

Federal Health Care Reform

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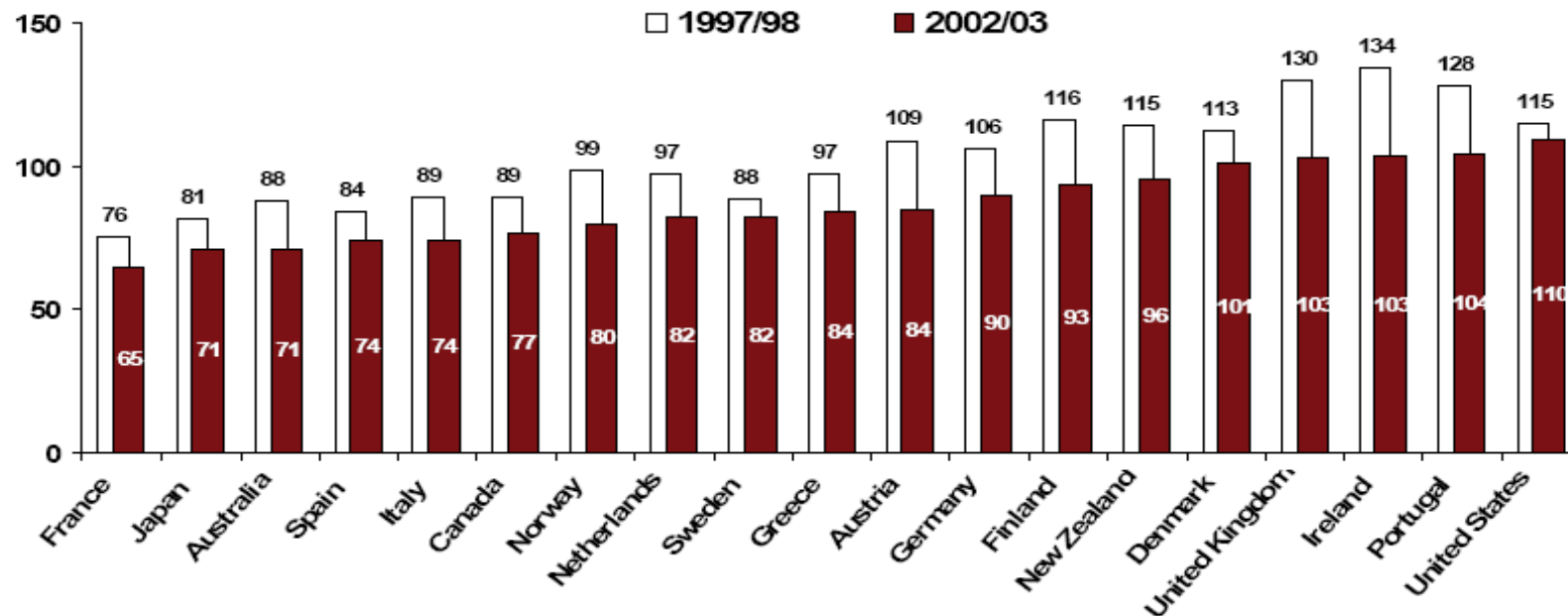
- The financing system is
 - Inefficient
 - Inequitable
 - And fiscally unsustainable
- The delivery system is
 - Fragmented
 - Not designed to care for chronic diseases
 - Haphazard and poor quality
 - High use of unproven and marginal therapies
- The Politics and the Policy

The Facts

- 47 million uninsured
 - Moral imperative of extending coverage
 - Added cost to system in form of higher taxes and premiums
- Quality of care in U.S. behind other developed nations, yet U.S. spends 50% more per person on health care than the average developed country
- Perverse incentives based on fee-for-service reimbursement
- High costs make U.S. business less competitive globally
- Insurance market must be reformed

