A. AHLA's 2030 Task Force Goal

The 2030 Task Force was asked to identify anticipated changes in the health law industry over the next 10 years. With this charge, the Task Force set out to study the major influencers of the health law industry. In this section, the Task Force examines federal health policy as one of those major influencers, and seeks to assess the Federal government vision of health care in 2030, and how that vision will affect the health law industry.

B. Executive Summary

Several megatrends will continue to shape federal health policy for the foreseeable future. Among those megatrends, the Task Force has identified the following: (1) an expanding role of the government in health policy, (2) an increased focus on cost containment, (3) a dynamic regulatory environment, (4) expanded federal enforcement activity, and (5) efforts to increase the role of the consumer healthcare purchasing. We anticipate that these new trends will place new financial pressure on clients, but also lead to more transactional activity and need for defense and compliance activity. Together, these implications may lead to increased demand for legal services, but also increased pressure on lawyers to deliver those services more efficiently.

C. Introduction

In 1988, noted futurist John Naisbitt coined the term "megatrends" with his bestselling book of the same title. In that book, Naisbitt defined the term this way: Megatrends are long-term processes of transformation with a broad scope and a dramatic impact. They are considered to be powerful factors which shape future markets

Federal health policy is in many ways large and small directed by political parties and individual actors in control of the agenda at the time. US Presidents (and their appointees) have federal health policy goals. Congress also has a substantial role in influencing federal health policy. House Speakers, Senate Majority Leaders and Committee chairmen all determine which legislation advances, and to varying degrees exert pressures on federal agencies that influence action.

As new administrations come to power and biannual elections bring change in congressional leadership, federal health policy priorities change. Between now and 2030, the US government will undergo three presidential elections and six congressional elections. How much change in party and individual leadership those elections cause, and the resulting precise course of federal health policy over the next decade is unknowable. But the year-to-year zig and zag of policy direction mostly cause blur around the edges of the field of vision. In the center of that field it is possible to identify durable high-level federal health policy objectives that are commonly held and shared by both parties and most political actors, such that seeing a broad trajectory of federal health policy, or megatrends, from here to 2030 is feasible.

In the course of our research, the Task Force has identified five megatrends in federal health policy that have been consistently pursued in recent decades, and are likely to continue to be pursued for at least the next decade. Which megatrends dominate the agenda at a given moment in time, and the specific policy proposals that those in power use to advance those megatrends will vary. Nonetheless, the megatrends are likely to remain and be relatively constant over the next decade, if not longer.

D. Method

These megatrends were identified and validated through one-on-one interviews with six seasoned federal health policy authorities. The following individuals hold or have held senior federal health policymaking positions, and remain actively engaged as business leaders involved with observing and shaping federal health policy. These individuals also represent bipartisan perspectives: three self-identified Republicans and three Democrats.

- **Tom Barker, Esq**., a partner at Foley Hoag, served as a Deputy General Counsel at the US Department of Health and Human Services, and now serves as an advisor on the Medicaid and CHIP Payment and Access Commission.
- **Kim Brandt, Esq**., is the Principal Deputy Administrator for Operations of the Centers for Medicare & Medicaid Services. She previously served as a lead health policy counsel with the US Senate Finance Committee.
- **Rodney Whitlock, Ph.D**., a vice-president at McDermott+Consulting, is a veteran health care policy professional with more than 20 years of experience working with the U.S. Congress, where he served as health policy advisor and acting health policy director for Finance Committee Chairman Chuck Grassley
- **Chris Jennings**, founder and president of Jennings Policy Strategies, Inc., is a notable health policy veteran who held senior health policy advisory roles for two Democratic presidents, including as Deputy Assistant to the President for Health Policy and Coordinator of Health Reform in the Obama Administration.
- **David Schwartz, Esq.**, the Head of Global Policy for Cigna, and previously served as Chief Health Counsel for the US Senate Finance Committee.
- **Chris Dawe**, Chief Growth Officer at Evolent, has served as Policy Advisor for Health Care at the White House National Economic Council, as Director of Delivery System Reform at the US Department of Health and Human Services, and as a Professional Staff Member for the US Senate Finance Committee

E. The Megatrends

The Task Force identified six federal health policy megatrends that are likely to shape health law over the coming decade.

