HEALTH REFORM AT THE CROSSROADS: HOW WE GOT TO THE ACA AND WHERE WE GO FROM HERE

Date: Thursday, February 13, 2014, 7:00 pm – 8:30 pm

Topic: THE ROADS (NOT TAKEN) TO REFORM: ALTERNATIVES TO THE ACA

Speakers:

Harold Luft, PhD, Former Director of IHPS and current Director, Palo Alto Medical Foundation Research Institute
Harold Luft, PhD, is Caldwell B. Esselstyn Professor Emeritus of Health Policy and Health Economics at the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco. He joined UCSF in 1978 and was Director of the PRL-IHPS from 1993 - 2007. In July 2008, he became Director of the Palo Alto Medical Foundation Research Institute. He continues to be involved in some activities at PRL-IHPS. His research and teaching have covered a wide range of areas, including medical care utilization, health maintenance organizations, hospital market competition, quality and outcomes of hospital care, risk assessment and risk adjustment, and health care reform. He has been involved in postdoctoral training for almost 40 years, having been co-director or associate director for four training programs sponsored by UCSF and/or UC Berkeley and continues to mentor fellows at PAMFRI. He is a member of the Institute of Medicine and served six years on the IOM Council. He was a member of and chaired the National Advisory Council of the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality). He served on the board of AcademyHealth for 10 years and was co-editor of the journal Health Services Research. He has authored or co-authored and edited a number of books and published numerous articles in scientific journals. Professor Luft received his A.B., M.A., and Ph.D. in economics (specializing in health sector economics and public finance) from Harvard University

Jim Kahn, MD, MPH, Professor of Medicine, UCSF
Professor Kahn’s research focuses on the empirical and modeled assessment of the cost, effects, and cost-effectiveness of global health prevention and treatment interventions. His primary disease area is HIV, with additional work in integrated community health campaigns, gestational diabetes, orthopedics, and other health conditions. His geographic focus is mainly the U.S. and Africa. Prof. Kahn is the PI of the Global Health Decisions project, which examined efficacy data for interventions for 8 global health conditions and is modeling disease burden reduction and cost-effectiveness for HIV interventions via a user-friendly graphic web interface. He is the lead cost and cost-effectiveness investigator for SEARCH and related studies of ART expansion in Kenya & Uganda. He leads two core economics courses at UCSF, global
health economics and decision and cost-effectiveness analysis. He coordinates the UCSF Global Health Economics Consortium (GHECon). He is an expert in the billing and insurance-related administrative costs of health care in the U.S. He is past president of the California chapter of Physicians for a National Health Program, which supports single payer health care.

**Stephen Parente, PhD, Professor of Health Policy, U. of Minnesota and advisor to McCain presidential campaign**

Dr. Parente is the Minnesota Insurance Industry Chair of Health Finance in Carlson School of Management and the Director of the Medical Industry Leadership Institute at the University of Minnesota. As a Professor in the Finance Department, he specializes in health economics, medical innovations, and health insurance. He has served as a consultant to several of the largest organizations in the medical industry: UnitedHealth Group, Blue Cross Blue Shield, Medtronic, Pfizer, Kaiser Permanente, CMS and the FDA. Dr. Parente’s portfolio includes $8 million in sponsored research to generate peer-reviewed publications on consumer directed health plans, health reform, health IT and technology evaluation. In Washington DC, he is the Governing Chair of the Health Care Cost Institute, an Adjunct Scholar of the American Enterprise Institute and on the Board of the Center for Health and Economy. He has testified to the US Congress and state government on health reform legislation. Dr. Parente was a health policy advisor for the McCain 2008 Presidential Campaign and served as Legislative Fellow in the office of Senator John D. Rockefeller IV (D WV) during the Bush and Clinton Administrations’ health reform initiatives. He has a doctorate from Johns Hopkins University and both a MPH and a Masters of Public Policy Analysis from the University of Rochester.

