



Federal Health Care Policy in a New Era

Edwin Park

Senior Fellow

Center on Budget and Policy Priorities

park@cbpp.org

March 19, 2009

Health Reform is Top Federal Health Agenda Item for 2009

- CHIP reauthorization and economic recovery legislation already enacted.
- Next up: comprehensive health reform, which is likely to also include changes to Medicare (including folding in legislation to address physician payments) and Medicaid.
- Three goals: how to achieve universal coverage, slow the rate of growth in health care costs, and improve quality.

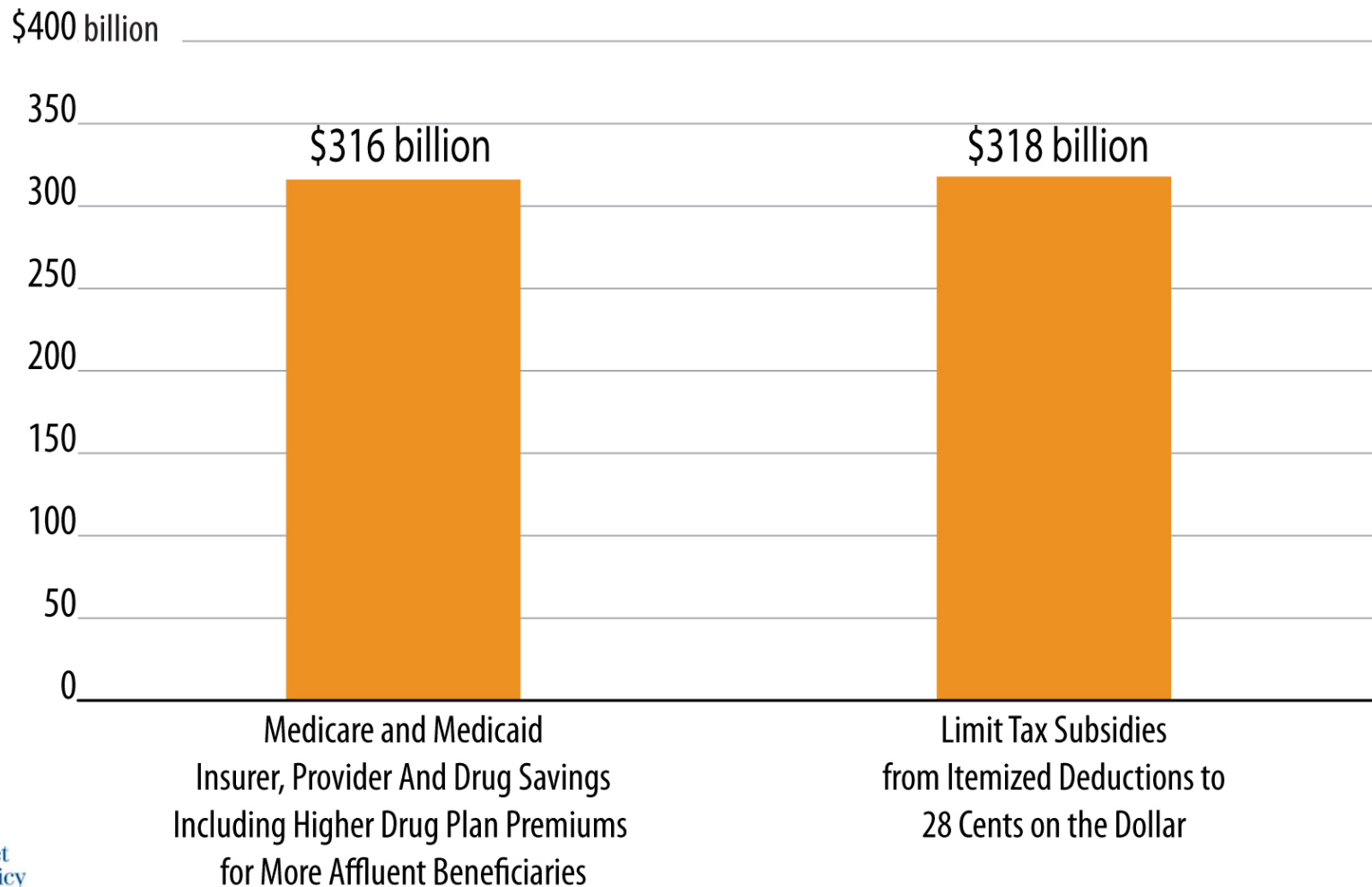
Process and Timetable

- Consideration of Obama Administration budget (released end of February) and crafting of Congressional budget resolution (beginning of April).
- Committees in House and Senate already working on health reform, particularly in Senate.
- Aim to mark up by the end of June in Senate Finance Committee with floor consideration before August recess.
- First year of incoming Administration is often the best opportunity for major legislation.

Obama Budget on Health Reform

- Identifies savings and revenues for a \$634 billion “down payment” on health care reform.
- Important because it recognizes that both savings *and* revenues will be needed.
- Does not specify how money will be spent.

Obama Administration Proposes “Down Payment” for Health Care Reform: \$634 billion over 10 years



Obama Administration Principles for Health Reform

- Will not send up detailed legislation but did outline general health reform principles in its budget:
 - Protect families' financial health.
 - Make health coverage affordable.
 - Aim for universal coverage.
 - Provide portable coverage.
 - Guarantee choice.
 - Invest in prevention and wellness.
 - Improve patient safety and quality
 - Maintain long-term fiscal sustainability of health reform.

Potential Health Reform “Consensus” Framework

- Seems to be some consensus from Administration and key Congressional leaders on the following framework:
- Expand coverage by building upon public programs and employer-sponsored insurance.
- Establish new health insurance purchasing pools for those without access to either.
- Slow the rate of growth in health care costs and improve quality through delivery system reforms, pay-for-performance, health information technology in both private and public sectors, comparative effectiveness research, etc.

Key Policy Issues in this Framework

- We have identified *four* key issues in health reform legislation that directly affect low-income individuals and families. Will be familiar to those involved in California's own health reform debate.
 - Designing effective health insurance pools.
