

Update on National Health Reform: A Moving Target

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August 18, 2009

Minnesota Senate Health & Human Services Budget Division

Chair: Senator Linda Berglin

Funded by a grant from the Robert Wood Johnson Foundation

Outline of Presentation

- Overview of Key Proposals
- Broad Implications
- Legislative Process
- Payment
- State Role in Health Reform
- What's Next

Legislative Proposals

Key Legislative Proposals

1. Kennedy's Senate "Affordable Health Choices Act"

- Senator Edward Kennedy (D-MA), Chair, Senate Health, Education, Labor and Pensions (HELP) Committee

2. Senate Finance Committee Draft Proposal

- Senator Max Baucus (D-MT), Chair, Senate Finance Committee
- Hopes to co-sponsor with Sen. Grassley (D-IA)
- "Gang of Six" (three democrats, three republicans)

3. House Tri-Committee Bill: "America's Affordable Health Choices Act" (H.R. 3200)

- Three Committees: Energy and Commerce, Ways and Means, Education and Labor
- Sponsor: Representative John Dingell (D-MI)

Provisions At a Glance

	Kennedy/HELP	Baucus/Finance	House Tri-Committee
Public Insurance Options	✓		✓
Insurance Exchange	✓	✓	✓
Individual Mandate	✓	✓	✓
Employer Mandate	✓		✓
Guaranteed Issue	✓	✓	✓
Premium Subsidy	✓	✓	✓

Key Provisions: Public Insurance Option

Kennedy/HELP	Baucus/Finance	House Tri-Committee
✓ Yes	x No	✓ Yes
“Community Health Insurance Option”	“Consumer Owned and Oriented Plan” (CO-OP)	Public Insurance Option
<i>Private entity</i>	<i>Consumer-governed non-profit corporation – Competitive bid</i>	<i>Run by DHHS Payment rates based on Medicare</i>

Key Provisions: Insurance Exchange

Kennedy/HELP

✓ Yes

State-based
insurance
exchanges

*-Administered by
state or non-profit*

*-State-based or
regional*

*“American Health
Benefit Gateways”*

Baucus/Finance

✓ Yes

State-based
insurance
exchanges

House Tri-Committee

✓ Yes

State or national
insurance
Exchanges

*-Administers public
plan option*

*“National Health
Insurance Exchange”*

Key Provisions: Individual Mandate

Kennedy/HELP

✓ Yes

Individuals must
purchase insurance
or pay a penalty
based on **cost of
insurance**

*Minimum qualifying
coverage
determined by
DHHS*

Baucus/Finance

✓ Yes

Will likely require
individuals to
purchase insurance
or pay a penalty
based on the
**average cost of
insurance**

*Minimum benefits
clause expected*

House Tri-Committee

✓ Yes

Individuals must
purchase insurance
or pay a penalty
based on **income**

*“Essential benefits”
minimum standard
determined by
advisory committee*

Key Provisions: Employer Mandate (“Pay-or-Play”)

Kennedy/HELP

✓ Yes

Employers must pay **60% of family premiums** or pay **\$750 for each employee who is not offered coverage**

Small business exemption with tax credits if offer ESI

Baucus/Finance

x No

Likely to include a “free-rider” provision that would **require employers to reimburse the government for employees who receive Medicaid or a tax credit in the exchange**

Tax credits for small businesses offering ESI

House Tri-Committee

✓ Yes

Employers must pay **65% of family premiums** or pay a **penalty based on payroll**

Small businesses with < \$500,000 on payroll are exempt

Payrolls < \$750,000 have a reduced contribution

Key Provisions: Guaranteed Issue/Rating Provisions

Kennedy/HELP

✓ Yes

No rating on health status, gender, class of business, claims experience

Rating on age (2:1 max. ratio), tobacco use, family size, and actuarial value of the benefit

Baucus/Finance

✓ Yes

No rating on health status.

Adjusted community rating with rate variation capped at 7.5:1.