**Edward Yelin, PhD, Moderator UCSF**

Dr. Yelin is a Professor of Medicine and Health Policy at UCSF. His research has emphasized health policy issues related to chronic disease, including the causes and consequences of work disability, the role of changes in the health care system in access to care, and the sources of disparities by race/ethnicity and socioeconomic status in outcomes of severe autoimmune diseases. His research has been continuously funded by NIH and AHRQ since 1980. In addition, Dr. Yelin is Vice Chair of the California Health Benefits Review Program (CHBRP) and Director of the Medical Effectiveness Center of CHBRP. CHBRP provides analysis of proposed health mandate laws for the State Legislation. Dr. Yelin has received numerous awards for his research and, in 1999, was elected to membership in the National Academy of Social Insurance, and organization of the foremost figures in research and policy related to health care, public income programs, and disability. In 2013, he was awarded the Harold S. Luft Award in Mentorship in Health Services and Health Policy. He is the author of more than 250 peer-reviewed articles and another 100 chapters, books, and professional reports.
Towards the Undiscovered Country of Market based Reform

Stephen T. Parente, Ph.D.
Minnesota Insurance Industry Chair of Health Finance in the Carlson School of Management and Director of the Medical Industry Leadership Institute at the University of Minnesota
Governing Chair, Health Care Cost Institute, Washington, DC
Board Member, The Center for Health and Economy, Washington, DC

The Undiscovered Country of Market Based Health Reform

- The Undiscovered Country (‘The Future’)
  - Shakespeare
  - Star Trek VI
- Market Based Health Reform
  - Use private health insurance market
  - Change insurance incentives to reduce uninsured through budget neutral and savings legislative options.
    - Fix 1940s era policy that is distorted the market
    - Reward innovation in quality and efficiency

Agenda

- The Healthcare Marketplace
- One Hundred Years of Health Reform
- Questions & Anxieties
- The Undiscovered County
- Budget projections and premiums
- Concluding comments
100 Years of U.S. Health Reform

**Gradualism**

- 1919: AMA Uses 'Red Scare' for NHI
- 1930s: Progressive Movement for NHI
- 1936: AMA Compromise
- 1949: Truman NIC for ex-New Dealers
- 1956-66: Medicare & Medicaid compromise
- 1965-66: Social Security
- 1966: Massive $$$ into NIH instead of NHI
- 1973: Kennedy NHI again
- 1974: Nixon HMO & Health, ESRD Planning
- 1974: Anatomy
- 2008-10: S-CHIP, MSAs, HIPAA

Gradualism: (n): The policy of approaching a desired end by gradual degrees.

(NHI) National Health Insurance could have happened in 1949 if not for the first multi-million dollar negative ad campaign.

Sir Luke Fildes’s 1891 painting: 'The Doctor'

'Keep politics out of the picture.'

1949, American Medical Association PR Campaign, Published in every major consumer journal of the day.

---

**The End of the Beginning:**

March 21, 2010; 10:45pm EST

- 1985: British National Health Service – most famous single payer system. Largest employer in all of Europe. Want to see it first hand as model for US based on course work at the University of Rochester, Rochester, New York. Want to see if it was exportable... to US.

---

**Personal Odyssey of Health Reform**

- 2005 - Management Intern British National Health Service – most famous single payer system.
Off to London to intern/work for:  
The British National Health Service

Personal Odyssey of Health Reform

• 1985 – Management Intern British National Health Service – most famous single payer system. Want to see it first hand as model for US
• 1986 – Return to US – Culture Shock
• 1988 – Start work for Blue Cross Blue Shield with Masters in Public Policy
• 1990 – Leave Blues to start PhD at Johns Hopkins in Health Economics

Long View:  
Personal Odyssey of Health Reform

• 1985 – Management Intern British National Health Service – most famous single payer system. Want to see it first hand as model for US
• 1986 – Return to US – Culture Shock
• 1988 – Start work for Blue Cross Blue Shield with Masters in Public Policy
• 1990 – Leave Blues to start PhD at Johns Hopkins in Health Economics
• 1994-99 – Finish PhD (94) and work in DC-based think tank learned how to survive as policy entrepreneur
• 1999-2000 – Come to University of Minnesota, got caught into ehealth promise and near death
• 2001-04 – Meld policy / insurance / IT / economics to study Consumer Driven Health Plans
• 2005-07 – Lead $1+ million of research from DHHS on health reform options. Led development of national simulation model for policy options.
• 2008 – McCain health policy adviser
My (old) Questions - Uno