 - Strengthening public programs like Medicaid and SCHIP.
 - Ensuring health insurance affordability for low-income individuals and families.
 - Paying for health reform with both revenues and savings while also instituting appropriate cost-containment measures throughout the health care system to “bend the curve” of ongoing, rapid health care spending growth.

1. Structuring Effective Health Insurance Pools

- New health insurance pools (“connectors” or “exchanges”) need to be established for those not eligible for existing sources of coverage.
- Design of such pools must ensure, however, that individuals in poorer health, especially those who are low-income, can enroll in affordable, comprehensive health insurance coverage.

Limiting the Risk of Adverse Selection

- Effective pooling requires taking steps to avoid the risk of “adverse selection.”
- If certain plans are primarily attractive to people in better health (like high-deductible plans attached to Health Savings Accounts), and individuals in poorer health enroll in other more comprehensive plans, then the premiums for the comprehensive plans will rise and become increasingly unaffordable.
- Using “risk adjustment” helps but is imperfect, and unlikely to address the problem of adverse selection.
- Requires benefits “standardization” (that will likely be opposed by insurers and some employers).
 - Minimum or “essential” benefits should be required.
 - Limit on variation between benefit designs across plans.
 - Limit number of choices to avoid confusion and selection.
 - Unified risk pools and insurers must offer all benefit designs.

Providing a Public Plan Option in New Pool

- “Public plan” option in new insurance pool would spur competition and provide a stable fallback plan for individuals and families.
- Big political battle, however, brewing over public plan option.
- Key policy issues:
 - How to craft a “level playing field.”
 - How to leverage advantages of public plan.
 - How to avoid private insurers selecting against public plan.

2. Improving Medicaid and SCHIP as Part of Health Reform

- Using Medicaid as a “building block” for universal coverage.
- In part, this is a recognition of the special role Medicaid now plays. Medicaid:
 - Covers benefits not otherwise covered by private insurance needed by people with disabilities and special health care needs.
 - Limits premiums and cost-sharing for its low-income beneficiaries.
 - Finances integrated state social, educational and health programs for vulnerable populations.
 - Supports health care infrastructure such as public hospitals and community health clinics located in disadvantaged communities.