House Tri-Committee

✓ Yes

No rating on health status, gender, or occupation.

Rating can vary by age (2:1 max. ratio), area, and family size.

Key Provisions: Expanded Medicaid Eligibility

Kennedy/HELP

✓ Yes

Expansion to
150% FPL for everyone

No asset test

Baucus/Finance

✓ Yes

Expansion to
100% FPL for everyone

Expansion to 133% FPL for children and pregnant women

House Tri-Committee

✓ Yes

Expansion to
133% FPL for everyone

Increase Medicaid payment rates for primary care to 100% Medicare rates

Key Provisions: Premium Subsidies

Kennedy/HELP

✓ Yes

Sliding scale subsidies for individuals and families up to **400% FPL**

Credits based on avg. cost of 3 lowest-cost qualified plans in area

For ≤400% FPL, premium contributions capped at 12.5% of income; capped at 1% for ≤150% FPL

Baucus/Finance

✓ Yes

Sliding scale subsidies for individuals and families up to **300% FPL**

Tax subsidy based on what draft proposal calls "Silver" plan benefit levels (one level up from minimum creditable).

No further details.

House Tri-Committee

✓ Yes

Sliding scale subsidies for individuals and families up to **400% FPL**

Credits based on avg. cost of 3 lowest-cost basic plans in area

Premium contributions capped at 12% for ≤ 400% FPL; capped at 1.5-3.0% for 133-150% FPL (cap scaled in between these FPLs)

Premium Subsidies and Medicaid Expansions (Family of Four FPL = \$22,050 in 2009)



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*Under Baucus proposal, children and pregnant women are Medicaid-eligible at ≤133% FPL, or \$29,327 for a family of four.

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Overview of Impact of Three Main Proposals

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Key Legislative Proposals: CBO Cost Estimates

Kennedy/HELP	Baucus/Finance	House Tri-Committee
<p>\$1.34 Trillion Cost over 10 years.</p> <p>Net \$1.04 trillion added to the deficit.</p>	<p>\$900 Billion Cost over 10 years.</p> <p>Goal of cost savings by 2019.</p>	<p>\$1.042 Trillion Cost over 10 years.</p> <p>Net \$239 billion added to the deficit.</p>

Key Legislative Proposals: Number of Uninsured in 2019

Kennedy/HELP	Baucus/Finance	House Tri-Committee
<ul style="list-style-type: none"> Uninsured reduced to 36 Million 	<ul style="list-style-type: none"> TBD 	<ul style="list-style-type: none"> Uninsured reduced to 17 Million



Currently there are **46 million** uninsured with projections to reach **53 million** by 2019 if no plan is enacted.

Legislative Process

Current Status of Proposals – *August Recess*

Senate:

- HELP Committee approved bill and passed out of committee and sent to Finance
- Finance Committee “gang of six” hopes to produce bi-partisan bill by Sept 15th

House:

- Tri-Committee’s mark-up generally complete

Obama:

- Has backed off his goal of signing legislation in September; hoping for end of the year

What Remains to Be Done

The State of Play What remains to be done with legislation to overhaul the nation's health care system, now that Congress has recessed until after Labor Day. This is what Democrats hope will happen.

The Senate health committee has approved a bill, but only the Finance Committee has jurisdiction over taxes and Medicare provisions to pay for the measure.



SENATE HEALTH COMMITTEE
Christopher J. Dodd, Democrat*
Michael B. Enzi, ranking Republican



SENATE FINANCE COMMITTEE
Max Baucus, Democrat, chairman
Charles E. Grassley, ranking Republican

A group of six negotiators on the Finance Committee — three Democrats and three Republicans — hopes to produce a bipartisan bill. Mr. Baucus has set a tentative Sept. 15 deadline for that group. The full Finance Committee would then work on the legislation.

Three House committees have approved their own bills. The Energy and Commerce Committee still needs to work through many amendments in September.



