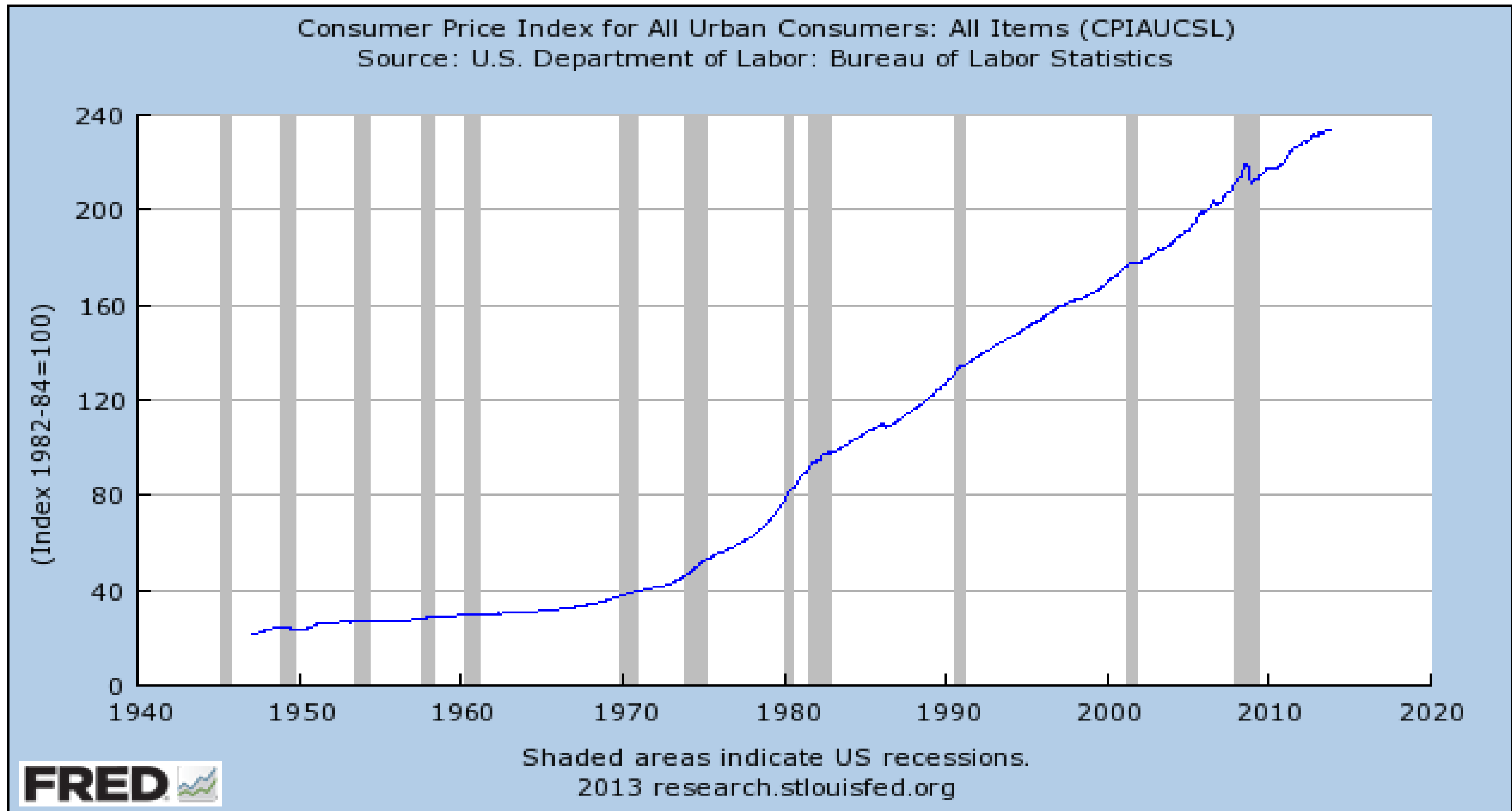
Per Capita Spending over 3+ Decades



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).

Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. Break in series: CAN(1995); SWE(1993, 2001); SWI(1995); UK (1997). Numbers are PPP adjusted. Estimates for Canada and Switzerland in 2008.

CPI – All Items: 1950 - 2010



CPI 2010 / CPI 1950 = 216.7 / 27.5 = **9.22** ==> **3.77%** avg annual rate of increase.
Per Cap NHE 2010 / Per Capita NHE 1950 = **60.14** ==> **7.07%** avg annl rate of increase.
Health Cost Per Capita was increasing about twice as fast as CPI during this 60 Yr Period.

COST—How Much Is Necessary?

- Some medical utilization is unnecessary & has more to do with <u>wants</u> than needs. How do we separate *basic* care vs. *essential* vs. *expansive*?
- At a certain point, additional spending on average leads to worse outcomes—as stated, some physicians estimate that 1/3 of the cost of care in the US is unnecessary.
- The ACA enabled programs to change the US delivery model (which is predominantly FFS) using alternate provider payment approaches, such as per episode payment.

