

KHN's 'What the Health?'

Episode Title: A Conversation With Peter Lee on What's Next for the ACA

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Julie Rovner: Hello, and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. This week we have a special episode, a look back and a look ahead at the Affordable Care Act. We're taping this special on Friday, March 25. As always, news happens fast and things might have changed by the time you hear this. So here we go.

Between covid and the potential overturn of *Roe v. Wade* and a war in Europe, the Affordable Care Act has been kind of flying under the radar this past year. But while the law just turned 12 years old and efforts for a full repeal have mostly faded, 2022 is going to be a pivotal year for the law that helps provide insurance for an estimated 20 million Americans. Congress needs to decide whether to extend additional subsidies it added to the ACA in 2021, which expire at the end of this year, or whether to let premiums jump back up dramatically. Congress and the Biden administration are also trying to figure out how to help the millions of people still caught in the so-called coverage gap in the 12 Republican-led states that have not expanded Medicaid. I have long maintained that the ACA is the ultimate paradox in big federal legislation. At the same time, it's provided insurance and other benefits to millions of Americans, it has still left millions more either without insurance or with insurance they still can't afford to use. I can't think of anyone who's thought more deeply about how the ACA came to be, how it's worked, and what may become of it than Peter Lee. Until earlier this year, Peter was the first and only executive director of Covered California, the largest state-run ACA marketplace, which enrolled a record 1.8 million residents of the Golden State for this plan year. Prior to helping create and stand up Covered California, Peter worked in Washington at the Department of Health and Human Services and for the highly respected employer group the Pacific Business Group on Health. Peter, it is an honor to have you here on "What the Health?" Thank you for joining us.

Peter Lee: Great to be with you, Julie.

Rovner: Let us start with the really big picture, like from the 30,000-foot view. What has the ACA accomplished and what remains to be done to really fix health care in the United States?

Lee: Well, that is a big question. I guess the twofold: I agree with you that it's been a challenge and it's [an] imperfect solution to an imperfect health care system. What it's accomplished is much of what it set out to do, which is to dramatically expand coverage in [the] patchwork health care world we live, and also totally overhaul how insurance is done in America — which I think doesn't get the attention it should. The expansion you noted earlier, 20 million Americans have insurance that wouldn't have it but for the Affordable Care Act. That's very inconsistent. The states that did not expand Medicaid still have, in many states, up to 20% of their population uninsured. States that adopted the Affordable Care Act [and] did the Medicaid expansion are now in very low single-digit uninsured rates. That's good. Not perfect, but good. The other thing we have is a new normal — that is, a new normal across the political spectrum. We now say the idea that insurance companies could turn you away because at some point you had asthma, that you have diabetes, that you're a woman, as a preexisting condition, is no longer what anyone accepts — Republicans or Democrats. Things such as insurance companies can't be rewarded for avoiding sick people. That's a new normal, in which we talk about ... we now have risk adjustment payments, so that a health plan that does a "good job" avoiding sick people writes a check. In California, that check totals about a

billion dollars in the individual marketplace, which is good news. It means a health plan isn't rewarded for not serving sicker people. So a number of those things — and also the “medical loss ratio.” I know it's a wonky thing, but you have some wonky listeners. The whole medical loss ratio rule that says health insurance plans must spend the vast majority of their dollars on health care or write a big check. That has fundamentally changed the nature of health insurance. So we've made, as a nation, very big progress. At the same time, and you highlighted this in your opening, some of the work undone is we have a lot of Americans who have insurance that can't afford to get the care that in theory that insurance provides. Most of them are in employer-based coverage. Some of them are in Affordable Care Act-sponsored plans that now have, today, their affordability should address because of the expanded subsidies under the American Rescue Plan. If those subsidies go away at the end of this year, there are going to be millions of Americans that join the millions of underinsured employer-coverage Americans. So on coverage, that's a gap. We also have a gap on the remaining uninsured in states that didn't expand Medicaid. Big gap there, but it is also for people who are undocumented. California is taking a run at that by seeking to provide coverage to “undocs” —people that are not currently legal residents. Covid has taught us that health and disease doesn't stop at the boundaries of people's coverage, if they're covered or not. Having a healthier community really means bringing everyone in. So those are some of the issues. The last one that I'd note beyond coverage, the nature coverage, is addressing quality. Inherent in the Affordable Care Act was “Let's do a better job at improving quality.” In many ways, I sadly note, that's the place we've failed the most. While we've expanded coverage and made it better, if you look at what have we done for improving the quality of health care in the last 10 years, it has not improved. And that's not just an ACA issue — that's with the employer sector, people in Medicare, and that's one of the frontiers that we have to be looking at.

