National Health Care Reform: The Proposals & the Politics

Elizabeth Lukanen, MPH
State Health Access Reform Evaluation (SHARE)
State Health Access Data Assistance Center, University of Minnesota

2009 Center for Health Interprofessional Programs Student Leadership Summit
Minneapolis, MN

December 5, 2009

*Funded by a grant from the Robert Wood Johnson Foundation*
Outline of Presentation

• History of Reform
• Current Drivers of Reform
• Key Players in Health Reform
• High Level Policy Overview
• Proposals Status
• Cost Estimates of Proposals
• Legislative Process – Next Steps
• Impact on Health Professionals

Outlook for Reform
History of Health Reform in U.S.

Source next 4 slides: Kaiser Family Foundation: National Health Insurance — A Brief History of Reform Efforts in the U.S.
1934-1939: National Health Insurance (NHI) Movement

• Great Depression
• Citizen groups called for Gov’t relief, but were focused on unemployment
• Congress was concerned that NHI would lead to the defeat of Social Security Act
• Increasingly powerful AMA opposed NHI
• Business and labor groups were not supportive, nor was the emerging private health insurance industry and the bill failed
1945-1950: National Health Insurance (NHI) Movement

• WWII, health insurance excluded from existing caps on wages
• Generous health benefits used to recruit
• Truman promoted “the right to medical care” in post war Economic Bill of Rights
• Unions believed they could negotiate for better benefits from their employers
• The AMA called it “socialized medicine”
• Public support was lost and the bill failed
1960-1965: Medicare and Medicaid

• ESI growing, but private plans began to use “experience rating,” pricing out sick and old
• Congress gave state grants to provide subsidies for elderly with limited success
• Johnson made Kennedy's “Medicare” a major priority
• Labor unions supported it to reduce the high cost of their retirees, AHA supported it to cover high cost of treating elderly
• Medicare and Medicaid Are Signed into Law!
1970-1974: Competing NHI Proposals

- Inflation was becoming a serious problem
- Since Medicare and Medicaid, health care costs had grown from 4 to 11% of the federal budget in 8 years
- Many bills were proposed, two strong bills emerged led by Sen. Ted Kennedy and President Nixon
- Competing interests, multiple bills and Watergate contributed to the failure

- Under Regan, federal debt soared as did health care costs
- Americans worried about losing health care
- Clinton vowed to introduce bill in first 100 days
- Complex bill was crafted behind closed doors
- Stakeholder support was often conditional
- HIAA and NFIB lead the opposition by raising concerns for the middle class
- Bill stalled and failed
Health Reform Today
What is Driving Health Care Reform?

Could be better!

Cost  Access  Quality

HEALTH INSURANCE

Could be better!
U.S. Health Care Costs

- The U.S. will spend roughly $2.5 trillion on health care in 2009
  - $8,160 per person
- Since 2000, inflation-adjusted costs have been growing at 5.5% per year, considerably faster than overall economic growth
National Health Expenditures Per Capita, 1986-2010

“Status Quo”
Projected Federal Spending

Projected Federal Spending Under One Fiscal Scenario
(Percentage of gross domestic product)

Source: Congressional Budget Office.
Note: The figure, from the December 2007 Long-Term Budget Outlook, portrays CBO's "alternative fiscal scenario," which deviates from the agency's baseline projections to incorporate some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.
Increase in number of uninsured

15.4% of the population in 2008

Drop in Employer-Sponsored Coverage

Quality: Misuse, Overuse, Underuse

• 2.5-fold variation in Medicare spending across counties cannot be explained by local prices, age, race and underlying health of the population (Wennberg J, et al.)

• Medicare beneficiaries in higher-spending, higher-utilization regions do not receive “more effective” care (Fisher ES, et al.)

• 54.9 % of American adults receive only half of their recommended health care (McGlynn EA, et al.)
Quality: Regional Variation

Medicare Spending per Beneficiary, 2005

Source: Dartmouth Atlas of Health Care
Key Players in Health Reform

Don't cut us, cut them!
Don't tax us, tax them!
Don't mandate us, mandate them!
Don't fine us, fine them!
Don't cap us, cap them!
Don't tax us, tax them!