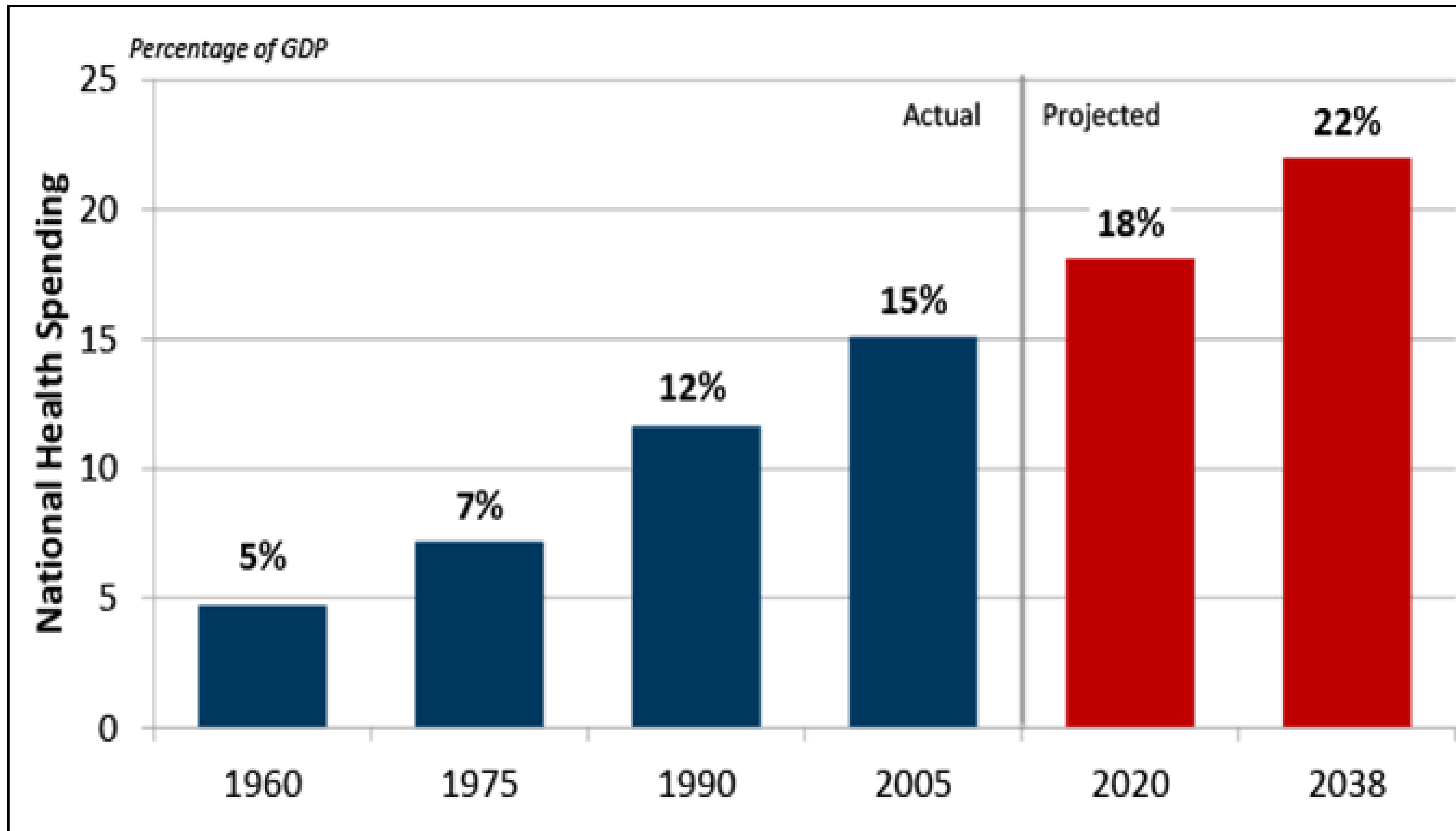
COST— (And Why Is It Increasing Faster Than CPI?)

- **Why does US pay more per procedure for CABGs, appendectomies, etc. than other nations?**
- Many other trend drivers help to relentlessly raise cost, such as defensive medicine from med-mal lawsuits in our litigious culture
- The Bottom Line—Health care cost increases faster than gains in productivity allow us to pay for it
- **Health Care cost as % of GDP is increasing!**

  (Not just in the US but all over the world)

