



Thoughts on Federal Health Reform

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Federal reform will be debated and hopefully passed in 2009 or early in 2010.

We know very little about the bill or bills that will be introduced or eventually emerge in the Senate and House. It will definitely need to be a bi-partisan effort to pass both houses. These are some educated guesses on what may be proposed.

- It will be a hybrid or mixed system of expanded public and private coverage – Medicare, Medicaid, private employer, and private individual insurance. But coverage will be guaranteed issue and guaranteed renewal with no pre-existing condition exclusions and with limits on health plans ability to charge higher premiums for those who are sick, injured or in poor health.
- It will allow all the insured to keep their existing employer-financed and private individual coverage.
- It will cover all kids.
- It is very likely to exclude the undocumented.
- A mandate might be phased in.
- Expanded coverage is likely to be phased in.
- It may shift federal resources from those with high incomes to those with lower incomes to pay for the coverage expansion. This could include controversial changes in the tax code and the financing of Medicare.
 - For example, high-income Medicare beneficiaries might pay a larger share of Part B premiums; higher income wage earners may get less of a tax break on their health coverage.
 - Lower income families and individuals, who now get little help through the tax code, might get refundable tax credits to help them afford their shares of premiums.
- It is unclear what the federal role, the state role, the employer's role, the individual's role, and the parents' role will be. My guess is that it will end up as a mixed national, state, individual and employer-based system.
 - Federal roles
 - It will continue to provide the Medi-Cal (Medicaid) and CHIP (Child Health Insurance Program) match and start to provide a match for the medically indigent adults (MIAs). These are likely to be capped at certain designated income levels (possibly 200% of FPL for adults and 300% of FPL for kids).
 - Tax credits/vouchers will be provided by the federal government to help assure affordability for individuals and some small employers. It is unclear at what income levels these credits begin and end: possibly they end at 400% of FPL—\$40,000 for an individual and \$80,000 for a family of four.
 - The Purchasing Pool/Health Insurance Exchange (which will offer coverage for individuals and small employers) may be operated at



the federal level, but is more likely to be run at the state or regional level, where individuals and small employers may access it more easily. It is more likely to be quasi governmental (like FDIC, for example) rather than a private entity.

- Medicare buy-in may become an option for individuals. Medicare pays providers less than private insurance and offers a wide choice of providers, though fewer utilization controls. Medicare buy-in will be an issue of high symbolic importance to some Democrats and Republicans. Allowing buy-in will effectively set a reimbursement floor. Medicare pays at average costs, so this would represent a large increase in revenues for providers who see a high percentage of uninsured and Medicaid patients. Commercial health plans and high cost providers will feel pressure to reduce their rates and costs, and are therefore likely to strongly oppose this option.
- Some entity will need to specify a minimum benefits package. It is unclear who would do so; arguably it should be an entity like the health insurance exchange that actually has to buy the package.
- The federal government is likely to end up with the role of “Enforcer”, if mandates are included, as it collects a far larger share of the nation’s taxes than the states.
- State roles
 - States will certainly be expected to continue their current Medicaid (Medi-Cal) match. This may additionally extend to parents and medically indigent adults. Some Governors may strongly object to any increase in their state financing responsibilities.
 - States will likely have a role in identifying, finding and enrolling the uninsured kids, parents and MIAs.
 - To the extent that the reform includes an expansion of Medi-Cal (Medicaid) and Healthy Families (CHIP), the states will run that aspect of the expanded program.
 - States or regional collaborations of states are likely to run the purchasing pool or Health Insurance Exchange, because they are more accessible to small employers, individuals and the state-licensed health plans and insurers. While we don’t need 50 different pools, we probably need at least 10 regional pools, such as a California pool and a New England pool, that have comparable costs of coverage and compatible delivery systems.
 - We would expect that states will not have the primary enforcement role if mandates are part of the reform, as enforcement will likely be done through the federal tax system.
- Employers
 - Employers will maintain their essential roles in buying coverage for their employees and will benefit from cost containment measures.