Rovner: Also, equity, I think that's been one of the big issues that's really come up in the last couple of years. Obviously, the ACA has done some things to help with equity, including, the Medicaid expansion in the states that did it and the subsidies for people with low incomes. But that's still an unrealized goal, isn't it, in many ways?

Lee: I totally agree. And part of that I didn't reference that, I should have, is that when I talk quality I mean equity as well. And I'm old-school. If you go back to the “Crossing the Quality Chasm,” which is [a report](#) the IOM [Institute of Medicine] issued 20 years ago and said, “We are doing a lousy job in health care quality in America,” and it said we should have health care that meets six core goals. It's safe. It's timely. It's effective. You get the right care when you need it. It's efficient. It doesn't cost more than it should. It's equitable and it's patient-centered. That's what we should be having in health care quality. That's what we should be looking at as our measuring stick. And we've largely not improved on those fronts of effective care — you get the right care when you need it — and equitable care. And you're absolutely right. The covid pandemic has put a healthy spotlight on the reality of disequity and disparities in care.

Rovner: So you've already touched on this, but expand a little bit more. What happens if Congress does not renew the subsidies that were created last year in the American Rescue Plan? I assume nothing good.

Lee: Well, worse than “nothing good.” Many bad things would happen. And I want to note that the American Rescue Plan increased subsidies in two ways. No. 1, it said for people that are getting subsidies, the very low-income people that are above Medicaid will get better subsidies. The original subsidies were good, but they really weren't good enough. If you're a low-income person and needed to pay \$100 a month for a premium that now you're paying \$20, for many that means the difference of signing up or not signing up. Similarly, if you're a low-income person, and you have help out-of-pocket when you see a doctor — today, we have many people who are in — what are those called — “silver” cost sharing plans that are paying \$5 to see a doctor. If they have to pay \$35, they won't go to the doctor. So the American Rescue

Plan subsidies make care more affordable for lower-income [people]. But the other thing it did is it got rid of the cliff, which was under the original Affordable Care Act that said — somewhat arbitrarily, but for budget purposes — you make more than 400% of [the federal] poverty [level], which is about \$50,000 for an individual, about. No matter how much your health care costs you, you will get zero financial help. And in California, I've met early retirees spending 25% and 30% of their income on their health insurance premium — on their premium, not what they spend out-of-pocket. The American Rescue Plan said drawing that arbitrary line was bad for health and bad for economic equity. Let's help people not spend a huge portion of their income. And, Julie, I don't need to remind you, but I'll remind the listeners that every other American gets federal financial help with their health insurance and health insurance coverage. All of us with employer coverage get a federal subsidy that's invisible to us, but it's the biggest expense in the federal government. And the people in the individual market who are in that ...

Rovner: It's the biggest expense in the federal government *on health care*.

Lee: On health care, on health care. Yeah, exactly. Yeah. And it's close to the mortgage subsidy for people that is a direct subsidy for Americans to buy houses. So it's a huge multibillion-dollar expense, but it's largely invisible. So again, back to the benefit. We now have in California, just give you a data point, about 10% of the enrollees in Covered California today make more than 400% of poverty *because* they're getting a financial leg up to make that bridge to Medicare, to actually not be spending 25% of their income. And those two things would go away come October when people start getting the renewal notices in the bill.

Rovner: In October of 2022, meaning for January 2023.

Lee: That's right. The coverage would stop in January, but people would get notices, and not just to be crass, but right around when they're thinking about voting. It's not good math. And what would happen if those subsidies go away is two things: One, millions across the nation will drop coverage. They will say, I just cannot afford it. Others will pick worse plans. Others will say, "I will go with that bronze plan, high-deductible, instead of the better plan that provides me with a lower cost sharing. So we're going to have fewer people with coverage, people with coverage, with worse coverage. It's really a sort of perfect bad storm, which is why, clearly, that in particular Democrats in Congress see this as really important to fix. They do understand that. And yes, there's a lot of other things in play: Ukraine, the economy, and, boy, is this something that would be a tragedy not to be fixed in the next few months.