WAYS AND MEANS Charles B. Rangel, Democrat, chairman
ENERGY AND COMMERCE Henry A. Waxman, Democrat, chairman
EDUCATION AND LABOR George Miller, Democrat, chairman



SENATE
Harry Reid, Democrat, majority leader
Richard J. Durbin, the Democratic whip

Democratic leaders in the Senate will merge bills from the two committees.

The House Rules Committee will work with the committees and Democratic leaders to meld the three versions into one measure.



HOUSE
Nancy Pelosi, Democrat, House speaker
Steny H. Hoyer, Democrat, majority leader

The two chambers vote on their respective bills, possibly by the end of September.

A House-Senate conference committee tries to work out a compromise, in consultation with the White House. If the bill is then approved in identical form by both chambers, it goes to the president.

President Obama hopes to sign legislation by the end of the year.



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*Mr. Dodd is leading the committee's work on health care in the absence of the health committee chairman, Senator Edward M. Kennedy, Democrat of Massachusetts, who is battling brain cancer.

Last Resort: Budget Reconciliation

Pros

- Can be passed on Democratic Vote (*do not need to bring Republicans along...*)
- Cannot be filibustered

Cons

- Five-year sunset provisions
- “*Byrd Rule*”: Any senator can raise a point of order against “extraneous” provisions *that do not affect revenues or mandatory spending*
→ **NO POLICY** – Eliminates policy provisions with no budget implications e.g. *insurance guarantee issue and rate regulation*

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Payment Reform

Payment Reform

- Limited substantive discussion of payment reform
- HIT stimulus funds cited as mechanism to increase efficiency
- Proposals include mostly blunt adjustments to payments and payment formulae
 - *i.e. no significant reform of payment policy*
- Obama does mention potential use of MedPAC to make recommendations for payment reform

Proposed Payment Reform Cuts

- \$500 billion of changes to Medicare over 10 yrs
 - charging wealthy seniors more for prescription drug coverage
 - cutting \$120 billion in payments to Medicare Advantage Plans
 - trimming projected payments to hospitals by \$155 billion in an effort to spur efficiencies
- New independent commission empowered to cut Medicare spending to meet pre-set savings targets (not MedPAC)



MedPAC Recommendations

- Use accountable care organizations (ACOs) to promote quality by offering bonuses and penalties related to cost and quality targets
- Restructure Medicare benefits, including supplemental coverage to better align cost sharing with quality targets
- Reduce payments to Medicare Advantage and incentivize innovation



Accountable Care Organizations

- Permits ACO pilot projects in Medicare
 - Reward physician groups working with hospitals and other providers
 - Incentive for high-quality, low-cost care over a sustained period
 - Allow for incentive payments to ACOs that exceed performance targets
 - Experimentation with regard to partial capitation and other payment models

Payment Reform: MedPAC Recommendations

Direction for payment and delivery system reform

Current fee-for-service payment systems

- Ambulatory surgical centers
- Clinical laboratory
- Durable medical equipment
- Home health care
- Hospice
- Hospital acute inpatient
- Inpatient rehabilitation facility
- Long-term care hospital
- Outpatient dialysis
- Outpatient hospital
- Physician
- Psychiatric hospital
- Skilled nursing facility

+

Recommended tools

- Disclosure of financial relationships
- Comparative effectiveness
- Linking payment to quality
- Reporting resource use
- Bundling individual services within a payment system (e.g., dialysis)
- Creating pressure for efficiency through updates
- Reducing unnecessary readmissions
- Gain sharing
- Price accuracy (e.g., primary care adjustment)

+

Potential system changes

- Medical home
- Payments "bundled" across existing payment systems (e.g., hospital and physician around hospitalization)
- Accountable care organization

State Role in Health Reform

State Role in Reform: Access Expansions

Medicaid/SCHIP expansions

- ✓ New screening and enrollment requirements
- ✓ Federal match for expansions but states will have some matching requirements
- ✓ Administer and finance wrap-around benefits for CHIP benchmark and other Medicaid products
- ✓ Currently no financing provisions for state administrative burden
- ✓ DSH payments will be reduced to finance expansion

