

HEALTH CARE

The Four Health Care Deal-Busters

Critics are grumbling that some key Democratic ideas could cause the consensus for comprehensive reform to fall apart.

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by Marilyn Werber Serafini

What could stop comprehensive health care reform in its tracks despite the emerging consensus that fundamental change is overdue? Interest groups and Republicans are already whispering about potential deal-breakers, even though Democrats have yet to make their opening bid.

The grumbling, which is growing louder, centers on three key Democratic ideas: creating a public insurance plan to compete with private carriers; holding down costs by revising the way Medicare pays providers; and requiring employers to provide insurance or otherwise contribute to the cost of their workers' coverage.

James Gelfand, senior manager for health policy at the U.S. Chamber of Commerce, said, "I can't say what will and will not be a deal-breaker in the final package, but [an employer mandate] is the No. 1 thing that could make employers walk away from the table."

The complaints even go beyond the content of the emerging plan. Republicans are also griping about the prospect of Democrats' bypassing the normal budget process on Capitol Hill. To Democratic leaders, the appeal of using the budget reconciliation process as the vehicle for health care reform is that they would only need a simple majority to pass the measure in the Senate, not a filibuster-proof 60 votes. Plus, attaching a health package -- estimated to cost as much as \$1.5 trillion over 10 years -- to reconciliation legislation would give Uncle Sam more flexibility in financing reforms because congressional "pay-as-you-go" rules requiring budget offsets for new spending would not apply.

In spite of the grouching, many players sound willing to give President Obama a chance to overhaul the health care system, notes Karen Davis, president of the Commonwealth Fund, a philanthropic research organization. Insurers, for example, appear ready to acquiesce to some sort of requirement that they cover all applicants, regardless of health -- provided that everyone is compelled to have coverage. And some Republicans acknowledge that their party may be ready to accept a mandate that individuals have insurance, if other changes make coverage more affordable.

"I'm hopeful that people, this far from the next election, will be calm and focused and realize that there will be major human suffering out there unless we organize the [health care] system to be more efficient," said Rep. Jim Cooper, D-Tenn., who was a key moderate player during the Clinton health reform drive. What follows is a look at the four big points of contention.

A Public Plan

When National Journal convened a panel of health policy experts in March to talk about reform, harmony reigned -- until discussion turned to creation of a public insurance plan. In striving for universal coverage, Obama, Senate Finance Committee Chairman Max Baucus, D-Mont., and others have proposed allowing the uninsured, and possibly others, to choose among a variety of options that would include one public plan.

Andy Stern, president of the Service Employees International Union, insisted that a public plan option is a "must have." Liz Fowler, who is on the Finance panel's Democratic staff, said that a public plan is "important for Democrats," who want to ensure that people in poor health have an affordable choice. But Karen Ignagni, president of America's Health Insurance Plans, called the public option a "red line for insurance reform. It's a stalking horse to end up with one system; 100 million people would be lost from the private health system."

Sen. Robert Bennett, R-Utah, warned that creation of a public plan would be the single biggest deal-breaker for Republicans if they see it as a pathway to single-payer, government-provided health care. "It can be a slippery slope," he said.

Much of the struggle over comprehensive reform stems from the long-standing ideological tug-of-war over the appropriate role of government in health care. Cooper, a member of the fiscally conservative Democratic Blue Dog Coalition, says, "The public plan, in the mind of many Republicans, is equal to Big Government.... Right now, there's not much trust in government."

Republicans, insurers, doctors, and hospitals worry that Medicare providers would be required to serve anyone in the new plan and to accept its prices, said Len Nichols, director of the health policy program at the New America Foundation, a nonprofit public policy institute. Private insurers fear that they wouldn't be able to compete, he said.

Public health plans typically have smaller administrative costs and better leverage to negotiate lower payments to medical providers. As a result, public plan premiums could be 30 percent less than premiums for comparable private coverage, actuary John Sheils of the Lewin Group, a health care policy research and consulting firm, wrote on National Journal's Health Care expert blog on March 23.

"Consequently, there would be a mass shift of enrollment from private coverage to the public plan. We estimate that about 119 million people would shift from their current -coverage to the public plan, which is a two-thirds reduction in the number of people with private coverage, currently 170 million people." Although consumers would appreciate low premiums, low payments to providers have negative consequences for the entire health care system, Ignagni wrote on the blog. "A government option could ... turn back the clock on innovative care coordination, quality improvement, and prevention and wellness programs."

