

Summary of the U.S. Healthcare Reform Initiative

FOR MANY OF US, the whirl of news about healthcare reform has left us somewhat unclear as to what it means. The bills that are currently being drafted and considered by committees of the U.S. House of Representatives and the U.S. Senate are complex and, if passed, will have far-reaching consequences throughout the United States and perhaps internationally. Healthcare reform legislation has the potential to fundamentally impact how we deliver, pay, and insure for healthcare, and, for the first time, may afford near-universal access to U.S. citizens. As a result, healthcare reform legislation may be more significant than the employer-based healthcare benefit system developed after World War II or the enactment of legislation that created the Medicare and Medicaid programs in the mid-1960s. At the same time, the prospect of healthcare reform presents significant opportunities and challenges to businesses, employees, their families, the uninsured, insurers, healthcare providers and their suppliers, which will remain with us for many years.

It is easiest to understand the current healthcare reform initiative as a set of three principal issues, including: (i) Access and Affordability; (ii) Funding and Cost Savings; and (iii) Sustainability.

Several committees within the U.S. House of Representatives and the U.S. Senate are charged with drafting the healthcare reform legislation. On the House side, the chairmen of the committees on Ways and Means, Energy and Commerce, and Education and Labor worked together to produce one bill, the relevant pieces of which were reviewed in the committee of jurisdiction. On the Senate side, the Finance Committee and the Committee on Health, Education, Labor and Pensions (“HELP”) are drafting separate healthcare reform bills. The Senate HELP Committee has completed its markup of legislation that encompasses the areas within its jurisdiction. The

Senate Finance Committee continues to work to find a bipartisan compromise before unveiling its bill. The House Ways and Means, Energy and Commerce, and Education and Labor Committees have each approved the portion of the House healthcare reform bill within their respective jurisdictions. The committee with the most significant jurisdiction in the House, Energy and Commerce, is continuing with its mark-up. The committees have chosen to address the principal issues in ways that are both different and similar and which are discussed below.

Access and Affordability

In 2009, it is estimated that expenditures upon healthcare within the U.S. will total approximately \$2.5 trillion or \$8,160 per person. This sum represents 17.6% of total U.S. economic output and is more than any other major economic power in the world spends on healthcare. By contrast, the U.K. spends \$2,723 per person or 8.3% of its economic output, while for Japan the numbers are \$2,358 per person and 8% of economic output. Yet, despite this extraordinary expenditure of dollars, the U.S. lags behind many countries in life-expectancy and measures of good health, and is one of the few major economic powers not to afford its citizens universal access to healthcare services. It is estimated that approximately 46 million U.S. citizens are without healthcare insurance coverage.¹ As part of the healthcare reform initiative, various proposals have been put forward to address the issue of access including proposals for insurance reform, expansion of Medicaid, and a public healthcare insurance option. Proposals for health insurance reform have included, among

1. The number is somewhat misleading since it includes illegal aliens, healthy young adults who choose not to carry health insurance and individuals who are eligible for Medicaid but chose not to participate in the program. The number also does not reflect those who are losing healthcare coverage as a result of the current economic downturn.

others, a prohibition upon exclusions for pre-existing conditions; a restriction upon premium ratings based on gender, health status, or occupation; a limitation upon the portion of premium dollars that may be used for administrative expense; a requirement of guaranteed availability and coverage; and a prescribed minimum set of benefits. Health insurers that satisfy these requirements, along with other requirements, would qualify to compete for subscribers through health insurance exchanges. To guard against adverse selection, a system of risk adjustment would be developed for plans with actuarial risk above and below the actuarial risk of all health plans participating in the exchange.

Proponents of healthcare reform argue that competition among plans participating in exchanges would encourage further reform by allowing for different benefit levels among plans as well as rewarding healthcare plans that are able to realize cost savings through programs that encourage both efficiencies and improvements in the quality of healthcare delivery. A criticism of the health insurance exchanges is that they include a firewall that precludes participation by individuals already eligible to participate in an employer-sponsored plan. By limiting participation in the exchanges, there is concern that the effect will blunt the benefits anticipated from competition among health insurers.

Many employers have found self-insurance as a cost-effective way to provide employee health benefits coverage. Such arrangements are expressly permitted under ERISA and U.S. tax laws. The House bill requires the Departments of Labor and Health and Human Services to conduct a study and report back to Congress within eighteen months with recommendations to protect against adverse selection in self-funded health benefit programs.

An expansion of the Medicaid Program has also been proposed to allow individuals and families who are above the poverty level, but unable to afford health insurance, to participate in Medicaid. One proposal would extend the Medicaid Program to

individuals whose income does not exceed 133% of the federal poverty level (\$14,400 per individual or \$29,330 per family of four). Since roughly half of Medicaid expenditures are borne by the states, the fiscal impact of expansion is unclear. Many governors, both Democrat and Republican, have expressed concern that the expansion will constitute an unfunded mandate that the states can ill-afford during this time of economic downturn and strained state budgets.

