The Obama Administration and the 111th Congress: Prospects for Health Reform

By Susan Dentzer
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As my GPS says...
Recalculating!
This presentation at a glance

- The administration’s reform framework
- Details of bills
- Unresolved issues
- Possible scenarios
- Some conclusions
The President’s 8 Principles for Health Reform

- Reduce rate of growth of health insurance premiums

- Premiums have more than doubled since 2000

- Average employer-based family plan now $13,375 annually, according to Kaiser Family Foundation/HRET survey; 131% increase since 1999

- Premiums driven largely by rising health costs
EXHIBIT 3
National Health Expenditures (NHE) As A Share Of Gross Domestic Product (GDP) And Average Annual Growth In NHE Versus Growth In GDP, 2005–2017

<table>
<thead>
<tr>
<th>Year</th>
<th>NHE as percent of GDP</th>
<th>NHE growth</th>
<th>GDP growth</th>
<th>Average annual percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>16.0</td>
<td></td>
<td></td>
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<tr>
<td>2006</td>
<td>15.5</td>
<td>0.5%</td>
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<tr>
<td>2007</td>
<td>15.0</td>
<td>0.8%</td>
<td></td>
<td></td>
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<tr>
<td>2008</td>
<td>14.5</td>
<td>1.0%</td>
<td></td>
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<tr>
<td>2009</td>
<td>14.0</td>
<td>1.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>13.5</td>
<td>1.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>13.0</td>
<td>1.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>12.5</td>
<td>1.8%</td>
<td></td>
<td></td>
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<tr>
<td>2013</td>
<td>12.0</td>
<td>2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>11.5</td>
<td>2.2%</td>
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<td>2015</td>
<td>11.0</td>
<td>2.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>10.5</td>
<td>2.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>10.0</td>
<td>2.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

**NOTES:** The left axis (NHE share of GDP) relates to the gray-shaded bars. The right axis (percent change in GDP and NHE) relates to the two line graphs.

Sean Keehan, Andrea Sisko, Christopher Truffer, Sheila Smith, Cathy Cowan, John Poisal, M. Kent Clemens, the National Health Expenditure Accounts Projections Team, Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming To Medicare, Health Affairs, Vol 27, Issue 2, w145-155w

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Christopher J. Truffer, Sean Keehan, Sheila Smith, Jonathan Cylus, Andrea Sisko, John A. Poisal, Joseph Lizonitz, and M. Kent Clemens,
Health Spending Projections Through 2019: The Recession's Impact Continues,
Health Affairs, Vol 0, Issue 2010, hlthaff.2009.1074v1-101377200
Pros and Cons

Michael E. Chernew, Richard A. Hirth, and David M. Cutler
Increased Spending On Health Care: Long-Term Implications for The Nation


1% point gap: health care is “affordable” through 2083; 54% of real increase in per capita income goes to health care

2% point gap: health care affordable only through 2020; over 75 years, 118.5% of real increase in per capita income devoted to health care (e.g., implausible)

Michael E. Chernew, Department of Health Care Policy, Harvard Medical School
Spending on Non-health Goods and Services, Assuming Different Gaps Between Real Per Capita GDP and Health Care Cost Growth, 2007-2083
The President’s 8 Principles for Health Reform

- Reduce high administrative costs, unnecessary tests and services, waste, inefficiencies

- Estimates that as much as 30% of health care spending is on care that is unnecessary, ineffective or even dangerous
The President’s 8 Principles for Health Reform

Aim for universality

- Estimated 46.3 million now uninsured as of 2008 Census Dept. Current Population Survey; approximately 36 million are U.S. citizens

- Estimated 30 million will not be able to afford full costs of insuring themselves and families

- Recession has added to public health insurance rolls; 2.6 million more on public coverage since ’07 (as of Census Bureau survey; probably many more since then)
The President’s 8 Principles for Health Reform

- Provide portability of coverage; no preexisting condition restrictions to deny coverage

- Provide choice of health plans and physicians; provide choice of keeping employer-based health plan

  - Translation: No Single Payer
  - “Public” plan: House bill contained; Senate instead proposed 2 nationally available private plans, at least one of which would be nonprofit, negotiated by federal Office of Personnel Management
The President’s 8 Principles for Health Reform

- Invest in public health measures to reduce cost drivers, including obesity, sedentary lifestyles and smoking; guarantee access to proven preventive treatments

- At current rates of weight gain, an estimated 86% of U.S. adults will be overweight or obese by 2030

- Increased prevalence of obesity has added almost $40 billion a year in medical spending from 1998 through 2006, including $7 billion in Medicare prescription drug costs.

