

National Health Care Reform: The Proposals & the Politics

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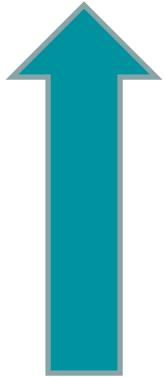
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Outline of Presentation

- Drivers of Reform
- Key Players in Health Reform
- Proposals Status
- High Level Policy Overview
- Cost Estimates of Proposals
- Legislative Process – Next Steps
- Outlook for Reform
- Impact on Community Health Centers

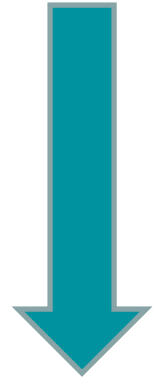
What is Driving Health Care Reform?



Cost



Access



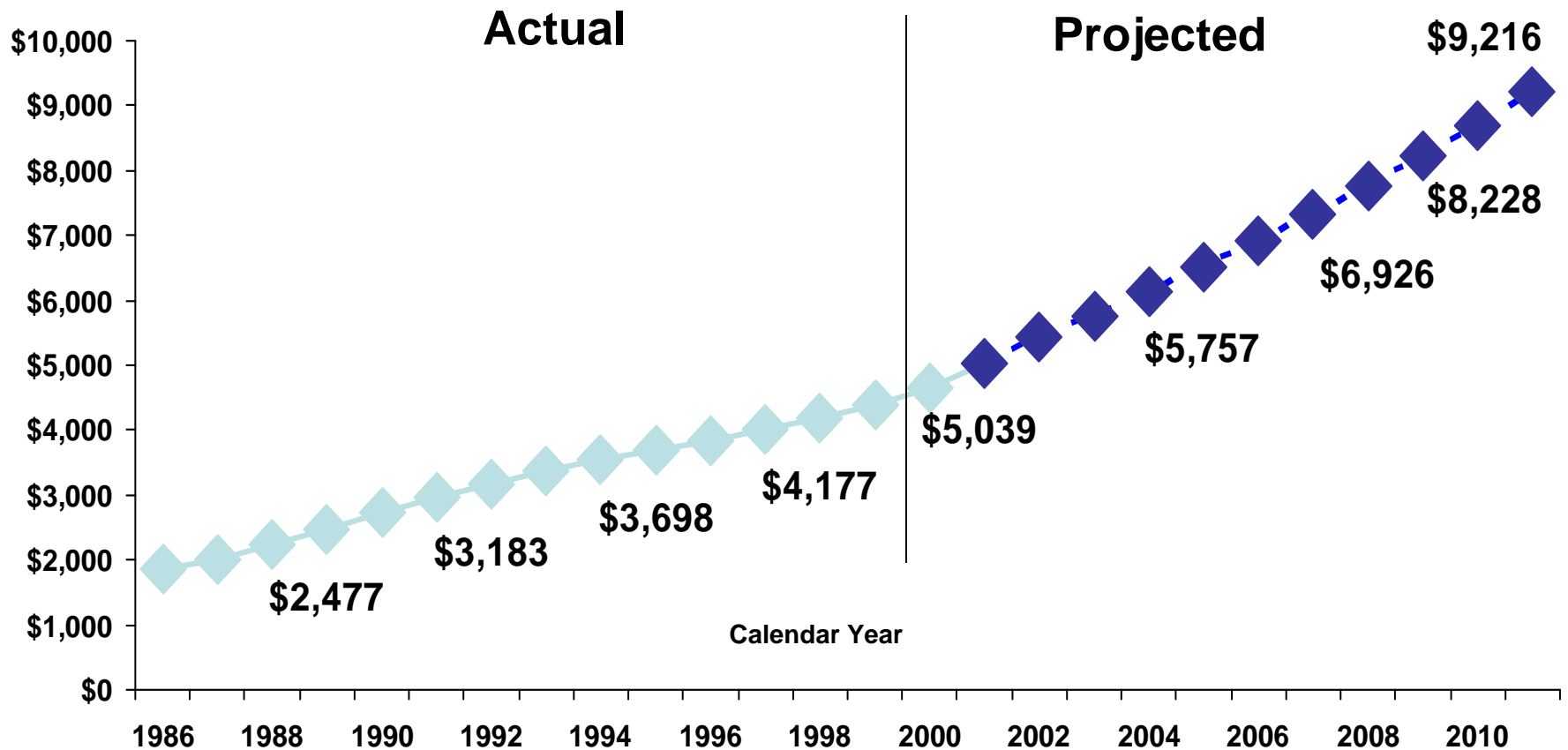
Quality

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

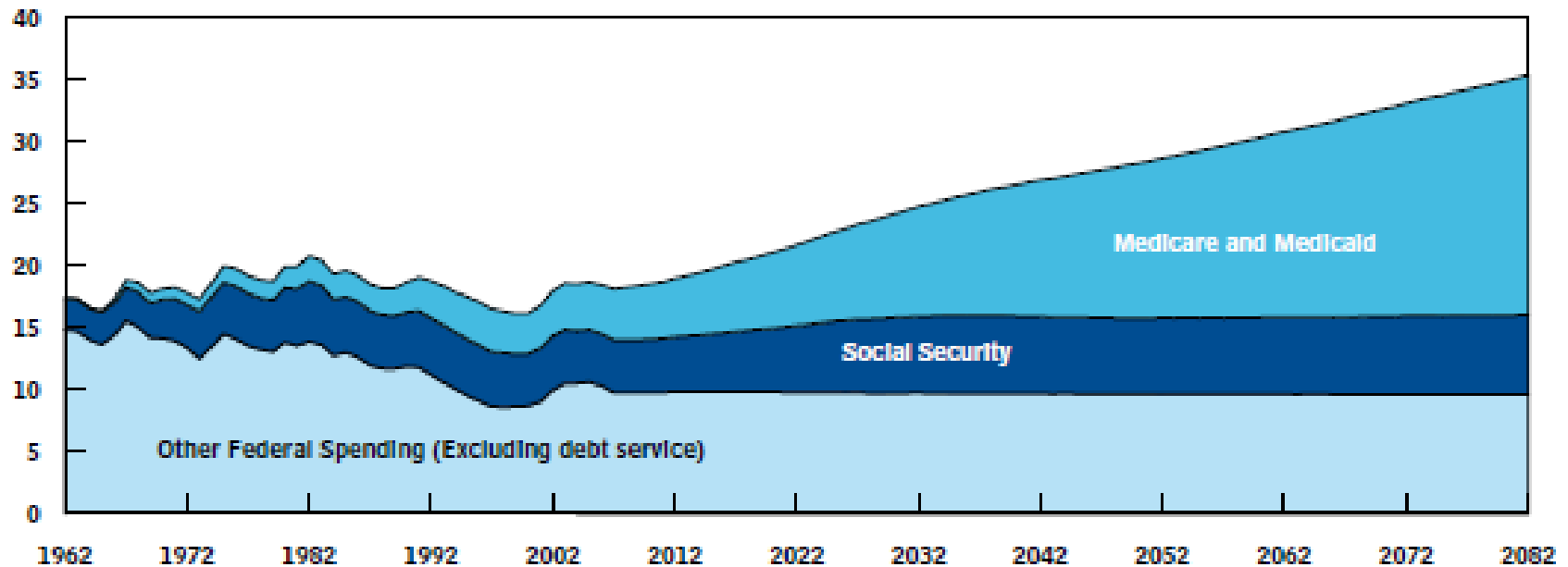


Source: CMS, Office of the Actuary, National Health Statistics Group.

