Update on Federal Health Care Reform

Texas Rural Health Forum
November 10, 2009

Federal Health Care Reform

Health Care Reform – Why Now?

Across the ideological spectrum the prognosis is remarkably similar - 47 million uninsured

- Moral imperative of extending coverage
- Added cost to system in form of higher taxes and premiums.

High costs make U.S. business less competitive globally

Quality of care in U.S. behind other developed nations, yet U.S. spends 50% more per person on health care than the average developed country

Perverse incentives based on fee-for-service reimbursement

Geographic variation in per capita health spending

Insurance market must be reformed

Necessity of "bending the cost curve"

Hewitt Associates Business Roundtable

- Health Care Reform: the Perils of Inaction
  - Hewitt projects that employer-based health care costs will increase 166% by 2019, resulting in a cost burden of $28,530 per employee
  - This price tag approaches three times the 2009 per-employee cost of $10,743

Factors Explaining Future Federal Spending on Medicare, Medicaid, and Social Security

25
20
15
10
5
0

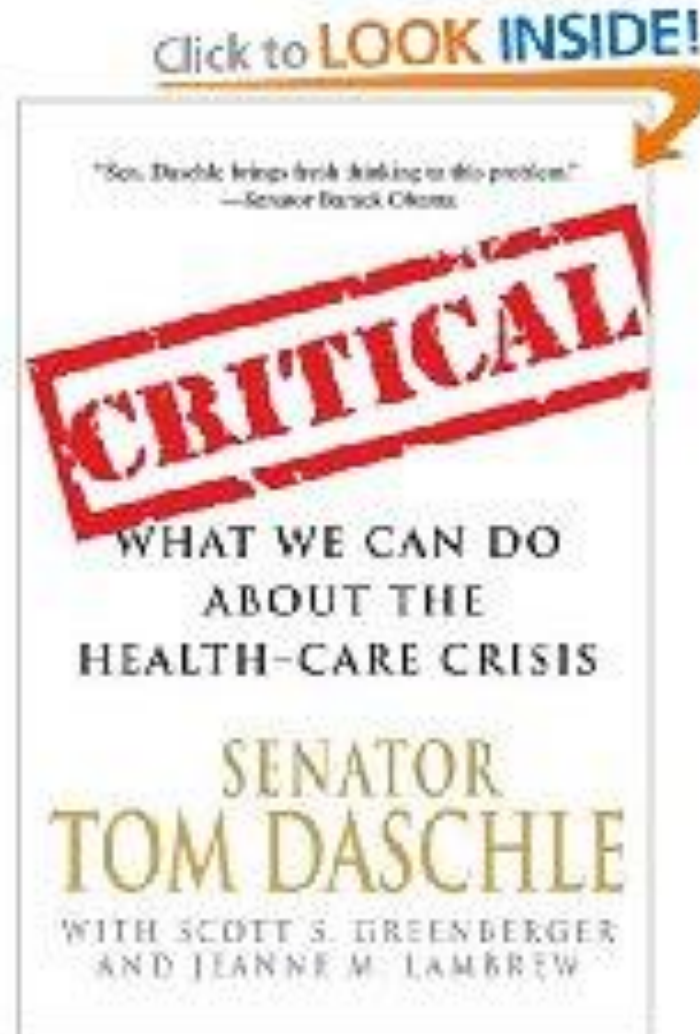
Effect of Excess Cost Growth

Effect of Aging

In the Absence of Aging and Excess Cost Growth

2009 2019 2029 2039 2049 2059 2069 2079

The Blueprint for Reform



Key Players in Federal Reform Efforts

- President Obama, HHS, OMB, CBO
- Senate Committees
  - Finance: Baucus, Conrad, Bingaman, Grassley, Enzi, Snowe
  - HELP: (Kennedy) Harkin, Dodd, Enzi
- House Committees
  - Ways and Means: Rangel
  - Energy and Commerce: Waxman
  - Education and Labor: Miller
- Interest Groups
  - American Hospital Association, CHA, Federation
  - AMA, AHIP, SEIU, PhaRMA

The Hospital “Deal”

- Seeks to cap liability at $155 B over 10 years
- Assumes increased “revenue” from expanded coverage
- Where appropriate, cuts should correspond to actual increase in coverage (triggers)
- Savings related to payment changes should be phased-in based on complexity (bundling) and clinical realities (readmission)
- Incentives vs. reductions (value-based purchasing)