Both the House and Senate proposals include penalties for employers and individuals who do not purchase insurance, with certain hardship exceptions. Employers with greater than 25 employees must offer insurance or contribute funds on their behalf or pay a penalty of either a fixed fee per employee (Senate HELP) or payroll tax equal to 8% of the cost of the employer's payroll (House). Similarly, under the individual mandate, individuals who do not maintain health insurance are subject to a penalty fee (HELP) or 2.5% tax on "modified" adjusted gross income (House). The penalties create a disincentive for failing to procure health insurance.

In addressing the principal issue of access, the most contentious proposal has been whether healthcare reform requires a public option to compete with private insurers in the exchanges. That is, whether the federal government should establish a public healthcare insurance option available to anyone who qualifies to purchase insurance in the newly-established exchange system. Basically, this would include individuals who are not insured and do not have access to employer-sponsored plans and those who do not otherwise qualify to participate in the Medicare or Medicaid programs. To ensure access, the public option would make government subsidies available to individuals whose income levels fall below certain specified levels. Proponents of the public option argue that it would encourage competition among health benefit plans which, in turn, would lead to cost savings through programs that encourage both efficiencies and improvements in the quality of healthcare delivery.

Opponents argue that a public plan would unfairly compete with private plans by mandating rates that are at or slightly above Medicare rates. In addition, a public plan would not have to raise initial capital and would be able to utilize the existing health care infrastructure of Medicare. The Director of the Congressional Budget Office (“CBO”) testified recently that the inclusion of a public healthcare plan significantly expanded federal government responsibility for health care costs in the long term—costs the CBO Director termed unsustainable.

Criticism of the overall cost of the reform bills has led to various proposals to offset their cost. In an effort to gain bipartisan support for healthcare reform, the Senate Finance Committee has labored to develop an alternative to the public option. One proposal under consideration is the creation of private-sector cooperatives. In these cooperatives, prospective subscribers with some direction and/or financial assistance from the federal government would join together to underwrite their healthcare and contract directly with providers on terms of payment.

Senator Wyden has proposed in separate legislation an alternative to the current health reform bills. Under what Senator Wyden calls the Free Choice proposal, health insurance exchanges would be open to all individuals. Those employees dissatisfied with coverage offered through their employer would be entitled to cash out of their employer plan and would receive a voucher to purchase coverage through a health insurance exchange. The amount of the voucher would be based upon the cost of the lowest level of insurance offered by the exchange and the percentage of premium paid by the employer under its current health plan. There is concern, however, that the proposed legislation would leave employer-based plans burdened with older and sicker beneficiaries. Senator Wyden argues that a risk of adverse selection can be addressed through a system of risk adjustment.

Funding and Cost Savings

In pressing a healthcare reform initiative, the President and Congress have been insistent on identifying the funding and savings that would pay for healthcare reform so as not add to the budget deficit. The CBO pegged the cost of the initial proposals for healthcare reform at \$1.6 trillion over ten years. However, revisions to these proposals have reduced this projection to slightly over \$1 trillion over ten years, which would be paid for through a combination of tax increases and cost savings.

Proposed tax increases have come in various forms. The House bill proposes a surtax ranging between one and 5.4% on U.S. taxpayers earning more than \$280,000 per year (\$350,000 for those who file jointly). However, other proposals to increase taxes have been suggested. The White House has proposed limiting the itemized deductions of individuals earning over \$250,000 per year. Another proposal would tax health benefit programs that exceed an agreed cost with a possible carve-out for union health plans. This proposal may include a further limit on tax benefits available through employer-sponsored flexible spending accounts.

Costs savings are anticipated to come in the form of Medicare payment reform, programs to improve the efficiency and quality of healthcare delivery, and programs to combat over-utilization, waste, fraud, and abuse. With regard to the former, pharmaceutical manufacturers have announced that they will find savings of \$80 billion over ten years, and hospitals have agreed to \$155 billion in reimbursement cuts over ten years. Some members of the Senate Finance Committee have called for similar concessions from insurers or have suggested imposing fees on health-care insurers. Other savings are anticipated from a reduction in payment levels to Medicare managed care plans and a new physician payment system tied to growth in the Gross Domestic Product. It is interesting, and perhaps unprecedented, that a coalition of

physician groups, including the American Medical Association at the national level, has announced support of healthcare reform generally and the public option specifically.

Finally, the White House has sent a proposal that would replace the Medicare Payment Advisory Commission (MedPAC) with an independent advisory council. Unlike MedPAC which only advises Congress on issues affecting the Medicare program, this new council would have authority to set Medicare reimbursement rates subject to the approval of the President. Congress could overturn action of the council only upon joint resolution.