“Status Quo” Projected Federal Spending

Projected Federal Spending Under One Fiscal Scenario

(Percentage of gross domestic product)

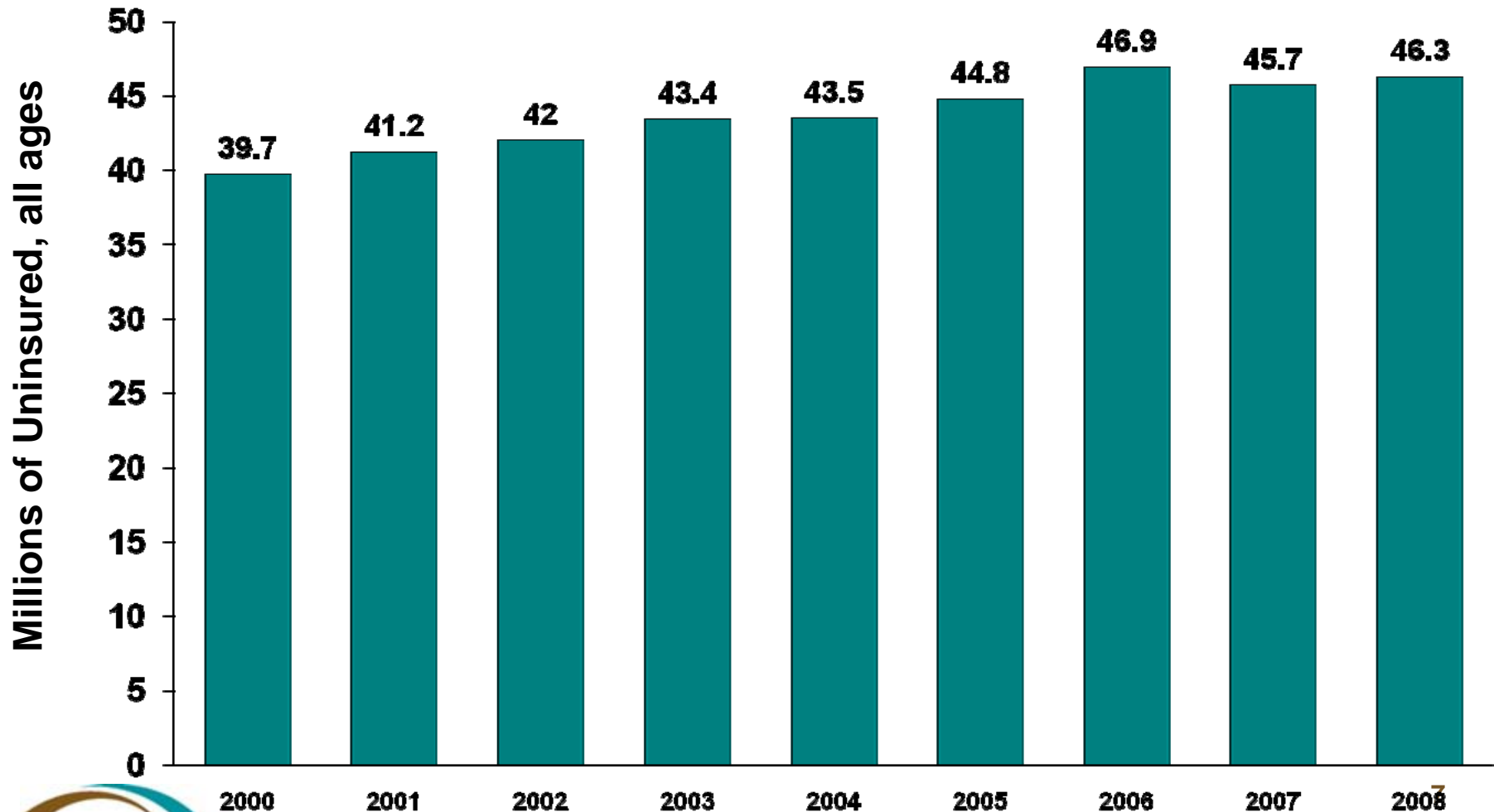


Source: Congressional Budget Office.