Mortality Amenable to Health Care

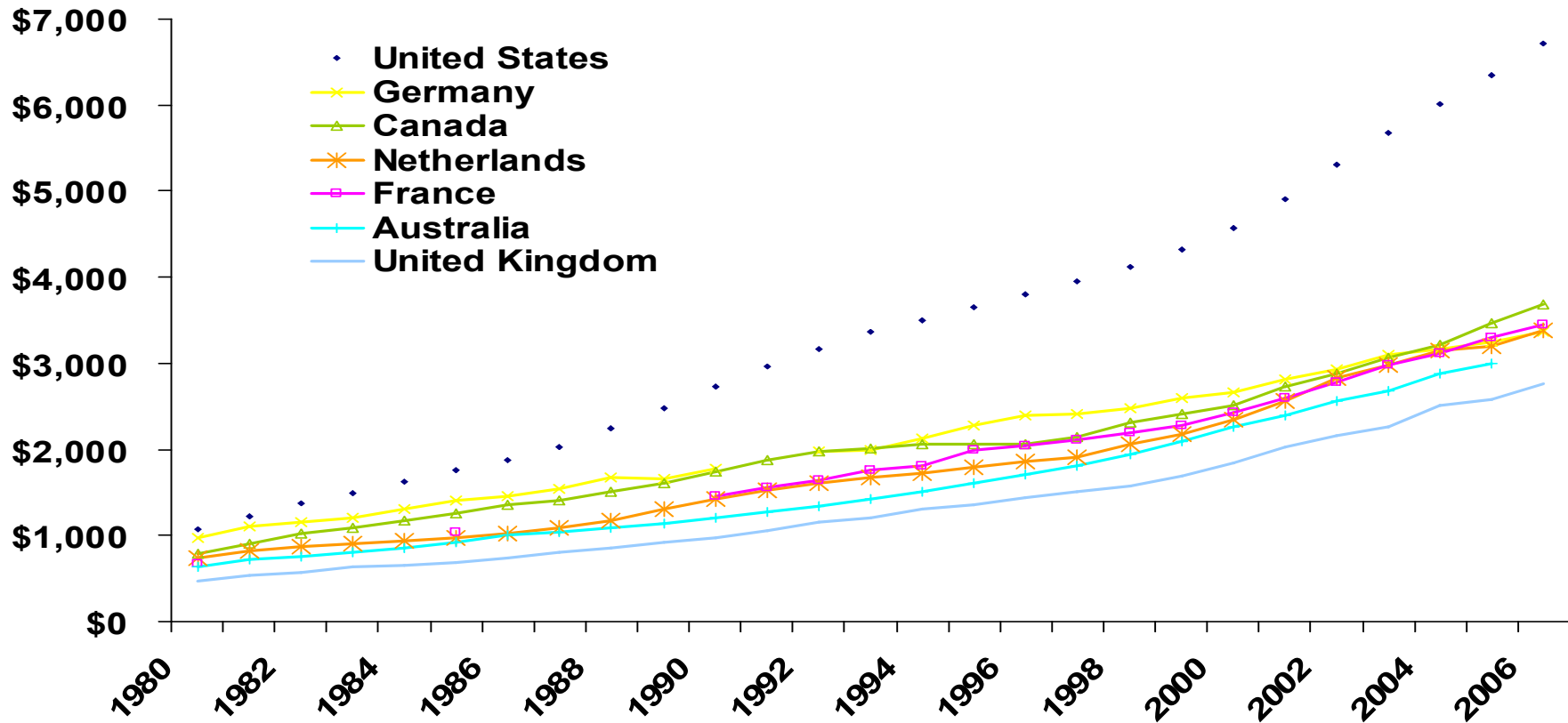
Deaths per 100,000 population*



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. See report Appendix B for list of all conditions considered amenable to health care in the analysis. Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee 2008).

International Comparison: Universal Coverage at Less Cost

Average spending on health per capita (\$US PPP*)



* PPP = Purchasing Power Parity.

Data: OECD Health Data 2008, June 2008 version.

None rely on private for-profit insurance,
all have a strong role for government.

Problems with Coverage

- 75% of the uninsured are in households where there is one full-time working adult
- 9 million uninsured children
- In 2006, the U.S. spent \$2,100,000,000,000 (\$2.1 trillion) on health care
- \$1 out of every \$6 spent in the U.S.

Problems with Cost

- More than 850 insurance companies adds greatly to administrative costs
- Administrative costs typically 11% of premium, and this does not include the costs to employers to purchase and manage health care spending
- Consider that Kaiser Permanente signs only one annual contract for the coverage of more than 400,000 employees and dependents with CalPERs
- Administrative costs are on the order of 0.5% of premium

Enthoven and Fuchs

Health Affairs 2006

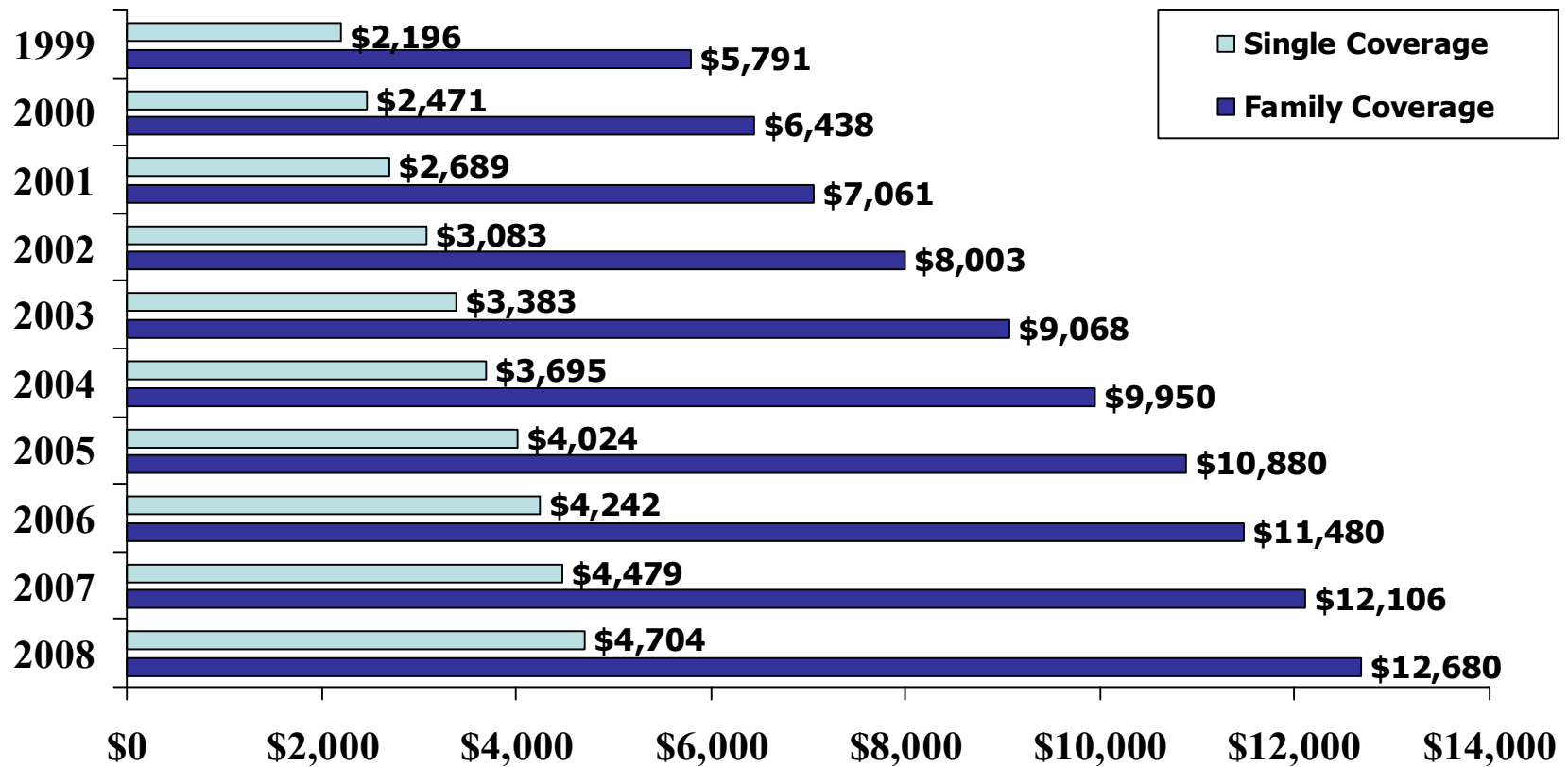
Problems with Cost

- Average cost of employment-based health insurance – over \$12,000 for family coverage
- This is over \$6 per hour for 2,000 hours