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For physicians, the downside of a public plan's paying less than the going rate for private insurers is obvious: less income. For would-be patients, the downside is that a doctor can be harder to find. Because Medicare pays less than private insurers for some treatments in some places, a recent Medical Group Management Association survey found that 24 percent of physicians' group practices already limit the number of Medicare patients they accept, said James Rohack, president-elect of the American Medical Association. He also pointed to a report by the Medicare Payment Advisory Commission, which advises Congress on Medicare payments, that showed that 30 percent of Medicare patients seeking a new primary-care doctor have trouble finding one.

Medicaid, the existing federal-state health plan for the poor, consistently pays less than private insurance. Rohack, who practices cardiology in Texas, said that in the border areas of his state Medicaid pays primary-care doctors only about 35 cents on the dollar charged. "The challenge we've experienced is that when you have a public plan, there reaches a point where, if budget cuts have to occur, many times they go to the physicians first, and then we're in the difficult position of having to care for patients."

According to the National Association of Children's Hospitals, Medicaid covers only about 70 percent of their facilities' costs for pediatric services.

Bennett and Cooper argue that a new public option simply isn't necessary to enhance competition and lower health care costs. The federal employees' health care system operates competitively even though it includes only private plans, Cooper says. "Regardless of the theoretical pluses and minuses, almost every Republican who spoke at the White House health care summit in March laid [opposition to a public plan] down as a marker," he said.

Nichols sees room for compromise. He and John Bertko, an actuarial consultant for the New America Foundation, published a report in March pointing out that more than 30 state governments offer their own employees a choice between private insurance and a health plan that the state self-insures, meaning that the government assumes the financial risk for costs. The state or its third-party administrator negotiates contracts with doctors, hospitals, and other medical providers and handles administration of the public plan. The key, Nichols says, is to run the public plan through an independent entity and apply the same insurance rules to everyone. "Plans operating with politically appointed managers can compete with plans run by private managers," he said, "provided the rules of engagement are similar or, preferably, identical."

However, Paul Ginsburg, president of the Center for Studying Health System Change, says he doesn't consider the state plans "public," and he contends that the state model is not what proponents of a federal public plan "really have in mind. When states offer a self-insured plan that is administered by an insurer, they are little different from large private employers who do the same thing," he said.

Whether health plans are defined as public or private, said Stuart Butler, vice president for domestic policy at the Heritage Foundation, it is "inconceivable that Congress would set up a public plan that would actually have to live by the same rules" as private insurers.

The Chamber of Commerce's Gelfand agrees. "Government prints the money. They have all the guns. And they make the rules as they go. They enforce the laws, and they choose selectively who to favor. They are -going to find ways to give themselves advantages."

Reaching agreement on a public plan option is especially difficult because some people would rather disagree than find a solution, Nichols said. "The Far Left wants a Democratic-only health plan, so they want to chase away the moderate Republicans, [and] this is a perfect device for that." The Far Right, he said, "wants to kill health reform, and they see this as a convenient device to call it a government takeover."

Paying the Tab

The White House and leading congressional Democrats say they intend to fully offset the cost of comprehensive reform by implementing cost-saving initiatives and tinkering with the tax code. In his 2010 budget proposal, the president envisions getting \$634 billion over 10 years through a combination of savings -- from anticipated improvements in care and efficiency -- and new revenues.

Baucus has said he plans to pay for reform and has expressed frustration that normal budget rules don't allow the kind of flexibility he wants in order to be able to invest upfront, before many of the savings are realized. Although he says that using budget reconciliation legislation to pass health reform isn't his first or second choice, he acknowledges that he will do so if that is what it takes to pass a bill.

Republicans have consistently said that health reform legislation must not be allowed to increase the federal deficit. Every Republican senator this week signed a letter urging congressional leaders to resist using reconciliation because it would limit debate and restrict amendments: "Unfortunately, the House Budget Committee's proposal does include such instructions. It is our understanding that the instructions will simply serve as a placeholder to push the Senate during its conference with the House. This is not only unwise, it violates the principle of bipartisanship to which President Obama and congressional leaders have publicly committed." On March 13, the Blue Dog Coalition wrote to the chairmen of the Budget committees, House leaders, and the president to -encourage fiscal discipline: "While we agree that reforming our health care system will eventually lead to savings, it would be -irresponsible to take on additional large-scale deficit spending in the short term without the ability to definitively quantify -future savings."

Its letter was in reaction to a March 9 letter from 30 major interest groups urging congressional budget leaders to take a flexible approach that "reaffirms the importance of offsets but accommodates the need for significant short-term expenditures that will help set the health system on a path toward significant long-term savings and improvement in the long-run fiscal future of our country." Signatories included AARP, America's Health Insurance Plans, the American Medical Association, Families USA, and the U.S. Chamber of Commerce.