Good news...we're seeing a growing consensus in positions on the health care debate!
President Barack Obama

- Reform one of highest domestic priorities
- Vocally supporting action across the nation
- Until now, has left details to Congress
- Iraq war, Iran Nuclear, Afghanistan war, competing for his time
- Sticking points: Universal coverage, lower costs, improve quality, protect consumer choice, public plan option (maybe?), budget neutrality
Administration

Director, Office of Health Reform
Nancy-Ann DeParle

HHS Secretary
Kathleen Sebelius

Director
Congressional Budget Office
Douglas Elmendorf

White House Chief of Staff
Rahm Emanuel

Director Office of Management and Budget
Peter Orszag
Committees

Senator Finance
Chair
Sen. Max Baucus, D-MT

Chair House Education and Labor
Rep. George Miller, D-CA

Senate Health, Education, Labor and Pensions (HELP)
Sen. Chris Dodd, D-CT

Chair House Ways and Means
Rep. Charles Rangel, D-NY

Chair House Energy and Commerce
Representative Henry Waxman, D-CA
Other Legislative Players

Speaker of the House
Nancy Pelosi (D-CA)

Senate Majority Leader
Harry Reid (D- NV)

Senator
Olympia Snowe
R- ME

Blue Dog Democrats
Special Interest Groups

President
America's Health Insurance Plans
Karen Ignagni

President-elect, American Medical Association
J. James Rohack

President
American Federation of Labor and Congress of Industrial Organizations
Richard Trumka

President
National Federation of Independent Business
Dan Danner

President of the Service Employees International Union
Andy Stern

AARP CEO
A. Barry Rand
High-level Policy Overview
Agreement Across Proposals
Agreement Across Proposals

Market Regulation

• Insurance exchange
  – Pool model for individuals, small employers and those without ESI

• Individual Mandate
  – With hardship waivers

• Insurance Market Reforms
  – No rating on health status, gender, or occupation; rate restrictions on age
  – Guaranteed issue
  – No annual/lifetime benefit cap
Agreement Across Proposals

Benefits/Quality

- Standards for “adequate coverage” or “minimal benefit package”
- Require no cost sharing on preventive services
- Wellness initiatives, focus on prevention
- Delivery System Reform, “Medical home”
- Money toward comparative effectiveness research
- Workforce development grants
  - Targeted towards nurses, primary care and rural areas
Agreement Across Proposals

Access

• Expand Medicaid to across-the-board eligibility floor, most likely up to 133% FPL
• Subsidies for families < 400% FPL to buy into the exchange through sliding scale “affordability credits”
• Employer Participation
  – “Pay or Play” Mandate or weaker “free rider” penalty
• Tax credits for small employers offering employer sponsored insurance
Agreement Across Proposals
Revenue/Savings

• **Savings**
  – Medicaid and Medicare
  – Medicare Advantage plans

• **New Revenue:**
  – Individual and employer penalties for violating mandate
Disagreement Across Proposals
Disagreement Across Proposals

- **Public Option**
  - Necessary in areas where there is high market consolidation?
  - Will it act like Medicare and set rates or will it negotiate for rates?
  - Can states opt out?
- **Size of Expansions and Tax Credits**
  - The lower the subsidy, the lower the cost and perception of government intervention
- **Assumptions about “affordability”**
Disagreement Across Proposals

• Federal Role
  – House wants Fed to play a strong role, Senate wants state to play a larger role
  – Locus of exchange, insurance regulation, financing Medicaid expansions

• Tort Reform

• New Revenue
Disagreement Across Proposals

• Payment Reform
  – Increase primary care rates relative to specialty care?
  – Cut Medicare payments attributable to avoidable hospital readmissions?
  – Tie Medicare hospital money to quality?
  – Medicare regional rate re-alignment?