Health care insurance = 1 minimum wage worker

Escalating Cost

Average Annual Premiums for Single and Family Coverage, 1999-2008

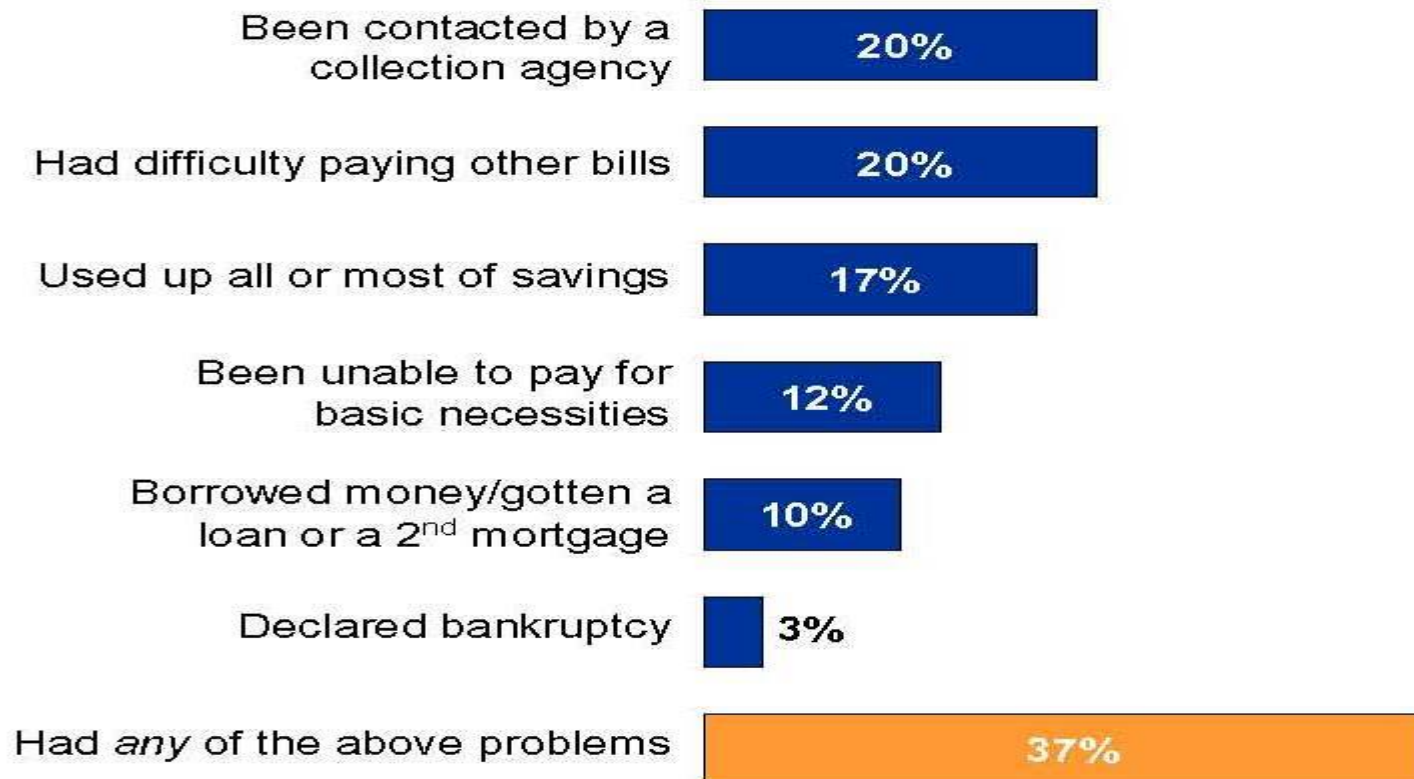


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.