Premium Subsidies

- ✓ Eligibility and enrollment of premium subsidies for small employers and families

State Role in Reform: Insurance Regulation

Insurance Exchange-State Level

- ✓ Development and implementation of insurance exchange and regulation
- ✓ Creation of infrastructure within federal requirements

Public plan implementation

- ✓ For eligibility and enrollment and determination of premium and subsidy level, processing of subsidy

Insurance Reform

- ✓ Implement new rating requirements
- ✓ Enforcement of individual mandate - Possibly through state tax forms
- ✓ Enforce national minimum benefit requirements



State Role in Reform: Other provisions

Medicare cuts to providers

- ✓ Pressure on physicians and hospitals, potential access issues for public program recipients
- ✓ Additional pressure for safety net providers

Medicare cuts to Medicare Advantage

- ✓ Might reduce options for seniors and dual eligibles

Cuts in disproportionate share

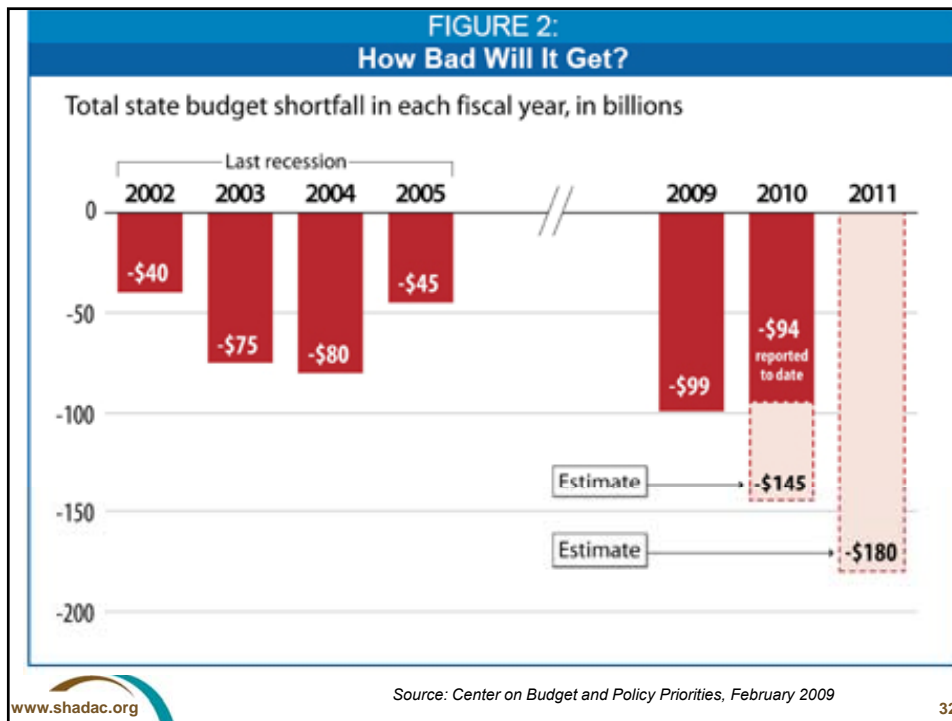
- ✓ Biggest impact on safety net providers e.g. HCMC