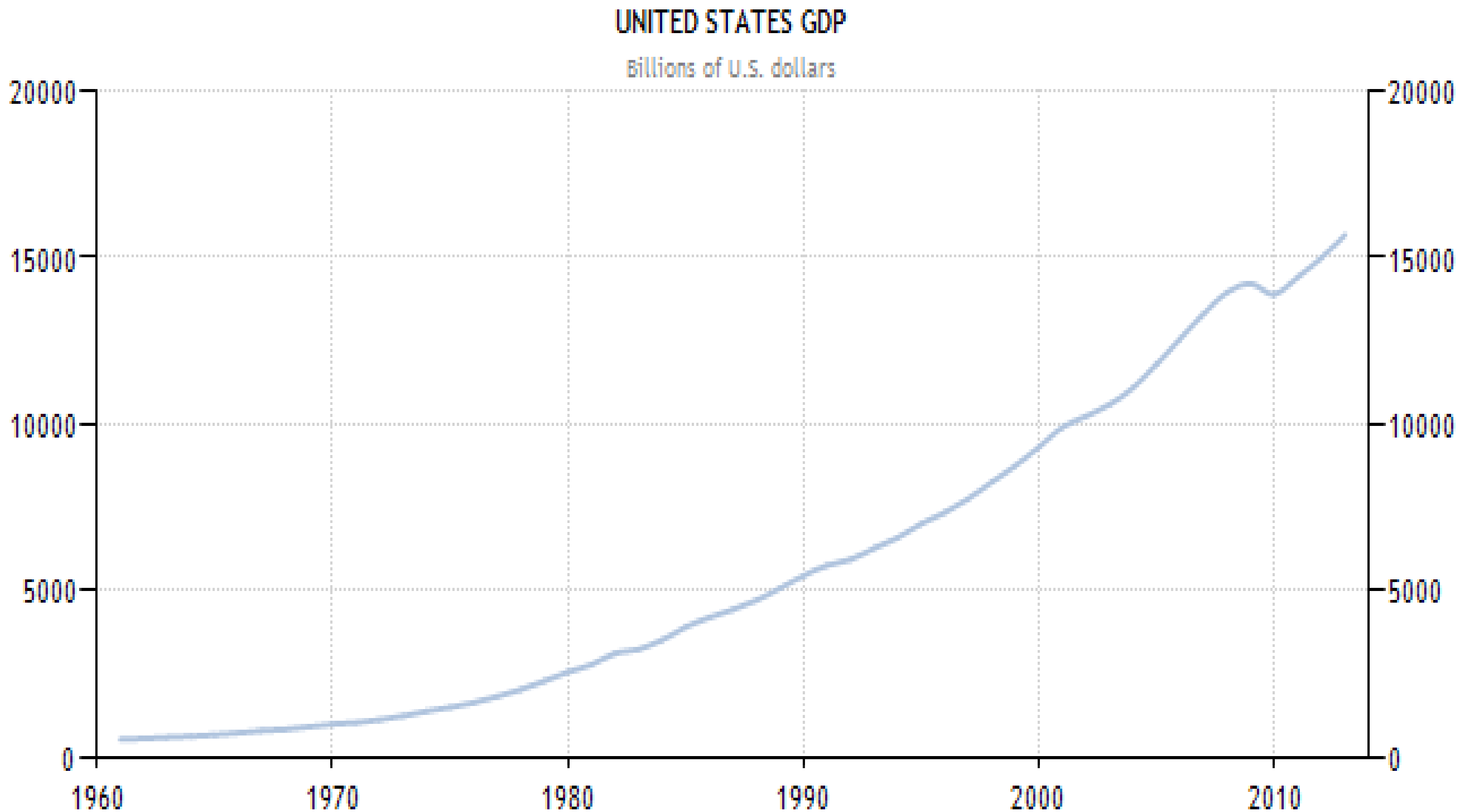
US Health Care Expense as % of GDP—

into the future

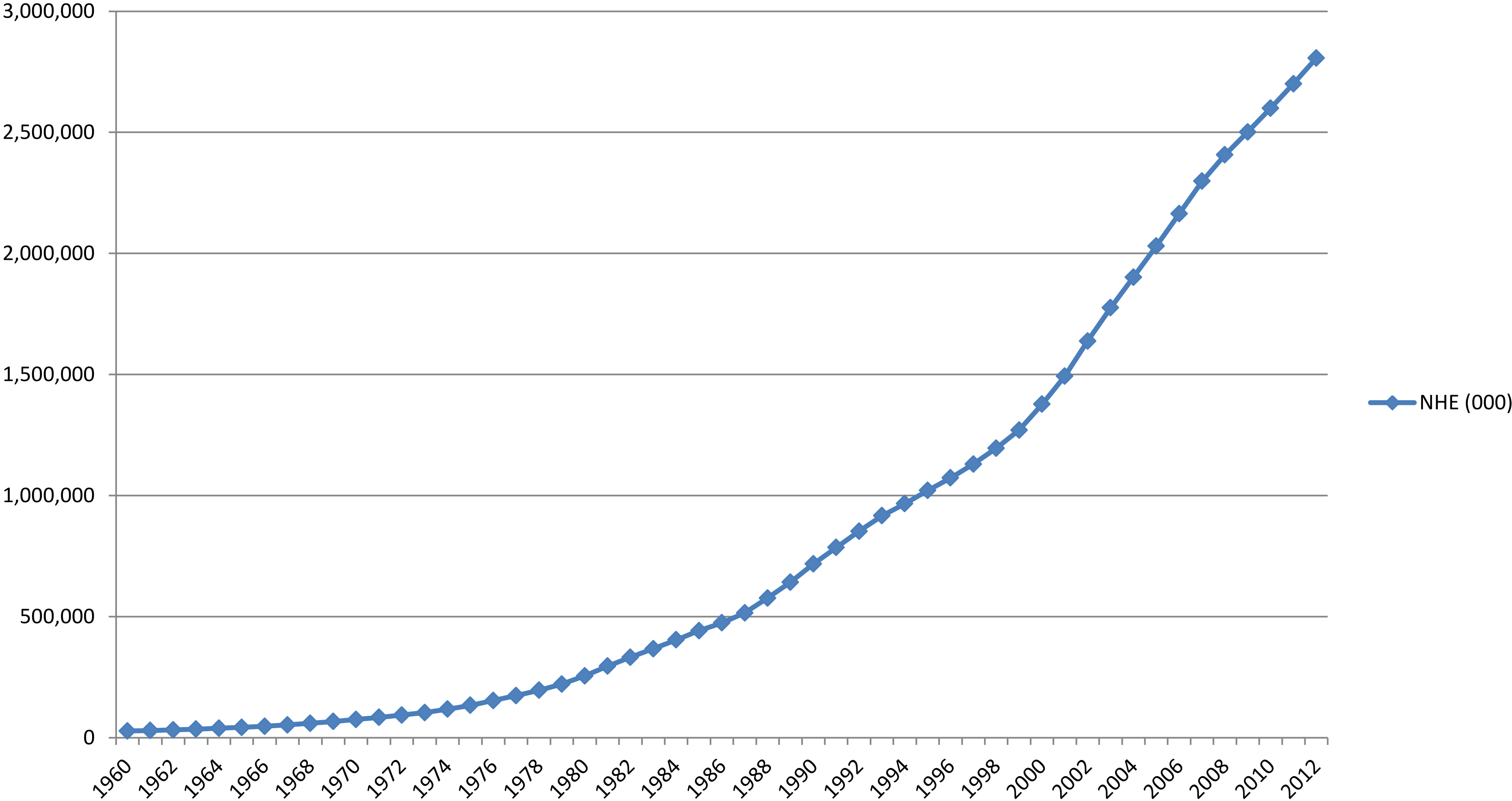


SOURCE: Data from the Centers for Medicare and Medicaid Services, *National Health Expenditures*, January 2012; and the Congressional Budget Office, *The 2013 Long-Term Budget Outlook*, September 2013. Compiled by PGPF.
