

An Economic Perspective on U.S. Health Reform

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Goals for Today

- What are the main components of current health reform legislation? (focus on HR 3200)
- What are the economic concerns underlying each component?
- How do the components relate to one another?
- How well does each component address the underlying concerns?

Main Components

Medicare
Reform

Insurance Market
Reform

Assorted Quality
& Efficiency
Initiatives

Universal Coverage
& Affordability

Economic Context: Medicare

- Medicare spending growth unsustainable
 - 75-year projected debt = \$34 *trillion* (2006 SSM trustees' report)
 - spending cuts or tax increases are inevitable
- Traditional Medicare plan widely seen as poorly designed
 - continued reliance on FFS
 - payments skewed to favor specialist services
 - relatively high OOP costs for beneficiaries
 - role of supplemental insurance (e.g. Medigap)

Economic Context: Medicare

- Private Advantage plans compete with traditional plan
 - perhaps offer better designed plans
 - but increases Medicare spending (14% avg subsidies)
- Ongoing failure to address large, unjustified geographic disparities in Medicare spending
 - Dartmouth Atlas Group: ~30% of Medicare spending represents waste

Economic Context: HI Markets

- Some markets clearly suffer from lack of competition
 - Alabama: one insurer has 90% of market
- But deficient competition not simply about numbers
- Individual and small group markets plagued by “search frictions” with numerous implications:
 - higher-than-competitive premiums
 - excessive marketing costs
 - excessive insurance turnover

17.5%/12%

Economic Context: HI Markets

- Providing more complex options to an already confused shopper makes it harder for shoppers to identify their best option (Frank and Zeckhauser, NEJM 2009)
- What individuals and small groups need is information to make comparison shopping easier
 - forces insurers to compete harder on price and value, lessens importance of marketing

Economic Context: HI Markets

- For consumers, financial incentive of insurers leads to insurance practices that are predictable...
 - deny coverage for pre-existing conditions (unless they can charge higher premiums)
 - deny renewals or raise premiums after onset of disease
- ... and some that are disturbing
 - rescissions
 - exploiting “fine print” to deny claims
- Consumers often find insurance least affordable when they need it most (when they lose job/health)

Economic Context: Coverage

- 17% uninsured and growing
 - 26% if exclude persons with public coverage
- Medical costs are leading cause of personal bankruptcies
 - roughly half of all bankruptcy filers had OOP medical costs exceeding \$5000 prior to filing (Himmelstein et al. AJM 2009)
 - three-quarters of these had insurance coverage
- Those with greatest difficulty affording HI operate in poorest-functioning part of HI market

Economic Context: Coverage

- Lack of insurance leads patients to forego necessary care
 - IOM: 20,000 premature deaths annually
- Leads patients to receive care inefficiently
 - excessive use of EDs
- Much of the uninsured costs are ultimately borne by everyone else
 - DSH payments, higher premiums