- Estimates that the medical costs of obesity could have risen to $147 billion per year by 2008.

Sources: *Obesity*, July 2008; study by researchers at the Johns Hopkins Bloomberg School of Public Health, the Agency for Healthcare Research and Quality and the University of Pennsylvania School of Medicine; also “Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates,” by Eric A. Finkelstein, Justin G. Trogdon, Joel W. Cohen and William Dietz, *Health Affairs*, vol. 28, no. 5 (2009), w822-w831.
The President’s 8 Principles for Health Reform

- Improve patient safety and provide incentives for quality care; support widespread use of health IT

- Plan must “pay for itself by reducing the level of cost growth, improving productivity and dedicating additional sources of revenue.”

- President vows in speech to Joint Session of Congress on Sept. 9, 2009 that he will not sign a bill that adds “one dime” to the federal budget deficit
Key Players -- Senate

• Senator Christopher Dodd (top), D-CT
• Led effort in Senate Health, Education, Labor and Pensions Committee following the death of Sen. Edward Kennedy, D-Mass
• Committee reported out own bill with only Democratic votes in July

• Sen. Max Baucus, D-MT, Chairman, Finance Committee
  led effort to craft bill that passed 14 to 9 on Tues. Oct. 13 with Sen. Olympia Snowe (R-ME) only Republican voting yes
Key Players, Senate

- Majority Leader Harry Reid
- Amended unrelated House bill (#3290) with Senate bill health reform provisions
- Prepared “manager’s amendment” with provisions pre-negotiated with Senate Democrats
- Senate bill passed with 60 votes (58 Democrats, 2 Independents) on December 24, 2009
Key Players, House

- Three committees produced different versions/components of one bill
- Rep. Charles Rangel (D-NY), plus Pete Stark (D-California) chairs Ways and Means Health Committee and health subcommittee
- Rep. George Miller (D-CA); chairs Education & Labor
Other Key Players, House

- Blue Dog Health Care Task Force

- Chaired by Rep. Mike Ross of Arkansas (right), member of the House Energy and Commerce

- Blue Dog caucus has approximately 45 Democratic members

- Total centrist group = 100
Key Players, House

- Blended House bill, Affordable Health Care for America Act (HR 3962), passed on 11/7/09

- 220-215 vote

- 1 Republican, Anh “Joseph” Cao of Louisiana (right) voted yes

- 39 Democrats, 176 Republicans voted no
GOP Alternative in House

- Republican Minority introduced its substitute for health reform bill in October
- CBO said could not do full cost estimate; sponsors said bill would cost $700 billion over 10 years
- Focus on tax breaks for individuals and families up to 3 times federal poverty level (= about $65,000 for family of four); $2,000 for individual, $5,000 for a family
- Also tax breaks for and small businesses to purchase/offer coverage

House Minority Leader
John Boehner, R-OH
GOP Alternative in House

- Grants to states to form high-risk pools for “uninsurables”
- Association Health Plans
- No individual or employer mandates
- Paid for via 1% across-the-board reduction in non-defense spending; efforts to combat waste, fraud and abuse; claimed savings from fewer malpractice lawsuits

House Minority Leader
John Boehner, R-OH
Prospects for Action
As It Appeared Three Weeks Ago

- No formal conference committee was appointed but key committee leaders were negotiating path forward

- Goal: Passage by both Houses and signed into law by Valentine’s Day
Prospects for Action at Present

- Complete and total uncertainty

- Election of Scott Brown to open Mass. Senate seat cost Democrats the ability to cut off filibuster – the current instrument of Senate control

- Brown had said he would not vote for Senate bill

- House Speaker Pelosi said in January that she did not have the Democratic votes in House to pass the Senate bill

- Still the leading option
Key Provisions of Bills
• N=approximately 36 million U.S. citizens
• Blue, green, orange slices = approximately 30 million
• Income levels shown = cutoff points for families of four at percentages of federal poverty level: 100%, 100-200%, 200-400% and 400% and above
Covering the Uninsured:
Those In or Near Poverty

- Medicaid expansion, primarily aimed to covering more poor and low-income parents and adults without dependent children.

