# With Challenge Comes Opportunity: The Obama Administration, the 111th Congress and the Future of Health Care Reform

By Susan Dentzer
Editor-in-Chief, *Health Affairs*
National Pay for Performance Summit
March 9, 2009

# This presentation at a glance

- **The backdrop: Quick overview of issues in U.S. health care and health**
- **Current realities and possible scenarios**
- **Emerging areas of consensus and disagreement**
- **Some conclusions**

# Health Insurance in Crisis: The Backdrop

# How Americans Get their Health Coverage

- Approximately 261 million Americans have health coverage in 2009 (out of approx. 300 million)
- Approximately 45 million uninsured as of 2007 (latest reported year); current number may be 48 million or more
- Sources of coverage:

➢ Private, employer-provided private coverage: approximately 177 million people, including spouses and dependents

➢ Individually purchased private coverage: approximately 10 million

➢ Publicly provided coverage:

- Medicare: approximately 45 million in 2009
- Medicaid and State Children's Health Insurance: About 43 million
- Other (military, VA, state and local employees, etc.): About 12 million

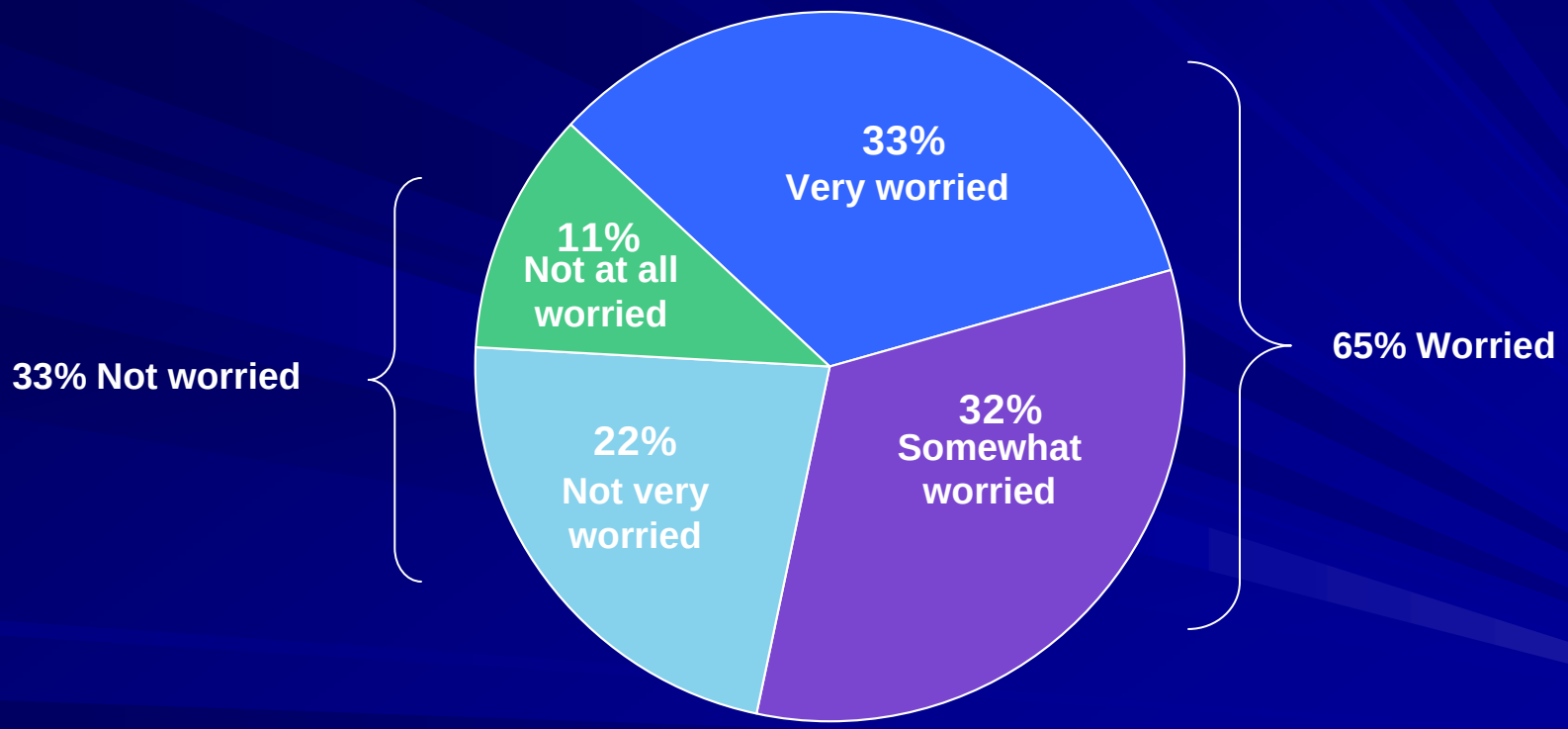
# Rising health insurance costs

- Average annual premium for employer-provided family coverage reached $12,680 in 2008; $4,704 for single coverage,
- Premiums rose an average 5% in 2007, slowest rate since 1999 but still outstripping the rate of inflation or growth in workers' wages
- Overall, premiums have doubled since 2000
- Health system cost trend continues at about 6.5-7% annually
- Polls show this is far and away voters' number one health concern

- Source: Employer Health Benefits 2008 Annual Survey, Kaiser Family Foundation and Health Research Educational Trust

# ’08 Exit poll: Health cost concerns

**How worried are you about being able to afford the health care services you need?**




Source: Edison/Mitofsky, National Exit Poll, sponsored by the National Election Pool. Conducted November 4, 2008

# Behind the numbers: Declining private coverage

- Private, employment-based coverage **fell from 2000 to 2007 in both percentage and overall terms**
- **Drop in employment based coverage fell from 59.7 percent of people in the U.S. in 2006 to 59.3 percent of people in 2006.**
- The number of people covered by employment-based health insurance, 177.4 million, was not statistically different from 2006.
- Just over three in five firms (63%) offered coverage to workers in 2008
- Significant drop from 69% in 2000
- Drop stems almost entirely from fewer small businesses offering health benefits, as nearly all businesses (98%) with 200 or more workers offer such benefits.

Sources: Census Bureau Current Population Survey, published Aug. 2007; Kaiser Family Foundation Employer Benefits Survey, published Sept. 2007

# The Rising Tide of Un-insurance: Public Coverage Picks Up the Slack

- Census Bureau's Current Population Survey, 2007 (published 8/08)
- Estimated number of uninsured fell 1.3 million to 45.7 million
- = Number (1.3 million) who gained public insurance coverage (Medicaid)
- Number of uninsured children fell by 500,000 to 8.15 million; also similar to number of children who became insured by Medicaid

# Cyclical Effects of Economy in Recession

- More firms & workers/dependents likely to drop coverage; CMS estimates contemplate that 3 million will lose private health coverage this year
- States now cutting back on Medicaid and S-CHIP despite earlier stimulus relief; new stimulus FMAP increase aimed at halting vicious cycle
- Kaiser Health Tracking Poll, Feb. 3-12, 2009; **53% say they have done any of these:**
  - relied on home remedies or over the counter drugs instead of going to see a doctor
  - skipped dental care or checkups
  - postponed needed health care
  - skipped a recommended medical test or treatment
  - not filled a prescription
  - cut pills in half or skipped doses
- Providers report cutbacks in elective surgeries & changes in visits to emergency room

Sources: Andrea Sisko, CMS, verbal comment, 24 February 2009; Kaiser Tracking Poll at www.kff.org

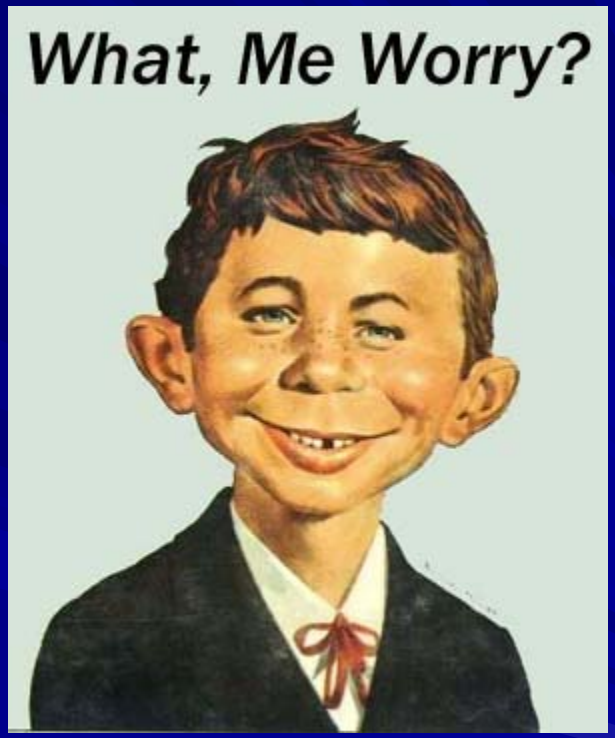
# Health Spending and Health Costs: The Backdrop