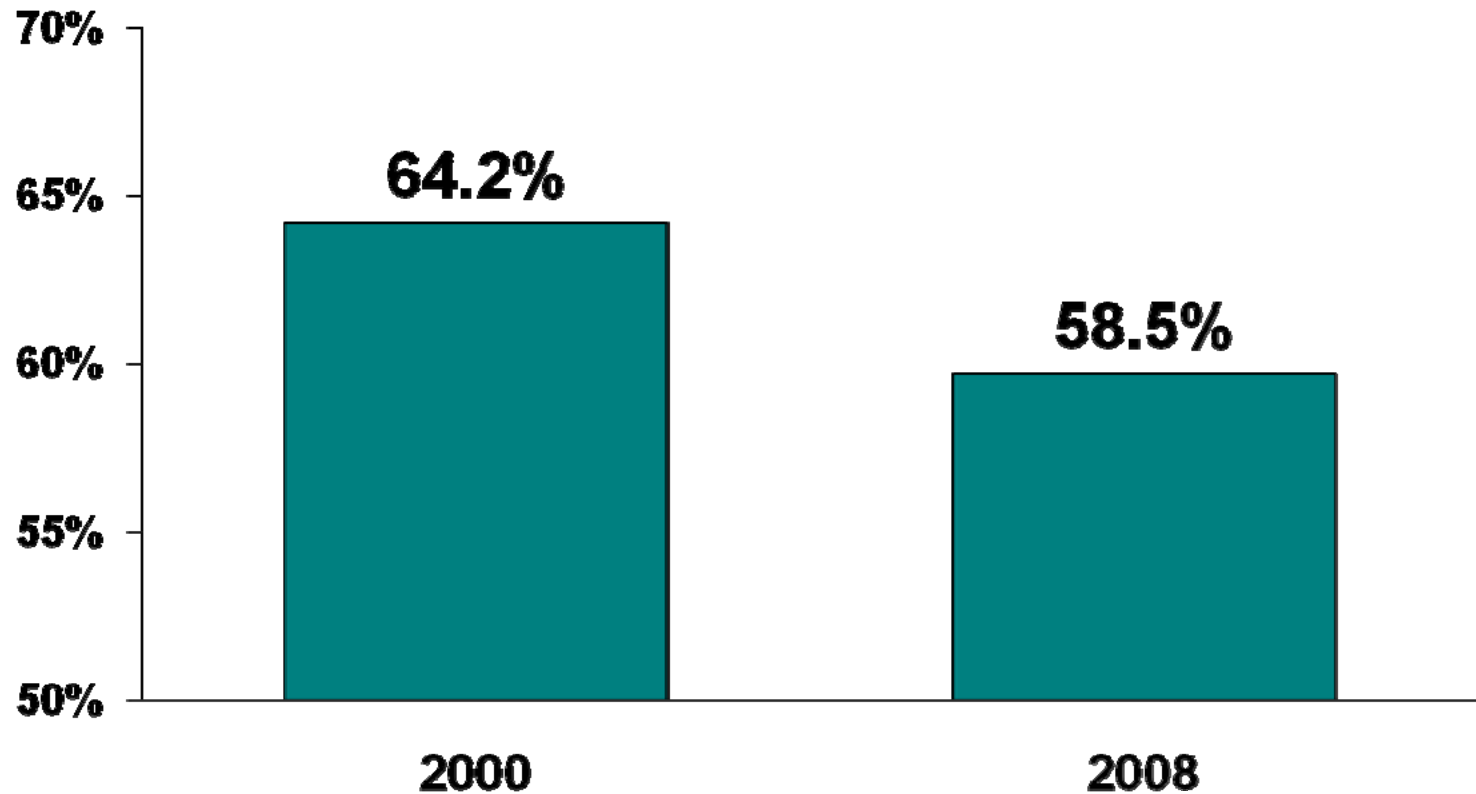
Note: The figure, from the December 2007 *Long-Term Budget Outlook*, portrays CBO's "alternative fiscal scenario," which deviates from the agency's baseline projections to incorporate some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