• Abortion
  – Prevent insurance purchased with federal subsidies from covering abortions?
Proposal Status: House
House – H.R. 3962

- Affordable Health Care for America Act
- Originated from 3 bills
  - Education & Labor (Miller, D-CA)
  - Ways & Means (Rangel, D-NY)
  - Energy & Commerce (Waxman, D-CA)
- Bill was merged via House Rules and moderated:
  - Public option softened
  - Premium subsidies reduced
  - Greater number of employers exempt from mandate
  - States pay for more of Medicaid expansion
House – H.R.3962

- Scored by CBO, brought to House Floor
- To gain support, an amendment passed to prohibit federal funds for abortion services in the public option and in the insurance "exchange"
- Late endorsements from AARP, the AMA and the Conference of Catholic Bishops were crucial
- On November 7 HR 3962 Passed (220-215)
  - 219 Democrats for, 39 voted against, garnered one Republican vote
- $891 billion over 10 years and will cover 36 million people
Proposal Status: Senate

[Image of a cartoon truck labeled 'DEMS HEALTH CARE BILL' being forced through a tunnel labeled 'SENATE PASSAGE' with a sign saying 'WE'LL RAM THIS THROUGH OR ELSE!']

[Signature: DAVE GRANLUND © www.davegranlund.com]
Senate – H.R. 3590

• Patient Protection and Affordable Care Act
• Originated from 2 bills
  – Health, Education, Labor and Pensions (HELP) Committee (Harkin, D-IA; Formerly Kennedy, D-MA)
  – Finance Committee (Baucus, D-MT)
• Passed out of committees by party line vote plus, historic vote in finance by Republican Olympia Snowe (R-ME)
• Bill was merged via Senate Rules and moderated:
  – States can opt out of public option
  – Tax on elective cosmetic surgery
  – Tax on “Cadillac plans” starting at higher threshold
  – Tax on medical devise manufacturers lowered
  – 5% Medicare payment cut for “outlier” physicians removed
Senate – H.R. 3590

• First hurdle: procedural motion to allow debate (needed and got 60 votes)
• Now Senate will take up amendments
• Adopting amendments is an uphill battle
• As it stands, it would cost $848 billion over 10 years and cover 31 million people
• Once the amendment process has concluded, full Senate vote
• Need 60 votes to cloture, 51 to pass bill
• Unless…they use reconciliation
Senate Reconciliation

• Reconciliation: Bill may pass the Senate with simple majority of 51

• Key problems with Reconciliation:
  – Byrd Rule: Can only take up “budget” matters to “reconcile” legislation with Senate Budget Resolution
  – Senate Parliamentarian decides what
  – Laws are time-limited to 10 year budget window; then sunset
    • Example: SCHIP – created in 1997, nearly lost in 2007
    • Example: “Bush tax cuts”
Senate

Problems with Reconciliation

• Lack of bipartisanship
• Reconciliation version could be too far right for the House, because some Democrats are excluded to get nominal Republican support
• Reconciliation version could be too far left for the House, because moderate Democrats and all Republicans are excluded
• Limited to “budget” matters, would exclude major aspects of reform (e.g. insurance market reforms)
Show Me The Money!
House – H.R.3962

- $891 billion over 10 years
- Net $138 billion deficit decrease over 10 years
- Permanent reductions in annual Medicare FFS rate updates
- Setting payment rates in the Medicare Advantage program based on per capita spending
- Changes to Medicare Part D
- Income tax surcharge on high-income
- Cancels ~21% reduction in Medicare physician payments (separate bill)
- Fees on medical device manufacturers
Senate – H.R. 3590

- **$848 billion over 10 years**
- **$130 billion deficit decrease over 10 years**
- Permanent reductions in annual Medicare FFS rate updates
- Setting payment rates for Medicare Advantage program based on average of the bids
- Excise tax on "Cadillac" insurance plans
- Fees on medical device manufacturers
- 5% tax on elective cosmetic surgery
- Reduction in DHS payments by $45 billion
- Maintains scheduled ~21% reduction in Medicare physician payments
Compare - Impact on the Number of Uninsured and Cost: 2019 Projections