- Why do we think COMPREHENSIVE health reform is possible when it was impossible under the Wilson, Roosevelt, Truman, Johnson, Nixon, Carter and Clinton Administrations?
  - In 2008, I asked: “Did a ‘stakeholder’ take a holiday, go out of business”? as a non-sequitur.
  - In 2010, my response has changed.
    - The medical profession has been neutralized as having an influence by waging a civil war between primary care and specialists. This is a first in the 100 year US health reform opera.

Personal Odyssey of Health Reform

- 1985 – Management Intern British National Health Service – most famous single payer system. Want to see it first hand as model for US
- 1986 – Return to US – Culture Shock
- 1988 – Start work for Blue Cross Blue Shield with Masters in Public Policy
- 1990 – Leave Blues to start PhD at Johns Hopkins in Health Economics
- 1994-99 – Finish PhD (94) and work in DC-based think tank learned how to survive as policy entrepreneur
- 1999-2000 – Come to University of Minnesota, get caught into ehealth promise and near death
- 2001-04 – Meld policy / insurance / IT / economics to study Consumer Driven Health Plans
- 2005-07 – Lead millions of research from DHHS on health reform options. Let development of national simulation model for policy options.
- 2008 – McCain health policy adviser
- 2009-14 – Professor and freelance adviser to Congress & Administration

My Questions - Duo

- Help me understand how my and many other Universities square the following simultaneous activities?
  - Health policy courses on how to cover the uninsured
  - Medical school course to increase ultra specialization
  - Business school courses to make more from less public health insurance programs through med technology and pharma.
- Or: Utility\(\text{\textit{America}} = f[H, M, B, X\text{\{other things\}}]\) subject to $36+ trillion of obligated Medicare funds.
- Oblique Answer: To quote my friends in finance, a ‘Business Venture’ is not called a Ponzi scheme unless it fails.
- Current Answer: To spend our way to a transformative medical breakthrough such as a cure for diabetes (20% of current cost).
My Questions - Tres

- Can we stop seeing ‘dead people’ in our public policy?
  - McCarran-Ferguson (1945): No interstate insurance purchase.
  - Employer-based health insurance tax exemption (1943 – origin moment)
- Or - are we willing to have 1940s medical care (e.g., ‘best practice for schizophrenia’ – pre-frontal partial lobotomy) in exchange for preserving these policies without question or debate?

My Anxieties

- Health economists find that technology is both good for society and huge cost driver.
- Stakeholders will/did not come clean over their past in an effort to say what is different this time.
- Actuaries find the best way to keep costs within general inflation is through catastrophic insurance.
- Advocating catastrophic insurance for all might be the surest way to a two year House of Representatives visit.

The Undiscovered Country of Market Based Health Reform

- The Undiscovered Country (‘The Future’)
  - Shakespeare
  - Star Trek VI
- Market Based Health Reform
  - Use private health insurance market
  - Change insurance incentives to reduce uninsured through budget neutral and savings legislative options.
    - Fix 1940s era policy that is distorted the market
    - Reward innovation in quality and efficiency

Unofficial History of Market Based Health Reform

- 1991: Heritage Foundation study on individual mandate and insurance reform
- 1992: Heritage proposal becomes GOP legislative proposal with:
  - Individual mandate with pay or play for employers
  - High risk pools & malpractice reform
  - Tax credits & insurance reform
  - Addition $5 for state Medicaid
  - Health IT investment
- 1993: Bill Clinton elected. Pay or play trashed
- 1996-7: HIPAA & SCHIP
- 2003: Bernanke at CEA proposes GOP reform
  - ESI tax exclusion financed credits or standard deductions for health insurance subsidy to rise uninsured.
- 2007-8: McCain health plan takes Bernanke plan
- 2009-10: ACA passes with most of 1992 Heritage plan
- 2009-2014: Coburn, Ryan, Hatch, Burr refine McCain
What happened after the 2008 election?

