What and Who is the Price? The Price is Right.

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Tom Price, nominated Secretary of HHS brings an in-depth history, and set of beliefs with him. Let's examine a few points and bullets of interest:

1. Orthopedic Surgeon by trade.

2. Fierce critic of PPACA.

3. One of congressman loyal to Trump candidacy.

4. Tea Party member.

5. Member of GOP Doctors Caucus.

6. Supports major changes to Medicaid and Medicare: "both programs would cease to be entitlements that require them to provide coverage to every person who qualifies, instead...converts Medicaid into block grants to states..." "The plan would also require 'able-bodied' applicants to meet work requirements to receive healthcare benefits."

7. Favors moving Medicare from a defined benefit program to a defined contribution program whereby older and disabled Americans would receive financial help to buy private insurance policies. Thereby, in a sense, privatizing Medicare.

8. A proponent of smaller Federal Government ceding authorities to the states.

9. A proponent of removing Federal regulations related to PPACA.

10. Author of "Empowering Patients First Act," a proposal that offers tax credits for people to buy insurance and encourages the opening of H.S.A accounts where money saved can be done so tax free and used for healthcare purposes tax free.

11. Favors rolling back Medicaid expansion adopted under PPACA, essentially favoring block grants to states that might even lead to competitive marketplace reforms.

12. An opponent of funding Planned Parenthood.

13. Quotes from Congressman Price: "President Obama's healthcare law violates every principle of healthcare that Americans hold dear."

14. "As a nation, we should promote the goal of reducing the number of Americans reliant upon government assistance and allow for personal choices in healthcare decisions."

15. A proponent of a balanced budget amendment, put forth a bill to reduce non-security and discretionary spending to 2008 levels.

16. Author of Pro-Growth Budgeting Act of 2013 that would require the CBO to provide a macroeconomic impact analysis for bills that are estimated to have a large budgetary effect.

17. Bills authored by and promoted by Congressman Price:

A. H.R. 2626, a bill to allow for tax credits and deductions for purchasing health insurance, to revise government employer contribution amounts, to reform malpractice lawsuits, to provide financial aid to introduce health information technology, tax credit for E.R doctors to offset costs incurred because of the Emergency Medical Treatment and Active Labor Act, and to promote interstate health insurance markets.

B. H.R. 464, a bill to require states to cover 90% of eligible children for the State Children's Health Insurance Program (SCHIP) in the programs for households with incomes below 200% of the federal poverty level and to prohibit SCHIP from funding child health for children in households above 250% of the FPL.

C. H.R. 6170, a bill to prevent the Secretary of HHS from precluding an enrollee, participant, or beneficiary in a health benefits plan from entering into any contract or arrangement for healthcare with any healthcare provider, excluding Medicaid and TRICARE.

D. H.R. 2077, a bill to repeal the medical loss ratio provision of the PPACA.

E. H.R. 1990 and H.R. 2009, bills to prohibit the Secretary of the Treasury, or any delegate Secretary from implementing or enforcing any provisions or amendments made by PPACA or Health Care and Education Reconciliation Act of 2010.

While there a number of other bills authored by Congressman Price, these are those most related to healthcare, healthcare issues, and PPACA. So, as a result of these readings and actions, what can we expect?

Here's my list:

1. Total dismantling effort of PPACA beginning with the removal by signature of every executive order/action taken by the Obama administration related to the PPACA law. That may be a "first" move within the first 100 days of the Trump administration. How many pages of regulations are there to PPACA? Over 25,000.

2. Total dismantling of PPACA regulations relating to fees (PCORI and Re-Insurance Transition), restrictions, requirements, that employers must abide by including those that are now under the authority of not only HHS but also IRS and DOL. If you cruise over the PPACA law and those provisions related to this they include but are not limited to the following:

    A. MLR, restrictions as 80% LR and 85% LR depending on group classification size,

    B. 30 hour per work week eligibility provision,

    C. Regionalized Underwriting requirements,

    D. Community underwriting requirement,

    E. Small Group vs: applicable Large Group differentiations,

    F. Fully insured rate ratio requirement,

    G. Affordability provisions, 9.62% of W2 safe harbor employee contribution protection,

    H. Eligibility provisions that require offering of benefit plans to 95% of eligible employees with restrictions and requirements as full time equivalents,

I. Fines related to employers for not offering coverage,

J. Controlled Group provision,

K. Fines for not meeting levels of qualified benefits,

L. Discrimination provisions as applied to total group whereby contributions for different classes of employees will be allowed again. This is a maybe but very probable.