Medical costs create serious financial problems for millions

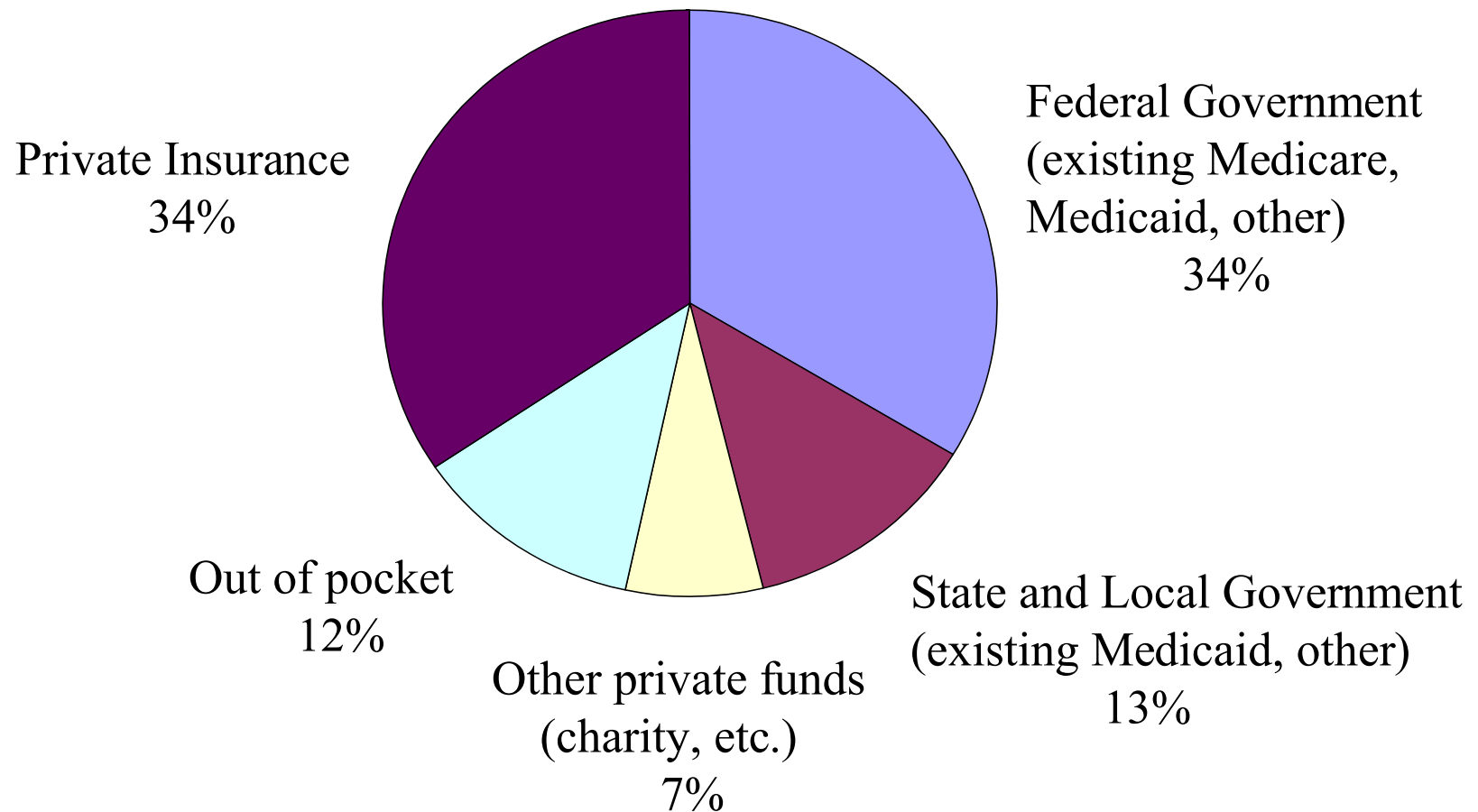
Financial Consequences of Medical Bills

Percent who say they have experienced each of the following in the past 5 years because of medical bills...



Source: Health Tracking Poll, Kaiser Family Foundation, April 2008

How We Pay for Health Care Today

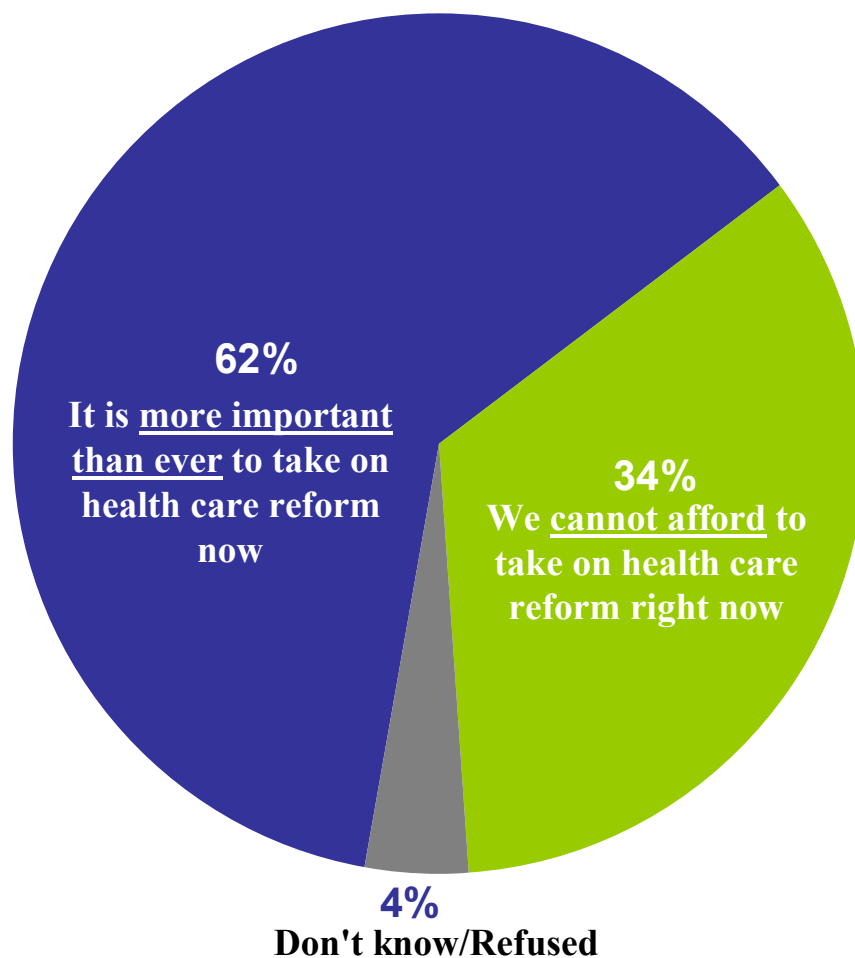


Source: *Health Affairs*, Feb. 2008; data for 2006

The Public Opinion Landscape and the Prospects for Health Care Reform

Challenges...

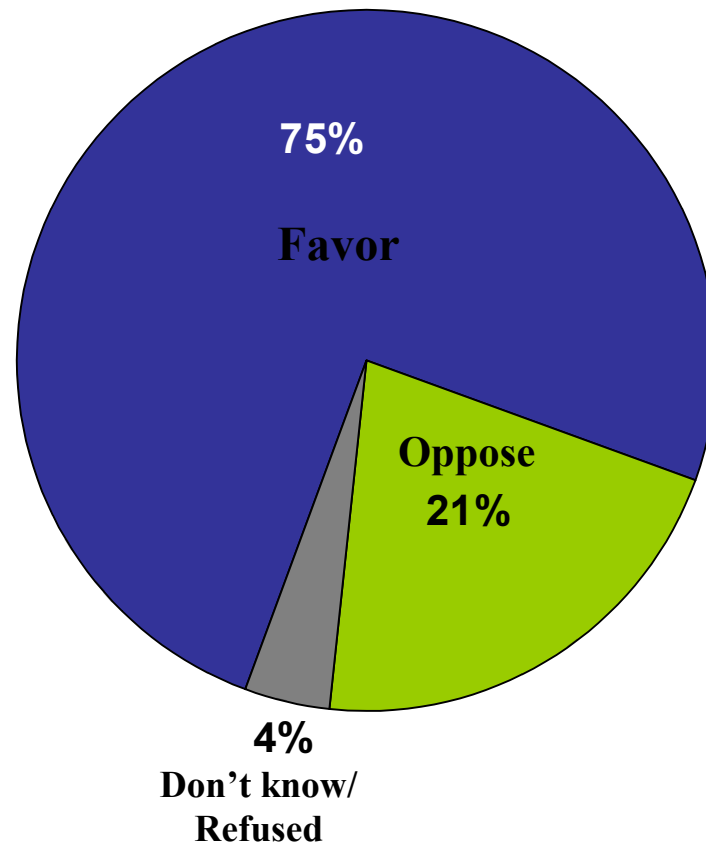
Health Care Reform in Economic Hard Times



Source: Kaiser Health Tracking Poll (conducted Feb. 3-12, 2009)

Agreement on Goals...