Medicaid and SCHIP: Issues to Be Addressed

- Medicaid and SCHIP programs must be strengthened to ensure that they are stable, effective and integrated programs within a reformed health system.
- Key issues to be addressed:
 - Complex “categorical” eligibility structure.
 - Programs are cut during economic downturns due to state budget deficits even when families most need them.
 - Millions of eligible individuals remain uninsured.
 - Inadequate provider rates have limited access to providers for some beneficiaries.
 - Providing additional federal support to offset greater state costs.

Improvements to Medicaid and SCHIP

- Improvements to address these weaknesses could include:
 - Simplified eligibility rules: income eligibility above some level for all individuals and families.
 - Countercyclical FMAP.
 - Simplified enrollment and renewal procedures to increase participation and to ensure seamless transition to other sources of coverage in a reformed system including employer-sponsored insurance and the new insurance pools.
 - Improved provider rates.
 - Greater federal support (e.g., higher FMAP, higher FMAP for dual eligibles, end of 2 year Medicare waiting period).

3. Ensuring Affordability for Low- and Moderate Income Individuals and Families

- One cannot achieve universal coverage without a mandate on individuals to have health insurance *and* making health insurance affordable.
- Nearly three-quarters of the uninsured have incomes below 300 percent of the poverty line.
- Must therefore ensure sufficient subsidies to individuals and families so they can enroll in health insurance while still having the resources to pay for other necessities like housing, food, heating costs, transportation, etc.

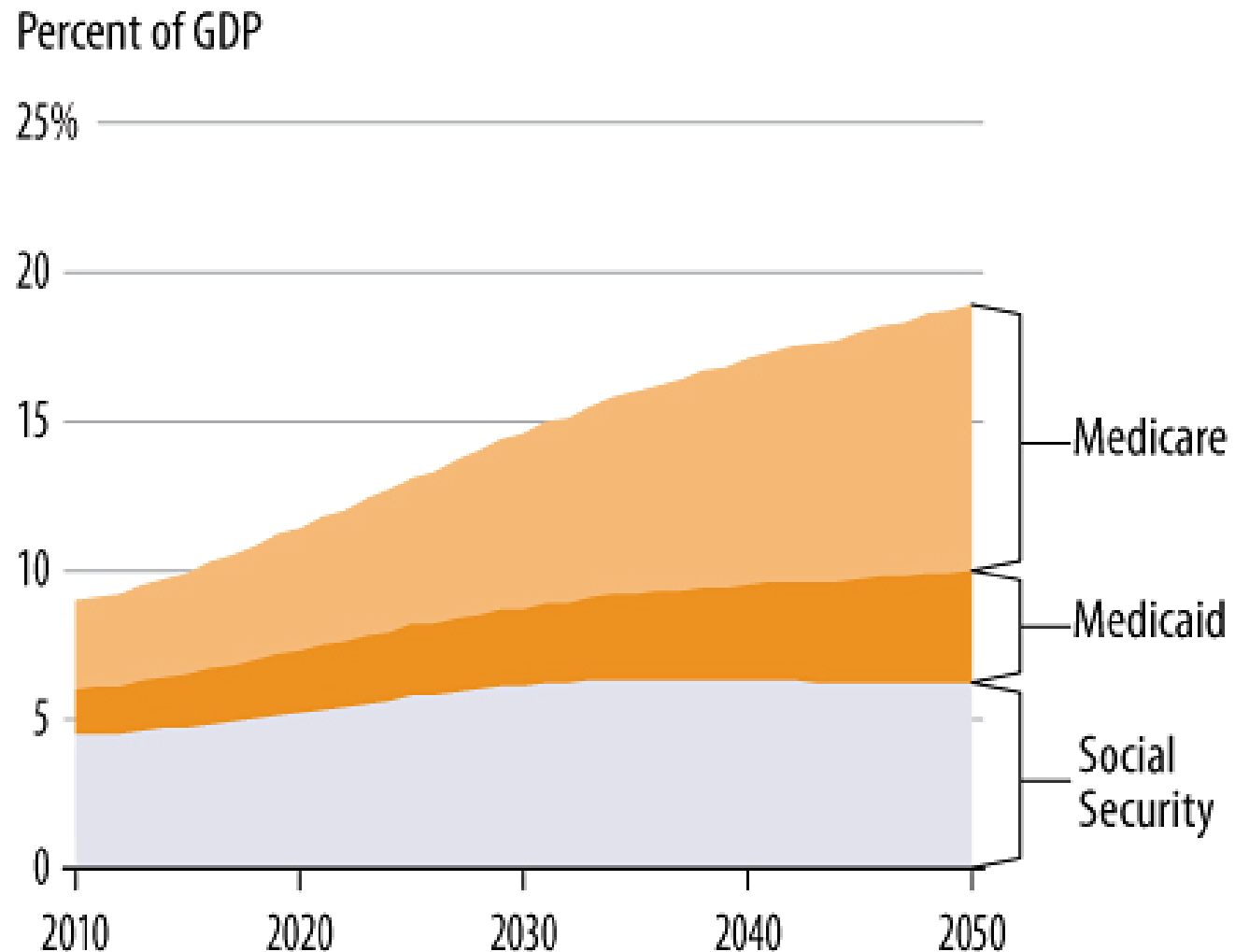
Establishing Limits on Premiums and Cost-Sharing