Rovner: So Covered California operates very differently from most of the other state-based marketplaces. And, as a result, it has done a better job covering more people at lower premiums than I think any other state, right?

Lee: Absolutely. Well, lower premiums relative to where we start. California's an expensive state, but our premiums in California in the last seven years went up about 45%. Nationally, they went up about 80%. So we've seen premiums increase dramatically. But you're right, we've done a lot to enroll people and we've enrolled more people who are, by [one] definition, healthier, which means lower costs for everybody. That's the secret sauce of what we've done. With another element, if I could, Julie: It's both having a healthier risk mix, but by being a pretty active purchaser with standard benefit designs, consumers create a competitive market that means health plans can't walk away with big profits or not spending it on health care. Because if they do, consumers will buy from another health plan. So we have actually made things more efficient and effective by actually having true competition for quality and value.

Rovner: And explain what it means to be an active purchaser, because I know that phrase gets thrown around, but a lot of people don't really appreciate how important it is.

Lee: You know, under the Affordable Care Act, whether you're in the federal marketplace or state marketplace, every plan has to offer essential benefits. That's standardized. The level of benefits by actual value is standardized. But beyond that, if you are a licensed health plan, you can get on most marketplaces ... and you can offer your own variant benefit designs. Covered California said from day one, we're going to turn health plans away if they don't meet minimum standards beyond regulatory standards. We will look closely at what they do in terms of having things like the same, identical benefits. So if you're picking between Blue Shield of California or Anthem and Kaiser [Permanente], you're comparing the networks and their approach to health care, not confused by differences of benefit design. That isn't the norm. Across the nation, if you are shopping for a silver plan in New Orleans or in Miami, you would have dozens of plans — with each health plan offering four or five silver variations. Not because they're better for consumers, because they're better for health plans getting people in their door. We say that's not the right way to compete. So being an active purchaser means sitting in the corner where the consumer sits and say, Let's help you pick the right plan for you. But then let's also require that health plan to pay differently for primary care. To approach equity, that we talked about earlier, constructively. We require all of our health plans to have not just standard accreditation, but to be accredited for addressing multicultural health care needs. We're the only marketplace in the nation that does that. And it's the right thing to do because we don't want people just to get an insurance card. We want people to get the right care at the right time. And so that's what it means to be an active purchaser. We've got a contract provision that's got re-upped that raise[s] the bar even higher because we don't think we've done enough in many ways to hold health plans to the standard that any Americans want their health plan held to.

Rovner: Well, this is the perfect segue into my next question, which is — I want to broaden the discussion here to talk about the entire health insurance ecosystem. I love this line that you wrote recently about the increasing role of private insurers in not just the Affordable Care Act, but also in Medicare and Medicaid. Quote “Health plans have generally not proven themselves to be engines fostering improvement in health quality equity or reducing the rate of increase in underlying cost of care. Rather, health plan innovation often means providing numerous options that vary on premiums, deductibles, copays, networks, medical benefits covered and, to a limited extent, services to address health-related social needs.” Close quote. In other words, and these are my words, not yours: Health plans have done an excellent job at confusing and frustrating patients and not so much else. Is that a plea for single-payer or for the private sector to do a better job? And if it's the latter, how might they go about doing that?

Lee: Well, it's actually a plea for not just ... for the private *and* public sectors to do a better job. I actually think competition can work, but it needs to be competition based on quality. And I just know, you know, the sad point, I think it's true that there's exceptions to the rule. In California and in 14 other states, Kaiser Permanente is an integrated delivery system. We look a lot at quality. Kaiser in California is in the 90th percentile of national scores on core things that we all think that every health plan should do well: Serve people with hypertension, the No. 1 cause of death in America. Help people with diabetes get the right care at the right time. They're at the 90th percentile. OK. The rest of our plans are all over the map. And this is the national story we're seeing. Health plans have not been rewarded financially or called to account financially for really delivering better care. And whether you're a large employer, you've done on the margins “pay for performance” — say, pay doctors a little bit differently. But have health plans faced any consequence from the last 20 years not doing better for diabetics, for people with heart disease? Absolutely not. Now the one micro-exception of that — well, two, they're not that micro — is one: In Medicaid, more and more Medicaid beneficiaries are served by managed-care plans, and states are looking actively at how to hold Medicaid plans to account. In Medicare, there's a bonus program for Medicare managed-care plans, but that bonus program has a very low bar. And in Medicare Advantage plans — boy, are consumers confused, because you'll get Medicare Advantage plans saying, “Come to us because of our