NOTE: CMS data used for years 1960-2020. The 2038 figure reflects the latest projection from CBO. National spending on healthcare is health consumption expenditures as defined in the national health expenditure accounts, and excludes spending on medical research, structures, and equipment. Graph by Peter J. Peterson Foundation

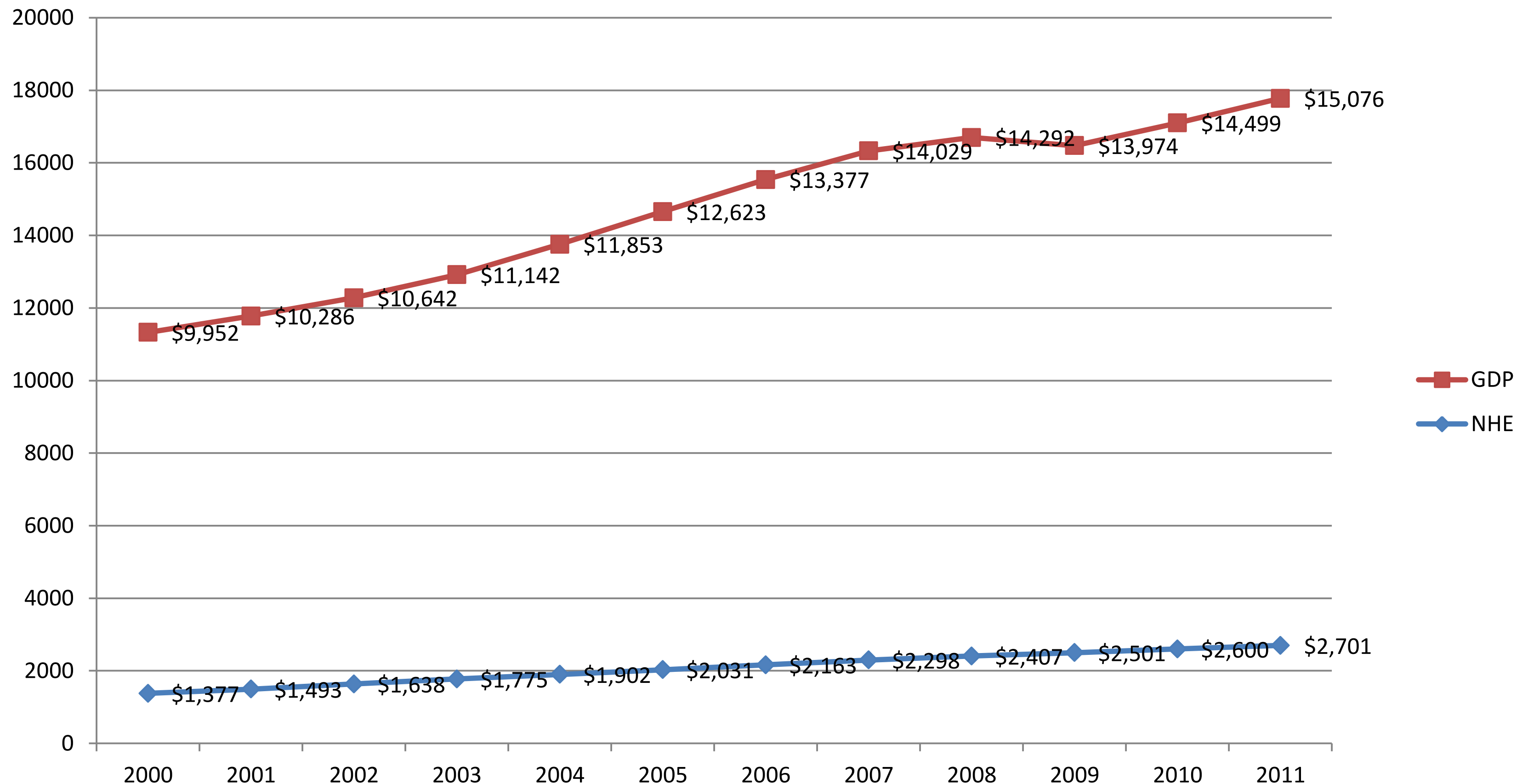
Growth of US GDP (1960 – 2012)



Growth of US NHE (1960 – 2012)