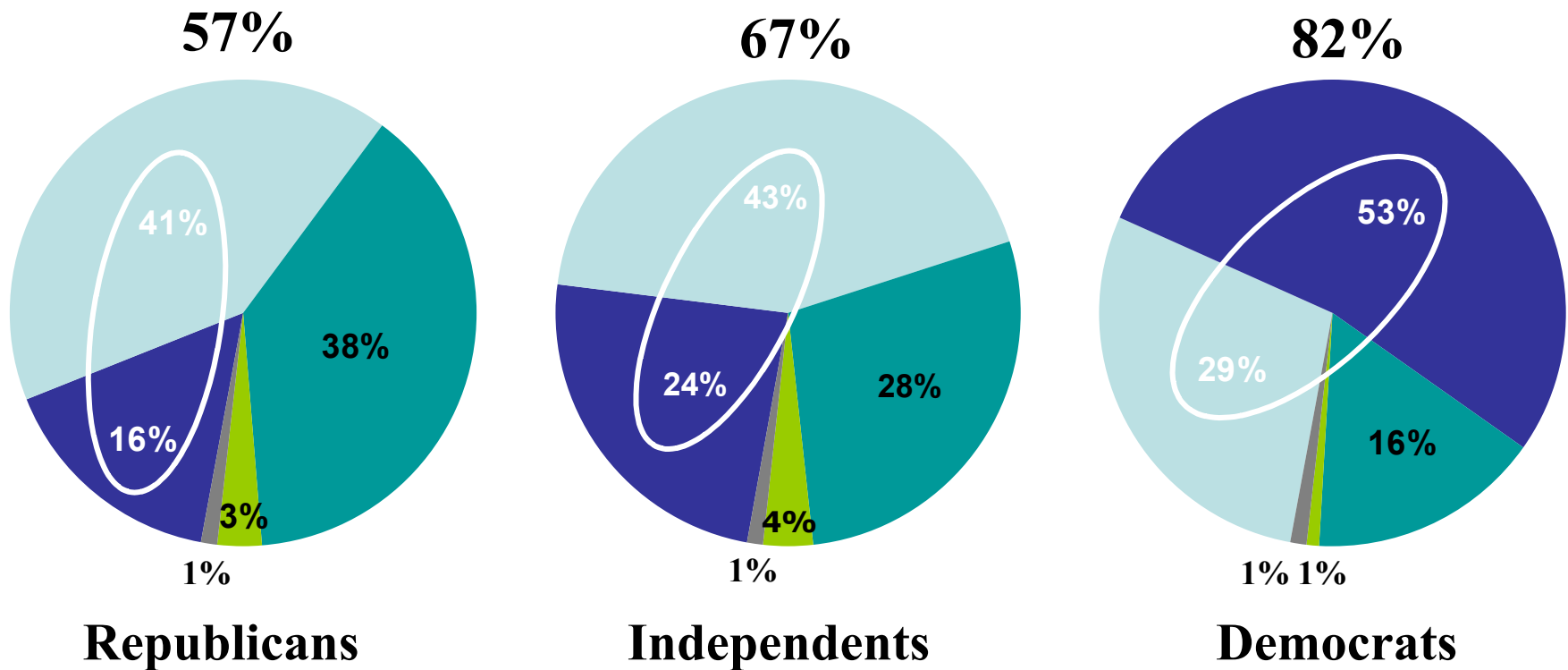
Those who favor or oppose the federal government doing more to help provide health insurance for more Americans?



Opportunities...

Agree: Major Changes Needed

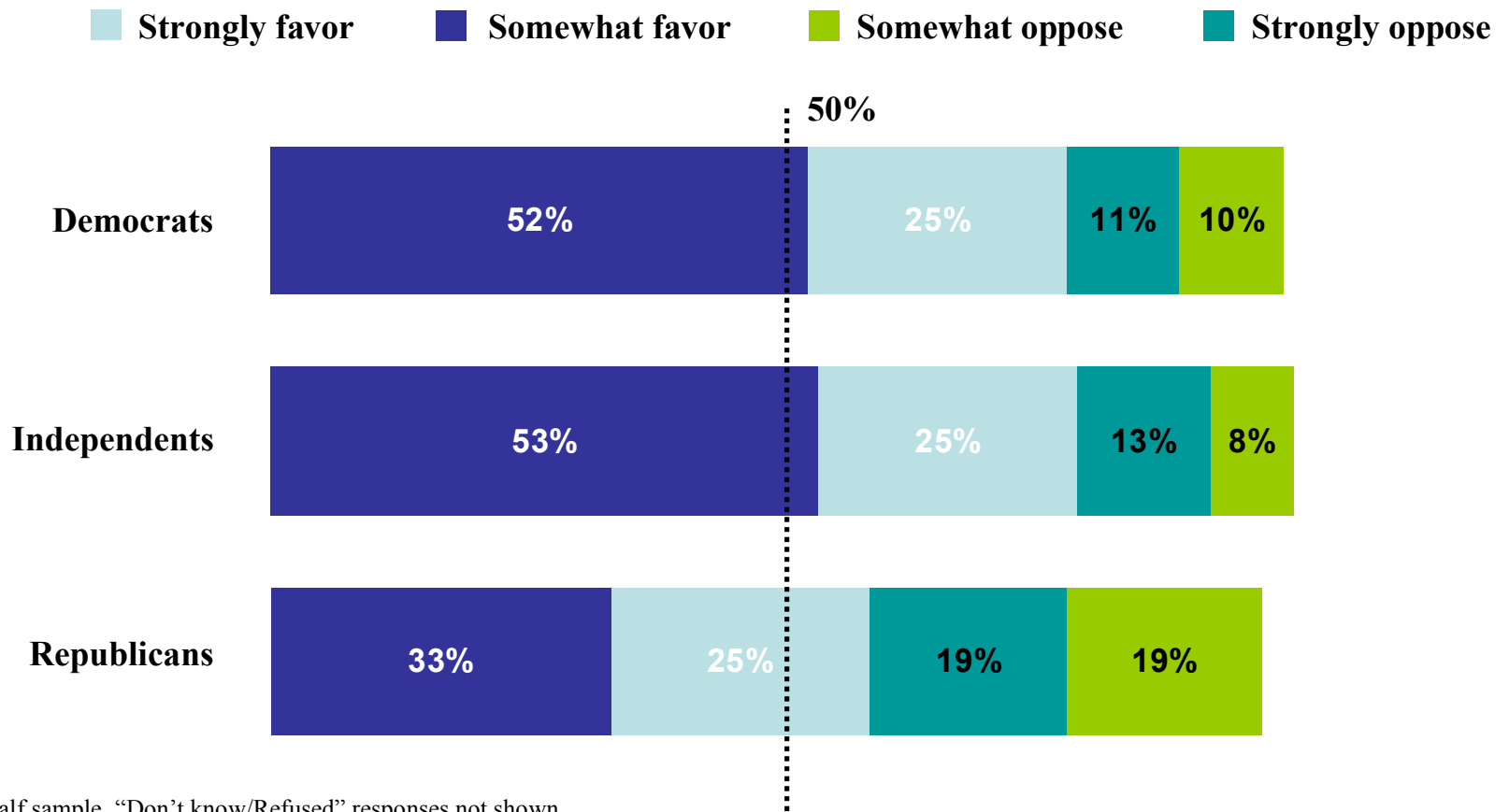
■ Needs complete overhaul ■ Needs major changes ■ Needs minor changes ■ Works fine as is ■ Don't know/Refused