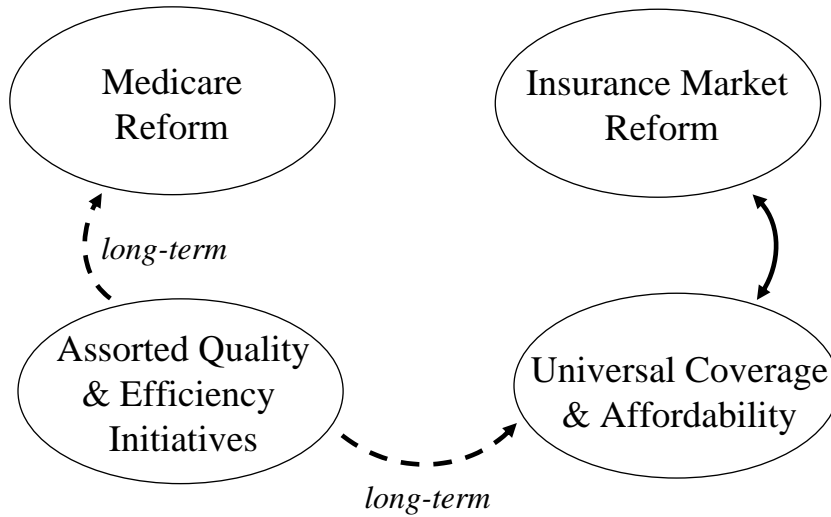
Economic Context: Quality/Efficiency

- Problems of over-use co-exist with problems of under-use (David Cutler)
 - variation in practice patterns suggest substantial confusion about evidence-basis for effective care
- System fragmentation undermines care coordination and degrades quality (Cebul et al., JEP 2008)
 - particularly in chronic care (receive about half of care recommended by established guidelines)
- HC quality is uneven
 - quality information is non-existent or poor
 - incentives for quality are weak

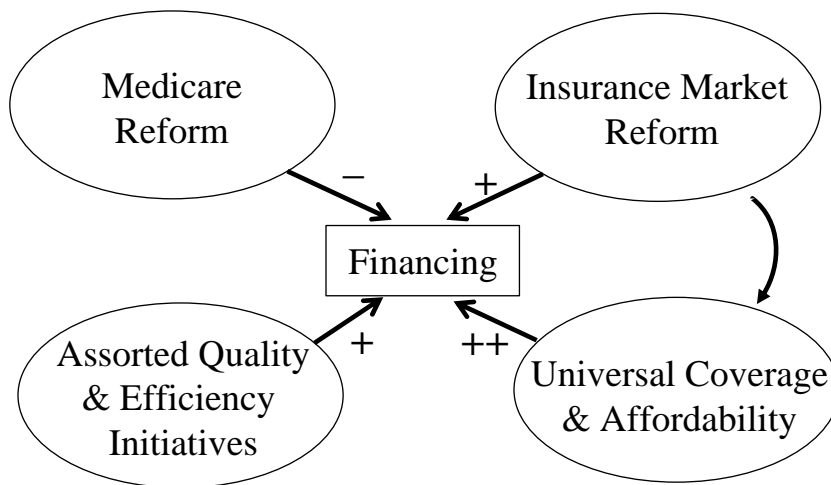
Economic Context: Quality/Efficiency

- Prices vary wildly, set through negotiations between providers and insurers (Uwe Reinhardt)
 - administrative nightmare
 - makes comparison shopping virtually impossible for most services
- Growth in HC spending at least partly due to rise in chronic illness (Ken Thorpe)
 - HC resources might be more efficiently put towards behavioral interventions instead of medical care (e.g. obesity epidemic)

How Components Relate to One Another



How Components Relate to One Another



Details: Medicare Reform

Payment reforms:

- increase relative payments for primary care and preventive services vs. specialist services
- reduce payments for potentially preventable hospital re-admissions
- phase out subsidies for Medicare Advantage (114% to 100%), with bonus payments to reward quality
- reduce DSH payments to hospitals
- reduce fraud

Details: Medicare Reform

Pilot programs to test new payment incentive models:

- accountable care organizations
- bundling of payments based on “care episodes”
- reimbursement of patient-centered medical homes

Coverage reforms:

- eliminate cost-sharing for preventive services
- eliminate the coverage “donut hole” in prescription drug coverage (Part D plans)
- increase asset test for Part D subsidies

Details: Insurance Market Reforms

Health Insurance Exchange:

- creates Exchange through which individuals and small employers can purchase “qualified plans”
- roles for new Health Choices Administration
 - organize/operate the Exchange, vet plans
 - provide information to enrollees that enable them to better compare plan options
 - define “essential benefits” standards based on recommendations by a Health Benefits Advisory Council chaired by the Surgeon General
 - design and operate a “risk pooling mechanism”
- Exchange can be opened to large employers beginning in year 3 at discretion of Commissioner

From HR 3200, Title II, Section 206:

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities.