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"While the cost savings from improving the efficiency and quality of health care will be significant, many of the anticipated savings will be realized in the long term, and may thus not be evident in a 10-year budget window," the interest groups wrote. "Moreover, [the Congressional Budget Office's] current scoring conventions do not recognize many of the savings to be achieved by a restructuring of the health care system."

A big unknown is how generous the Office of Management and Budget and CBO will be in calculating future savings from health reform. Baucus questioned OMB Director Peter Orszag at a recent hearing about the prospect of offsetting early investments with savings expected to be realized later. Orszag responded that not enough research has been done to quantify savings from untested quality initiatives, such as improving health information technology. Obama wants the package to be budget-neutral over its first 10 years, Orszag said.

When he was CBO director last year, Orszag said he hoped to change the widespread belief in Washington that CBO is Scrooge-like in its assessments -- giving more weight to a proposal's potential costs than its potential

savings. Back then, he specifically cited "comparative effectiveness," or the evaluation of competing treatments' value, as something that CBO might not have calculated as saving money in the past, but perhaps should factor in.

Orszag has emerged as an administration leader on health reform, but CBO will be responsible for "scoring" the health care package once it is unveiled later this spring. Orszag's successor at CBO, Douglas Elmendorf, has not yet said whether he wants to take possible health care savings into account in determining the cost of such reform initiatives.

Putting the Squeeze on Costs

Obama's budget proposes raising \$318 billion for health reform by reducing to 28 percent (from either 35 percent or 33 percent) the itemized deduction rate for couples with annual incomes over \$250,000. Baucus wants to limit the employee tax exclusion for employer-provided health benefits, a change that could raise about \$500 billion over 10 years, according to Urban Institute President Robert Reischauer.

Raising taxes is almost never a politician's preference, but Obama and Baucus apparently see it as a more promising path than trying to squeeze large sums out of Uncle Sam's payments to medical providers. "No one wants to raise taxes, and taxing the exclusion causes heartburn, but when people look at what it takes to finance reform with captured savings, suddenly people come back to the tax money," Nichols said.

Medical providers are increasingly nervous, meanwhile, about so-called quality initiatives, which Democrats and Republicans alike are pushing as a source of savings. Quality requirements "could blow this up, absolutely," Nichols warned.

Obama proposes to save \$26 billion through new incentives to reduce hospital readmissions for Medicare patients. The president's plan would also pay physicians more money for "high-quality" care. "It's all controversial because it penalizes [providers] for doing what they are doing now," Nichols said. "[Reform advocates] have to get physicians on board."

Evidence shows that paying providers more for better care can improve quality and lower costs, says Ginsburg of the Center for Studying Health System Change. He co-authored an article for the journal *Health Affairs* in 2007 that focused on the Virginia Mason Medical Center in Seattle. When Aetna found that Virginia Mason charged more than the competition but didn't get better results, the big insurer threatened to exclude certain of the center's departments from its list of high-performance providers. (Employers got a better deal if their plans used doctors and hospitals on that list.)

Aetna and some of its major customers agreed to start paying Virginia Mason "per episode of care," rather than "per service" for lower-back pain, cardiac arrhythmia, gastroesophageal reflux disease, and migraine headaches. The switch meant that Aetna would pay Virginia Mason once for everything it did in response to, say, someone's back pain, not pay separately for a consultation, an MRI, and physical therapy.

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The result? Virginia Mason began spending less on each of the four conditions. Data showed that costs for MRIs related to back pain declined by 11 percent, Aetna says, resulting in savings of \$18,000. Similar reductions in MRIs for migraines netted \$97,000 in savings.

In response to Virginia Mason's concerns that reducing its use of MRIs in diagnosing and treating back pain hurt an important moneymaker, Aetna and its employer clients agreed that if the hospital could halve its MRIs for low-back pain, the employers would share half of the savings through higher reimbursements for physical therapy.

But the AMA's Rohack is not persuaded that such an approach would be productive with most doctors. Most of the health systems that would benefit from such arrangements are large, integrated entities in which doctors are employees or have a shared stake in the business, he said.

"The majority [of doctors] are independent physicians or small groups. For them to come together to talk about how you deal with [cutting costs] is a violation of law. We're going to have to get the law fixed if we're going to deal effectively with how to shift the risk back to those providing care for outcomes."