- House: Expansion of eligibility up to 150% of federal poverty level ($33,100 for family of four in 2009)

- House: States receive full federal funding for costs of expansion populations in 2013 and 2014 (does not apply to previous eligible who may sign up because of individual mandate)

- From 2015 on, states pay 9 percent and the federal government pays 91 percent.

- House bill ended CHIP and moved CHIP-eligibles to the exchange or Medicaid in 2014.
Medicaid and CHIP: Senate provisions

- Medicaid eligibility expansion of up to 133% of federal poverty level

To finance coverage for the newly eligible states will receive 100% federal funding for 2014 through 2016.

Beginning in 2017, financing for the newly eligible will be shared between the states and the federal government.

Total from newly eligible and increased enrollment among currently eligible: projected at 15 million.

States to maintain Children’s Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. Benefit and cost-sharing rules to continue as under current law.

Beginning in 2015, states to receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%.
Medicaid: Special Provisions for Some States

- Louisiana

- Nebraska -- to continue receiving 100% federal funding for newly eligibles after 2017

- CBO said this deal extended to all states would cost $35 billion from 2010-2019

- Massachusetts

- Vermont

Nebraska Democratic Sen. Ben Nelson
## Covering the Uninsured: Insurance Exchanges

<table>
<thead>
<tr>
<th>House bill</th>
<th>Senate bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>One national exchange; states may also set them up</td>
<td>State-run “American Health Benefits Exchanges” and “Small Business Health Options Program Exchanges”</td>
</tr>
</tbody>
</table>
Standardized benefits packages

- Broad categories of covered services

- New Health Benefits Advisory Commission, with physicians and other expert members, helps define “essential benefit package.”

- Four tiers of plans with actuarial value from 70 percent to 95 percent (“basic,” “standard,” “premium,” and “premium plus”).

- Top tier offer additional benefits such as adult dental or vision, gym memberships, or private hospital rooms.

- Out of pocket expenses on all plans limited to $5,000 per individual and $10,000 for a family (lower levels for low- and middle-income families).
Covering the Uninsured: House Bill
The Low to Moderate Income

- “Affordability credits” for population between 133 percent of poverty ($29,327 for a family of four) to 400 percent of poverty ($88,200 for a family of four).

- Would enable purchase of coverage through new insurance “exchanges” that eventually would be opened to all employers.

- Credits are offered on a sliding scale, declining as incomes increase.

- In effect, lowest-income people have to pay 1.5 percent of incomes toward premiums; people at 400 percent of the federal poverty level pay 12 percent of income toward premiums.

- Cost-sharing limited to 3 percent of plan costs at the lowest tier rising to 30 percent of plan costs at 350-400 percent of federal poverty level.
### Effect of Affordability Credits and other provisions, House bill

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Premium Limit as % of Income</th>
<th>Total Share of Plan Costs Paid by Families</th>
<th>Annual Out-of-Pocket Cap (Individual/Family)</th>
</tr>
</thead>
<tbody>
<tr>
<td>133-150% FPL</td>
<td>1.5-3%</td>
<td>3%</td>
<td>$500-$1,000</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>3-5.5%</td>
<td>7%</td>
<td>$1,000-$2,000</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>5.5-8%</td>
<td>15%</td>
<td>$2,000-$4,000</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>8-10%</td>
<td>22%</td>
<td>$4,000-$8,000</td>
</tr>
<tr>
<td>300-350% FPL</td>
<td>10-11%</td>
<td>28%</td>
<td>$4,500-$9,000</td>
</tr>
<tr>
<td>350-400% FPL</td>
<td>11-12%</td>
<td>30%</td>
<td>$5,000-$10,000</td>
</tr>
</tbody>
</table>
Available to families with incomes between 100-400% FPL to purchase insurance through the Exchanges

Premium credits will be tied to the second lowest-cost silver plan in the area

Set on a sliding scale; premium contributions thus limited to 2.8% of income for those at 100% FPL to 9.8% of income for those between 300-400% FPL

Premium credits and cost-sharing subsidies through the Exchanges available only to U.S. citizens and legal immigrants who meet income limits.

Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.8% of income.
Small business tax credits

House bill: For businesses with 25 or fewer employees and $40,000 or less in average wages; up to 50% credit of employer’s contribution toward employees’ coverage for 2 years.