# Strengths of U.S. health care: a sampling

- Innovation and access to new treatments and technologies
- Prestigious world class academic medical centers
- Higher cancer survival rates than rest of world
- Convenience

# Pros and cons

- **Alfred E. Neuman's famous equation of health care (as per Uwe Reinhardt)**
- **$1 of health spending = $1 health income**
- **Ergo, booming health spending means booming health economy, which is good**



# Health Care: We're Getting Value

- Analysis of increased spending on MI care, 1984-98
- Nearly half of cost increases (45 percent) result from people getting more intensive technologies over time; increased prices account for 33 percent.
- Life expectancy for the average person with a heart attack was just under five years in 1984 but had risen to six years by 1998.

David Cutler, Harvard (top);
Mark McClellan, Brookings

Source: David M. Cutler and Mark McClellan
Is Technological Change In Medicine Worth It?
Health Affairs, September/October 2001; 20(5): 11-29.

# Health Care: We're Getting Value

- Authors valued the health benefit of this additional year of life at $100,000.
- Subtracting "value" (what we would pay for an extra year of life) from costs, the net benefit is about $60,000
- Equals $7 gain for every $1 spent.
- Source: David M. Cutler and Mark McClellan, Is Technological Change In Medicine Worth It?
  Health Affairs, September/October 2001; 20(5): 11-29.

David Cutler, Harvard (top);
Mark McClellan, Brookings

# The Value Equation? U.S. versus the rest of the Organization of Economic Cooperation and Development Countries*

- U.S. has highest per capita expenditure on health care (50% greater than Luxembourg or Switzerland)
- U.S. per capita spending grew from $5,800 to $6,800 --17% -- in the 3 years from 2003 to 2006
- The US spends ~$650 billion more annually on health care than peer OECD countries after adjusting for higher national income (wealth)

*the world's 30 largest industrialized countries

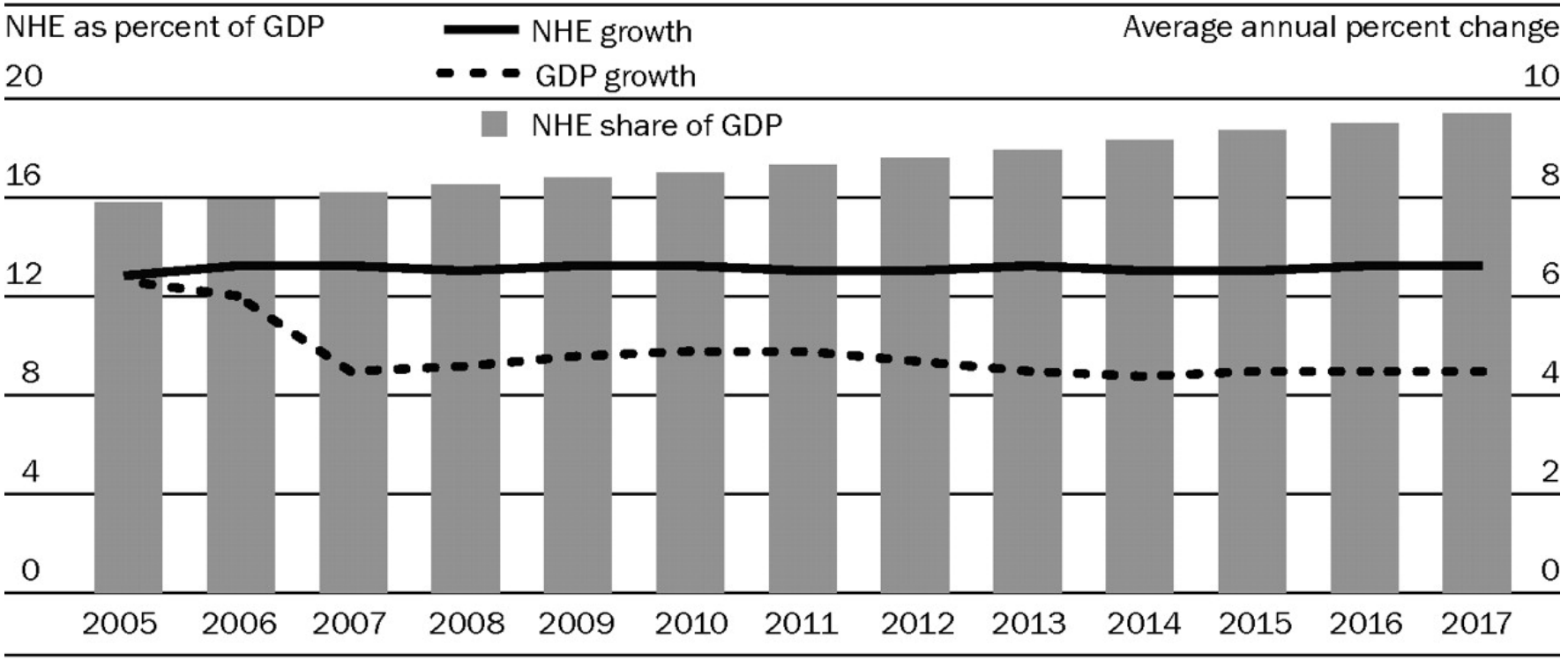
- Source: McKinsey Global Institute; OECD

# Pros and Cons

- **If we spend so much on health care, we have less to spend on everything else**
- **Thought experiment: What would happen if real (inflation-adjusted) per capita health spending grew just one percentage point faster than real per capita GDP, versus if spending grew by 2 percentage points faster than real per capita GDP?**
- **Both rates are above historical norms**

## EXHIBIT 3

## National Health Expenditures (NHE) As A Share Of Gross Domestic Product (GDP) And Average Annual Growth In NHE Versus Growth In GDP, 2005–2017