Senate Finance Committee

- On October 13 voted 14-9 to approve its legislation - the bill received one Republican vote, from Sen. Olympia Snowe (R-ME).
- Legislation would cost $829 billion over 10 years, is fully paid for, and reduces the federal deficit by $81 billion
- Would expand coverage to 91% of all those residing in the U.S., with 25 million remaining uninsured at the end of the 10 years

Senate Finance Committee

- Key provisions:
  - **No public plan** - institutes a network of nonprofit health care cooperatives to compete with private plans
  - creates insurance market reforms
  - requires individuals to have coverage
  - implements a fee for employers with more than 50 FTEs who do not offer health coverage and whose employees receive federal subsidies through an exchange

Senate Finance Committee (cont.)

- seeks to reduce Medicare and Medicaid spending through annual update reductions to providers ("market basket updates")
- calls for an independent Medicare Commission to make policy recommendations to Congress that would be implemented unless overridden
- replaces the scheduled 21 percent cut in Medicare physician payment rates in 2010 with a 0.5 percent increase
- implements a value-based purchasing program for hospitals and physicians (budget neutral)

Senate Finance Committee (cont.)

- Additional Provisions:
  - Targeted hospital readmission penalties
  - DSH reductions “triggered” by uninsured reductions
  - Bundling of payments – establishes pilots
  - Physician self-referral – restrictions placed if physician has ownership interest and on expansion for grandfathered facilities (September 1, 2009)
  - GME = no cuts to IME payments and redistributes unused residency slots
  - Incentives to reduce Hospital Acquired Infections

Senate Finance Committee (cont.)

- Additional Provisions:
  - Accountable Care Organizations – provider groups working together to improve Medicare quality/costs
  - Primary care and general surgery bonuses for health professional shortage areas
  - Promoting disease prevention and wellness:
    - Medicare: coverage for a prevention and wellness plan and preventive services; incentives for healthy lifestyles
    - Medicaid: improving access to preventive services and incentives for healthy lifestyles; medical home state option for beneficiaries with chronic conditions

SFC Legislation – Rural Impact

- Cost-based hospitals generally protected from payment reductions (e.g., market basket updates, readmission penalties)
- Rural hospitals would be impacted by DSH cuts (depending on triggers)
- Extends FLEX grant program until 2012
- Extends outpatient hold harmless for small rural and SCHs
- Extends reasonable cost reimbursement for lab services in small rural hospitals
- Extends Medicare dependent hospital program
- Temporary improvements to Medicare IPPS for low-volume hospitals
- MedPAC study on adequacy of Medicare payments for providers serving rural areas.

Continued Failure on Physician SGR Fix

- On October 21, The Senate failed to achieve the 60 votes needed to invoke cloture to fix the physician payment formula, failing by a vote of 47-53
- The $250 billion bill would freeze for 10 years Medicare payments for physicians, who face a 21% cut on Jan. 1
- The bill did not provide funding so would have added to the federal deficit

The “Reid Surprise”

- On Oct. 26, Majority Leader Harry Reid announced that the merged Senate reform bill will include a public health insurance option that allows states to "opt out" of participation in a national plan
- Sent the “merged bill” to the Congressional Budget Office for official scoring and would then bring the measure to the Senate floor for debate and amendments

The “Merged” House Bill – H.R. 3962

- "America's Affordable Health Choices Act of 2009“ released by House leadership on 10/29
- Expected to expand coverage to approximately 96 percent of those legally residing in the U.S. and cost slightly less than $900 billion
- **Revenue:**
  - 2.5% excise tax on any medical device used in U.S.
  - 5.4% tax on individuals with AGI in excess of $1M
  - 2.5% “individual mandate” penalty
  - 8% large employer payroll penalty for “skimpy” coverage

H.R. 3962 (cont.)

- **Market Basket Update** = $119 B reduction over 10 years
- **Public Option** – included as part of a national insurance exchange:
  - Allows the HHS Secretary to negotiate public plan payments based on rates between "current aggregate Medicare rates" and "aggregate rates paid by private insurers"
  - Allows providers to opt out of participation
- No **Independent Medicare Commission**

H.R. 3962 (cont.)

