



THOUGHTS ON FEDERAL REFORM: LET'S NOT DELAY

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The time is now to support a major fix of the nation's health system. Congress is starting to act and bills are clearing their first committees. There are two key debates and a third that is not getting enough attention.

Part 1: Financing Reform

The first debate is about how you pay for reform, and the choices are sure to offend someone, possibly everyone, but they need to be made. The estimated cost of the reform package over the next 10 years is \$1 trillion. Senators Grassley and Baucus are right, it seems to me, in suggesting that there is ample room to save and redirect money in the existing system. However savings in Medicare and Medicaid are typically counted by CBO towards financing the reform package while private sector savings are not scored by CBO in financing coverage expansions. For example, reducing the Medicare premium subsidies paid to HMOs would fully count towards financing the reform package as would reductions in what Medicare and Medicaid pay for prescription drugs. But reductions in what consumers must pay out of pocket for their care by capping out of pocket expenditures does not count towards paying for reform.

One proposal has been to reduce federal DSH and other supplemental hospital payments since reform increases coverage of the uninsured and adjusts Medi-Cal payments up to Medicare levels.¹ Hospitals have recently agreed to \$150 billion in savings over 10 years, including DSH restructuring; more may be needed. Covering the uninsured and increasing Medi-Cal payments to hospitals would substantially increase hospital revenues, and it makes much better sense to reduce DSH and supplementary payments in a thoughtful way rather than to further fuel health inflation by passing out windfall profits to the health industry.

California has substantial DSH and supplementary payments through Medicare and Medicaid (at least \$2 billion) that will be impacted by reform. Some of these funds will still be needed by those hospitals that continue to treat a high volume and percentage of the residually uninsured. These subsidies should be phased down as coverage is expanded and payments are increased, but with the caveat that the residual amounts should be carefully re-targeted to those facilities that continue to see high percentages of uninsured after reform.

¹ According to the OSHPD 2006 Hospital Data, California hospitals have \$1.7 billion in bad debt and charity care, \$2 billion in Medi-Cal underpayments and \$2.4 billion in Medicare underpayments. Private insurance reimbursements contribute \$6.4 billion in excess of hospital costs. Dam and Wulsin, A summary of Health Care Financing for Low Income Individuals in California 1998-2008 (Insure the Uninsured Project, 2008) at www.itup.org/reports



Another idea being discussed in Senate Finance Committee is to reduce the estimated \$300 billion annual tax subsidy for private, mostly employment-based insurance; their goal is to increase incentives for cost-conscious shopping. The tax subsidy on average underwrites one third of the costs of coverage. The tax subsidy is highly regressive, mostly benefiting those with the highest incomes and the most costly forms of coverage, while those with lower incomes and fewer benefits get little or no tax subsidy towards the costs of their coverage; it makes no sense at all as either social or economic policy.

This inequity is not easy to reform by tinkering and is quite stoutly defended by both labor and business. The tinkering ideas are to tax employment-based health benefits that exceed a certain amount as income to the employee. For example if the average cost of family coverage is \$12,000 annually per employee, the tax might be applied to the increment of health benefits costing in excess of \$15,000 annually per employee. This impacts higher income individuals with high marginal tax rates and costly coverage the most, transforming this small increment of the tax subsidy into a progressive tax.

However the costs of health benefits are only partly determined by the scope of coverage being offered; i.e., all other things being equal, a fee for service indemnity plan with an open network of providers and low copays and deductibles is going to cost more than an HMO with a closed network and low copays and deductibles. The premium is also determined by age and family size so coverage costs more for employers with lots of older workers or if their employees have a sizeable number of dependents; thus coverage that is roughly equal in terms of covered benefits and provider networks may well cost three times as much for older workers or for family coverage as it would cost if most of the employees are young, single males in their 20's. In our view the tax advantage for private employment-based insurance should be retained and turned on its head so that low wage workers get the largest subsidy and the subsidy is phased down as incomes rise; this will not happen unless labor and business join together and ask for it. This could be done in a cost-neutral fashion and would help immensely with the affordability challenges of reform for both employers and employees.

Another aspect of financing reform involves the mandate and the subsidies for uninsured individuals to purchase and employers to pay or play for their employees. Both the House and the Senate have individual mandates. The mandates depend critically on resolving affordability, which will require subsidies to make coverage affordable. The subsidies are as yet undefined, but will require all of the uninsured except the lowest income to contribute towards the costs of their coverage; some of these contributions will be quite substantial; for example a self employed family of four with both parents in their 50's and an income in excess of 300% of FPL would probably pay the most. Based on recent media reports, subsidies may stop at about 300% of FPL to reduce the over-all costs of the bill. Under this scenario, eighty percent of the uninsured Californians could qualify for subsidies while twenty percent do not. In our work two years ago, we identified the groups of the uninsured most needing subsidies above 300% -- those uninsured working individuals who would otherwise pay three times as much as other individuals due to their age or their family composition. Subsidies should be very carefully targeted to help these two groups.



The pay or play proposals for employers being discussed in the House and the Senate are very different. In general, there is an exemption and/or tax credit subsidy for the smallest employers and a financing responsibility for all others. The House has set the “play” option at 72.5% of individual coverage and 65% of family coverage and has designed the “pay” option as a graduated payroll tax, beginning 0% of payroll for payrolls of less than \$250,000 annually and increasing rapidly to 8% of payroll for annual payrolls in excess of \$500,000. The Senate HELP Committee set the fee (pay option) at \$750 per full-time employee – just over twice the fee established in the Massachusetts reform legislation. The argument in favor of the 8% of payroll calculation is that this is set at about the average paid by those employers who offer coverage and thus this will act as a partial disincentive for employers who might otherwise drop coverage for their employees. The argument in favor of the much lower Senate HELP Committee version is that it mitigates any concerns that the reform will cost jobs during an uncertain and uneven economic recovery. In our view it makes sense to mitigate the sticker shock and any potential negative impacts on job creation by going with the Senate version to start and later moving toward a more gradual and graduated payroll tax, which is a better way to finance health coverage than a flat fee. If substantial numbers of employers were to drop coverage and pay the flat fee instead, which they did not do in Massachusetts, the fee could be raised when the economic situation improves.

