



## Forging Health Reform Consensus

By Karen Davis



Cooler weather has arrived and, with it, cooler heads are moving forward with health reform. Despite the summer demonstrations against congressional health care legislation, there is widescale recognition that the U.S. health system cannot continue on its current course. Ever-

rising numbers of uninsured, insurance premiums that are out of reach of even middle-income families, and the strain on businesses and government budgets from a health sector consuming a greater and greater share of the nation's economic resources make the status quo untenable.

Still, most Americans remain perplexed by the different versions of health reform presented in legislation from three committees in the House of Representatives and two committees in the Senate. The daily headlines highlighting differences in opinion on specific provisions suggest bipartisan and even Democratic party agreement is elusive. Yet, even though the Senate Finance Committee is still considering legislation and the final bills going to the House and Senate floors have yet to be formed, there is, in fact, significant consensus on the framework for reform across all the bills moving through Congress. It includes: affordable health insurance coverage for all; increased choices; incentives for accountability; greater transparency; shared responsibility; redirected resources; and opportunities for learning and acting as reform is implemented.

### Affordable Coverage for All

On the key goal of ensuring affordable coverage for all, the proposals under consideration include four common elements: expansion of the Medicaid program to all of the lowest-income individuals and families; provision of income-related assistance to make premiums affordable for moderate-income families; an essential benefit package to ensure financial access to health care; and an affordability standard to ensure that no family faces serious financial hardship as a result of illness or injury.

The House proposal and Senate Finance Committee Chairman's Mark include expansion of Medicaid up to 133 percent of the federal poverty level (almost \$30,000 for a family of four), while the Senate Health, Education, Labor, and Pensions (HELP) proposal would raise the bar to 150 percent of poverty. Both the House and the two Senate versions would provide assistance in paying premiums for families up to four times the federal poverty level (about \$88,000 for a family of four). Each bill would set a maximum on the most that any family in this income bracket would pay for health insurance at about 12 percent of income for higher-income families. Individuals with lower incomes or who are covered by employer plans would pay less. While the differences in the subsidy amounts for different incomes across the House and Senate bills are important, all of the bills recognize that, with premiums now exceeding \$13,000 a year, even average-income families cannot afford health insurance on their own.

All of the proposals also call for creation of an essential benefit package that covers hospital, physician, prescription drugs, preventive care, and other services, with the details

left to those responsible for implementing the legislation. Different options would be available, with individuals able to make trade-offs between lower premiums and higher out-of-pocket costs. But all plans would be required to cover a minimum “actuarial value,” or share of all expenses, ranging from 65 percent to 95 percent. This range is comparable to the share of expenses covered by the plans typically held by working families and members of Congress. The House bill and Senate Finance Committee Chairman’s Mark ensure that lower-income families have affordable out-of-pocket costs. Again, the differences among proposals on the table are important but there is consensus on the basic structure.