- Health reform must include substantial premium subsidies based on income.
- How one designs the premium subsidies is important because certain design choices could lead to low-income individuals enrolling in plans with less comprehensive coverage.
- Limits on deductibles and other cost-sharing and ensuring adequate benefit packages (danger of underinsurance) are also critical.
- Cost-sharing disproportionately affects low-income individuals' access to needed care.
- Total out-of-pocket limits could be based on income along a sliding-scale (percentage of a family's income).

4. Paying for Health Reform and Slowing the Rate of Growth in Health Care Costs

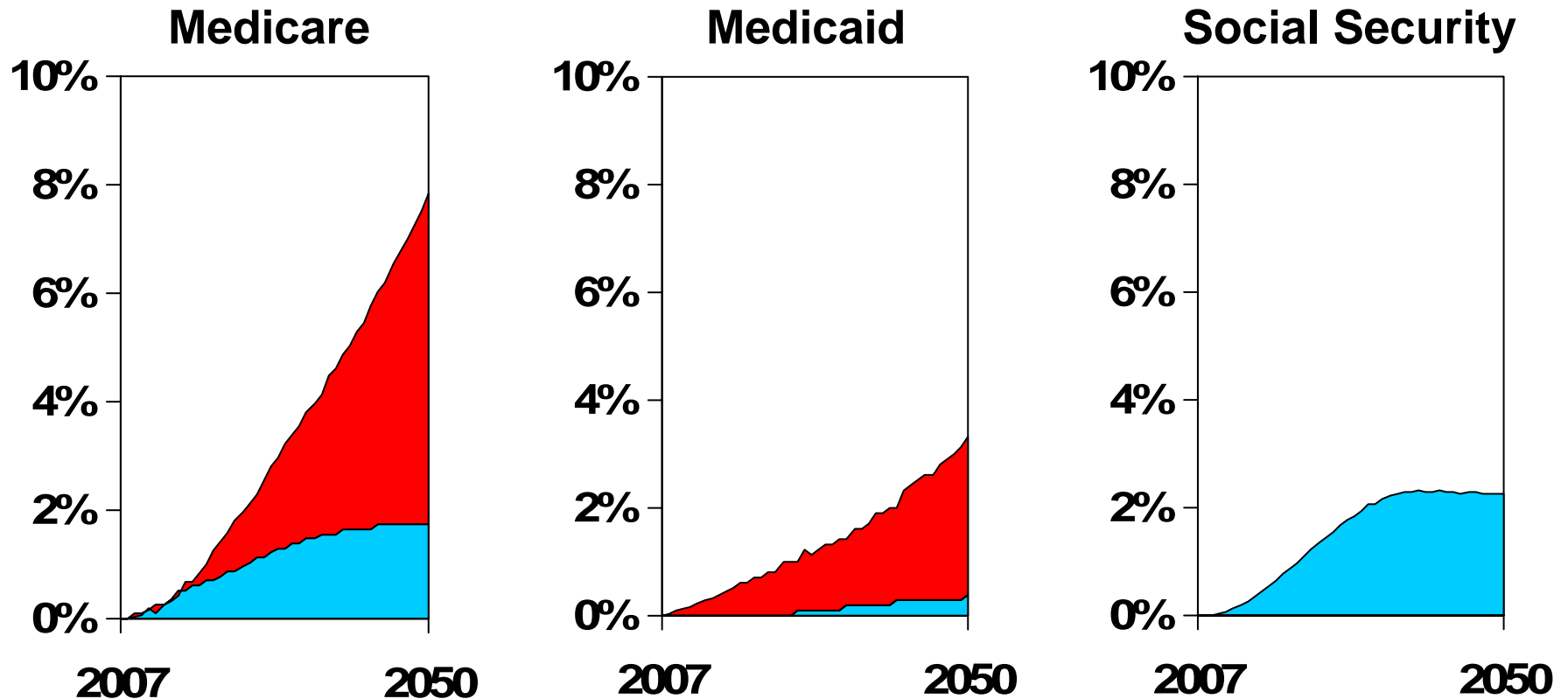
- Financing/cost-containment are essential elements of any health reform effort but they could be the most politically difficult and controversial issues within health reform.
- In short-run, it is critical to identify new revenues and program savings to provide offsets to pay for cost of providing universal coverage and make needed improvements in Medicaid/SCHIP.
- While economic recovery legislation was not subject to PAYGO, health reform will likely have to be paid-for, as indicated by Obama budget.
- In the long run, effective cost-containment measures adopted throughout the U.S. system could slow the rate of growth in overall health care spending, which makes Medicare and Medicaid more sustainable and thus improves the federal fiscal outlook.
- Cost-containment, however, should be designed in a way to improve the quality of care and protect access to care for vulnerable populations including the low-income.