Increase in number of uninsured

15.4% of the population in 2008

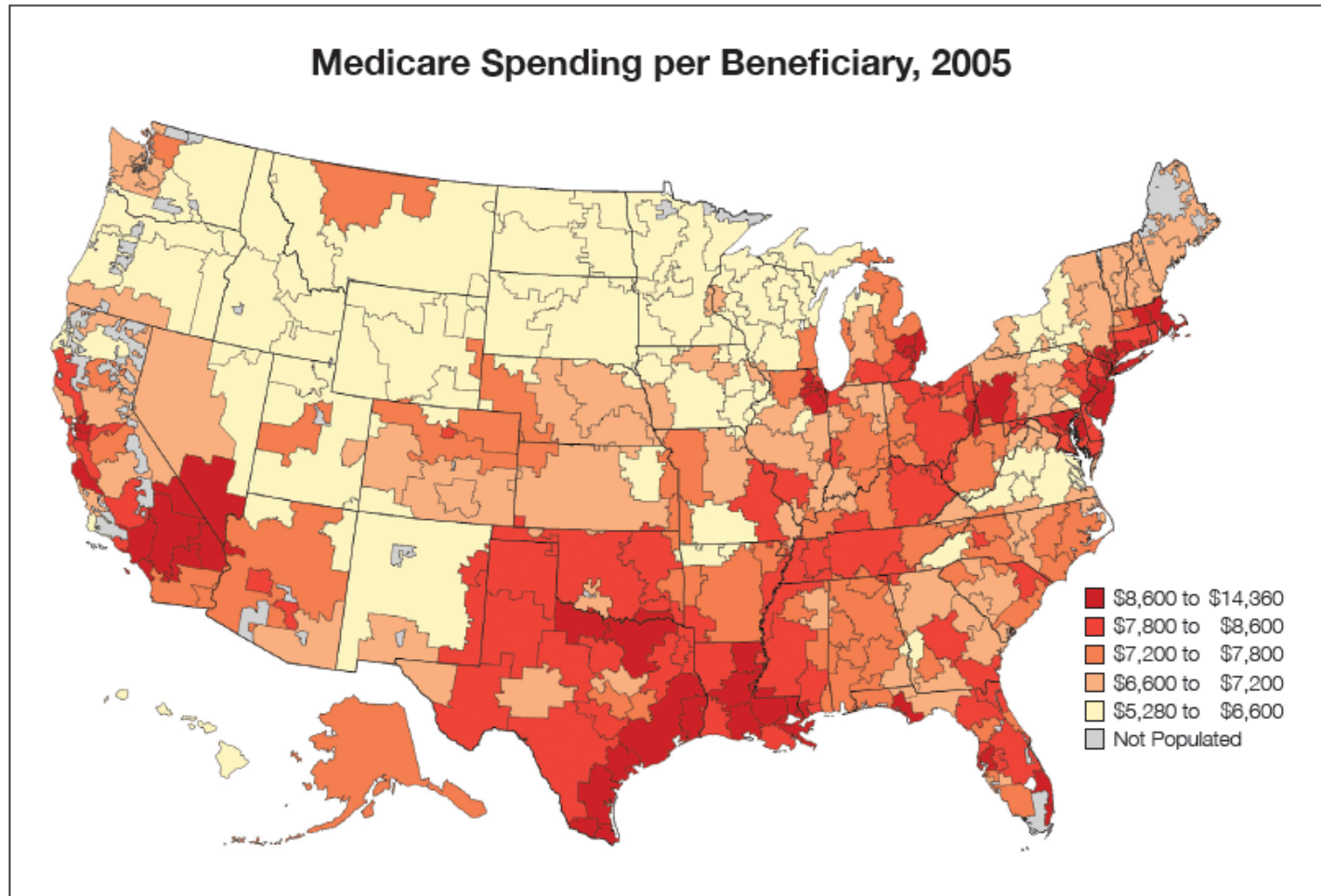


Drop in Employer-Sponsored Coverage



Source: US. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*.