- Health reform emerged on the agenda and both the democrats and republicans wanted their proposals scored.
  - Worked some with Obama Administration until April, 2009.
  - Worked with McCain and former campaign staff from Feb 2009 on.
- Summer, 2009: Released estimates of initial Democrat health reform plan to cost $2+ trillion over 10 years. Received personal defamation campaign from Rep. Charlie Rangel and staff from House Ways & Means committee. Initial government (CBO) estimate days later was $1.9 trillion.
- Fall – Winter, 2009: Moderate GOP Senators enlisted me and faculty from Wharton to develop a back-up health reform plan that covered as many as possible while being budget neutral. Moderate GOP Senators shut down by GOP leadership to force complete party line passage in December.

Applying Model in NY State
Yielded Wall Street Journal Op-ed

Meaningful Market-Based Health (GOP Moderate – 2009) Reform Proposal

- Uninsurance is reduced by 35% (46% if base is US citizens only) to newly cover approximately 17.6 million people
- Subsidy - Tax Recovery = Net cost:
  - $49 billion subsidy for voucher, annual 2013
  - $50.6 billion tax capture, annual 2013
  - Total cost over ten years: $435 billion
  - Total revenue over ten years: $450 billion
  - Net cost (surplus): $15 billion over ten years
- Private insurance crowd out: Not an issue.
Instead: Impact of Health Reform Reconciliation Bill, as of 3/15/2010

- Uninsurance is reduced by 59.8% (81% if base is US citizens only) to newly cover **32 million people**, 17 million of whom through State Medicaid Agencies.
- CBO (Congressional Budget Office) Estimates – 3/18/2010
  - CBO 10 year cost: $940 billion
  - CBO deficit savings $130 billion
- My estimates – 3/19/2010
  - 10 year cost: $1.36 trillion
- My Summary: Additional costs will eliminate deficit savings and add to deficit by $287 billion
- On April 22, 2010 the Medicare/CMS actuary concluded health reform would add $251 billion to the deficit.

Health Reform Goal: Expansion Uninsured Impact 2010-2019

CBO: 2010-2019 Spend ($ billion)

CBO: 2010-2019 Tax/Save

As of 4/22/2010, CMS Actuary forecasts uninsured in 2019 to be 22 million.
CBO: Projected Savings on Vote Eve, March 21, 2010

Net Change in the Deficit

By 2019, $122 billion deficit savings

CBO: Projected Additional Cost/Savings of Pending Changes

By 2019, $676 billion additional deficit burden

Current vs. Pending Budget Effect – CBO’s Own Numbers

Net impact: $554 billion additional deficit 2010-2019
$1.4 trillion additional deficit 2020-2029

Individual/small group premiums will increase at 8% per year, minimum
The Way to Cost Savings with ACA

- Accountable Care Organizations (ACOs)
  - Hospitals with horizontals (e.g., physician group practices) and verticals (e.g., sub-specialty surgical theatres)
  - Contract on per patient basis with health plan or employer.
  - Like 'old school' HMOs except hospital driven
  - Medicare 'Pilots' for ACOs
  - Little track record for success other than Mayo Clinic and Kaiser Permanente emulation.

Problem on the Horizon: The ACO Slow Waltz of Fear and Loathing

**Insurers (Public & Private)**
- We need Fee for Service (FFS) claims to make our systems work.
- How will we measure performing exactly?
- OK. Great. Give us that and the FFS data and we are good.
- Guess so. You always have an another way. Cash practices.
- OK. Then we'll pay old school.
- Fee for service

**Providers (Hospitals & Docs)**
- We hate FFS claims because it puts us on the factory floor. Just pay us for performing.
- With the ACO/medical home/EMR software you made/ bribed us to buy. What @#$%! That is more work and you will pay less.
- We haven’t done that since the Depression, then you came in....