**SOURCE:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

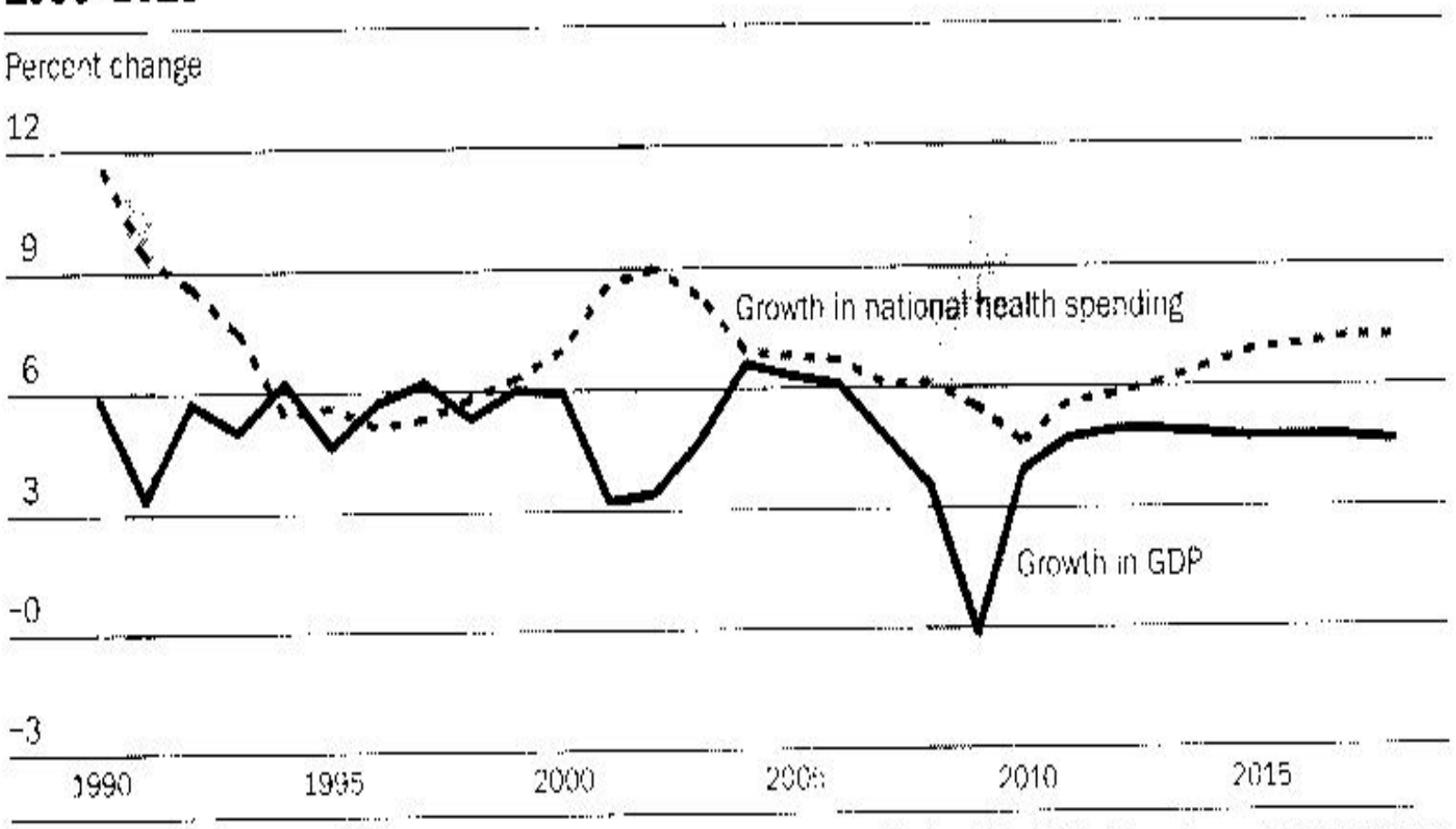
**NOTES:** The left axis (NHE share of GDP) relates to the gray-shaded bars. The right axis (percent change in GDP and NHE) relates to the two line graphs.

**Sean Keehan, Andrea Sisko, Christopher Truffer, Sheila Smith, Cathy Cowan, John Poisal, M. Kent Clemens the National Health Expenditure Accounts Projections Team,
Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming To Medicare,
Health Affairs, Vol 27, Issue 2, w145-155w**

HEALTH AFFAIRS

# CMS Updated Projections, February 24, 2008 – before 6% contraction in 4Q 08 GDP announced

## Growth In National Health Spending Versus Gross Domestic Product (GDP), 1990–2018




**SOURCES:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and National Bureau of Economic Research.

**NOTES:** Historical data through 2007, projected data from 2008 to 2018. Recessions took place during July 1990–March 1991; March 2001–November 2001; and December 2007–2009 (projected) and are denoted by shading.

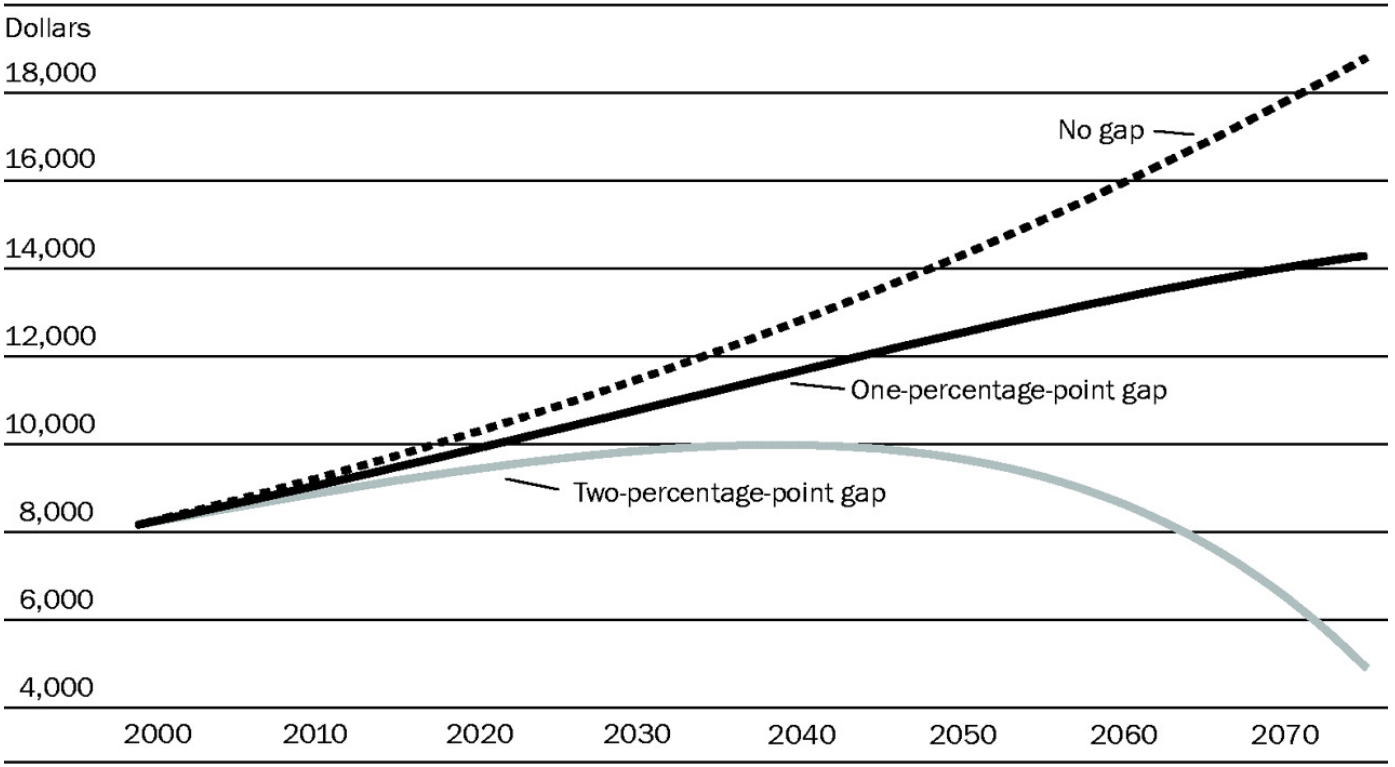
# Pros and Cons

- **Michael E. Chernew, Richard A. Hirth, and David M. Cutler Increased Spending On Health Care: How Much Can The United States Afford? Health Affairs, July/August 2003; 22(4): 15-25.**
- **1% point gap: health care is "affordable" through 2075; 55% of real increase in per capita income goes to health care**
- **2% point gap: health care affordable only through 2039; 124.2% of real increase in per capita income devoted to health care (e.g., impossible)**

**Michael E. Chernew,
Department of Health Care Policy,
Harvard Medical School**

**EXHIBIT 4**

**Spending On Nonhealth Goods And Services, In 1999 Dollars, Assuming Different Gaps Between Real Per Capita GDP And Health Care Cost Growth, 1999–2075**




**SOURCE:** Authors' tabulations.
**NOTE:** GDP is gross domestic product.

**Michael E. Chernew, Richard A. Hirth, and David M. Cutler,
Increased Spending On Health Care: How Much Can The United States Afford?,
Health Affairs, Vol 22, Issue 4, 15-25**

# Backdrop of Fiscal Concerns: The Nation's Implied Promises about Medicare

- Present value of promised benefits as of 2006
- Social Security: $6.4 trillion
- Medicare Part A (hospital insurance): $11.3 trillion
- Medicare Part B (doctors and outpatient): $13.1 trillion
- Medicare Part D (prescription drugs): $7.9 trillion
- Total Medicare: $32.3 trillion (omitting Part C, Medicare Advantage plans)
- Total Medicare and Social Security: $38.7 trillion
- Source: Government Accountability Office, 2007

# “Excess” U.S. Spending on Health Care: Where Does It Go?

- Outpatient care accounts for 65% of the spending above expected
- Growth is fueled by rising demand, technological innovation coupled with higher reimbursement, insurance benefit design, and physician self referral
- Hospital outpatient care was the fastest growing component of overall outpatient spending from 2003 to 2006
- Compound annual growth rate: 9.3%

*Source: McKinsey Global Institute Analysis, 2008

# “Excess” U.S. Spending on Health Care: Where Does It Go? Prescription Drugs

- U.S. pays far more for branded pharmaceuticals, less for generics than other OECD
- U.S. consumers pay for higher pharma marketing expenditures in U.S.