Medicare, Medicaid and Social Security Expected to Rise Rapidly

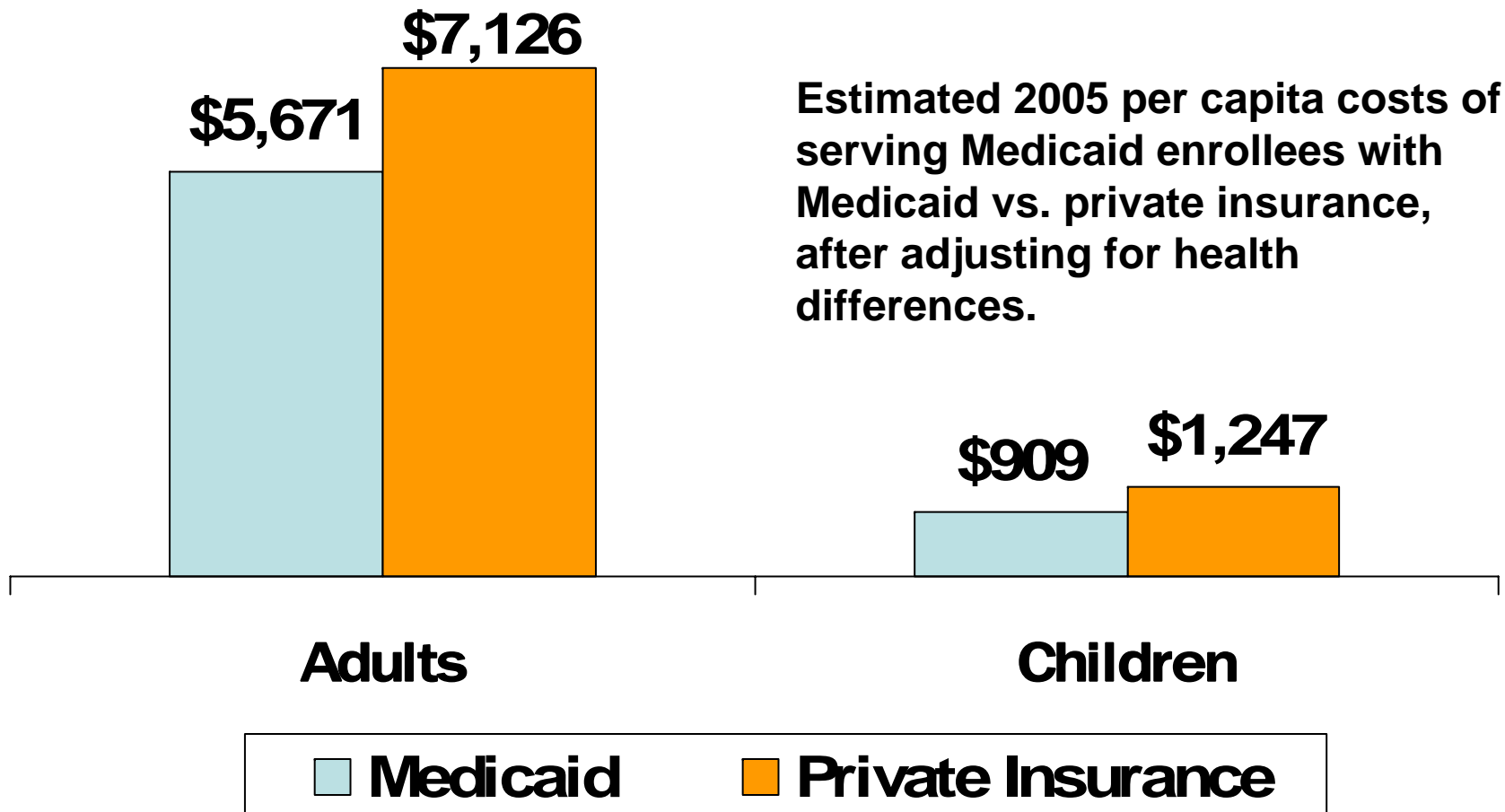


Rising Health Care Costs Are Main Driver of Growth in “Big Three”