- **Medicaid** is expanded to 150% of FPL beginning in 2013 (fully federally financed until 2015 then drops to 91%)
- **Medicaid DSH** is reduced $10 B over 3 years beginning in 2017
  - Methodology for cuts depends on state rates of uninsured and actual use of DSH funds
- **Medicare DSH** is gradually reduced beginning in 2017 if these is a reduction in the number of uninsured (restored based on uncomp. care)

H.R. 3962 (cont.)

- **Readmissions** – penalties for hospitals (including CAH) with rates higher than expectations for 3 conditions
- **Bundling** – calls for the HHS secretary to develop a plan to reform Medicare payment for post-acute care services
- **Value-Based Purchasing** – no provisions for hospitals but can be used by CMS
- **Accountable Care Organizations** – allows voluntary pilots where physician practices can share in Medicare cost savings

H.R. 3962 (cont.)

- **Physician Self-Referral** – eliminates whole hospital and rural provider exceptions under Stark law but includes a January 1, 2009 grandfather date with growth restrictions
- **Physician Payment** – does not include SGR fix; must be addressed separately
- **Rural Providers** – extends Section 508 reclass, the outpatient hold-harmless provision, the floor on the work geographic practice cost index and the rural ground ambulance add-on

H.R. 3962 (cont.)

- **340B** – expands the program to outpatient drugs for children's, cancer, critical access, Medicare dependent, and sole community hospitals and rural referral centers
- **Insurance Reforms:**
  - Out-of-pocket medical costs capped at $5,000 a year for individuals and $10,000 a year for families
  - Children could remain on their parents' insurance through age 26
  - Insurers couldn't deny coverage for pre-existing health conditions or drop people from coverage once they developed an illness
  - Extends Cobra coverage allowing people to remain on their old insurance plans until the new health-insurance exchange takes effect in 2013

H.R. 3962 – Floor Vote

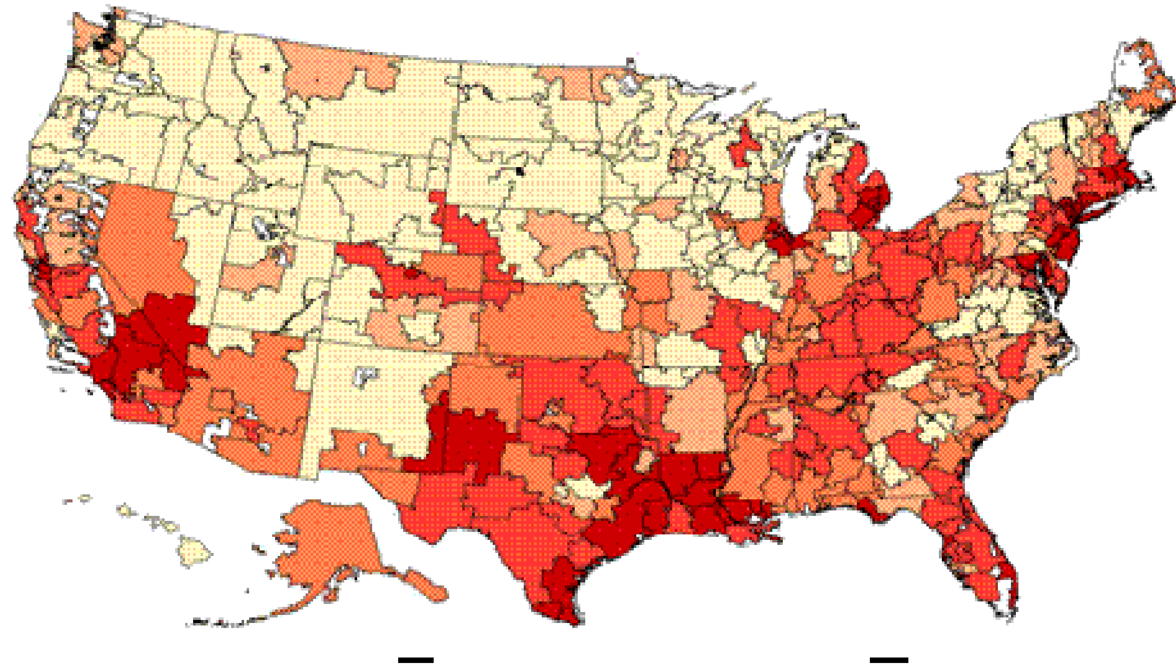
- House approved bill Saturday night by a vote of 220-215 (218 needed)
- In the final tally, 219 Democrats voted for the legislation, and 39 voted against it (Chet Edwards)
- Rep. Joe Cao (R-Louisiana) was the only Republican who voted in favor of the bill