The House added in a surcharge on high-income earners that is expected to raise \$544 billion over 10 years and apply to the top 1.2% income earners. While this tax is appropriate given the enormous redistribution of wealth to the highest income earners, in our view, it does not connect to the reform of the health system in the same way as a tobacco tax, soda tax or a revision in the tax exclusion for health benefits does.

Not yet being hotly discussed is the role of states in paying for reform. All three bills will cover the lowest income uninsured through Medicaid. In California this means Medi-Cal (Medicaid) coverage for the MIAs (medically indigent adults) heretofore a county responsibility and an increase in the eligibility level for parents from 100% to 133% of FPL. In the House version, the federal government would pay 100% of the new costs; in the Senate versions, this issue is undecided. If the federal match were indeed 100%, there would be strong incentives for states to find that all eligibles are MIAs. A different option would be for states to pay at roughly their existing match rates for the new eligibles and adjust the FMAP to assure cost neutrality to the states.

Unfortunately not all states are at the same starting point; some already have a federal match for MIAs and cover individuals with incomes in excess of 133% of FPL; they would be unaffected. Most do not cover MIAs, and some have eligibility levels as low as 24% of FPL.

We think it makes most sense for states to pay the same matching rate for new Medicaid eligibles as they would for current eligibles. The Federal Medical Assistance Percentage (FMAP) should be adjusted down a few points so that the financial impacts of federal reform are cost neutral to the states. This could reward those states that have been most willing to finance public programs for their uninsured. For the state of California, reform



would provide coverage for the MIAs and some working parents below 133% of FPL and increase hospital, doctor and other provider reimbursements to Medicare levels, which is going to help the uninsured get access to care and dramatically improve bottom lines for providers, but could cost the state budget with the need to finance the match. An adjustment in FMAP will be crucial for California.

A different approach is to link the FMAP to a state's poverty rates since eligibility for Medicaid under the reform package will be linked to those rates. This should help California, where poverty rates are reasonably high. A third idea under discussion would vary the FMAP countercyclically, so that when national recessions hit state budgets hard, the federal government provides automatic assistance. This should also provide for a speedier readjustment of the FMAP as states and regions are differentially impacted by recessions.

Part 2: Public Plan

The public plan option is the other high visibility issue attracting quite a bit of national attention and discussion. It is assumed that the public plan is going to be Medicare, which has a long, successful history of covering the elderly and some of the disabled in a nationwide plan, and providers will be paid at Medicare rates plus. The biggest advantage of Medicare is that it has low administrative costs; the other perceived advantage is its strength in restraining reimbursement rates (at least more so than private commercial insurance). Its two large weaknesses are in controlling the 30% of medical care that is of limited or no utility; this is due to its fee for service structure and open provider networks, and the difficulty in making Medicare program changes, given the partisan political stalemates on most issues in Congress and the perceived lock of special interest groups on the public decision-making process.

We think that in areas of California where there is little or no provider and plan competition, the Medicare option would be a real advantage. However in areas with strong price competition and a strong local safety net, we think California's public plans that participate and compete effectively in Medi-Cal and Healthy Families are an alternative and indeed a far better option than is fee for service Medicare.² These public plans have lower administrative costs than do competing private for profit plans and do a better job at negotiating reimbursement rates and controlling inappropriate utilization than the public fee for service system. Most importantly, they reinvest their savings in system improvements, such as the local Healthy Kids programs.

Part 3: Payment Reform

A missing part of the national discussion and debate are provider reimbursement reforms. As a nation, we have high priced, low use health care as compared to other countries, and we reward specialists disproportionately to primary care and family practitioners.³ "Pay

² We already have good public plans in Orange and Los Angeles, San Bernardino and Riverside, San Joaquin and Kern, Santa Barbara, San Luis Obispo, Monterrey and Santa Cruz, San Mateo, Santa Clara, San Francisco, Alameda and Contra Costa, Solano, Napa, Sonoma and Yolo counties and they can and should be expanded.

³ In some high tech medical tests we have both high costs and high use as compared to other nations.



for performance” is a promising reimbursement methodology that rewards those providers and plans that do an excellent job in improving the quality of their patients/subscribers medical conditions. Pay for performance will require reliable data that is readily accessible to and understandable by patients and providers alike. The data will need constant improvements to adjust for “selection bias”, as the most skilled professionals and hospitals and some health plans may attract the most severely ill patients.

Fee for service reimbursement rewards more and more care while a capitation payment rewards less and less care. Health payment reform needs to move us towards a better system of reimbursement with the proper incentives to improve both quality and efficiency. Bundling of hospital payments is a very small part but an important starting point in devising better reimbursement models.⁴ Reform will need to rectify the imbalance between primary care and specialists if we expect to have a well-balanced delivery system; this will be extraordinarily difficult for Congress to do; yet it must be done and integrated delivery networks and accountable care organizations are the most likely venue to achieve it.

What are your thoughts on reform and are you communicating them to your elected representatives.

⁴ Massachusetts has begun discussions on just such an overhaul, calling for global budgets for accountable care organizations, which would be adjusted by the sickness of the patients and the organizations success in improving their health status. State officials, health plan, medical society and hospital association leaders agree that the time has come for this payment reform. Sack, K., Mass. Panel Backs radical Shift in Health Payment, New York Times July 17, 2009