Source: Kaiser Family Foundation/Harvard School of Public Health, *Pre-Election Poll: Voters, Health Care and the 2008 Election* (conducted Sept 10-21, 2008).

Pre-Existing Conditions: By Party

Favor or oppose requiring health insurance companies to cover anyone who applies, even if they have a prior illness:



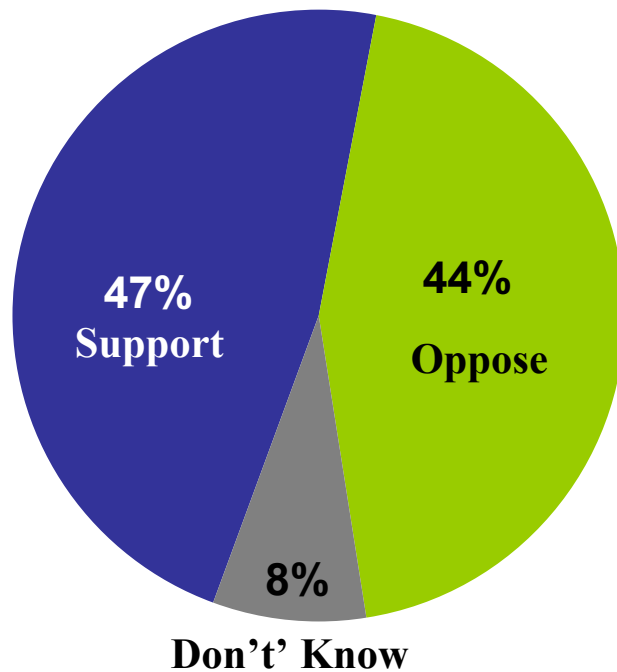
Note: Asked of half sample. "Don't know/Refused" responses not shown.

Source: KFF/HSPH *The Public's Health Care Agenda for the New President and Congress* (conducted Dec. 4-14, 2008)

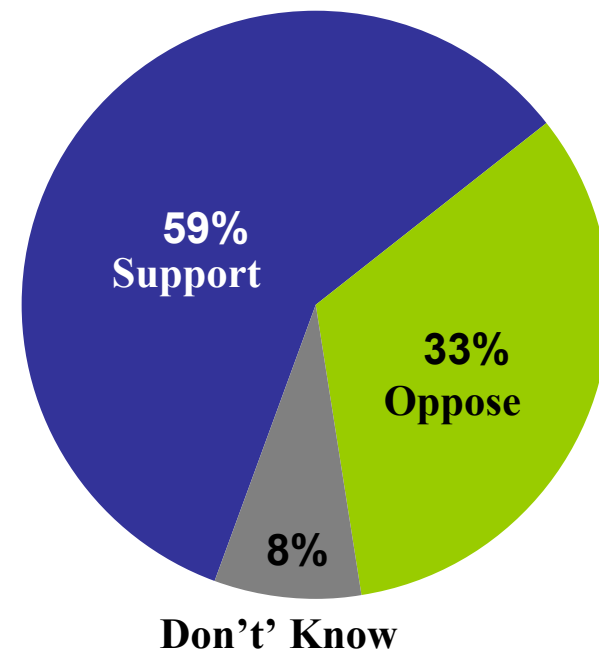
Opportunity to Combine Approaches

Example: Health insurance mandates

Requiring individuals to purchase insurance



Requiring individuals to purchase insurance; role for employers, the government and insurance companies