*Source: McKinsey Global Institute Analysis, 2008

# “Excess” U.S. Spending on Health Care: Where Does It Go?

- U.S. spends $91 billion more annually than would be expected on health administration and insurance
- $34 billion annually on administration and marketing of private health insurance
- Largely attributable to existence of private insurance system, which is intrinsically more expensive
- With respect to public insurance administration, 20% of increase over last 3 years has come in spending to administer Medicare Part D

*Source: McKinsey Global Institute Analysis, 2008

# The Value Equation? U.S. versus the rest of the Organization of Economic Cooperation and Development Countries*

- U.S. has lower life expectancy and higher infant mortality
- Leaving aside social determinants of health, we know U.S. health care isn't "fixing" the situation

*the world's 30 largest industrialized countries

- Source: McKinsey Global Institute; OECD

# What is Driving the Growth in Health Care Spending?

- Advancing technology
- Accounts for between one-third and two-thirds of growth in health spending
- Technology drives spending through both substitution and expansion
- Much technology beneficial
- Some doesn’t provide sufficient value or is applied too broadly

# What is driving the growth in health spending?

- Productivity in the health care sector is in all likelihood increasing at a low rate
- There is little competition on the basis of price – and indeed, in many markets, consolidation of hospitals and other factors have driven prices up sharply
- Benefit structures offer little reward for choosing low-cost providers
- Fee-for-service payment penalizes rather than rewards re-engineering care to increase efficiency
- Source: The Synthesis Project

Real health care: It's not like on "House"

# Americans and Chronic Illness

- **Chronic disease is the #1 cause of death and disability in the US**
- **Expenditures on chronic illness account for 75% of total US health spending**
- **About 2/3 of the rise in spending over the past 20 years is linked to rising prevalence of chronic disease**
- **Better care coordination, emphasis on prevention may or may not save money**

Source: Partnership to Fight Chronic Disease, Policy Platform, September 2007

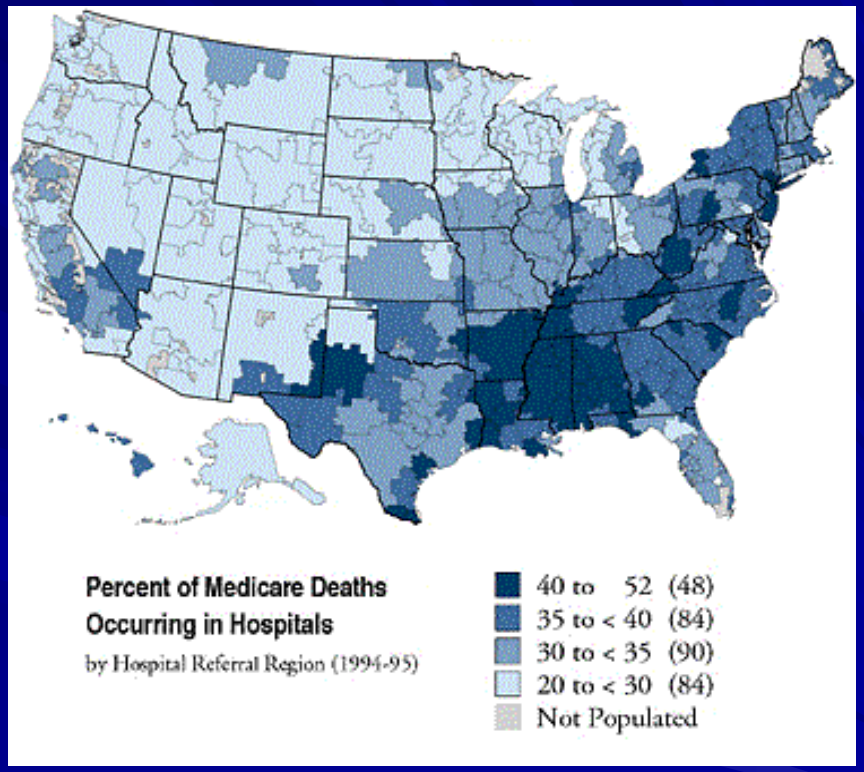
# What is Driving the Growth in Health Care Spending?

- Health Status
- Increasing rates of obesity a major driver of health spending
- Explains approximately 12 percent of growth of health spending in recent years (Congressional Budget Office)
- Will continue as driver until obesity trend reversed

- Source; The Synthesis Project; Congressional Budget Office

# Variations in Chronic Disease Care

- 2006 edition of the Dartmouth Atlas of Health Care
- Analysis of records of 4.7 million Medicare enrollees from 2000-2003
- Enrollees had at least one of 12 chronic illnesses
- Atlas examined care and cost in last 6 months of life



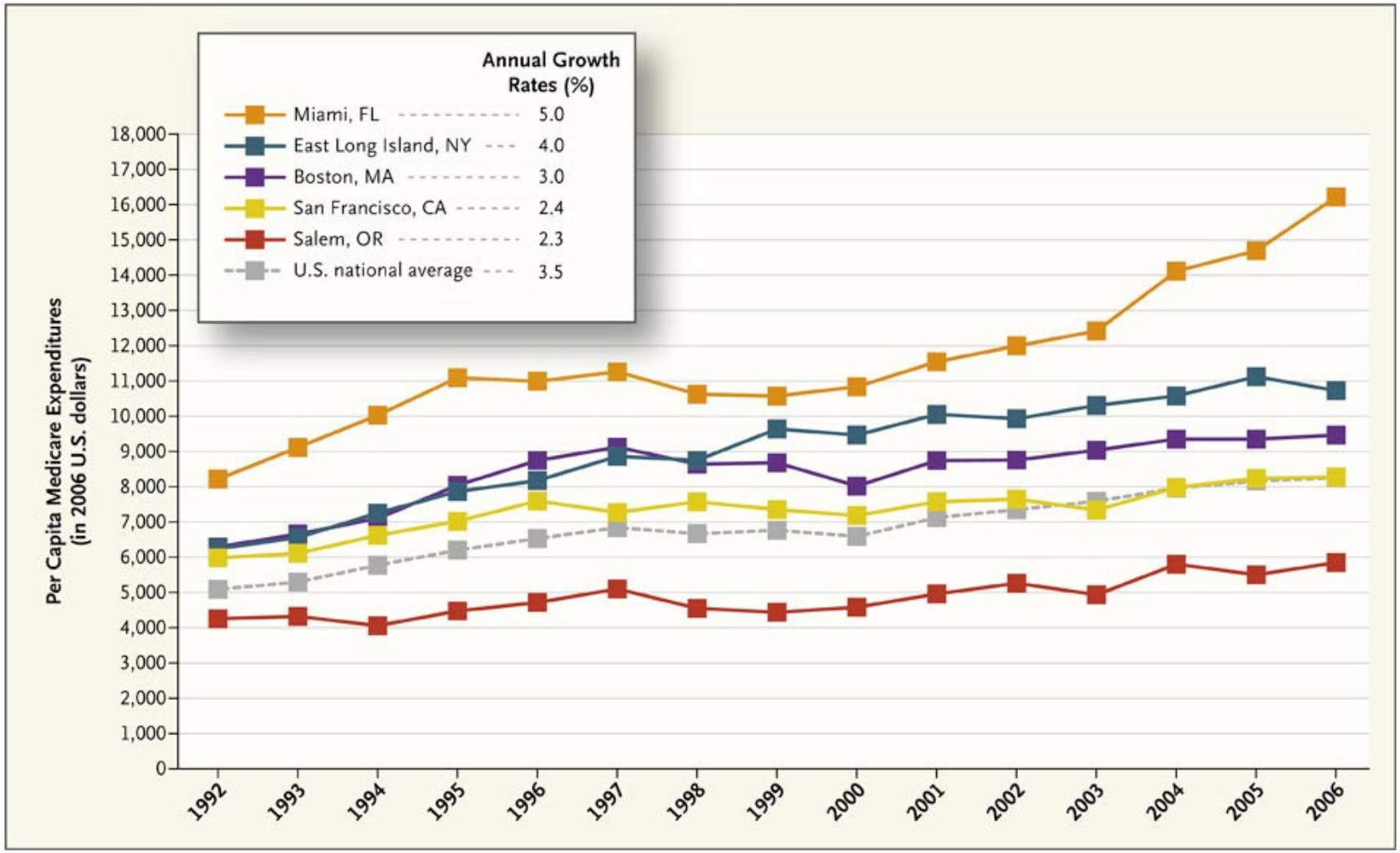
# Inexplicably wide range in care and cost