Quality: Regional Variation



Source: Dartmouth Atlas of Health Care

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.)

Key Players in Health Reform

President Barack Obama



- Reform one of highest domestic priorities
- Vocally supporting action across the nation
- So far, 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



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



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



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

Other Legislative Players



Speaker of the House
Nancy Pelosi (D-CA)

Senate Majority Leader
Harry Reid (D- NV)

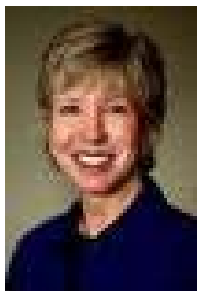


Senator
Olympia Snowe
R- ME

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



Proposals Status: House

House – HR 3200

- America's Affordable Health Choices Act
- Jurisdiction held by 3 committees
 - Education & Labor (Miller, D-CA)
 - Ways & Means (Rangel, D-NY)
 - Energy & Commerce (Waxman, D-CA)



House – HR 3200

Passage

- In Energy & Commerce, “Blue Dogs” fought to limit government intervention and cost
- Final Energy & Commerce version included amendments required by “Blue Dogs” :
 - Cost of Medicaid expansion shared with states
 - Reduction in subsidies to population between 133-400% FPL
 - More small employers exemptions from mandate
 - Public plan must negotiate provider rates, and follow same insurance reforms



House – HR 3200

Passage (continued)

- Committee Votes
 - Passed Education & Labor by party line vote of 26-22
 - Passed Ways & Means by party line vote of 23-18
 - Passed Energy & Commerce by party line vote of 31-28

Proposal Status: Senate



Senate

- Jurisdiction held by 2 committees
 - Health, Education, Labor and Pensions (HELP) Committee (Harkin, D-IA; Formerly Kennedy, D-MA)
 - Finance Committee (Baucus, D-MT)