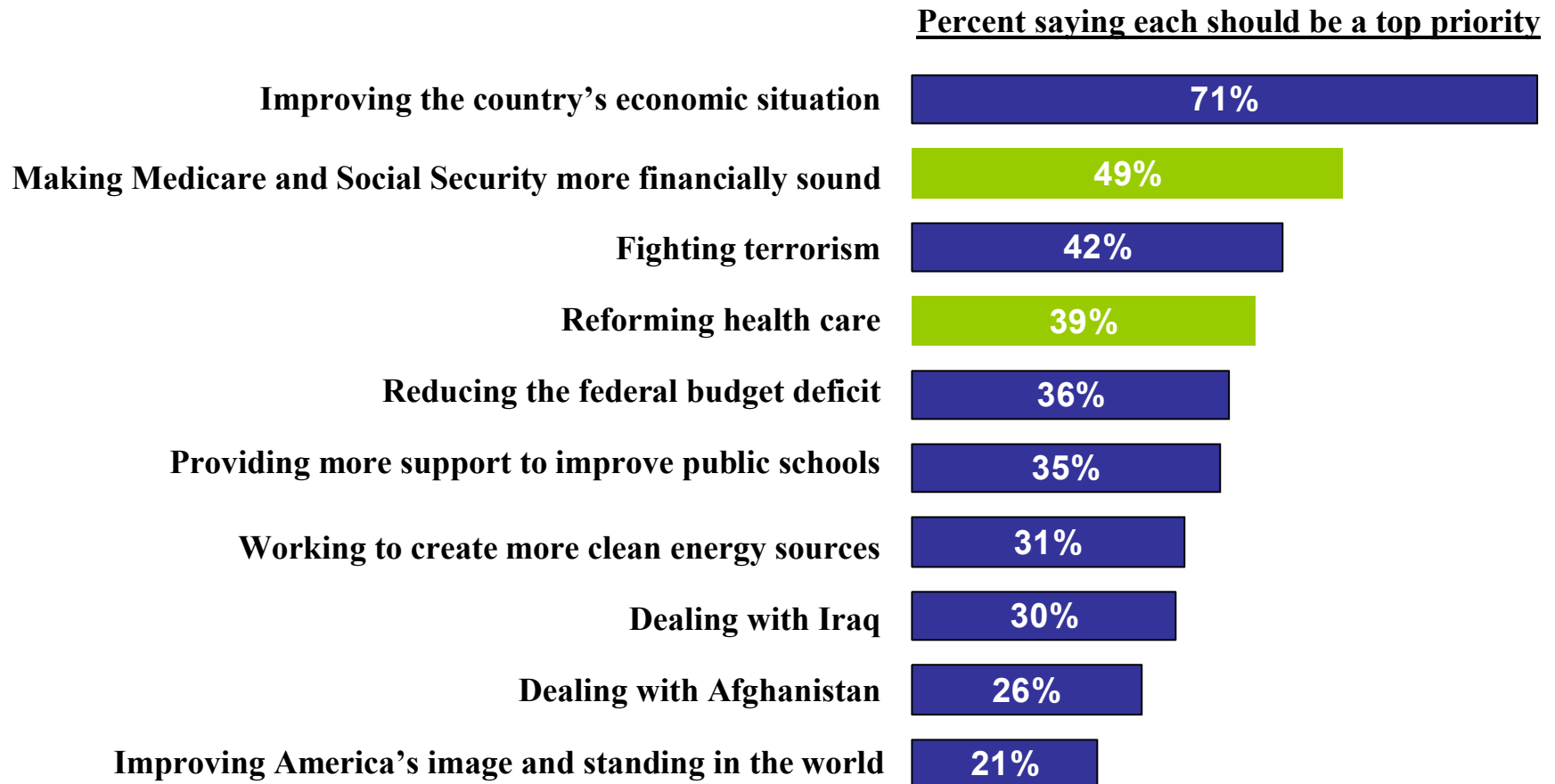
Note: Not exact wording of options

Source: NPR/KFF/HSPH *The Public on Requiring Individuals to Have Health Insurance* (Feb. 14-24, 2008)

Summary

- Challenges *and* opportunities to mobilize public interest in health reform
- Linking solutions to individual concerns, particularly affordability is key

Priorities for the President and Congress



Note: Various items based on half samples

Source: Kaiser Health Tracking Poll (conducted Feb. 3-12, 2009)

The President's Principles for Health Care Reform

- Protect Families' Financial Health...reduce growing premiums and other costs...protect from bankruptcy due to catastrophic illness.
- Make Health Coverage Affordable... reduce high administrative costs, waste, inefficiencies.
- Aim for Universality... put the United States on a clear path to cover all Americans.
- Provide Portability of Coverage... not locked into their job just to secure health coverage.
- Guarantee Choice... provide a choice of health plans and physicians... have the option of keeping their employer-based health plan.

-- "A New Era of Responsibility," President's Budget, Feb. 26, 2009

The Mandate Model

- Everyone required to have insurance
- Employers must offer insurance or contribute
- Continued reliance on private insurance, with the option of a public plan
- “Keep what you have” → Doesn’t address underinsurance.
- No regulation of insurance company premiums, deductibles, co-pays, or payment and denial practices
- Increases the system cost by hundreds of billions of dollars
- No cost savings or realistic way to control costs, as long as there are many separate plans and payers

Why a Public Option?

- Provide stability, wide pooling of risks, transparency, affordability, broad provider access, source of data
- Competitive benchmark to force private plans to reduce prices, improve coverage (“keep them honest”)
- Lead in restraining costs and improving quality
- Without it, there’s no reform, since there is no other change in the system

Source: Jacob Hacker, *Healthy Competition*, Berkeley Law and Institute for America’s Future, April 2009

Why Not a Public Option?

From supporters of private insurance –

- “Unfair competition” from government
- Would undermine private insurance, use inherent powers of government to limit competition, underpay doctors and hospitals
- Will eventually lead to “government-run” system

From single payer supporters –

- Private insurers will selectively market to the healthy (“adverse selection”)
- Retains private insurance
- Doesn’t get all the savings possible with single payer

What Will Control Costs under the Congressional Plan?

- Emphasis on prevention
- Computerization
- Chronic disease management
- Payment reforms (e.g., medical home, “bundling”)
- Comparative effectiveness research

- The Congressional Budget Office says these will (1) not cut costs significantly and (2) not limit the continuing rise in cost.

Covering the Uninsured and the Underinsured?

- \$1 Trillion/seven years = \$130 billion/yr
- Number of Uninsured Covered: 37 million
- Number of Uninsured Remaining: 17 million

[Source: Congressional Budget Office, Letter to Rep. Charles Rangel, July 17, 2009]

- Number of Underinsured: 50 million+
- Even a Trillion dollars is not enough
- Total cost of making health care affordable: \$200-300 billion/year

Key Players in Federal Reform Efforts

- President Obama
- HHS Secretary Sebelius, OMB Director Orszag
- U.S. Sens. – Baucus, Conrad, Bingaman, Grassley, Enzi, Snowe
- U.S. Reps. – Miller, Rangel, Waxman
- American Hospital Association, CHA, Federation
- American Medical Association
- America's Health Insurance Plans
- Service Employees International Union
- Pharmaceutical Research and Manufacturers of America

The Numbers Game

- Total Number in House = 435 members
- Simple Majority of House = 218 votes

-
- Democrats in House = 256
 - Blue Dogs Democrats = 51 votes
 - Democratic Progressive Caucus = 57 votes
 - Republicans = 177 votes

The Numbers Game

- Total Number in Senate = 100 members
- Magic Number = 60 votes

-
- Democrats = 58
 - Republicans = 40
 - Independents = 2

*Will come down to Senate moderates – they don't even know where they stand,

Senate Finance Committee

- Passed “framework” last week:
 - institutes a network of nonprofit health care cooperatives to compete with private plans
 - creates insurance market reforms
 - requires individuals to have coverage
 - implements a fee for employers with more than 50 FTEs who do not offer health coverage and whose employees receive federal subsidies through an exchange

Senate Finance Framework (cont.)