Details: Insurance Market Reforms

Four categories of plans will be available in Exchange:

- basic plan: includes “essential benefits package” and covers 70% of expected costs
- enhanced plan: covers 85% of expected costs
- premium plan: covers 95% of expected costs
- premium plus plan: premium plan with additional benefits such as oral health and vision care

All plans must include “basic” version, can offer others

Details: Insurance Market Reforms

Regulation of Exchange Plans:

- guaranteed issue and renewability*
- community rating: premium variation within an area only permitted on basis of age (limited to 2-1 ratio) and family vs. individual coverage*
- no annual or lifetime limits on coverage
- annual limits on OOP costs (\$5000/individual, \$10,000/family)
- limit plan’s medical loss ratio as set by DHHS (~85%)*
- other requirements:
 - network adequacy standards
 - contracts with essential community providers
 - state licensing still applies
 - all plans must participate in risk pooling mechanism

Details: Insurance Market Reforms

Public Plan Option (controversial and unlikely):

- Exchange to include a public option set up by Congress
- Public option must be self-financing from premiums paid by enrollees
- Provider payment rates originally set to Medicare rates + 5%, modifiable by DHHS after 3 years
- Providers can opt out of treating public plan enrollees

Details: Coverage/Affordability

Medicaid expansions:

- eligibility expanded to all individuals in households below 133% of FPL
- increase Medicaid payment rates for primary care to 100% of Medicare rates
- coverage expansions to be federally financed
- SCHIP enrollees to obtain coverage through Exchange

Details: Coverage/Affordability

Employer mandates (“pay or play”):

- employers required to contribute 72.5% (65%) to premium cost for single (family) coverage for workers
- reference premium is lowest cost plan that meets established “essential benefits” criteria
- penalty = 8% of payroll
- penalties reduced (eliminated) for small employers with payrolls < \$400,000 (\$250,000)

Premium subsidies to small employers:

- 50% premium credit of premium costs paid by employers with <10 employees earning <\$20,000
- credit phased out as employee count/average wage increases

Details: Coverage/Affordability

Individual mandates:

- individuals required to have health coverage
- penalty = 2.5% of AGI
- exemptions for financial hardship, religious objectives
- individuals cannot meet mandate by purchasing coverage from individual market (must use Exchange)

Premium affordability credits:

- available to families up to 400% of FPL
- credits based on family income and average cost of three lowest cost plans in the area (sliding scale, OOP cost 1.5-12%)
- credits limited to US citizens and legal immigrants

Details: Quality/Efficiency Initiatives

Center for Comparative Effectiveness Research:

- established to conduct, support and synthesize research on outcomes, effectiveness and appropriateness of HC services

Center for Quality Improvement:

- established to identify, evaluate, develop and implement best practices in HC delivery; develop quality metrics

Quality Reporting:

- require hospitals and ambulatory surgical centers to report on infection rates
- improve quality reporting on skilled nursing facilities

Details: Quality/Efficiency Initiatives

Other:

- require disclosure of financial relationships between providers and the developers of drugs, devices, etc.
- develop a national strategy to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities
- reform GME to increase training of primary care providers
- create standards for financial transactions to reduce administrative complexities in billing

The Verdict

Medicare reform:

- Generally sensible, but fail to address long-term fiscal problem
- Savings used to (partially) finance other aspects of reform

HI market reform:

- Economic no-brainer, and the Exchange strategy is very sensible approach
- Current distasteful practices of insurers undermine the purpose of insurance
- Could question the notion that all consumers should pay equal rates (smokers, the obese?)

The Verdict

Universal coverage and affordability

- Eases implementation of HI market reforms, but ultimately a moral issue

Assorted Quality & Efficiency Initiatives

- Should be thought of as long-term investments
- CCE, in particular, could lay groundwork for reducing Medicare costs as painlessly as possible – by eliminating unnecessary costly care

Thank you!

(Hopefully, there's time for questions)