Senate

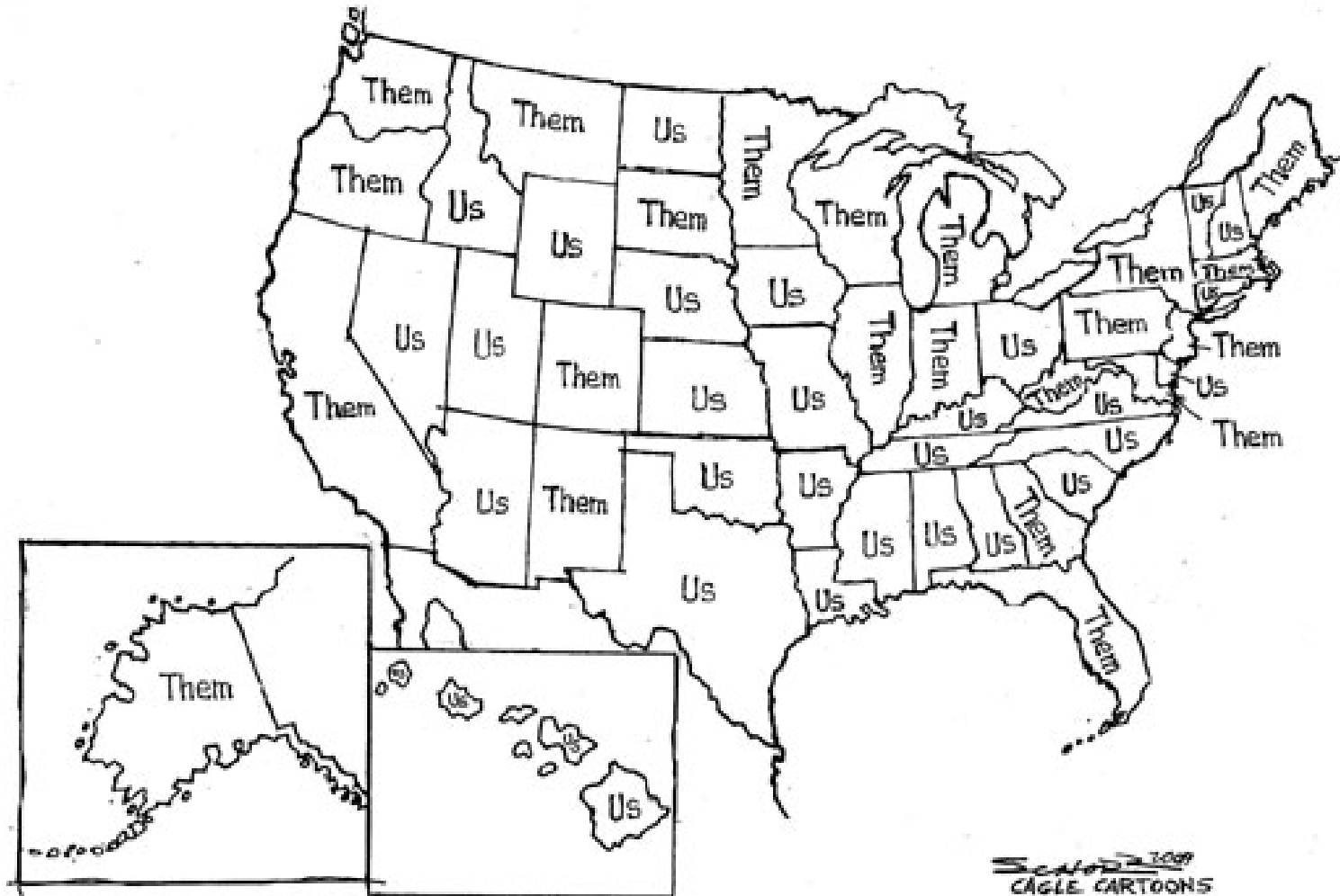
- Passed HELP Committee by a party line vote of 13-10
- Passed Finance Committee with a vote of 14-9 and a historic vote in favor by Republican Olympia Snowe (R-ME)
- Also, Senate Budget Committee passed a Budget Resolution in April with a vote of 53-43
 - Reform must be budget neutral over 10 years
 - Any bill that goes through Senate must follow this

High-level Policy Overview

Provisions At a Glance

Provision	HELP	Finance	House Tri-Committee
Public Plan	✓	Co-ops	✓
Insurance Exchange	✓	✓	✓
Individual Mandate	✓	✓	✓
Employer Mandate	✓	Free Rider Penalty	✓
Guaranteed Issue	✓	✓	✓
Medicaid Expansion	✓	✓	✓
Premium Subsidy	✓	✓	✓

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:
 - Tax “Cadillac” plans
 - 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?
- 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
 - Tax insurers? Tax the wealth? Sugary beverage tax?

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?

Impact on the Number of Uninsured 2019 Projections

Senate HELP

- Uninsured reduced to 36 million

Senate Finance

- Uninsured reduced to 25 million

House HR 3200

- Uninsured reduced to 17 million



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

Show Me The Money!



House – HR 3200

- **\$1.042 Trillion over 10 years**
- **Net \$239 billion deficit increase**
- Permanent reductions in annual Medicare FFS rate updates
- Setting payment rates in the Medicare Advantage program based on per capital spending
- Changes to Medicare Part D
- Tax on insurance plans with relatively high premiums
- Cancels scheduled 21% physician payment cut

Senate Finance

- **\$829 billion over 10 years**
- **Net deficit reduction of \$81 billion**
- Permanent reductions in annual Medicare FFS rate updates
- Setting payment rates in the Medicare Advantage program based on average of the bids
- Reduction in DHS payments by \$45 billion
- Excise tax high premium health plans
- Fees on manufacturers and importers of drugs and devices



Senate HELP

- **\$645 billion over 10 years**
- **\$1 Trillion with Medicaid expansion**
- Some Savings due to reduction in uninsured
- No authority to make changes to Medicare and Medicaid