Senate bill: For businesses with no more than 25 employees and average annual wages of less than $50,000; up to 35% credit for employer’s contribution toward employees’ coverage.
Insurance Market Reforms

- All bills: new federal requirements on health insurance in individual and small-group market; applies to coverage sold through and outside exchanges
- Eliminate medical underwriting and preexisting condition restrictions
- Guaranteed issue & renew ability
- No annual or lifetime limits on all plans in all markets; cost-sharing eliminated for preventive services (except value-based insurance design arrangements)
- Modified community rating; premiums could vary only according to certain terms, e.g., tobacco use, age, family composition, geographic differences (age rating of 2:1 in House, 3:1 in Senate)
- House bill: young adults could remain on parents’ plans to age 27
<table>
<thead>
<tr>
<th>House bill</th>
<th>Senate bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, one national public plan</td>
<td>Two privately-run national plans negotiated by OPM; one would have to be</td>
</tr>
<tr>
<td></td>
<td>nonprofit; health insurance cooperatives</td>
</tr>
</tbody>
</table>
House Version, Public Plan

- “Actuarially sound;” self-sustaining; no government subsidies except to get started

- “Level playing field” with private plans; subject to same market reforms & reserve requirements

- Would keep private plans “honest”; in 36 states, the top two insurance companies dominate two-thirds of the market.

- Rates paid to providers to be negotiated
Eligibility for enrollment

Those who lack a “qualified” health plan (mainly uninsured); those not enrolled in employment based insurance, Medicare or Medicaid

Veterans, military (no subsidies) and their spouses/dependents

Small businesses with twenty-five or fewer employees permitted to buy in 2013; with fifty or fewer employees in 2014; with 100 or more in 2015

Any employer at the discretion of the new “Health Choices Commissioner” as of 2015 on

Workers whose premiums for employment-based coverage exceeded 12 percent of income; they could choose subsidized coverage through exchange and employer makes a contribution

Congressional Budget Office estimates total enrollment will be 6 million in 2019
# Employer mandates

<table>
<thead>
<tr>
<th>Component</th>
<th>House</th>
<th>Senate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer mandate</td>
<td>Yes; employers with payrolls of $500,000 and over contribute 72.5% of costs of coverage for worker or 65% of family or pay 8% of average payroll</td>
<td>A “free rider” provision so that employers with more than 50 employees working full time that don’t offer coverage must pay $750 fee per worker, if any one worker who gets tax credit for health insurance through exchange. Also: Employers with more than 200 employees required to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.</td>
</tr>
<tr>
<td>Component</td>
<td>House</td>
<td>Senate</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Individual Mandate</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Penalties if don’t have coverage</td>
<td>Yes; equal to 2.5 percent of adjusted gross income, not to exceed cost</td>
<td>Yes; phased in; equal to the greater of $750 per year up to a maxi-mum</td>
</tr>
<tr>
<td>and not exempted for other reasons--e.g., affordability</td>
<td>of average national premium for individual or family basic coverage on the exchange</td>
<td>of three times that amount ($2,250) per family or 2% of household income</td>
</tr>
</tbody>
</table>
Coverage levels achieved

- House bill: CBO estimates 96% of legal residents under 65 would be covered in 2019
- Approximately 18 million people would be uninsured
- Senate bill would cover 94% of legal residents in 2019
- Would leave about 25 million uninsured, the CBO estimated.
Long-Term Care Provision

- Community Living Assistance Services and Supports (CLASS) Act provisions in House and Senate HELP bills

- Workers make voluntary contributions for premiums under opt-out arrangement; CBO estimates premiums in Senate version of $146/month

- After five years, eligible for lifetime cash benefit of not less than $50/day to purchase long-term services and supports

- Provision integral to financing of overall reform package

- Program accumulates surplus in initial years; accounts for approximately $70 billion of $130 billion in deficit reduction over 10 years in Senate bill

- One year stay in a nursing home currently averaging $75,000 = $200-plus per day

- Home health care running as high as $46 per hour (Genworth, 2009 Cost of Care Survey)
Assistance to retirees/early retirees, House bill

- $10 billion temporary reinsurance program for employers that provide health benefits for retirees age 55-64.

- Prohibition on employers from reducing retirees’ health benefits post retirement unless active employees’ benefits also reduced.
Delivery system reforms

To large degree, health care reform in US = delivery system reform

“Bending the curve” – what opportunities exist for achieving greater value in care, lowering costs/prices

Chronic disease treatment = estimated 75% of US health expenditures

Ergo, delivery system reform = chronic disease care reform; emphasis on prevention, coordination, elimination of unnecessary care (e.g. hospital readmissions)

Payment reforms to stimulate
Delivery System Reforms—House Bill

- Broad authority handed to Secretary of HHS for new demonstration projects in Medicare to test concepts such as, medical home, value-based purchasing, accountable care organizations, bundled payment

- Medical home models to be tested include an “independent patient-centered medical home model” and a “community-based medical home model” built around community health centers.