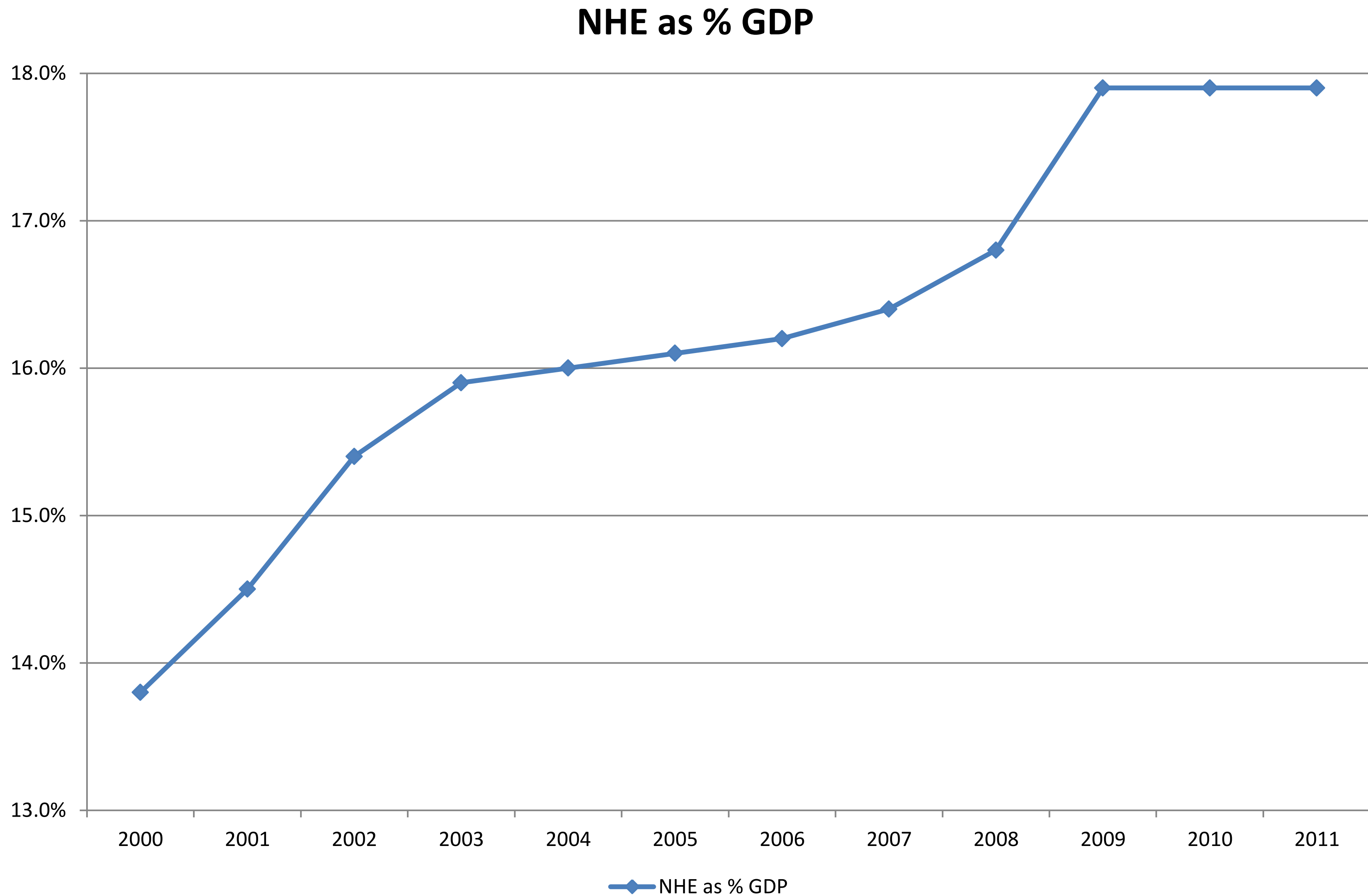


Growth of US NHE & GDP (2000 – 2011)



GDP 2011 / GDP 2000 = 15.076 / 9.952 = 1.51 , which => avg annual growth of 3.8%.
NHE 2011 / NHE 2000 = 2.701 / 1.377 = 1.96 , which => avg annual growth of 6.3%.
Hence, NHE is increasing at much faster rate than GDP during this 11 year period.

US NHE as % of GDP (2000 – 2011)



State of the System Prior to the ACA

The status quo had become UNSUSTAINABLE—

PART II

ENTER THE **TRIPLE AIM**

- Dr. Donald Berwick left this important legacy to help the ailing US health care system:

1. **Improve the individual experience of health care**
2. Improve population health
3. **Lower the per capita cost of care**

What The TRIPLE AIM Means

- 3 Interdependent Goals for the Common Good
- The Triple Aim implies a care organization is accountable for all 3 aims for all people (and each person) in its population
- The role of a CCO, ACO (or PCMH; MCO, HMO…) implies **coordination of care** across all the many “siloed” providers of fee for service (FFS) care

Understanding the US Health System

- A panoramic collage of systems, sub-systems, safety nets, programs, and some gaping holes, esp. for low-income working people. No one understands it in totality.
- It's beyond our understanding—<u>too complex</u>; it defies our ability to *see* most of the dots, let alone connect them
- Intractably entangled cause & effect relationships; incomplete & subjective data colored by personal experience— it confirms our innate "innumeracy".

Misunderstanding the US Hlth Care System

- State/county/MSA comparisons by geographic area show significant variation in cost, access, and quality; layer in many other differences & disparities in health coverage that affect cost and access in a "melting pot" nation of over 300+ million people…
- International comparisons of systems are often problematic—hard & soft measurement metrics vary across countries, such as that used for infant mortality, satisfaction with system, ...
- Expectations in the US tend to run high—people want choice, no cost or low cost, state of the art, & immediate gratification
- US system is a leviathan of enormous scale—about $3 trillion annually— ~18% of GDP

Who Are The Stakeholders?