1. Increasing role of government programs

Based solely on current demographic trends, the number of individuals enrolled in Medicare is expected to increase from 59 million today to 79 million by 2030 simply because of the aging of America.[1] Moreover, the number of individuals enrolled in Medicaid is likely to increase as more states embrace the Medicaid expansion encouraged by the Affordable Care Act.[2]

Moreover, federal policymakers are expected to seek new ways to decrease the number of uninsured and underinsured Americans. For nearly the entirety of the last century, federal leaders have sought to decrease the number of and extent to which Americans are exposed to the costs of medical care. President Harry Truman is largely credited with being one of the first US

[1] https://assets.aarp.org/rgcenter/health/fs149_medicare.pdf

[2] At present, 37 states (including D.C.) have expanded Medicaid, but 5 states have sought to expand Medicaid in 2019 alone.

presidents to pursue a federal health insurance program. President Lyndon Johnson realized that vision in 1965 with the enactment of Medicare and Medicaid, and nearly every US President since has in ways large or small increased the scope of eligibility or benefits of those programs.[3] President Barak Obama famously signed the Affordable Care Act, which further narrowed the number of uninsured by 20 million people.[4]

Today, there are 27.4 million Americans with no insurance coverage and another 31 million who are considered underinsured.[5] Extending health insurance coverage is a major topic in the 2020 presidential election (as it was in the 2018 mid-term congressional election), and is a goal likely to be pursued by whomever occupies the White House.

Specifically how different leaders may pursue this goal will vary, but regardless of who is in charge, they likely will seek to leverage existing federal and state programs like Medicare, Medicaid and the Affordable Care Act, among others. The net result will be an increasing percentage of individuals enrolled in and payments coming from government programs.

2. Increasing focus on cost containment

Healthcare presently accounts for 17.9 percent of the gross domestic product, and that percent has been rising at a rate of 3.9 percent, annually, over the last decade.[6] The rate of medical inflation, presently 5.7 percent, routinely outpaces the general rate of inflation in the US.[7] These trends are expected to increase as new medical breakthroughs and technologies (*e.g.,* CAR-T therapy) increase the cost of items and services. Virtually every federal policymaker shares concern about these trends and about the burden they impose on the federal budget and taxpayers.

There are many ways in which federal policymakers can and will seek to wrest control of the growth of the cost of healthcare, but typical and likely ways include the following:

- **Rate regulation –** One of the easiest to implement and therefore most frequently used tools to contain federal healthcare spending is by simply reducing the amount the Federal government pays for services. Recent examples include (1) site neutral policies that seek to eliminate disparities in the amount federal programs pay for similar services in different settings (*e.g.,* the 2015 law that directed Medicare to pay the same amount for certain services furnished in hospitals and physician offices), (2) targeted service-specific payment reforms or reductions (*e.g.,* the 2018 law reducing Medicare payment for physical and occupational therapy services to 85 percent of then current levels), (3) lower annual inflation adjustments (*e.g.,* the 2018 law that reduced annual inflation

[3] President George W. Bush signed the Medicare Modernization Act, which, among other things, established Medicare Part D providing Medicare coverage for certain prescription drugs.
[4]https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act
[5] https://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-underinsurance-and-how-rising-deductibles-will-make-it. (Adults in the survey are defined as underinsured if they had health insurance continuously for the preceding 12 months but still had out-of-pocket costs or deductibles that were high relative to their incomes)
[6] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html
[7] https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

adjustments for physician services from 0.5 percent to 0.25 percent), and (4) clawbacks (*e.g.,* the 2011 law that cut Medicare payments by two percent across-the-board).