Cost savings from programs to combat overutilization, waste, fraud, and abuse are more difficult to quantify. For example, it is anticipated that cost savings would be realized as a result of the uninsured having access to lower cost, healthcare provider settings and no longer relying upon hospital emergency rooms for treatment. However, these savings are difficult to quantify, and it is possible that any savings would be offset by an increase in utilization as a result of the additional coverage afforded as a result of healthcare reform.

There has been some discussion of the increased cost that comes from “defensive medicine” practiced as a result of the tort system that exists among the states. Tort reform proposals have not been included in the healthcare reform proposals.

Sustainability

The third principal issue in healthcare reform is sustainability. As noted earlier, some studies have shown that the U.S. healthcare system is more costly and less effective in terms of life expectancy and other measures of good health than the healthcare systems of other developed countries. More importantly, ongoing increases in the cost of U.S. healthcare are not sustainable. The challenge of healthcare reform, therefore, is two-fold. First, it must provide sources of funding and cost savings that, in time, improve access and affordability. Second, healthcare reform must

also result in a healthcare system, which over the long-term is economically sustainable.

The healthcare reform initiative addresses the issue of sustainability in two ways. First, healthcare reform makes the assumption that a healthier public will consume fewer healthcare resources and prove less costly to treat. The healthcare reform proposals, therefore, put an emphasis upon wellness and prevention. For example, the HELP bill provides for a voluntary insurance program for assisted living services that will encourage those with certain disabilities to continue to live independently and avoid the more costly alternative of nursing home care and the indigency that “spending-down” for Medicaid eligibility often entails.

The second way that the healthcare reform initiative seeks sustainability is through encouraging quality and efficiency in healthcare delivery. Under the current healthcare system, most healthcare information is not compiled mechanically or in a manner that makes it readily accessible. As a result, the ability to share healthcare information, even information that is not patient specific, is limited. For example, coordinating care among healthcare providers can be difficult without an ability to share readily a patient’s medical record. It is also very difficult under the present system to evaluate one modality of care over another. This, in turn, precludes studies that evaluate efficacy and cost. Similarly, it is very difficult to explain why the cost of healthcare varies among different geographic regions of the country.

The first step in remedying the current situation was contained in the American Recovery and Reinvestment Act of 2009 (the Economic Stimulus), which provides federal funds for research to compare the effectiveness and quality of alternative modalities of care and further encourages healthcare providers to convert to systems of electronic medical records. The healthcare reform initiative continues this effort with provisions designed to lead to efficiencies, cost savings, and quality improvements that, in turn, will

make the U.S. healthcare system as envisioned under the healthcare reform initiative sustainable. Toward this end, the Senate HELP Committee bill provides for the establishment of a Center for Health Outcomes Research and Evaluation within the Agency for Healthcare Research and Quality. The purpose of the Center is to foster research with respect to comparing healthcare outcomes, effectiveness, and appropriateness of healthcare services and procedures in order to identify the most effective manner of prevention, diagnosis, treatment, and clinical management of diseases and disorders.

It is unclear, however, whether the healthcare reform initiative does enough to reduce the cost of healthcare within the U.S. and thereby ensure sustainability. As mentioned earlier, Douglas Elmendorf, the director of the CBO, has noted that the proposals of the House and the HELP Committee may not realize the projected cost savings and may not reign in the cost of healthcare within the U.S..

Well respected medical providers such as the Mayo Clinic and Intermountain Healthcare also have expressed concern about the House and HELP healthcare reform proposals. They have made the point that to achieve a sustainable healthcare system,



the healthcare reform initiative must address payment reform as well as efficiency, quality, wellness, and prevention. Concerns expressed by the Mayo Clinic and Intermountain Health are especially noteworthy. Their manner of healthcare delivery, which has been termed the accountable care model, relies upon coordinating a patient's care among various providers compensated on a salaried or similar basis as opposed to a fee for each service, and has been held up as the healthcare delivery model through which cost savings, efficiency, and high quality will be realized under healthcare reform.

Finally, there is Massachusetts, which three years ago enacted a healthcare reform plan that included universal access through subsidies and employer and employee mandates. Despite reform, healthcare costs in Massachusetts have continued to rise at an annual rate of 6-9%. To remedy this situation, a commission appointed by the Massachusetts legislature has recommended payment reform that would eliminate reimbursement on the basis of a fee for service, and would replace it with a global payment that is similar to monthly capitation payments in an HMO. The lesson from Massachusetts is that for healthcare reform to be sustainable, it must include provisions that address payment reform as well as quality, efficiency, wellness, and prevention.

In sum, the healthcare reform initiative is historic in its significance. It has the potential to fundamentally impact how we deliver, pay, and insure for healthcare as well as affording, for the first time, near-universal access to U.S. citizens. Identifying funding and savings is an additional goal of the healthcare reform initiative. Finally, it is important that the healthcare reform initiative leads to a system that is sustainable over the long term. To do so, payment reform as well as an emphasis upon quality, efficiency, wellness, and prevention will be required.

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