- Average number of days spent in hospital, chronically ill Medicare beneficiaries, last 6 months of life
- 10.1 at Stanford University Hospital
- 12.9 at Mayo Clinic (St. Mary's Hospital, Rochester MN)
- 16.5 at Massachusetts General Hospital
- 23.9 at New York Presbyterian, NYC (right)

# Physician visits in last 6 months of life

- New York University Medical Center: 76.2 visits
- Robert Wood Johnson University Hospital, NJ (right): 57.7
- University of Kentucky hospital: 18.6 visits

# Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992-2006




Fisher E et al. N Engl J Med 2009;360:849-852

The NEW ENGLAND JOURNAL of MEDICINE

# What is to be done?

# The Commonwealth Fund's "Path to a High Performance U.S. Health System" Report, Feb. 2009

- A package of initiatives could slow U.S. health spending growth by almost $3 trillion over 10 years
- Net of coverage expansion costs = $1.9 trillion over 10 years

Commonwealth Fund President
Karen Davis

Source: Davis K. N Engl J Med 2009;360:852-855

**Table 1. Sources of Savings under the Path Proposal and the Projected Net Effect on the Federal Budget and National Health Expenditures (2010–2020).***

| Variable | Federal Budget | Total National Health Expenditures |
|---|---|---|
| | *billions of dollars* | |
| Affordable coverage for all | | |
| Covering net costs of insurance expansion and redistribution of coverage sources | +1,924 | –432 |
| Payment reform (aligning incentives to enhance value) | | |
| Enhancing payment for primary care | –30 | –71 |
| Encouraging adoption of the "medical home" model | –101 | –175 |
| Bundling payment for acute care episodes | –211 | –301 |
| Adjusting prices to reflect value | –407 | –464 |
| Improving quality and health outcomes | | |
| Accelerating the spread and use of health information technology | –101 | –261 |
| Creating a center for comparative effectiveness | –232 | –634 |
| Public health policies and taxes on harmful products | | |
| Reducing tobacco use | –95 | –255 |
| Reducing obesity | –154 | –406 |
| Total net effect | +593 | –2,998 |

* Data are from the Commonwealth Fund Commission on a High Performance Health System.[1]

# The Lessons?

- No magic bullets; battle must be waged on multiple fronts
- Substantial infrastructure investments may precede savings – e.g., HIT, comparative effectiveness research; workforce investments
- Major systems changes needed – e.g., payment reform to encourage efficiency; performance-based payment; reexamining certificate-of-need?
- Major delivery system changes probably needed; e.g., accountable health organizations?
- Increasing focus on prevention/wellness/fighting obesity may require more public health than conventional health care interventions; different health care work force

# The Obama Administration: Actions to Date

# The Obama Administration and The 111th Congress: Actions to Date

- Children's Health Insurance Program (now CHIP; formerly S-CHIP) expanded and reauthorized for five years (2009-2013) in CHIP Reauthorization Act (CHIPRA) of 2009
- Estimated to add 6.5 million more children to insurance rolls in 2013 via CHIP and Medicaid; total CHIP enrollment would rise from 7 million now to 11 million
- Requires mental health parity for states that include mental health/substance abuse services; previously, 3 in 5 states limited coverage
- Allows states option of immediately enrolling legal immigrant children
- Estimated cost $73.8 billion over five years; fully funded by 62 cent increase in federal excise tax on tobacco, to $1.01/pack for cigarettes

# The Obama Administration and The 111th Congress: Actions to Date

- American Recovery and Reinvestment Act (so-called stimulus package)
- $787 billion in spending over next five years
- Roughly $1 in $5 of the stimulus package goes to health care

**Health Care Spending Provisions of the American Recovery and Reinvestment Act of 2009.**

| Program or Investment Area | Amount and Purpose of Funding |
|---|---|
| Comparative effectiveness research | $1.1 billion, of which $300 million will be administered by the Agency for Healthcare Research and Quality, $400 million by the NIH, and $400 million by the secretary of health and human services. |
| Continuation of health insurance coverage for unemployed workers | $24.7 billion to provide a 65% federal subsidy for up to 9 months of premiums under the Consolidated Omnibus Budget Reconciliation Act. The subsidy will help workers who lose their jobs to continue coverage for themselves and their families. |
| Departments of Defense and Veterans Affairs | More than $1.4 billion for the construction and renovation of health care facilities. |
| Health information technology | $19.2 billion, including $17.2 billion for financial incentives to physicians and hospitals through Medicare and Medicaid to promote the use of electronic health records and other health information technology and $2 billion for affiliated grants and loans to be administered by the Office of the National Coordinator for Health Information Technology. Physicians may be eligible for grants of $40,000 to $65,000 over multiple years, and hospitals for up to $11 million. |
| Health Resources and Services Administration | $2.5 billion, including $1.5 billion for construction, equipment, and health information technology at community health centers; $500 million for services at these centers; $300 million for the NHSC; and $200 million for other health professions training programs. |
| Medicare | $338 million for payments to teaching hospitals, hospice programs, and long-term care hospitals. |
| Medicaid and other state health programs | $87 billion for additional federal matching payments for state Medicaid programs for a 27-month period that began October 1, 2008, and $3.2 billion for additional state fiscal relief related to Medicaid and other health programs. |
| National Institutes of Health | $10 billion, including $8.2 billion for new grants and related activities and $1.8 billion for construction and renovation of NIH buildings and facilities, extramural research facilities, and research equipment. |
| Prevention and wellness | $1 billion, including $650 million for clinical and community-based prevention activities that will address rates of chronic diseases, as determined by the secretary of health and human services; $300 million to the Centers for Disease Control and Prevention for immunizations for low-income children and adults; and $50 million to states to reduce health care–associated infections. |
| Public Health and Social Services Emergency Fund | $50 million to the DHHS to improve the security of information technology. |

# The Obama Administration and The 111th Congress: Actions to Date

- American Recovery and Reinvestment Act
- Medicaid provisions: $87 billion from 10/1/08 to 12/31/10 in increased federal contributions (FMAP) to states
- Medicaid expansion to jobless killed in conference agreement
- COBRA provisions: Federal government to pay 60 percent of costs of employer-provided health insurance extensions for unemployed from September 1, 2008, for nine months; estimated cost $20 billion

# The Obama Administration and The 111th Congress: Actions to Date

- American Recovery and Reinvestment Act
- $1 billion for prevention initiatives
- $10 billion for increased biomedical research via National Institutes of Health

# The Obama Administration and The 111th Congress: Actions to Date

- $1.1 billion for comparative effectiveness research over 5 years
- Creates new federal coordinating council; Institute of Medicine to submit a report to the Congress and the Secretary/HHS by June 30, 2009, on priorities for research
- $400 million goes to NIH, $400 million to Secretary of HHS, $300 million to AHRQ
- Purpose is to conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions
- Encourages the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.
- Report language expresses intent of Congress that purpose is to study the medical effectiveness of different approaches to treating illness, not to mandate coverage

# Mental health and comparative effectiveness

- Medically ill patients receive appropriate treatment about ½ the time; those with serious mental illness, only about ¼ of the time*
- Information on absolute and relative effectiveness of many medications, especially psychotropics, under “real world” practice conditions is often lacking; need for “practical clinical trials”
- If we introduce the concept of cost-effectiveness, the evidence is even poorer
- We may take umbrage at cost-effectiveness being part of the equation for an individual patient, but in a societal sense, if we need to use our limited resources as effectively as possible to help the greatest number of people cost effectiveness must be taken into account
- Case of Tennessee and state Medicaid (TennCare) budget for atypical antipsychotics