Legislative Process – Next Steps

Path to the President: Overview

- Combine committee bills, introduce on floor
 - House must combine 3 bills, need simple majority
 - Senate must combine 2 bills, need 60 votes or reconciliation
 - Leaders will need to make compromises
- Pass bill in each Chamber
 - Amendments will be proposed and rhetoric will fly
- Combine bills in conference committee
 - What leadership will be chosen?
- Vote on chamber floor for combined bill
 - No additional amendments allowed

House – HR 3200

Next Steps

- As amended by Energy & Commerce it has advanced to the full House, where versions will be merged via House Rules Committee
 - Pelosi, White House and other House Leaders will give input
- Merged version will be scored by CBO
- Then House will take up various amendments
- Once that process has concluded, full House vote
- Passage requires simple majority

House – HR 3200

Questions

- Will “Blue Dog” amendments survive?
- Do they have the votes for a more “liberal” version?
- Will House moves toward the Senate version, under pressure from White House (making it more conservative)?
- How will the CBO score the bill?



Senate

Next Steps

- Bills will be merged on the Senate Floor, per Senate Rules Committee
 - Heavy input by Reid and White House, key meetings already being held
- Then CBO will score the merged bill
- Full Senate will address the merged legislation
- Then Senate will take up various amendments (uphill battle)
- Once that process has concluded, full Senate vote
- Need 60 votes to cloture, 51 to pass bill

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)



Senate Questions

- Will a comprehensive reform bill be able to secure 60 votes?
- Will it cancel scheduled 21% physician payment cut?
- How will the CBO score the bill?
- Will some type of public option survive?
- Can Democrats count on Sen. Snowe's support?
- What is achievable through Reconciliation?
 - Is reform *possible* when limited to finance only?
 - Is reform stable if it sunsets?



Conference Committee

- The versions that pass the House, and Senate respectively, will not be identical
- A Conference Committee will be formed to reconcile the two versions, and it will be scored by CBO
- This version will return to the respective Chambers for a final vote
- If those versions pass, the bill goes to the President

Outlook for Reform...

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 will be tackled in the next phase
- Quality will also be dealt with in next phase

Impact on Community Health Centers



Impact on CHCs - New Money

- Increases in funding to CHCs
- Increased funding for National Health Service Corps (recruitment, loan repayment)
- Grants for community-based enrollment initiatives (HELP)
- Prevention and Wellness grants
- Grants for state, local, and tribal health departments to support core public health infrastructure and activities (House)
- New grant for community-based residency training program

Impact CHCs – Coverage Expansion

- Increased FMAP to states through 2019 (Senate Finance)
- Requires single, streamlined online application (Senate Finance)
- Undocumented immigrants are not eligible for federal benefit, some verification required
- New eligibility rules and categories might pose major confusion in short term



Impact on CHC - Exchange

- Exchange may facilitate and centralize enrollment, CHC knowledge will be crucial
- Exchange plans must consider “Essential community providers” in-network (HELP)
- Insurers in state exchanges required to pay FQHC PPS payment rate (Senate)
- Undocumented immigrants can’t purchase insurance through exchange (HELP)

Impact on CHCs – Payment Changes

- Maintained or expanded payment for teaching hospitals including FQHCs
- Increased funding for primary care services
- Remove cap on Health Center Medicare payments (MATCH Act)
- Likely reduction in DHS payments



Impact on Health Centers (HC) – Massachusetts Example

- Despite reduction in uninsured, caseloads rose
- % of low-income adults uninsured fell, but less than statewide drop
- % of statewide uninsured receiving care at HC rose
- Overall revenues rose slightly
- Insurance expansion helped patients get care
- Many newly insured were previously their uninsured patients
- Some newly insured had higher needs when coverage started
- Greater role in enrollment, new procedures & systems meant increase in administrative burden
- Faced challenges recruiting and retaining clinicians due to increased demand



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