### Increased Choices

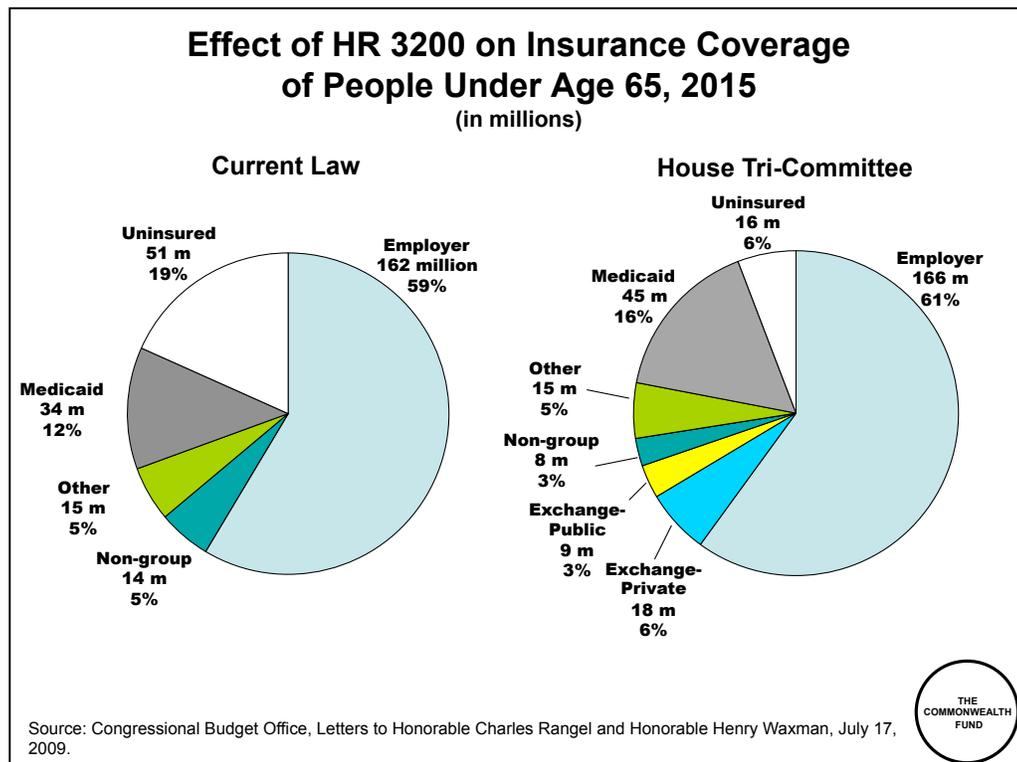
The most contentious issue is whether a new public health insurance plan would be offered through a health insurance exchange or the marketplace. What is lost in this debate is that all of the proposals would establish such an exchange and set rules on participating plans, including their availability to all on the same terms regardless of health status. These rules would dramatically increase the availability and affordability of coverage for those who have

been excluded from the insurance market because of serious health conditions.

The proposals also would expand people’s insurance plan choices. The House would include a public health insurance option, which would be sponsored by the government. The Senate HELP proposal includes a community health insurance plan offered by the government but with claims administered by private parties, and the Senate Finance Committee Chairman’s Mark includes a nonprofit, consumer-controlled private plan. The structure of the plans and potential premium savings differ, but there is shared recognition that the private insurance market needs to change—and that change can best be accomplished by offering new affordable public or nonprofit plan choices in the marketplace.

### Incentives for Accountability

An important aspect of the reform bills that has remained under the radar screen is that all seek to transform the health system from one that rewards doing more to one that rewards getting better health outcomes for patients. Both



the House and the Senate Finance Committee Chairman's Mark would improve the coverage of preventive services. Today, only half of adults are up to date with preventive care. No single provider takes responsibility for reminding patients of screenings and ensuring that such services are offered on a timely basis, and financial barriers lead many patients to put off care as long as possible. Likewise, many chronic conditions go uncontrolled because there is no system of accountability for monitoring care over time.

Both the House and Senate Finance Committee Chairman's Mark would establish a Center on Payment Innovation that would reward physicians, hospitals, and health care organizations that agree to be held accountable for ensuring their patients get the best care. This change in accountability for health outcomes, quality of care, and prudent stewardship of resources is a seismic shift from the current system, which simply pays for units of services—each test, each procedure, each face-to-face visit with a physician, each emergency room or hospital encounter. Instead, patients would be encouraged to identify a physician, nurse practitioner, or clinic as their principal source of care. That provider or practice would be responsible for that patient and rewarded for focusing on providing accessible, coordinated, patient-centered care delivered through interactions by telephone, telemedicine devices, or the Internet; during the day or on evening and weekends; and by a physician or a care team that includes nurses, pharmacists, and other health professionals.

### **Greater Transparency**

One of the reasons the U.S. has the costliest health system in the world is that information on the quality and cost of care is not readily available to consumers in a system where profit on the provision of health care is accepted. What may turn out to be the sleeper in health reform are various provisions that would shine more sunlight on economic transactions, such as the profit margins and administrative expenses of insurance companies, the content of insurance policies purchased by consumers, and the financial relationships between physicians and medical device manufacturers and pharmaceutical companies.