- seeks to reduce Medicare and Medicaid spending through annual update reductions to providers
- calls for an independent Medicare Commission to make policy recommendations to Congress that would be implemented unless overridden
- replaces the scheduled 21 percent cut in Medicare physician payment rates in 2010 with a 0.5 percent increase
- implements a value-based purchasing program for hospitals and physicians (budget neutral)

Senate Finance Framework (cont.)

- To help pay for the measure, Baucus' framework would levy a tax of 35 percent on insurance companies for the value of any health insurance plan above \$8,000 for singles and \$21,000 for family plans
- Cost of plan is now \$880 billion over 10 years, according to the CBO
- Still wrestling with hot-button topics including illegal immigrants and medical malpractice

Senate Finance Framework (cont.)

- Additional Provisions:
 - Targeted hospital readmission penalties
 - DSH reductions “triggered” by uninsured reductions
 - Bundling of payments – establishes pilots
 - Physician self-referral – restrictions placed if physician has ownership interest and on expansion for grandfathered facilities (November 1, 2009)
 - GME = no cuts to IME payments and redistributes unused residency slots
 - Incentives to reduce Hospital Acquired Infections

Senate Finance Framework (cont.)

- Additional Provisions:
 - Accountable Care Organizations – provider groups working together to improve Medicare quality/costs
 - Primary care and general surgery bonuses for health professional shortage areas
 - Promoting disease prevention and wellness:
 - Medicare: coverage for a prevention and wellness plan and preventive services; incentives for healthy lifestyles
 - Medicaid: improving access to preventive services and incentives for healthy lifestyles; medical home state option for beneficiaries with chronic conditions

Plan B – Senate?

- Senate Rules
 - Non-germane Amendments are in order, *unless* invoke cloture
 - 60 votes for cloture: motion to proceed to debate health care legislation; on individual amendments; and to end debate and move to vote.

Plan B – Senate?

- Reconciliation
 - Only 51 votes required for final passage
 - Limited debate (20 hours)
 - Amendments must be germane
 - But...created to permit spending cuts/tax increases (e.g. Medicare cuts) that might not survive the procedural hurdles faced by normal legislation (e.g. 60 votes).

Reality Check

- The Medicare Physician Fairness Act
 - Senator Reid unable to secure votes necessary to get the bill out of the Senate.
 - No permanent fix for the sustainable growth rate formula in the Medicare Physician Fee Schedule.
 - Intention to pass a measure which would forestall the projected 21% decrease in physician payments expected for 2010.
- Anti-trust Exemption
 - Senate Judiciary Committee Chairman Patrick Leahy declared the time had come to do away with that protection.

House Tri-Committee

- Energy and Commerce, Ways and Means, and Education and Labor
- America's Affordable Health Choices Act of 2009 (H.R. 3200)
 - Allows the HHS Secretary to negotiate public plan payments based on rates between “current aggregate Medicare rates” and “aggregate rates paid by private insurers”
 - Allows states to set up cooperatives
 - No Independent Medicare Advisory Council

H.R. 3200 (cont.)

- Readmission penalties for rates higher than expectation (\$19 B over 10 years)
- DSH = \$16.6 billion in cuts with triggers
- No value-based purchasing at this point
- Geographic pmt. adjustments after IOM study
- New Medicare formula to pay physicians = \$228.5 B / 10 yrs

H.R. 3200 (cont.)

- Physician self-referral – similar to Senate with January 1, 2009 grandfather date
- GME / IME – same as Senate Finance
- Cost = \$1.5 trillion over 10 years
- Pay for:
 - \$544 B from income tax increases
 - \$37 B from business tax increases
 - \$500 B from cuts to Medicare and Medicaid
 - Penalties paid by individuals and employers

House Version of Reform

- Readmission penalties for any reason (\$16 billion over 10 years).
- Public plan uses Medicare rates for 3 yrs.; more expansive after 2015
- No value-based purchasing.
- Medicare/caid DSH: \$20 billion, 2017-2019.
- Geographic adjustments after IOM study.
- New Medicare formula to pay physicians.

Key Points of Disagreement

- Level of subsidy for lower-income individuals (up to 400 percent of FPL)
- Required employer coverage vs. pay-or-play
- Public Plan Option – Medicare-based vs. networks of cooperatives with competitively negotiated rates
- How to pay for the legislation (e.g., surtax on the wealthy, changing tax exclusion for employment-based insurance, employer “play or pay” tax, sugary beverage and alcohol tax increase)

Federal Issue Summary – Provider Impacts

- Potential Medicare payment cuts
 - P4P, Readmissions
- Potential cuts to DSH payments (triggers)
- Will payment cuts be offset by expanded coverage?
- Will coverage expansion include a “public plan” and how will rates be determined?
- More scrutiny on “geographic variation”
- Potential impact on physician self-referral

Will the Mandate Plan Pass?

- Will business accept the mandate to provide coverage?
- Will private insurance companies accept guaranteed issue and community rating?
- Will conservatives accept the new taxes needed to fund the subsidies for the individual mandate?
- Will the general public support a plan with a mandate to purchase insurance?

The Bottom Line on the Congressional Plan

If it does pass in some form, it would likely:

- Make the world's most expensive system even costlier.
- Not achieve universal coverage
- Not improve coverage for the average person.
- Not make affordable insurance available.
- Not contain the continuing growth in cost.
- Not achieve President Obama's goals.

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Texas Issues / Concerns

- Illegal immigrants
- Impact on nonprofit hospitals' tax-exemption
- Impact on state Medicaid, DSH, UPL programs and funding
- Treatment of rural hospitals (CAH, SCH, etc.)
- Physician/hospital alignment – clinical integration

Timing

- Pressure to do something before Thanksgiving
- Not likely to have an agreement until 11th hour
- Agreement beforehand makes susceptible of claims of not fighting hard enough

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Implications

- Push to integrate
- Restrict physician income to Medicaid (non-ancillary) services
- Push to large hospital-centered integrated systems
- Physicians have three choices:
 - Large integrated systems
 - Community clinics
 - Small practices for paying customers

Questions?