- *Source: McGlynn EA et al., “The quality of health care delivered in the United States,” NEJM 348 (26) (2003): 2635-45; Wang PS et al., “Adequacy of Treatment for Serious Mental Illness in the United States,” American Journal of Public Health 92 (1) (2002): 92-98

# The Classic Comparative Effectiveness Studies including cost-effectiveness: Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE)

- NIMH trials on treatment choices for schizophrenia; more than 1,400 participants at 57 sites; 18-month duration
- Found that older antipsychotics taken as a whole had no substantial advantages over atypical antipsychotics
- First generation antipsychotic medication perphenazine was less expensive and no less effective than newer second generation “atypical” antipsychotic medications olanzapine (Zyprexa®), quetiapine (Seroquel®), risperidone (Risperdal®), or ziprasidone (Geodon®)
- Vigorous debate about what should be impact on public policy; former NIH Director Elias Zerhouni: Results reported to CMS; “nothing happened”

# The Obama Administration and The 111th Congress: Actions to Date

- Health Information Technology Provisions of ARRA (HITECH)
- $19 billion in budget authority ($2 billion discretionary, $17 billion to be invested through Medicare and Medicaid
- Devolves much authority to Secretary of HHS
- Solidifies role of National Office of the Information Coordinator at HHS to oversee agreement on standards, interoperability
- Creates new Regional Extension Centers to provide assistance and $300 million for RHIOs

# The Obama Administration and The 111th Congress: Actions to Date

- Health Information Technology Provisions of ARRA (HITECH)
- Invests $2 billion in research and development on HIT, training etc.
- Includes provisions that would give physicians “temporary” bonuses of $44,000 to $64,000 if they show they have adopted electronic health record systems
- Hospitals would receive bonuses up to $11 million
- After 2014, imposes Medicare payment penalties on physicians and hospitals not using EHRs

# The Obama Administration and The 111th Congress: Actions to Date

- Expands security and privacy provisions of the Health Information Portability and Accountability Act of 1996 ("HIPAA"), and generally extends some of those regulations to non-HIPAA-covered vendors of personal health records and their business partners.
- Preempts any contrary state laws, but leaves intact any state laws and regulations that impose stricter requirements on the handling of patient information.
- In effect, this means that if you are covered by HIPAA and the HITECH Act, you must meet new minimum standards while continuing to monitor and comply with the ever-increasing patchwork of laws governing patient information in every state
- Opt in" privacy standards assuaged concerns of privacy advocates; could prove problematic for adoption

# What’s Ahead?

# What's Ahead?

- A nod to the immortal Yogi Berra:

"Prediction is very hard, especially about the future."

# The Obama Plan During the Election Campaign: Then

# Proposals: Sen. Obama

- Universal Coverage? He said this was ultimate aim but no explicit commitment to achieve it by certain date
- Shore up employer-based system; employer mandate of unspecified amount on larger employers to provide coverage; “pay or play”
- Tax credits for small businesses to offset up to one-half their contributions to employees’ insurance
- Mandate on parents to provide health insurance for their children or enroll them in S-CHIP or Medicaid; no enforcement mechanism specified

# Proposals:
# Sen. Obama

- New “National Health Exchange” – an FEHBP-style purchasing pool open to any who don’t have employer-based or public coverage
- Private plans would be offered through pool; all would have to offer a standard package of benefits; community rated
- Also offered: a new public insurance plan, the “National Health Plan,” along lines of Medicare

# Proposals:
# Sen. Obama

- Increase  focus on prevention/wellness
- Shift toward primary care
- Workforce investments, including nursing

# Proposals:
# Then-Sen. Obama

- Total projected increase in federal outlays: $50-$65 billion annually; 10-year cost roughly $500-650 billion
- Most independent estimates pegged cost at least double that; Lewin Group estimated the 10-year cost of plan at $1.17 trillion (2009-2019)
- Obama said plan would be paid for in part by rolling back the federal income tax cuts on high-income taxpayers and, when these expire in 2011, dedicating the new federal revenues to health care

# Effects of Financial System Meltdown/Recession

- **Total federal government has pledged, committed, lent or spent to arrest economic downturn to date: More than $9 trillion**
- **Includes more than $7.5 trillion by Federal Reserve to expand money supply and shore up banks**
- **In addition to $700 billion already spent or being spent now for Troubled Assets Relief Program (TARP), an additional $750 billion is likely to be needed, according to Obama administration**
- **Total Federal budget/taxpayer exposure from TARP, rescues of AIG, Fannie Mae, Freddie Mac, 2 of the Big 3 automakers, broader bailout effort at this point unknown**
- **Taxpayers now own 80% of AIG; federal government has pledged a total of $160 billion to date**
- **New $75 billion home foreclosure plan**

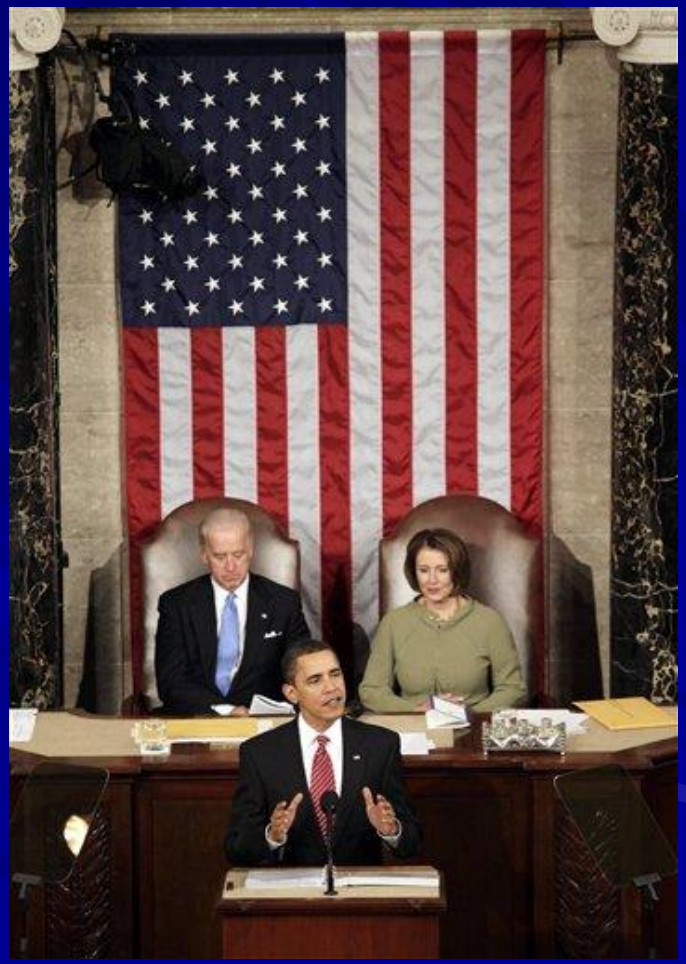
# Effects of Financial System Meltdown/Recession

- **Economy contracted sharply (6 percent annual rate) in 4Q 2008; recession now deemed likely to persist through 2009**
- **Economy appears to be seeking even deeper into recession**
- **National unemployment rate hit 8.1 percent in February ‘09, highest in more than 25 years**
- **Fiscal 2009 budget deficit estimated by White House at $1.755 trillion, or 12.3% of GPD, highest since World War II**
- **Additional large deficits projected for next several years, along with substantial increase in federal debt**

# Result: Great Expectations on Enactment of Reform, Lowered Expectations on Content?

- Budget blueprint includes "a down payment on the principle that we must have quality, affordable health care for every American."

  --President Obama in address to Congress, February 24, 2009



# The President's 8 Principles for Health Reform

- Reduce rate of growth of health insurance premiums
- Reduce high administrative costs, unnecessary tests and services, waste, inefficiencies
- Aim for universality
- Provide portability of coverage; no preexisting condition restrictions to deny coverage

# The President's 8 Principles for Health Reform

- Provide choice of health plans and physicians; provide choice of keeping employer-based health plan
- Invest in public health measures to reduce cost drivers, including obesity, sedentary lifestyles and smoking; guarantee access to proven preventive treatments
- Improve patient safety and provide incentives for quality care; support widespread use of health IT
- Plan must "pay for itself by reducing the level of cost growth, improving productivity and dedicating additional sources of revenue."