hearing aids, come to us because of our exercise program,” not “Come to us because you're more likely to be alive if you have heart disease.” That's bad for consumers, it's bad for the health care system. And I think that if we could wave a magic wand and have single-payer, is that better or worse? I'm not sure. I don't believe in magic wands. What we can do is, whether you're a state or the federal government, say, if we're going to have an environment that has multiple health plans, let's have consumers pick on things that are meaningful. Which is, does that plan do a better job? Meaning you're going to live if you have hypertension, you're more likely to not have your leg amputated if you have diabetes. That is not on the table today, and it should be for every major purchaser.

Rovner: When I started covering health care, the big hope was being able to better measure some of these things and to use electronic medical records and, you know, artificial intelligence and, you know, ways to help people guide them along their paths. And yet what I see right now is all of these half-realized things. I was looking at Twitter yesterday and some woman said she went to pick up a prescription and they wouldn't give it to her because, according to their records, she was 13 months pregnant. She obviously was not, you know, and, you know, electronic medical records that don't speak to each other. It's there a way to fix that in order to maybe realize some of this? Or were we just a little bit too glib in the 1990s about how easy it would be to make health care more systematic, if you will?

Lee: I don't think we were glib, but in the '90s, and I was part of this, I sort of, you know, smack myself upside the head for being part of the measurement industrial complex in America, you know, having been on the board of NCQA [National Committee for Quality Assurance] and National Quality Forum. It *is* true you can't improve what you don't measure. Measurement is vital. What did happen, though, was the hope we had for electronic health records, of being engines of improvement, became engines of work and burden on clinicians that have driven them bonkers and not provided them tools to improve. So what we did at Covered California is select a very small set of measures — for the key measures that we're looking at — for blood pressure control, diabetes control, preventing people from having colorectal cancer, because if you screen for that you can actually prevent it, and childhood immunizations. Now what we're doing at Covered California is on these very small set of measures putting what will be up to 4% of premium at risk. Four percent. I want to know — we've looked at our data over the last seven years. On average, our plans, we had 11 plans, made 2.5% profit. Four percent is a big number. But coming back to the question of being an active purchaser, does that mean health plans don't want to play in the individual market in California? Absolutely not. We've got national plans knocking on the doors of Covered California, even while we're raising the bar for quality. Every employer, every public purchaser should be saying: Health plan, you need to focus on quality and it's going to cost you if you don't. If we don't monetize quality, if we don't make it actually matter to a health plan's bottom line, it won't get the care, attention and focus that it should get.

Rovner: So I know that you're taking a break after having run Covered California for a decade and you well deserve it. Any hints about what you'll do next or what you would like to do next? Obviously, you have much more to share with the health policy community.

Lee: Well, I'm not sure where I'm going to land, but I'll note the two domains that I want to focus on. One is this area that we're talking about right now: holding health plans as entities that they've said we will take care of your populations and they're not by and large doing it. So how do we set up financial mechanisms and other accountability mechanisms so they do the job the Americans given to them? Whether it's through Medicare Advantage, through Medicaid managed care, through employers saying take care of our populations. The second area that I am really looking at working on is on the employer sector. You know, we spent a lot of time in the last 20 years trying to get Medicare to buy better. You know, I helped stand up the Center for Medicare & Medicaid Innovation. The work it's doing on accountable care organizations is

good and important work: promoting better care coordination integration. Employers are walking away from holding health plans to account. What employers are doing by and large is saying, "If you pick a big PPO, we're going to address cost by playing with cost shifting, not by making sure care is better organized. I think that's a problem. And it's a problem in particular because about 30% of Americans that have employer-based coverage are lower income and their health care costs mean they unlikely to get care when they need it. That's wrong. The Affordable Care Act addresses that well and functionally by having income-adjusted subsidies, income-adjusted benefits. I think one of the things we as a nation need to look at is to have an employer system — if we're going to keep it — make it work for lower-income people as well as for high-income people. So those are, Julie, domains I'm interested in working in. Where will I plan to do that? I'm not sure, but those are the right issues for me to try to contribute in the years to come.

Rovner: Well, I'm sure we'll be talking again. In the meantime, Peter Lee, you have given us much to think about. Thank you so much for doing this.

Lee: My pleasure, Julie. Great to be with you.