Under the reforms, patients would have more information on the quality of care and prices. The gradual shift to global fee systems of payment for total care of a condition—like a hip fracture or heart surgery—would help patients know

what to expect before selecting a source of care, as well as help physicians and hospitals benchmark their performance against their peers. The Commonwealth Fund Commission on a High Performance Health System National Scorecard found that performance improves on quality measures that are publicly reported. Even though the Congressional Budget Office does not attribute significant savings from changes in provider behavior, greater transparency on quality and total fees could lead to substantial shifts in both provider and patient behavior and lower costs over the long term.

### **Shared Responsibility**

It is not surprising that everyone is worried about who will pay for health reform. But the truth of the matter is that coverage for all is affordable if everyone does their part. Those without coverage are being asked to contribute to premiums on an affordable sliding-scale based on income, whether they are young and healthy or older with complex health conditions. Young adults would pay lower premiums than older adults, and some proposals add options for young adults to continue coverage under their parents' plans up to age 26.

Employers are also expected to do their part, which will level the playing field between those companies that provide coverage and those that don't. Exceptions and special treatment will exist for very small businesses struggling to meet payroll and for workers whose share of the premium offered by employers is still burdensome.

### **Redirected Resources**

The federal budget price tag for expanded health coverage seems staggering—\$900 billion to over \$1 trillion over a 10-year period under the House and Senate bills. Yet it's important to keep in mind that over the next decade the U.S. will spend \$40 trillion on health care—and the new federal outlays represent about 2 to 3 percent of total health spending. To finance this expansion of coverage, about half of the resources will come from slowing growth in provider payment rates under public programs by about 1 percent a year—which hospitals and other health care providers have agreed is possible given savings that will be generated by efforts to improve productivity and eliminate waste. Pharmaceutical manufacturers have offered to cut the price of brand-name drugs in half for seniors hitting a gap in their Medicare drug plan called the “donut hole.”

Other savings will come from eliminating overpayments to Medicare managed care plans and levying fees on insurers and device manufacturers. Under the House bill, additional revenues may be generated by reversing some of the tax cuts of the last three decades for the wealthiest households or, under the Senate Finance Chairman's Mark and possibly the revised House bill, by taxing non-essential insurance benefits or certain health industry suppliers.

## Learning and Acting as Reform Is Implemented

Some have called for proceeding at a slower pace, cautioning that the reforms represent a major redirection in the health system and that not all of the consequences are known with certainty. But the proposals in the House and Senate have numerous provisions that call for phasing and monitoring and provide opportunities to make adjustments as reform is implemented. The health insurance exchange, for example, would be established in 2013, and initially open only to individuals and very small firms. This would provide ample time for planning and addressing design issues, and would give discretion to those operating the exchange to decide when to expand to larger firms. As the exchange goes into operation, new transparency on insurance administration and review of premiums would assess whether intended efficiencies are occurring.

The Center for Payment Innovation would implement new methods of payment for physicians, hospitals, and health care organizations ready and willing to participate, with

discretion for the Secretary of Health and Human Services to spread successful innovations more broadly. A new commission has been suggested in the Senate to monitor trends in federal budget spending and identify areas of waste and potential additional savings and to expedite the implementation of remedies. This might reasonably be extended to system-wide review of health expenditures for employers and working families. Based on the system reviews, Congress could act to modify reforms, including phasing in various provisions more slowly or quickly, or adding additional safeguards or savings.

## A Consensus-Minded Approach

All of the provisions described—in combination with those in the American Recovery and Reinvestment Act of 2009 that are investing in health information technology and comparative effectiveness research—would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term. Each bill now in Congress would also make sure that Americans with insurance maintain stable, affordable coverage and that uninsured Americans gain coverage.

Focusing on areas of consensus rather than our differences or most preferred solution should help make reform this year a reality. The framework for health care transformation has been laid out—our final task is to work through the remaining issues without derailing our efforts and pass this legislation, which has the power to improve the financial health of our nation and the financial and physical health of its people.