# President's Proposed "Health Reform Reserve Fund"

- **$634 billion over 10 years (2010-2019)**
- **About ½ ($318 billion) to come from additional income tax increases on upper-income taxpayers ($200,000 singles, $250,000 individuals)**
- **About ½ ($316 billion) to come from health care savings, including**
  - **$175 billion in competitive bidding to reach payment/prices for Medicare Advantage plans**
  - **$38 billion in reduced Medicare payments to hospitals**
- **Meaningful revenues to fund coverage expansions (including tax hikes) do not begin to crop up until 2011 and 2012**

# “The President proposes… Congress disposes”

- Senate Budget Committee Chairman Kent Conrad, Democrat of North Dakota
- Worried about the administration’s projected long-term budget/spending outlook, which sees deficits fall until 2013 and then begin to rise again.
- Predicted trouble for plan to limit itemized deductions for individuals earning more than $200,000 and couples earning more than $250,000: "I would put that high on the list of things that will be given a thorough scrubbing and may well not survive."
- Says need exists to completely revisit revenue/tax structure

# Control and contours of the new 111th Congress

- Democrats have decisive margin in House (255-174)
- Nonetheless, serious differences of opinions between liberals and “Blue Dogs” over fiscal issues in particular
- House Speaker Nancy Pelosi, 11/5/08: "The country must be governed from the middle."

# Control and contours of the new 111th Congress: The Senate

- Dems to have at most 59 votes in Senate (depending on outcome of Minnesota race)
- Total falls short of 60 votes needed for effective control/ability to cut off filibuster
- Bottom line: Senate Dems will probably still need to pick up several Republican votes to pass anything; argues for more bipartisan approach
- Stimulus experience reinforces this; Senate only passed bill with support of 3 Republican moderate senators, Collins and Snowe of Maine and Specter of Pennsylvania

# In Crisis is there Opportunity?

- President Obama, Weekly Radio Address, 5/7/09: Downturn offers chance "to discover great opportunity in the midst of great crisis."
- Other perspectives: Americans may be more receptive in current climate to broad government action, especially in wake of financial bailout
- There's broad recognition that economy can't be stabilized in any long-term sense without reining in excessive health spending
- Key to fiscal success for all future Presidents and Congresses

# In Crisis There Is…Crisis!

- Huge federal budget deficits, soaring national debt and sharply contracting economy leave little if any room for action
- Financing an expansion of coverage especially difficult in this environment; phase-in may be most achievable
- Other revenue options for financing coverage expansions could include limits on non-taxability to individuals of employer provided health benefits; anathema to unions
- No good financing options, especially in recession
- Argues for minimalist scenario; lots of hearings, “turbocharged” demonstration projects to test new payment methodologies, passage of smaller initiatives (e.g. workforce expansion assistance)

# Key Players – And the Missing

- Loss of former Sen. Majority Leader Tom Daschle was major setback
- Gov. Kathleen Sebelius, D-Kansas, now nominated and likely to be confirmed
- Nancy Ann DeParle named head of White House Office of Health Reform
- Other nominations of key positions – e.g. administrator of CMS – have been stacked up and should now proceed

# Prospects for Action:
# Full Steam Ahead?

- President says he wants to enact health reform by the end of the year

- All chairs of key Senate and House committees – Baucus, Kennedy, Rangel, Waxman -- have now said they intend to have bills on floor by the summer

# Prospects for Action: Senate

- Sen. Finance Committee chairman Max Baucus (D-MT) taking lead on bill
- Has formed bipartisan "Board of Directors" for health reform in Senate
- Working closely with Ranking Member Sen. Chuck Grassley (D-IA)
- Plans to put out three discussion drafts of legislation in spring on delivery system reform, cost containment, coverage

"Call to Action" issued in Nov. 2008 blueprint for reform; closely mirrors Massachusetts approach

# Key Players, Senate

- Sen. Ted Kennedy (D-MA) seriously ailing from brain cancer
- Chairs Senate Health Education Labor and Pensions (HELP) committee; Ranking Member Mike Enzi
- Kennedy “is the one guy who can bring all the Democratic interest groups together…I pray for him every day,” says Sen. Orrin Hatch (R-Utah)

# "Healthy Americans Act"
# Sen. Ron Wyden, Democratic of Oregon

# and Sen. Bob Bennett, Republican of Utah

- Employers now offering health coverage would lose ability to deduct premiums; must convert health insurance premiums into higher wages

- Employers who don't now offer coverage would begin making Employer Responsibility Payments; after 2 years all employers must make them

- Employers may continue to offer wellness, prevention benefits and long-term care insurance

- Individual mandate to obtain coverage through new state Health Help Agencies (2 in each state)

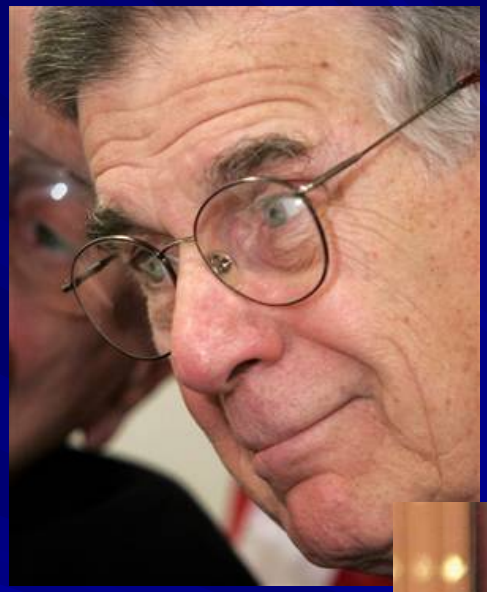
- HHA's must offer at least 2 plans, one = BCBS plan in FEHBP
- Premium subsidies to individuals and families up to $80K for family of 4

# Prospects for Action: House of Representatives

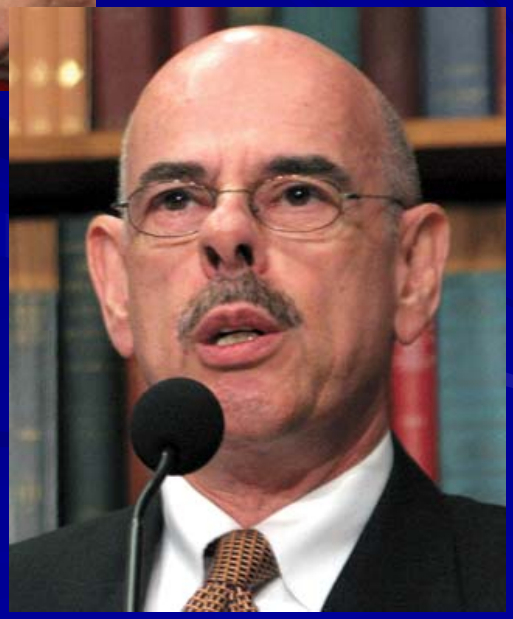
- House Majority Leader Steny Hoyer (D-MD)
- 3/5/09: “I assure you the bill is not written…I urged every committee chair to make sure we have Republicans in from the beginning as part of it.
- “Nobody believes that action is not necessary.”

# Key Players, House

- Rep. Pete Stark, D-California, chairs Ways and Means Health Subcommittee



- Rep. Henry Waxman, D-California, chairs Energy and Commerce committee



- As yet unclear whether bills will emerge from these committees or one under leadership of Speaker Pelosi

# Key Players in House -- GOP

- Rep. Roy Blunt, R-MO
- Chairs House GOP Health Care Solutions Working Group
- Minority Leader John Boehner

# Areas of disagreement

# Revenues for funding coverage expansion

- **Baucus has signaled resistance to raising taxes on high-income earners through limiting deductions**
- **Broad interest in imposing a cap on tax expenditure; Wyden-Bennett plan e.g.**
- **Strong labor opposition**

# Collision over New Public Plan in Health Information Exchange?

- Many Dem members, especially on left, say it's an absolute must
- E.g., Rep. Jan Schakowsky, D-IL
- Could save 20-30% of costs to payers –e.g. large businesses struggling with health care costs

# Collision Ahead over Public Plan in the National Health Insurance Exchange?

- Rep. Roy Blunt, R-MO
- Chairs House GOP Health Care Solutions Working Group
- “I’m concerned that if the government steps in it will eventually push out the private health care plans millions of Americans enjoy today.
- “This could cause your employer to simply stop offering coverage, hoping the government will pick up the slack.”