**House**
- $891 million
- Net deficit reduction $138 billion
- Uninsured reduced to 10 million

**Senate**
- $848 million
- Net deficit reduction $130 billion
- Uninsured reduced to 15 million

Currently there are **46 million** uninsured with projections to reach **53 million** by 2019 if no plan is enacted.
Legislative Process – Next Steps
Path to the President

✓ Combine committee bills, introduce on floor
  – DONE

✓ Pass bill in each Chamber
  – One down, one to go
  – House Amendments will continue to be debated

✓ Combine bills in conference committee
  – What leadership will be chosen?

✓ Vote on chamber floor for combined bill
  – No additional amendments allowed
Potential Impact on Health Professionals
Impacts on Health Professionals

- Workforce development grants to recruit new nurses into the profession
- Loan repayment for nursing programs
- Nurse Practitioners recognized as primary care providers
- Prevention and Wellness grants
- Grants for state, local, and tribal health departments to support core public health infrastructure and activities (House)
- Maintained or expanded payment for teaching hospitals including FQHCs
Impacts on Health Professionals

- Grants for alternative dental health care providers pilots (House)
- Grants for oral health training
- Provisions for children’s oral health
- Money for oral health prevention campaigns
- Grants for effectiveness of research-based dental caries
- Tax on “Cadillac” plan may impact dental coverage (if dental and health combined)
Impacts on Health Professionals

- Increased funding for primary care services
- New residency training slots geared toward primary care medicine and general surgery
- Increased funding for National Health Service Corps (recruitment, loan repayment)
- New grant for community-based residency training
- Grants program to fund pharmacist-delivered medication therapy management services
- Pharmacists included in medical home models
- Changes to Medicare Part D (doughnut hole)
Impacts on Health Professionals

- Increase in demand may mean strain on providers (particularly primary care)
- Increase in comparative effectiveness research may impact practice patterns (long term)
- Changes to Medicare payment rates
- Undocumented immigrants are not eligible for federal benefit, some verification required
Outlook for Reform...
Open Questions

• Will a comprehensive reform bill be able to secure 60 votes in Senate?
• Will it sick with a scheduled 21% physician payment cut and risk losing AMA support?
• Will agreed upon subsidies make health care “affordable”?
• Will some type of public option survive?
• Will pro-choice democrats vote for a health bill that excludes federal dollars for abortion?
• What is achievable through Reconciliation?
  – Is reform possible when limited to finance only?
  – Is reform stable if it sunsets?
Democrats can’t achieve 60 votes in Senate, rely on reconciliation

• Vastly limited reform:
  – Coverage expansions, including subsidies
  – Medicare payment reform
  – Tax “high cost benefit plans”
  – Reduce DSH (Medicaid and Medicare)
  – Pay for comparative effectiveness studies
  – Create tax credits for small businesses and others
  – Workforce development grants

• This would exclude, mandates, insurance market reform, creation of exchange

• The less-controversial initiatives could be included in a companion bill
Democrats Achieve 60 Votes

- Most likely a “moderate” version of reform
  - Coverage expansions with low federal price tag
  - No public option, unless with limited trigger
  - Establish federal benchmark for qualifying plans
  - Individual mandate (softened)
  - Employer mandate (softened)
  - Insurance market reforms
  - Some Medicare spending reductions
  - Likely need both high income surcharge and excise tax
My Two Cents

- Timeline will continue to push out
- A high-level framework will be passed, but will be phased in over time to allow for recovery of economy
- Reform is not likely to bend the cost curve
- Issues like payment reform and quality will be tackled in the next phase
- This will be a cornerstone for continued health reform in the future
Contact Information

Elizabeth Lukanen, M.P.H
elukanen@umn.edu

State Health Access Data Assistance Center

www.shadac.org

University of Minnesota

School of Public Health
Division of Health Policy and Management
2221 University Avenue, Suite 345
Minneapolis, Minnesota 55414
(612) 624-4802