- The **livelihoods** of about 15 million US residents depend on the US health system (almost 10% of the work force)
- Everyone is ultimately a patient, hence
- Everyone is stakeholder to varying degree
- Widespread bias exists—some have personal interest; others have a business stake and something to gain or lose

The ACA

- Its primary intent, like Romney's plan for universal coverage in MA, is **increased access** for the non-Medicare population
  - It is the most significant change to the US health system since Medicare and Medicaid in 1965
- Is a federal law over-riding (weaker) state laws in an insurance system long governed by state insurance departments since the McCarran-Ferguson Act was passed in 1945

The **ACA**, Slide 2

- The government's role is generally ***reactive***
- The ACA imposes uniform minimum standards over insurance business in all states; however, prior to the ACA, all states were **not** the same, especially for Small Group and Individual Health Insurance markets
  - NY state regs were already more rigorous than ACA
  - Some South and SW states were far less strict, and had far larger uninsured rates than the national avg.
- **The ACA is unfolding differently state by state**.

The **ACA**, Slide 3

- In addition to **increasing access** through Public Health Exchanges for Individual cvg. and Small Groups, the ACA addresses cost and quality to a lesser extent—it does so through coordinated care, Accountable Care Organizations (ACOs), alternate provider payment, etc.
- The ACA is a voluminous and multi-faceted plan of large proportion. It is also a **leviathan**.

The ACA, continued

- Leviathan meets Leviathan:

Some Background Noise

- Aging of the population: Living longer on avg
- The wave of baby boomers is coming—the "silver tsunami" generation born post-WWII following lower birth rate during war years

(fewer active young workers relative to older)

- The US population is growing (while it ages)

How **the Other Half** Lives

- About half of all the health coverage in the US is ***Self-Funded***—it is <u>not</u> a fully insured product; hence, it is <u>not</u> regulated by the state ins dept.
- ACA requires self-funded hlth plans to (easily) meet a 60% Min AV standard w/out necessarily providing all essential health benefits. Eligibility requirements
- Most self-funded plans were at least as generous as fully insrd, since largest ER groups self-fund
- Some ER grps converted to self-funding hoping to avoid the ACA's complications, but most ERs large enough to convert had already done so earlier.

Underlying Questions

Some Political *Static*:

- Debate over non-profit role vs. for-profit (and privately held vs. publically-traded)
- Should profit motive be allowed for none, some, or all of health care goods & services?
  - If some, which ones?
- Is health care a "public good" or a "private good"?

More Questions

- **What Do the People in the US Want?**
- Acceptance of for-profit health care? Publically traded? Profit margins for top technology firms are much greater than publically-traded hlth insurers—people have different views re these 2 industries.
- Sociological prerequisites: Does US culture & economy have sufficient ”social trust” for ACA’s personal responsibility to work?
- The Will of the People vs. Business Interests vs. Politics?

Impediments to Domestic Spending

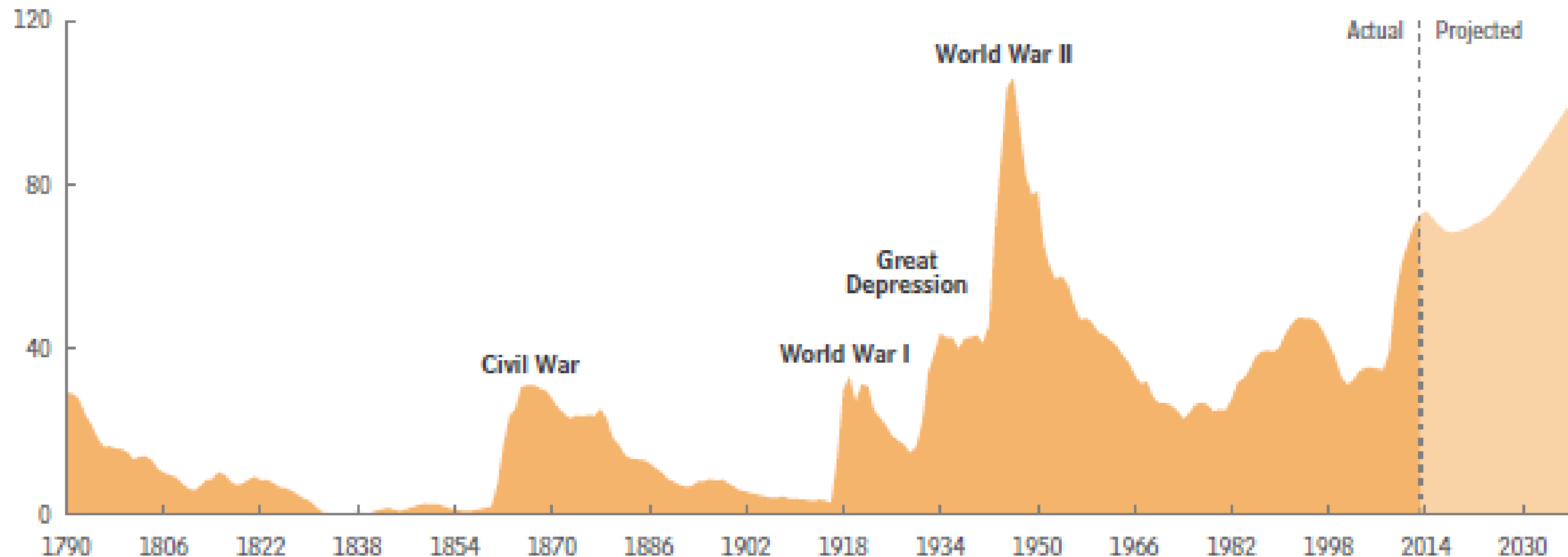
- **Economy:** Just prior to 9/11, US was living within its annual means. Current US record-high debt as % GDP is driven by factors unrelated to health system—post 9/11 military spending; downturn in economy & stimulus spending. Concern over debt level now confounds decision-making about domestic spending—guns or butter… and/or healthcare, infrastructure, etc…

Federal Debt as % of GDP

Figure 1-1.