Concern about State Infrastructure

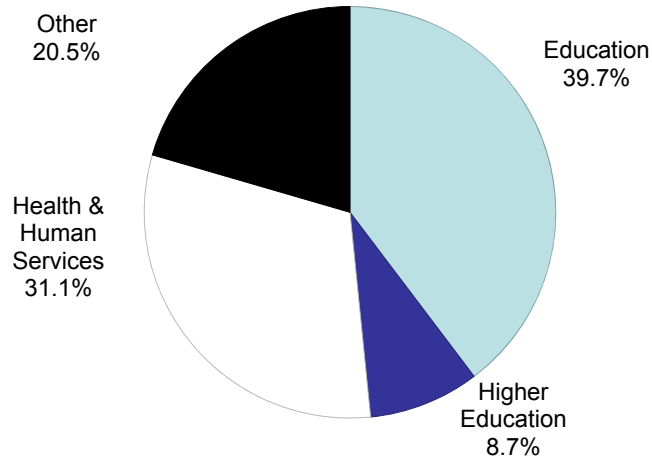
- Total 2009 first-quarter tax revenue declined in 45 of 47 early-reporting states
 -Personal income tax **fell 15.8%**
- States face \$183.3 billion in budget shortfalls between FY 2009 and FY 2011
- States have already addressed \$46.2 billion in budget gaps in the first half of FY 2009

State infrastructure is stressed!! Cost of implementation not addressed.....



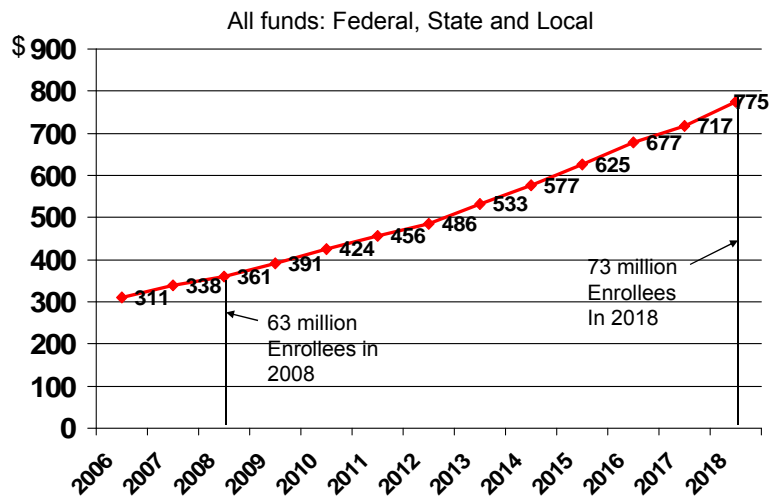
Minnesota Budget

Allocation of General Fund Resources FY 2010-2011 by Program
 Projected Spending: \$36.7 Billion



Source: November 2008 Forecast, House and Senate Fiscal Staff Presentation, February 09

Medicaid Spending Projected to Increase by 8% Annually to Over \$700 Billion in Ten Years: 2008 - 2018



Source: Health Management Associates estimates based on data from CBO and CMS, 2008.

Minnesota Reform Strategy

- MN is well-positioned to inform Congress to move on broader payment reforms
- Key action in measurement, transparency, provider peer group, and financial incentives for quality care
- e-health requirements will help with new stimulus funding opportunities

MN Health Reform from 2008 (1)

- Statewide health improvement program (SHIP) to reduce obesity and tobacco use in Minnesota
- Development of certification standards for medical home and increased payment
- Data collection and peer grouping for cost and quality measurement

MN Health Reform from 2008 (2)

- Promotes transparency and accountability by establishing “baskets” of health care services to:
 - *Allow consumers and other purchasers to compare cost and quality of care across providers*
- Requirement for electronic health records by ensuring providers use nationally-certified electronic health record systems
 - All prescription drugs electronic orders by 2011

States continue their own reform....

- States still innovating around the margins
- Need the federal funding to do more
 - Now tied to Medicaid/SHIP
 - Guarantees an increasing role for states
- Many barriers to reform including ERISA, financing, and political will....
 - Universal coverage will require federal action
- State role in discussions at national level not clear – limited discussion of state role and costs for implementation

What Next?

- Big hurdles
 - Public Plan
 - Financing
- Possibility – *a high-level framework for reform with phased in time frame to allow for recovery of economy, development of the details, including payment reform for later...*
- States continue strategies for access and coverage without more detail and assurance of national reform

Outlook for Reform...



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