Implementation Timeline for Major ACA Provisions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of plans</td>
<td>Medicaid/Medicare beneficiaries payment program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase out of Medicare drug coverage gap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in Medicare Part B (hospital care) rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in Medicaid coverage of preventive services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in Medicaid payments for primary care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elimination of excess Medicare payments for services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of 100% tax on medical devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cap on flexible spending accounts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of health insurance exchanges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prohibition of annual limits on coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of essential health benefits package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requirement of health insurance (individual market)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requirement of maximum $25,000 annual out-of-pocket limit for Medicare Advantage plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expansion of Medicaid coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Not Quite Rube Goldberg... Federal 'Data Hub' Architecture

- Outreach
- Web Portal
- Eligibility
- Shop and Compare
- Health Plan
- Enrollment
- Administrative Services
- Consolidated Billing
- Enhanced Coverage
- Interoperability
- Health Insurance Agency
- Certification
And Medicaid Expansion Will be a Political Litmus Test for Years

$S$ are States’ Responsibility for Expansion in 2023.
If Asked: A 21st Century Version of Health Reform

- Get actuarially certified risk profiles for all insured based on existing data
  - Let people get them like they would a credit report
  - Equifax and Experia are standing by and waiting for the go-switch
- Government and private federal exchanges portals
  - Take risk profiles from (1) and provide a ‘lock in’ by Internet click
  - Target the younger population not buying coverage today through the web. Brokers handle the rest. Gives brokers time to get a Plan B.
- Where the market fails from (2), auction off the high risk
  - Given (1) and (2), who are the vulnerable and why
  - Target resources to fill the insurance gaps using federal and state resources
- Let the Employer-sponsored market evolve; it’s not broken

Republican Play Book for Health Reform (as of 2/13/2014, 8:00am EST)

- 2014 – All depends on midterm elections and Healthcare.gov success
- GOP: Pivot from ‘Party of No’ to Party of “It Depends”
  - Offer Credible Replacement Options
    - Coburn, Burr & Hatch (2014): The CARE Act
    - AEI proposal featuring Mike Chernew (Harvard) and Jay Bhattacharya (Stanford)
    - Medicare reform: Coburn /Lieberman (2012)
- Healthcare.gov stress fractures by midterms
  - Net new sign-ups in exchanges 4 million or less (down from 7 million promised)
  - Premium spikes and plan exits
Republican Play Book for Health Reform (as of 2/13/2014, 8:00am EST)

- 2015 – Two pathways
  - GOP Senate and House majority
    - Repeal and Replace negotiated as ACA fixes. Most likely plan design will be Coburn, Burr and Hatch variant.
      - 5:1 community rating instead of 3:1
      - Medicaid expansion block-granted to 80% to 100% FPL maximum
      - Credits available to 300% FPL instead of 400% FPL
      - Credits are age-adjusted
      - Cadillac tax turns into a Buick tax or Chevy with GPS & leather tax
    - Status Quo or Democratic House majority
      - Chips away median voter tested changes to ACA
        - Remove device tax
        - Remove individual and employer mandate
        - Allow state exchanges to phase back to federal

Summary

- Health reform has 100 years of history.
- Republicans have more history on the board than commonly acknowledges.
- The Part of No will change in 2014
- ACA will likely get fixed/revised by Democrats and Republicans by 2017.
- Some times ‘Rocky Road’ is desirable, unfortunately this is unlikely to be one of those times – but it won’t last.
- The Undiscovered Country will advance beyond Star Trek by Democrats and Republican.

Thank You & Questions

Stephen T. Parente, Ph.D.
Minnesota Insurance Industry Chair of Health Finance
Director, Medical Industry Leadership Institute
Professor, Department of Finance
Carlson School of Management
University of Minnesota
321 19th Ave. S. Room 3-122
Minneapolis, MN 55455
612-624-1391 (w), 612-281-8220 (m)
sparente@umn.edu
http://www.tc.umn.edu/~paren010