The Debate on Geographic Variation

- ***New Yorker and Dartmouth Atlas fuel debate over geographic variation***
  - *A number of Members of Congress representing rural, small community and small urban districts from around the country have become increasingly active in working to pursue aggressive and redistribution forms of "delivery system reform."*

Geographic Variation in Cost

Medicare Spending Per Capita by Hospital Referral Region, 2006



The Debate on Geographic Variation

THE NEW YORKER

ANNALS OF MEDICINE

THE COST CONUNDRUM

What a Texas town can teach us about health care.

by Atul Gawande

JUNE 1, 2009

Costlier care is often worse care. Photograph by Phillip Toledano.

Geographic Adjustment – House Bill

- **Calls for two Institute of Medicine (IOM) studies:**

  (1) Determine the accuracy of the geographic adjustment factors in the hospital and physician payment systems. Provides $8 billion over two years (FY 2012-FY 2013) to implement (adjustments to the payment systems would be budget neutral

  (2) Examine growth in intensity and services in per capita health spending and whether payments systems should be modified to incentivize "high value" care (mandates a fast-track process through Congress for implementation)

Impact on Texas Budget

- Mandated Medicaid changes shift costs to the state after two years
- 150% FPL expansion requires more than $3 billion per year, starting in 2015
- Concerns over capability of enrollment systems and provider network adequacy

Texas Issues / Concerns

- Illegal immigrants (Section 1011 extension)
- Cumulative impact of Medicare RAC program
- Impact on nonprofit hospitals' tax-exemption
- Impact on state Medicaid, DSH, UPL programs and funding
- Treatment of rural hospitals (CAH, SCH, etc.)
- Workforce shortages
- Physician/hospital alignment – clinical integration

Opposition Strategy

ORGANIZATIONAL CHART OF THE HOUSE DEMOCRATS' HEALTH PLAN

President
U.S. Congress
Institute of Medicine
IRS
Treasury Dept.
Health & Human Services Dept
Veterans Administration
Defense Dept.
Labor Dept.
Nurse Education & Training
Health Insurance Exchange Trust Fund
Clinical Preventive Services Taskforce
Individual Tax Return Information
National Center for Health Workforce Analysis
Health Benefits Advisory Committee
Public Health Investment Fund
CMS
Medicaid
S-CHIP
Medicare
Public Health Workforce Corps
National Health Service Corps
CER Trust Fund
Comparative Effectiveness Research Commission
Ombudsman
CCER
Advisory Panels
Community Health & Care Centers
NPDB
HIPDB
Mandate: Buy Insurance
Advisory Committee on Health Workforce & Evaluation
National Coordinator for Health IT
Surgeon General
Office of Civil Rights
Office of Minority Health
Bureau Of Health Information
Taxes
Health Affordability Credits
AHRQ
Language Demonstration Program
Accountable Care Organization
STATES
Regulations, Mandates, State Health Agencies, state Health Information Exchanges
Consumers
Center for Quality Improvement
Federal Mandates for Website Design
Low-Income Subsidy (families with 4x poverty level)
Health Choices Administration: HCA Commissioner
Inspector General
National Priorities for Performance Improvement
Physician Quality Reporting Initiative
Mandate: Provide Insurance
Private Insurers
Reinsurance Program
Benefit Levels
Financial Disclosure Reports: Any Transfers between Providers & Suppliers
Cultural & Linguistic Competence Training
Health Care Providers
Taxes
Premiums
Traditional Health Insurance Plans
Health Insurance Exchange
Qualified Health Benefit Plans
Public Health Plan
Public Plan Ombudsman
Health Care Goods & Services
Special HIE Inspector General
Small Business Tax Credits
Employers

Source: Joint Economic Committee, Republican Staff
Congressman Kevin Brady, Ranking House Republican Member

Congressional Schedule

- Senate waiting for CBO scoring – probably pushes debate until after Thanksgiving
  - Concerns over public plan and financing strategy
- White House – concerns over negative feedback for members of Congress during Thanksgiving recess
- Plan B – budget reconciliation process?

Questions?

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