Sources of cost growth in the “Big Three” as a share of GDP

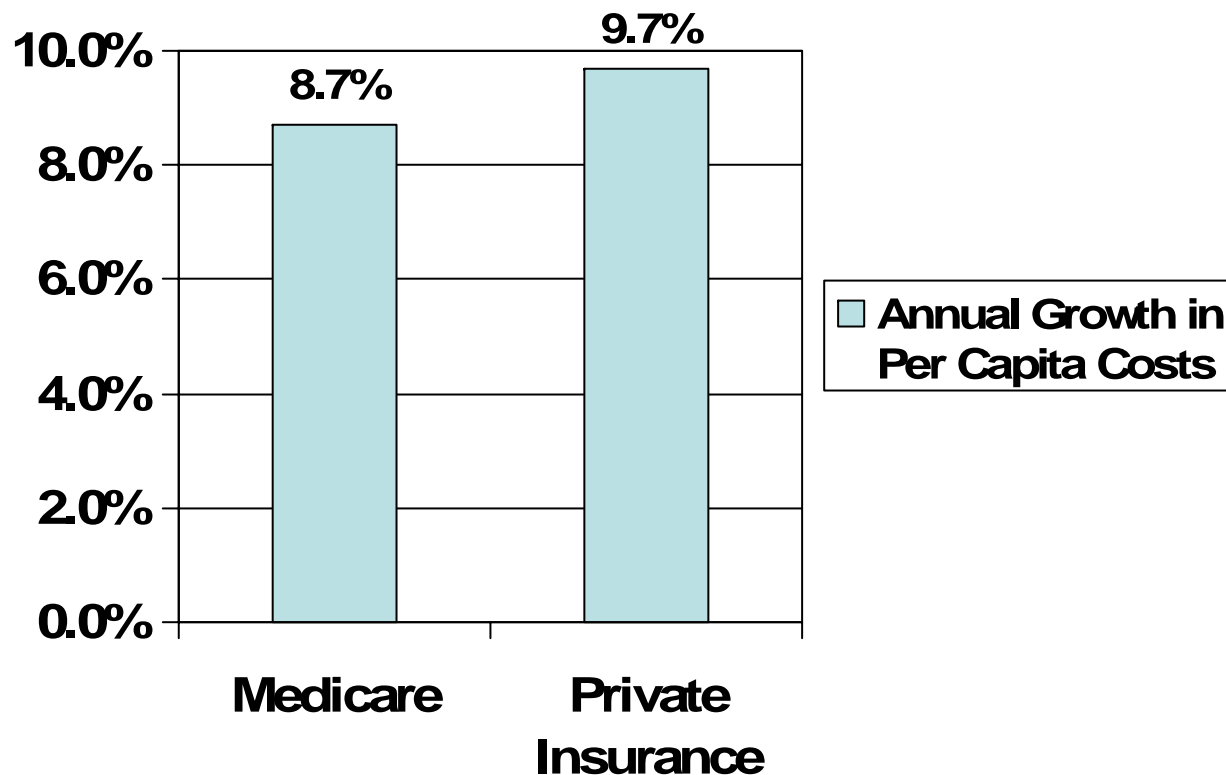


Medicaid Costs Are Similar or Lower than Private Sector Health Costs



Medicare Costs Have Risen More Slowly than Private Insurance

Average Annual Per Capita Growth Rates in Medicare and in Private Insurance (1970-2006)



Illustrative Financing/Cost-Containment Proposals

- Use of comparative effectiveness research and expanded use of health information technology, which were funded in the recovery legislation.
- Health care delivery system reform and pay-for-performance in Medicare and throughout the system.
- Curbing Medicare Advantage overpayments and other Medicare reimbursement rate changes.
- Reducing prescription drug costs.
- Modifying or reforming current tax subsidies for health insurance.
- New revenue sources outside the health care system.

Difficulties for Financing/Cost-Containment

- Politically challenging. Impacts lots of special interest groups by directly affecting their “bottom line.”
- Very complex and some strategies are unproven.
- Some provisions may not produce positive results for an extended period and may even increase costs in the short-run because they require upfront investment of resources.

Curbing Medicare Advantage Payments

- Private insurers in the Medicare Advantage program cost 14 percent more (about \$1,000) than traditional Medicare fee-for-service to cover the same beneficiary.
- Medicare bill enacted in summer 2008 modestly curbed these overpayments and placed new requirements on private plans to limit enrollment growth.
- “Leveling the playing field” would eliminate these overpayments, lower Medicare premiums for beneficiaries and improve Medicare’s overall finances, saving anywhere from \$157 to \$175 billion over 10 years.