Failing to address the statutory obstacles would make these cost-cutting proposals a deal-breaker for the AMA, Rohack said. "If the intent of all of this discussion on health system reform is not to improve quality but just ratchet down costs, then we can control a lot of costs by quitting doing things," he said. "We can cut costs of colonoscopies by cutting back on colonoscopies. But then people will be showing up with expensive Stage 4 colon cancer."

He added, "If we're going to control costs by not doing things because there's no reason to do it -- but the reason we're doing it is because we're afraid we're going to be sued -- then that's a real problem.... That is a potential deal-breaker."

Employer Mandates

Dan Danner, president of the National Federation of Independent Business, joined his group in 1993, the year that President Clinton's health reform effort collapsed. One of Danner's lingering memories is that Clinton's employer mandate was a deal-breaker, especially for small businesses.

Today, small businesses see employer mandates, in any form, as a "lightning rod," he said. Many Democratic health reform proposals would require employers to offer coverage or pay into a system that helps workers buy their own insurance. Some proposals would exempt or subsidize small businesses.

Danner isn't buying the idea of an employer mandate no matter the supposed exceptions. "It's a job killer. It doesn't make sense to mandate anything an employer can't afford.... We have a heck of a big stake in this." Big Business also hates employer mandates. Asked whether the U.S. Chamber of Commerce could accept a compromise, Gelfand instead ticked off ideas being floated in Washington that are troublesome to his organization. His worst fear is that employers and policy makers will cut a deal, only to have the government renege and pile on new mandates.

Both Obama and Baucus have talked about exempting small businesses from mandates. "Whatever they decide a small business is, it will ... get smaller and smaller and smaller until it is nobody," Gelfand predicts. "This is an effort to triangulate the business community and get small business on board, to defuse the opposition."

He also dislikes proposals to excuse employers from mandates if they cover workers. "It's a lie," Gelfand said, contending that businesses would still face huge administrative requirements for proving that they offer insurance and meet certain minimums on benefits and contributions. Moreover, he is skeptical that the government would maintain a carve-out for employers that offer insurance, arguing that decision makers would eventually "shrink it until no one is left out."

He adds, "I cannot see a reason why we would ever be in favor of permanently locking business into taking orders from Washington and transforming employers into piggybanks that Washington can use to fund health care programs."

Greg D'Angelo, a policy analyst at the Heritage Foundation, points to Massachusetts as reason for concern. In 2006, the commonwealth enacted universal health coverage legislation that required employers to "play or pay." The results show that employers nationwide are right to be afraid, he says. "I don't usually like the 'slippery slope' arguments, but this is a real fear," he said. "This wasn't supposed to be very burdensome, but now that it is in place, there is a constant push to increase the requirements, make it more burdensome, to raise more revenues."

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Specifically, Massachusetts required companies with 11 or more employees to make a "fair and reasonable" contribution toward workers' health insurance. The state's health department defined "fair and reasonable" to mean that employers either had to offer insurance, with 25 percent of workers taking it, or contribute at least 33 percent of the cost of a worker's premium when that worker got private insurance or went through the state's "connector" to buy coverage. Employers failing to meet at least one of the two requirements faced a fine of up to \$295 per worker each year.

The state implemented the mandate in October 2006. A year later, it had collected only \$7.7 million in employer fines, D'Angelo said. Massachusetts had anticipated that more employers would do "the wrong thing," he said, and that the state would take in closer to \$45 million.

Last year, the health department proposed changing the requirement so that employers would have to meet both tests. That sparked "pretty intense" opposition from the business community, D'Angelo said. In the end, Massachusetts exempted employers with 50 or fewer workers from the toughened requirement. D'Angelo contends that the change was all about the money. "They had a budget gap of \$150 million for fiscal year 2008," he said. "The fears of the [National Federation of Independent Business] and others are well-founded. This is proof positive."

Gelfand offers another example. San Francisco has an employer mandate that is in litigation. This year, businesses with 20 to 99 employees must spend at least \$1.23 per worker hour on health care. Larger companies must spend \$1.85.

The problem, according to Gelfand, is that some insurance plans available to these workers cost less than the amount the employer must contribute under the law. The Golden Gate Restaurant Association challenged the requirement in court, contending that it was illegal under the federal Employee Retirement Income Security Act. The association lost but is appealing, he said.

In Washington, discussions among policy makers and stakeholders are still civil, but the debate could quickly turn harsh. The risk, the Commonwealth Fund's Davis said, is that on all sides of the debate "people will get more dug in over time.... If we get into a situation where every interest says it could buy into everything except those provisions that affect me, the whole thing could unravel."