- **Shifting risk from the government to the private sector –** The federal government steadily over the past four decades has been shifting risk to contracted payers and providers. It began with prospective payment systems, but now is increasingly reflected in increased use of managed care programs in both Medicare and Medicaid, larger payment bundles, value-based purchasing programs and two-sided risk models, all of which are intended to incentivize reduced utilization and cost. The Maryland all-payer model is one extreme example, but one that conceivably could be extended to other states or regions.
- **Care alternatives** – Policymakers likewise are bringing new ideas and flexibility to the mode of care, allowing greater use of distant care through telehealth technologies, greater use of lower-skilled and lower cost providers (*e.g.,* nurses instead of physicians), and greater availability and use of preventive services.

3. Dynamic regulatory environment

Nearly every two-year Congress features at least one piece of substantial healthcare legislation (*e.g.,* the Medicare Access and CHIP Reauthorization Act of 2015 and Bipartisan Budget Act of 2018); major legislation (*e.g.,* the Medicare Modernization Act of 2003 and the Affordable Care Act of 2010) has been enacted about once per decade. These laws invariably spawn new and revised regulations. Additionally, some administrations pursue increased regulation of the health industry, while others may seek to deregulate. The current administration, for example, recently proposed sweeping changes to federal physician self-referral and kickback proscriptions, which are part of a larger deregulatory agenda.

Regardless, of the particular legislative directive or objective sought by a given administration, this ebb and flow will create and continue a dynamic regulatory environment, one in which healthcare regulations are frequently being re-written and evolving.

4. Same or increased enforcement activity

In 2018, the most recent year for which data is available, the federal government recovered $2.8 billion through federal enforcement activity.[8] As the role of the federal government in paying for health care increases, the level of enforcement activity likely will increase too. New technologies also will provide law enforcement with enhanced tools to detect and pursue fraud, waste and abuse.

5. Increase in consumer empowerment

One of the ways in which the current administration is seeking to contain healthcare costs and federal expenditures is by enlisting consumers in consumption decisions. There are many reasons why consumers are insulated from or unable to make informed consumption decisions, but it is widely believed that inadequate and imperfect information is a substantial contributor. The current administration is seeking to address this deficiency by requiring greater disclosure of the cost of healthcare. The US Department of Health and Human Services is presently seeking to require pharmaceutical manufacturers to disclose the cost of their drugs in advertising, and to

[8] https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018

require hospitals to disclose payer-specific negotiated rates for select items and services. This is not a Republican-only objective. The Affordable Care Act, enacted by a House and Senate controlled by Democrats, and signed by a Democratic president, likewise required hospitals to post charge information. The trend of new transparency policies and technological advancements making disclosed information more comparable should be expected to continue over the next decade.

F. Implications for the Health Law Industry

These megatrends will affect the health law industry in many ways, but some of the more profound and anticipated implications are likely to be the following.

1. **Increasing financial pressure on clients** – Government programs are generally perceived to be less favorable payers for items and services than their commercial counterparts. If true that an increasing percentage of patients will be enrolled in government programs, and policymakers will seek to pay less for items and services furnished to these individuals, health sector stakeholders will be under increasing downward revenue pressure. This financial pressure may induce stakeholders to control their cost of goods and services purchased, including legal costs. Stakeholders may seek to achieve this by bringing more capability in house and seeking less costly external service providers.

2. **Increasing transactional activity resulting from alignment and consolidation.** Increasing downward revenue pressure will encourage health sector stakeholders to offset revenue losses through other sources (*e.g.,* payer mix and expanded services) and to reduce costs to maintain margins. These stakeholders may seek to consolidate with other stakeholders to increase market power (*i.e.,* horizontal consolidation) or diversify services (*i.e.,* vertical consolidation). Disruptors seeking improved ways of delivering items and services will enter markets. Stakeholder alignment and consolidation, and the emergence of disrupters will require commercial transactions (*e.g.,* contract arrangements, mergers, acquisitions and joint ventures), and this transactional activity could lead to increased demand for legal services.

3. **Increasing need for compliance and defense activity.** Ever-changing regulatory environments and increasing transparency obligations will sustain demand for lawyers with specialized health law expertise. Growing enforcement activity likewise will generate need for lawyers with specific knowledge of the industry and attendant regulatory environment.