- Secretary of HHS to figure out how to pay medical homes on a prospective basis – e.g., global payment

- Tie-in to accountable care organizations: performance-based payment designed in part to meet population health goals
Accountable Care Organizations Proposal by Elliott Fisher, MD, Dartmouth and Mark McClellan, MD, PhD, Brookings Institution

- Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system

  - Sufficient size to support comprehensive performance measurement, shared EHRs, patient decision-support, care coordination

  - Capable of prospectively planning budgets and resource needs

  - Could chart budget growth (patient per capita costs) in given hospital referral region of 1 percent annually; if providers achieve, they share in dedicated pool of savings
Payment-Driven Delivery System Reforms, Senate Bill

- Pilot projects on medical home, accountable care organizations, bundled payments
- $10 billion for new Centers for Medicare and Medicaid Innovation Center
- Hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures
- Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
Workforce Issues, House Bill

- Increases to the National Health Service Corp;
- More training of primary care doctors
- Expansion of the pipeline going into health professions, including primary care, nursing and public health;
- Greater support for workforce diversity
- Expansion of scholarships and loans in needed professions and shortage areas
Manufacturers/distributors must electronically report to the HHS Office of the Inspector General any payments or other transfers of value above a $5 de minimus made to a “covered recipient”

Includes physician, physician group practice, other prescribers, pharmacy or pharmacist, health insurance issuer, group health plan, pharmacy benefit manager, hospital, medical school, sponsor of a continuing medical education program, patient advocacy or disease specific group, organization of health care professionals, biomedical researcher, group purchasing organization.

Requires hospitals, manufacturers and group purchasing organizations to report the nature of ownership arrangements by physicians.

Failure to report is subject to civil monetary penalties
Comparative Effectiveness Research

- House bill: New CER department to be created within Agency for Healthcare Research and Quality

- Supported by a combination of public and private funding that will conduct, support and synthesize CER

- Independent stakeholder Commission makes recommendations to the Center on research priorities, study methods, ways to disseminate research.

- Majority of the Commission members required to be physicians, other health care practitioners, consumers or patients.

- Center and Commission prevented from mandating payment, coverage or reimbursement policies. Research findings not to be construed to mandate coverage, reimbursement or other policies to any public or private payer
Comparative Effectiveness Research, Senate Bill

- Non-profit Patient-Centered Outcomes Research Institute

- Overseen by an appointed multi-stakeholder Board of Governors and assisted by expert advisory panels.

Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage.
Prevention and Wellness: Senate bill

- Establish new federal council to coordinate federal prevention, wellness, and public health activities.
- Develop a national strategy to improve the nation’s health.
- Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs.
- Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.
- Permit employers to offer employees premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related goals.
Paying for Reform: Payment Changes
Medicare Payment Changes

- House bill: No Medicare Commission or Independent Medicare Assessment Commission

- Senate bill: 15 - member, independent Medicare Advisory Board

- To present Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries.

- But: hospital payment issues excluded; Commission also prohibited from making “any recommendation to ration health care,” raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.
Medicare & Medicaid changes

- Hospitals: Productivity adjustments and reductions in market basket updates per recommendations from MedPAC, OIG, GAO

- Skilled nursing facilities: follows MedPAC recommendations on tying payment to costs
Medicare & Medicaid changes: DSH

- Secretary of HHS to study Medicare DSH and report to Congress with recommendations on targeting DSH payments to reflect costs associated with low-income patients.

- Medicare DSH payments reduced starting in 2017 if the uninsured rate drops by a certain number of percentage points between 2012 and 2014.

- Secretary of HHS to reduce Medicaid DSH payments by $10 billion in 2017-2019; largest reductions on states with the lowest percentages of uninsured individuals or the least effective targeting of funds on DSH hospitals.
Medicare changes: Readmissions

House: Payment changes to post-acute care providers to discourage preventable hospital readmissions.

Senate: CMS to track readmissions, launch pilot project in 2012

Starting in 2012, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is rehospitalized with a preventable readmission within seven days.