- There may be a phased in “pay or play” tax/fee/assessment for those who offer no coverage. It could be graduated by size and might exempt smaller businesses.
- There is likely to be some form of refundable tax credit to help small, low wage employers with affordability.
- One of the open questions is whether the purchasing pool/Health Insurance Exchange is available to employers who offer coverage, and at what employer size the pool option is foreclosed. Can employers who have opted to “play” (i.e., buy their own coverage for their employees) buy into the pool?
- Currently, employers decide what classes of employees are covered, for what services, in what plans, and how to split employer/employee financial responsibilities. Some of that flexibility may be curtailed. Should there be a floor? If public subsidies are entailed, should there be any ceilings? For example, can you buy the most expensive, extensive plan for your workforce and still get all the same tax advantages you now enjoy?
- Parents and other individuals
 - Parents and other individuals will choose a plan, pick their doctors and may choose to purchase or upgrade with supplemental coverage. There will likely be some agreement on a minimum benefits package. If public subsidies are entailed, should there be any ceilings? For example, if you receive refundable tax credits and are buying through the pool, do the tax credits cover costs in the least expensive plan, the average cost plan or the most expensive plan? In the supplemental plan? Are individuals publicly subsidized for the incremental cost of their purchasing decisions?
 - There will likely be financial incentives to instill, improve and reward healthy habits – e.g., stop smoking, lose weight, eat healthy if diabetic. What plans really work and how should these incentives be structured?
 - Most will pay part of the premiums; some will pay all (those who are without employer or public subsidies and have an ability to pay), possibly with tax credits to defray some of the cost.
- What is the local/county role likely to be?
 - To the extent that the county has its own managed care plans for public patients or public employees (for example, San Francisco, Los Angeles, Orange and Santa Clara), those plans are likely to continue to exist and will probably have a broader role in extending coverage for the heretofore uninsured.
 - To the extent that the county operates its own network of hospitals and clinics – i.e., acts as a provider – that role is likely to continue with a real opportunity for expansion, as the uninsured are covered. Long-term success is likely to depend on system transformation in a more competitive playing field.



- California counties are likely to retain key roles in outreach, application assistance, enrollment and eligibility adjudication, although some of these roles may shift to private non-profits and/or the state depending on comparative efficiency.
- If the state is required to pay a match for the MIAs, it is very likely either to assign that role to the counties or to recapture realignment funds to make those matching payments.
- A federal bill(s) will have a lot of cost containment, mostly of the managed competition, stronger incentives variety. Medicare and Medicaid, to a lesser degree, will experience a fair share of the cost cutting, since their spending growth is likely to overwhelm federal spending unless checked.
 - Providers will need to install and effectively use health information technology. This technology must be interoperable with other providers who treat their patients and with the payors.
 - Prices, costs and quality will become more transparent to their patients and more readily comparable to other providers and plans.
 - There will be payment incentives to improve patient quality, e.g., pay for performance incentives.
 - There will be reliable studies comparing the clinical and cost effectiveness of treatments and medical devices. Eventually this will be used to set payment rates.
 - Payments are likely to be bundled in order to improve coordination and quality of care.
 - Payment differentials between primary care practitioners and specialists are likely to be reduced.
 - A greater dose of competition with generics and foreign competition will be applied to pharmaceutical and medical device manufacturers to get their prices down. Increased regulation will be used to bring marketing abuses under control.
 - Medical underwriting opportunities for health plans will be vastly reduced and probably eliminated.
 - Under all likely reform scenarios, providers and plans are going to become far more accountable for reducing health costs and improving patient quality. Those providers in large metropolitan areas who are the slowest to adopt health information technology, improve care coordination, and increase quality are going to lose lots of patients unless they meet the prices and quality of their competitors. Those health plans that prove least able to control the rise in health prices are going to lose lots of subscribers.

Prepared by Lucien Wulsin, March 22, 2009