Federal Debt Held by the Public Under CBO's Extended Baseline

(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.

Notes: The extended baseline generally adheres closely to current law, following CBO's 10-year baseline budget projections through 2023 and then extending the baseline concept for the rest of the long-term projection period. The long-term projections of debt do not reflect the economic effects of the policies underlying the extended baseline. (For an analysis of those effects and their impact on debt, see Chapter 6.)

Data from 1929 onward reflect recent revisions by the Bureau of Economic Analysis to estimates of gross domestic product (GDP) in past years and CBO's extrapolation of those revisions to projected future GDP.

Yet More To Consider

- In all OECD nations, NHE has increased steadily as a percentage of GDP over the past 50 years
- At **18%** today, US Health Expenditure continues to consume an increasing portion of **GDP**. (We're told it cannot exceed 100%, like the dew point; but the dew point cannot borrow from the future like the govt can)
- **Can we GROW our way out of this?!?** **Productivity growth** is… necessary.

Key ACA Mandates

- **UNIV CVG**—Guar Issue: Everyone must have ins or pay a penalty; premium subsidy at 100% - 400% FPL: Singles w/ $11.5k - $46k; Families w/$23.5k - $94k annual income
- **3 Rs Market Mechanisms** promote pooling and inclusion of less healthy people; produce more stable health insurance markets for "consumers"
- **Health Exchanges** promote mgd. competition
- The **4 Metal-Plans** help standardize covered hlth benefit plans (Essential Benefits vary by state)

The 3 Rs

Similar to Medicare Advantage, the ACA has the following Market Stabilizers:

1. Risk Adjustment: Zero sum—insurers w/ older, sicker members are subsidized by insurers with younger, healthier members. Applies concurrently every year for all Indiv & SG, on and off H. I. Exchange. Permanent program
2. Risk Corridors: An insurer (QHP) that profits too much, gives back to the federal gov't; and vice versa. Risk Adjstmnt and Reins are applied prior to Risk Corridor. 3 year program; same for Reins.
3. Reinsurance: Everyone in all types of cvg pays in $5.25 PMPM. Insurers w/ high-cost members in <u>Individual</u> mrkt receive 80% of claims between $60k and $250k.

Individual Exchange Roll-Out in Q4 2013, and Enrollment Stats

DATE	Number Enrolled In / Signed Up for Exchanges In US
Oct 15, 2013	0 / 0
Oct 25	700,000 / ? (~ 27,000 ?)
Nov 13	Almost 1 mil / 106,185 (79,391 State; and 26,794 Fed)
__________	____
Nov 30	1.8 mil Apps = 3.7 mil people = 2.3 mil eligible = 365k selected plans
Dec 31, 2013	2.1 million signed up— more federal than state (media 1/13/2014)
Jan 31, 2014	
Feb 15, 2014	

Present And Future RAMIFICATIONS Of The ACA On STAKEHOLDERS

Who Are The Key Stakeholders?

How Will They Be Affected?

7 Key Stakeholder Groups (some overlap)

1. **The 300 + million people residing in the US**
2. **PROVIDERS of all sorts:**
   - Hospitals & other institutions
   - Physicians and non-physician prof. providers, …
   - Labs, clinics, allied & ancillary services; PBMs, Pharma, …
3. **PAYERS**—Insurers, MCOs, TPAs
4. Employers-- (Health coverage supports employee productivity and adds to cost of production)
5. Vendors, Suppliers, Consultants, etc.
6. Present and Future Generations of Americans
7. Anyone left

Stakeholder #1

Assuming the ACA is not de-funded or overturned

1. The 300 million + people in the US:

~30 mil of the 50 mil Uninsured are expected to ultimately obtain health ins… and health care.

- Over **15 million** non-Medicaid uninsrd could enter **Exchanges**; almost half are expected to enroll with premium subsidies in 2014

- Premium rates released Sep 2013 show national avg. Single rate of $328 per month for silver plan—lower than expected, but…

Stakeholder #1, continued

AFFORDABLE HEALTH INSURANCE:

- Premium subsidy will go to working poor earning less than 400% of FPL.
- Those enrollees earning up to 250% of FPL will receive a subsidy in the form of reduced cost-sharing (CSR) for silver plan coverage. Sliding scale applies—lowest income enrollees receive largest cost-sharing reductions.

Stakeholder #1, continued

- If all states expand Medicaid, another 14 mil uninsured could obtain new Medicaid coverage; **26 states have accepted as of Nov 29, 2013—CBO estimates 9 mil new MCaid cvrd next year**
- The vast majority of people in the US have ESI, employer-sponsored health coverage, & their health cvg will be largely **un**affected, (unless their ER drops ("dumps") their EE cvg in 2014…)
- ACA projected to cost ~ $1 trillion over 10 yrs paid by various taxes w/out increase to fed debt
- More slides & comments could go here...

Stakeholder #2

2. PROVIDERS:

- There will be more insured patients for whom to provide care—

  What unit costs will the newly insured pay? Commercial? Medicare? Medicaid?