Payment cut by 10 percent if a patient with a selected condition is rehospitalized with a preventable readmission within 15 days.
Medicare changes

- Hospitals and ambulatory surgical centers to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention.

- Graduate medical education incentives for the training of primary care physicians. Encouragement for medical residency training in non-hospital settings

- Expansion of productivity adjustments to hospital outpatient departments
Medicaid

- Medicaid Global Payment demonstration project
- States could pay a safety net hospital or network under a global capitated payment arrangement rather than fee-for-service
- Demo doesn’t have to be budget neutral
- With 25% of U.S. population possibly to be in Medicaid, great interest in making it a “world class program”
- Opportunities: Coupled with provisions for “community transformation” grants and “grants to eligible entities to promote positive behaviors and outcomes for populations in medically underserved communities through the use of community health workers.”
Institute of Medicine to report to CMS on the validity of geographic adjusters in Medicare physician and hospital payments and recommend improvements.

CMS may spend up to $4 billion per year, for two years, to increase payment rates as appropriate.
Payment related studies: Geographic variation

- Institute of Medicine to study the extent and cause of geographic variation in spending on health care (including all payers).
- To focus on major contributors to variation such as input prices, health status, socioeconomic factors, and access to services.
- IOM will make recommendations for addressing variation in Medicare; CMS to implement changes unless Congress votes to disapprove.
Home Health Study

- MedPAC to undertake study to examine variation in Medicare margins among home health agencies.

- Factors considered will include patient characteristics (including health and socioeconomic factors), agency characteristics, types of services provided.
Medicare Advantage Changes

- House: Beginning in 2011, reduces MA payments over three years to achieve parity with 100 percent FFS rates; Senate: competitive bidding

- Bonuses to high-quality plans in high-enrollment areas where reductions likely to be most disruptive.

- Beginning in 2014, requires MA plans to maintain medical loss ratios of at least 85 percent

- Limits Medicare Advantage cost sharing to no greater than cost-sharing in traditional Medicare.
“Bending the Curve”

Take-Aways

- Not going to be accomplished on platform of existing system
- Will come about only through major combined delivery system and payment reforms – e.g., ACOs, global payment
- Watch Massachusetts
Emerging Legislative Proposals: Costs

- House bill: Gross costs scored by CBO at $1.02 trillion over 10 years (to 2019); net costs result in $109 billion reduction in federal deficits over period ($30 billion after CLASS act provisions)

- Provision of House bill that would prevent Medicare physician payment cut now split off as separate bill; would add approximately $240 billion to deficit over 10 year period

- Senate bill: Scored by CBO at $848 billion over 10 years; fully offset by savings & revenues; $130 billion net pay-down in deficits

- By comparison: total national health expenditures 2009-2014 estimated at $33 trillion (CMS)
Paying for Reform: Quest for Revenues

Former Louisiana Democratic Sen. Russell Long

Chairman, Sen. Finance Committee

“Don’t tax him, don’t tax me, tax that fellow behind the tree.”
Financing, House Bill

- Surcharge on taxpayers with adjusted gross income in excess of $1 million (married filing jointly) and $500,000 (single) at a rate of 5.4 percent.

- “Cats and dogs” aspects include eliminating nontaxable reimbursements of over the counter medications from HSAs, HRAs, and health FSAs; limiting contributions to health FSAs to $2,500

- Excise tax of 2.5 percent on medical devices
Financing Smorgasbord: Bones of contention

- Senate bill’s proposed industry fees: insurers, pharmaceutical companies, device manufacturers

- Limit on deductibility of executive and employee compensation to $500,000 per individual for health insurance providers

- Tax of 10% on the amount paid for indoor tanning services

- Senate: Passed excise tax of 40 percent in 2013 on plans valued at more than $8,000 for individual coverage and $21,000 with family coverage; Obama and unions negotiated higher family threshold to $24,000, exempted costs of dental and vision plans, postponed application of tax to healthcare plans negotiated under union contracts.

- Congress’s Joint Committee on Taxation estimated tax would soon hit 4 out of 10 health insurance plans, particularly for those older/sicker or working for small business

- Senate resisted House surtax on millionaires; it increased Medicare portion of payroll tax on high-income earners
Unresolved Issues
Abortion, House plan


- Insurance plans receiving federal subsidies cannot cover elective abortion services.

- Public plan would not be able to cover the procedure at all, except in cases of rape or incest or when continuing the pregnancy threatens woman’s life.