Therefore, what provisions will then most likely remain?
Think in terms of the mandated benefits, preventative care, women's healthcare, no life time maximums, mental healthcare parity, age 26 eligibility, although after reading about Mr. Price, there may be new definitions here such as "student to age 26," or "parents are at least 50% financially responsible," etc. These benefits are politically "explosive" and while there is a "cost" that cost can be underwritten as claims cost not fixed cost. No doubt, attacks on ERISA are over and as a matter of fact, the applications of ERISA that have been applied to fully insured plans may remain in place, except for the discrimination penalties and rules that evoke such penalties.

What else to look for?
As you can tell this is a total reversal of Federal Government control through requirements on employers and restrictive mandates that cost employers, but yet apply to employees; moving to individual consumer directed allowances to create marketplace alternatives and competition. So, we go from one end of the spectrum to the other. Congressman Price also advocates a cap on the employer tax exemption for benefits at somewhere between $8,000- $10,000 meaning that if an employer's health plan cost is more than that amount per contract year to provide healthcare benefit plans to their employees, the amount over will not be allowed to be deducted as an exemption. Whether or not this "idea" will apply to union plans, bargained agreements, Taft Hartley's etc. remains to be seen.

For sure, there will be an end to the re-insurance subsidies that will impact the future fate of the exchanges. It is entirely possible exchanges may continue but be turned completely over to states to determine their function and feasibility. The Federal Government will probably completely withdraw from any functions relating to these exchanges, unless of course, they can be completely privatized and only "regulated" by Federal and State rules that apply to their operation, funding, and plan offerings. Very important, we'll also have to see how the Trump administration treats the ACO provision. This provision has been the impetus for providers across the country to form into new umbrella type partnership arrangements without concern for monopolistic behavior, however, should the ACO provision be repealed, then what? We'll see.

Also, since it is very apparent, once we review "the underlying business theme" of all of the Trump appointments, what will be the new administrations reactions to the Anthem-Cigna merger and the Aetna-Humana merger? Will these mergers be looked upon as positive for business, or will they be viewed from a "monopolistic" perspective? Do either of these mergers make them larger than United Health Care? All obvious and intriguing questions. Wall Street has obviously reacted positively to what they believe will be the new administration's moves regarding not just PPACA but the health marketplace in general. Health Care equities are playing well right now as is most of the market anticipating a new era of relief from Federal Government oversight and regulation.

No doubt however, the markets have learned from the Obamacare experience. New innovations, new risk taking products, new ways of underwriting-taking more risk and developing the tools to quantify that risk, have all been created. These innovations will in all probability remain. Now, the real efforts to watch, which Obamacare really never addressed, is the root cause of healthcare cost, and the overall capability to quantify healthcare quality. The private marketplace as well as the Federal programs under CMS have entered into new arenas regarding new ways to reimburse for hospital inpatient and outpatient services as well as physician

services. New companies and methods that have been and are being innovated by private entrepreneurs remains very active and prevalent- Bundled Pricing, Cost Based Pricing, Episode of Care Pricing, Integrating Quality of Performance with Price, and even the resurgence of Performance-based Capitation Models, will only become more urgent and more inventive as stimulated and encouraged by the private market place.

So, in the end, my overall title for the upcoming year and into 2018 is: CHAOS AND CHALLENGE, which leads to tremendous opportunities. And for those of you who think this changes the direction of the market place toward self-funding, sorry, WRONG. Self-funding methods, vehicles, and product inventions will continue a strong marketplace presence. This marketplace presence will remain and continue unless Carriers learn that being in a partnership with their clients, over 50 lives especially, means complete provision and disclosure of data; cooperation in terms of just not selling "stuff" like wellness mechanics, but actually performing wellness features and functions to the point of proving a guaranteed ROI; and releasing and disclosing total underwriting methodology of how premiums are calculated; instead of trying (along with the brokers who represent them,) to hold employers hostage by NOT being a partner; will be the NEW mandate of the marketplace. As long as the self-funded marketplace acts more in terms of being such a partner, and the fully insured marketplace carriers do not, self-funding will not only grow, but be demanded by employers. Thanks for reading.

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