- FFS reimbursement was lucrative for some
- Will PCPs finally be reimbursed for effective evaluation & management (E&M) services? For Care Coordination?
  - Use of alternative primary care-givers to meet increased demand—Physician Assistants & APRNs?
  - Will there be a PCP shortage?

Stakeholder #2—Providers

- Hospitals—the newly insured will pay full cost of care instead of none or some, which should help reduce hospitals' bad debt. Hospitals do not seem to be asking for a truce to be called in their medical arms race… Does their competition for market share help improve quality of care and outcomes? And does this help explain why some care in the US *is* already the best in the world?

Stakeholder #3, Payers (Insurers, HMOs, Issuers of Hlth Ins Cvg)

- A mixed bag of partial “winners and losers”:
  - Each Exchange needs critical mass of issuers
  - Amongst “Payers,” winners include some well-positioned MCOs with advantageous delivery models (Staff and Group Model HMOs) providing long-standing coordination of care, outstanding primary care, and collocation of services; they tend to be urban.

What's Not To Like About the ACA?

- Some pushback is based on opposition to the cost of creating a **new entitlement** w/ 2 aspects:
  1. Cost of subsidized premium//cost-sharing for newly insured in Exchanges--up to 400%//250% of the FPL
  2. Cost of newly insured under Medicaid; states will eventually pay for some, fed taxpayers pay the rest.
- Some opposition comes from industries threatened by the ACA

WHAT THE FUTURE HOLDS

(Assuming the ACA is neither de-funded nor overturned)

Axiom # 1 about Forecasting—

The longer the range of the forecast, the greater is the invitation to look ridiculous

WHAT DOES THE FUTURE HOLD?

- **Must Address COST** next:
  - Mgd competition makes insurance more of a commodity purchase—puts pressure on payers to drive down the cost of medical benefits, SG&A, and profit.
  - **Transparency** helps to enable consumers to make better price/quality decisions.

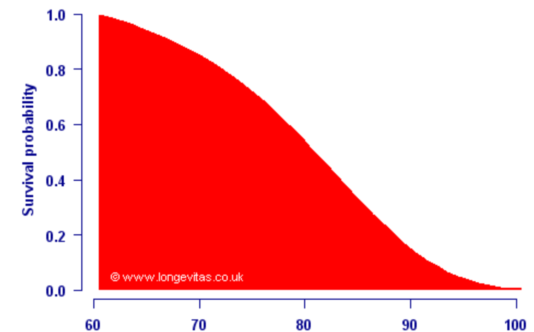
WHAT DOES THE FUTURE HOLD?

- More standardization of:
  - **benefit plans** (for ease of comparison…)
  - provider reimbursement
  - sales; administrative; operational process
- Mergers/acquisitions; altered competition
- Could Universal Coverage lead to Single Payer?
- Change in tax handling of ER health benefits?

WHAT DOES THE FUTURE HOLD?

… in addition to death and taxes

- Higher cost. Where will it all end? We're already discussing 3-D printing of replacement organs, nano-tech implantation, reversal of aging process...
- The **squaring of the life-curve**...



How cost spirals ever upward:

- Longer avg life expectancy ==>
- More h.c. cost per lifetime ==>
- More longevity ==>
- Need more retrmnt income (social security) in non-wrkng yrs ==>
- More longevity ==> …

- IMMORTALITY?!? Probably Not... anytime soon…

Is There A Better Way?

- Your thoughts go here…

Many want to point fingers and place the blame on other stakeholders, but …

Is There A Better Way?

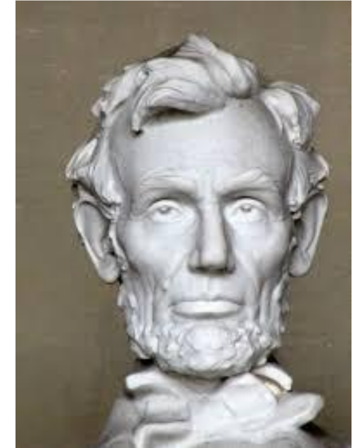
4 suggestions that are pure opinion:

1. Permanent stop loss program for Ind @ ~$150k PMPY post-2017
2. More uniformity in provider reimbursement—too much variation across and within coverage types (MCare vs. Comm. vs. MCaid), but esp w/in Comm, (and even in MCaid from state to state). Variation is costly to administer! Do not have to pay providers the same service fee for Comm, MCare, & Mcaid; **but** find better approach—too much cntrcting expense now; less in Maryland. This could take years to phase in and achieve.
3. Reduce duplication of hospital infrastructure in urban settings. What is unnecessary? Objective oversight of Need. Balance.
4. Better monitor/manage the increase in utilization & overall spending—outcomes research/best med practices; reduce zero-value care; reduce wrong services in wrong place at wrong time

CONCLUSION

- ACA is the federal govt's reaction to the problem of Declining Access to health insurance… mostly.
- Must now ramp up **health care cost containment** in a more global & concerted manner.
- Medicare is a separate but related issue… its overall cost has increased more than 100-fold since its 1965 inception, and per capita costs by over 50-fold…
- HC cost will rise faster than CPI, but some of what it buys is invaluable.

CONCLUSION, final slide



- It is too soon to tell how all of the ACA will play out… and this is **only the first step** in improving the US health care system.
- There are no feasible alternatives, and we cannot do nothing.
- If the US cannot solve the access problem, how will we ever be able to solve the larger problem of cost that awaits us next?

Thank You

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