- Effectively means women buying coverage through exchanges could not obtain abortion coverage
Abortion: Senate Bill Provisions

- No insurer required to cover elective abortions.

- New state-based exchanges would have to offer at least one plan covering elective abortion and one that doesn’t.

- Plans that cover abortion would have to segregate premium revenues to ensure that federal subsidies aren’t used to pay for abortions; would effectively require such plans to charge their customers an extra abortion premium.

- “Conscience clause” prohibiting health insurers from discriminating against either abortion providers or health care providers who refuse to perform the procedure.
Immigrants

- No provisions in any bill to cover or pay for care for undocumented

- No eligibility of undocumented in any bill to receive subsidies, enroll in Medicaid

- House bill: undocumented immigrants could purchase coverage at full cost through exchange, including public plan

- Senate bill: Undocumented immigrants barred from buying coverage through exchanges
What’s Ahead?

A nod to the immortal Yogi Berra:

“Prediction is very hard, especially about the future.”
Can and will health reform be enacted into law this year?
Possible scenarios

- House takes up Senate bill, passes it

- New package assembled to “fix” problems that House leaders have with Senate bill – “sidecar”

- Fix (sidecar) is structured as “reconciliation” bill so can pass the Senate with 51 votes

- Pelosi said in Jan. she didn’t have the votes for this approach; nonetheless negotiations are continuing

- 50 percent odds?
Possible scenarios

- Bipartisan negotiations begin over scaled down package with commonly agreed upon elements

- Whether there are any “commonly agreed upon elements” other than in abstract is unclear

- Vastly smaller package passes both houses of Congress; signed into law as November elections approach

- 5-10 percent odds?
Possible scenarios

- No final health reform bill signed into law this year
- Democrats, in particular, move on to focus on jobs and economy
- “Failure to enact health reform” or “success in derailing reform” (depending on perspective) becomes 2010 election issue
- 35-40 percent odds?
Polls

- Washington Post, Harvard School of Public Health and Henry J. Kaiser Family Foundation poll of Massachusetts voters, January 20

- 48 percent opposed national health reform legislation; 43 percent supported

- 68 percent backed Massachusetts’ own system of near-universal coverage

- Nationally, voters from different parties sharply split on support vs. opposition to reform

- Greatest support is for tax credits to small businesses
Outlook: Elections 2010

- Political analyst Stuart Rothenberg

- Out of 435 seats in House, 58 Democratic seats now in play, up from 47 in December

- Republican seats in play = 14

- 256-178 margin currently, ergo Democrats likely to retain control

- In Senate: 57 Democrats, 2 Independents, 41 Republicans

- 7 Democratic seats in play

- 4 Republican seats in play
The future of U.S. health reform: Competing views
“The Americans always do the right thing...after they’ve exhausted all the other alternatives.”

Sir Winston Churchill
“I don’t believe there’s any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can’t completely ignore.”

Comedian George Carlin
View #4:

“If the world were rational, men would ride side-saddle.”

Author Rita Mae Brown
“….Better brace yourselves for a whole lotta ugly comin’ at you, from a never ending parade of stupid!”

Queen Latifah (a/k/a Motormouth Maybelle, Hostess of “Negro Day,” in *Hairspray*)
“Harry and Louise”: 1993

Louise: “Having choices we don’t like is no choice at all.”

Harry: “If they choose..

Louise: “we lose.”
Harry and Louise Today:
Sen. Barbara Mikulski, D-MD*

“Harry needs a knee replacement. His wife has diabetes. They both have lost their jobs and they’re too young for Medicare.

“They have grandchildren who have autism and food allergies and they’re wondering, ‘What the hell did we fight health care [reform] for?”

*At White House Summit on Health Reform, March 5, 2009
“We’re not at a Harry and Louise moment. We’re at a “Thelma and Louise” moment, and we’re about to drive off the cliff.”

*At White House Summit on Health Reform, March 5, 2009*
Harry and Louise Now*

**Harry’s diagnosis:**
“Too many people are falling Through the cracks.”

**Louise’s prescription:**
“Bring everyone to the table and make it happen.”

**”Harry and Louise Return” video, Aug. 2008**
“When history calls, history calls.”

--Maine Republican Senator Olympia Snowe, explaining why she was only GOP senator who voted for Senate Finance Committee bill on October 13, 2009
The Verdict on National Health Reform?

“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”

--the late Jerry Garcia of the Grateful Dead
The End