- Produces savings that could be reinvested in achieving universal coverage, as well as in improvements for low-income Medicare beneficiaries.

Capping Itemized Deductions

- Example: Obama proposal to cap use of itemized deductions at 28% bracket. Important because it recognizes that you need additional financing outside the health care system.
- Attacked as discouraging charitable giving, undermining housing market.
- Only top 1.2 percent of tax filers would be affected (TPC).
- CBPP estimates that proposal would reduce charitable giving by only about 1.3% compared to giving under current tax rates (which determine the value of the tax subsidy).
- Estate tax proposal would *boost* charitable giving as compared to repealing the estate tax.
- “Fixing” health care is a big boost to charitable organizations (less uncompensated care).

Consequences of Failing to Find Sufficient Financing and Institute Reasonable Cost-Containment Measures

- But the alternative, politically easier path likely leads to poor outcomes that would harm (or fail to help) vulnerable, low-income individuals and families.
- Health reform is enacted but:
 - Unaffordable premiums and cost-sharing charged to the low-income because of inadequate subsidies despite mandate.
 - Less comprehensive benefits being provided.
 - Particular difficulties for the most vulnerable (those with chronic illnesses, special health care needs and disabilities) in accessing needed care.
 - Falls well short of universal coverage.
- Health reform is not enacted at all:
 - More uninsured, higher costs, continued poor quality.
 - No system-wide cost-containment, so leads to direct cuts to Medicare and Medicaid over the long-term with harmful consequences for the tens of millions of seniors and low-income individuals and families who rely on them.