# Collision Ahead over Public Plan in the National Health Insurance Exchange?

- Sen. Charles Grassley, R-Iowa
- Ranking member, Senate Finance Committee; working with Baucus on bill
- “There’s a lot of us that feel that the public option…is an unfair competitor” to private health plans
- Will lead to crowding out of private insurance, when “we have to keep what we have now strong, and make it stronger.”

# Collision Ahead over Public Plan in the National Health Insurance Exchange?

- President Obama, White House Summit, 3/5/09
- "I'm not going to respond definitively."
- "The thinking on the public option has been that it gives consumers more choices, and it helps…keep the private sector honest, because there's some competition out there."

# Collision Ahead over Public Plan in the National Health Insurance Exchange?

- “I recognize, though, the fear that if a public option is run through Washington, and there are incentives to try to tamp down costs….that private insurance plans might end up feeling overwhelmed.

- “It’s a serious concern and a real one. And we’ll make sure that it gets addressed, partly because I assume it will be very hard to come out of committee unless…that’s something that we pay attention to.”

- Source: Sen. Obama, White House summit, 3/5/09

# Areas of lack of consensus/ongoing debate and discussion

- Role of mandates, employer or individual
- Necessary to get to universal coverage; insurers argue individual mandate needed to make sure all are in system, move away from risk selection
- Obama was for employer mandate during campaign; open to individual mandate later post reforms
- Baucus has endorsed individual mandate; Democrats overall split
- Republicans also split over individual mandate

# Emerging Areas of Consensus: Health Insurance Exchange(s)

- National, regional or state health insurance exchanges
- Modeled after Massachusetts Connector Authority
- In original Obama plan
- Rep. Roy Blunt (R-MO), GOP Health Care Solutions Working Group: "Government is organizing" the health insurance market, not "prescribing" or "operating" the system

# Emerging areas of consensus

# Emerging Areas of Consensus: More Comparative Effectiveness Research

- Use ACCR provisions as starting point; dramatically increase funding
- Compare clinical effectiveness and outcomes; perhaps do additional cost-effectiveness analysis
- Do not use as basis to mandate coverage or payment decisions but make information broadly available to payers
- Sen. Max Baucus (D-MT), chair of Finance Committee: “We don’t have to put cost-benefit in comparative effectiveness analysis,” because doctors and hospitals will respond and make wise spending decisions.
- Jerry Shea, AFL-CIO: cost comparisons will be needed to impact overall spending

# Emerging Areas of Consensus: End-of-Life Care

- Bill Novelli, president, AARP
- White House summit, 3/5/09
- "There is huge opportunity…in terms of end of life…the quality of life, the quality of death and the cost, the costs that can be squeezed out of the system."
- Rep. Michael Burgess, R-TX: Could begin by having Medicare as part of "welcome to Medicare" visit pay doctors for making certain enrollees complete advance directives

# Emerging Areas of Consensus: Workforce Issues

- Increasing investment in more primary care providers and in particular training nurses, physician assistants
- Dealing with state-driven scope of practice issues? Sen. Rockefeller, D-WV
- Investing in nursing faculty positions

# Emerging Areas of Consensus: Workforce Issues

- President Obama, WH Summit, 3/5/09
- “Nurses…don’t get paid very well…And when it comes to nurse faculty, they get paid even worse than active nurses…There are a lot of people who would love to be in that helping profession and yet we just aren’t providing the resources to get them trained.”
- “That should be a bipartisan no-brainer.”

# Emerging Areas of Consensus: Cost Containment (at least in abstract) and coverage expansion go hand in hand

- President Obama, WH Summit, 3.5.09
- “For those of you who are passionate about universal coverage…don’t think that we can solve this problem without tackling costs.
- “And the flip side is…I don’t think it is a viable option as means of controlling costs…to prevent [people] from getting vital care that they need.
- “We’ve got to balance heart and head as we move this process forward.”

# Emerging Areas of Consensus: Prevention and Wellness

- President Obama, WH Summit, 3/5/09
- “If we went back to the obesity rates that existed back in 1980, we’d save the system a trillion dollars.”
- Sen. Tom Harkin, D-Iowa
- Better food options in national parks; walking and biking trails included in transportation bills; a working group that focuses all federal agencies on how they can promote health

# Emerging Areas of Consensus: Payment Reform

- Widespread agreement fee for service must be limited or replaced
- Consensus to shift more payment to primary care providers – except among specialists
- Uncertainty about various approaches – P4P, bundled payment
- “Turbocharged” demonstration projects likely result?

# Emerging Areas of Consensus: Dealing with Unwarranted Variations

- Obama, WH summit, 3/5/09
- "Data and evidence have to drive the process."
- "If there are states like Minnesota that are providing as good or better care than over states, and yet are keeping their costs lower, and Medicare and Medicaid reimbursements are better controlled, shouldn't we be learning from what those states are doing, and then making that more generally applicable?"
- "If we can find better practices, then doctors have to be willing to learn from the experience of others in terms of controlling costs."

# New fly in ointment? Concerns about impact on economy

- Tom Donohue, U.S. Chamber of Commerce, at White House summit, 3/5/09
- “If we take out 20 to 30 percent of [health care] cost…we’re going to have an effect on the economy.
- “Health care and the people in that business have been the driver of this economy…we need to think about that.”

# Dawning Awareness of Realities

**Unspoken as yet, except in budget blueprint: Coverage expansions will have to be phased in**

# The future of U.S. health reform: Competing views

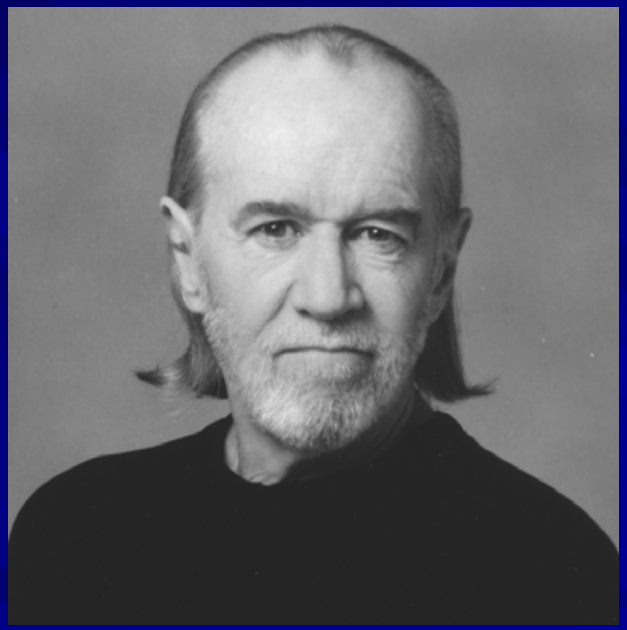
**View #1:**

**“The Americans always do the right thing…after they’ve exhausted all the other alternatives.”**

**Sir Winston Churchill**

## View #2:

**“I don’t believe there’s any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can’t completely ignore.”**



**Comedian George Carlin**

# View #4:

**“If the world were rational, *men* would ride side-saddle.”**

**Author Rita Mae Brown**

# “Harry and Louise”: 1993

**Louise: “Having choices we don’t like is no choice at all.”**

**Harry: “If they choose..**

**Louise: “we lose.”**

# Harry and Louise Today:
# Sen. Barbara Mikulski, D-MD*

**“Harry needs a knee replacement. His wife has diabetes. They both have lost their jobs and they’re too young for Medicare.**

**“They have grandchildren who have autism and food allergies and they’re wondering, ‘What the hell did we fight health care [reform] for?”**

***At White House Summit on Health Reform, March 5, 2009**

# Sen. Sheldon Whitehouse (D-RI)*

**“We’re not at a Harry and Louise moment.**

**We’re at a “Thelma and Louise” moment,**

**and we’re about to drive off the cliff.”**

***At White House Summit on Health Reform, March 5, 2009**

# Harry and Louise Now*


**Harry's diagnosis:**
**"Too many people are falling Through the cracks."**

**Louise's prescription:**
**"Bring everyone to the table and make it happen."**

***"Harry and Louise Return" video, Aug. 2008**

# The Verdict on National Health Reform?

**“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”**

**--the late Jerry Garcia of the Grateful Dead**

# The End