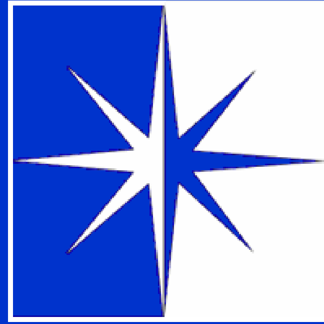

Financing Health Reform: Shared Responsibility *IS* The American Way

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Overview

- Why Now
- Competing Visions
- Capturing Savings from System Reform
- Employer Role(s)
- The Individual Mandate
- What States Should/Can Do

Why Are We Here?

- 3 Health System Problems
  - Low value for dollar
  - Mediocre and uneven quality
  - Inequitable access

- Problems are Serious, Linked, and Festering from Neglect

Why NOW?

- Premium / income is higher and growing
- International competition is more threatening
- More awareness of LINKAGES among problems
  - costs of spotty quality
  - consequences of being uninsured
- System stresses appear more unsustainable to more people
  - ER waiting times, generalized access problems
  - Cost-shifting from "hidden tax" part of low value per dollar

Competing Visions

- Each Man for Himself – Individualism
  - Consumer-centric
  - Tax neutrality
  - Individual market
  - NO regulations (or Shadegg-DeMint, which is the same thing)
- Government for all – Socialism
  - Equity-centric
  - Government sole payer
  - Population health management
- Practical Idealism – Realism
  - Result-centric (cover all in *sustainable* system)
  - Markets are flawed, but powerful (with some regulation)
  - Purchase requirements make markets work better
  - Comparative effectiveness data, electronic information system and incentive realignment are keys to Efficiency and Justice

Capturing Savings from Delivery System Reform

- Good Idea

- It will be hard
  - One person's cost is another's income
  - "Excess" cost is income too
  - System savings not necessarily payer's or state's

- It will take time
  - Cost-shifts have multiple participants, time horizons

- It must be sought
  - We simply cannot afford current trajectories, period

Where to Begin?

- BUY SMARTER!
  - McKinsey says higher relative prices account for 40% of higher US spending vs. rest of country
  - Value of services < cost
    - 30% of spending can be safely saved
- Attack root problems
  - Incentive mis-alignment
  - Overuse of good new technologies
  - Under-application of current evidence base
  - Too small an evidence base

Incentive Mis-Alignment

- Fee-for-service for providers + low-cost sharing for most patients + small effective evidence base => too much low value/redundant care
  - Share savings from smarter care with providers and patients
  - Set bundled payment at "efficient" level
- Technology "approval" = ticket to market
  - Beating placebo ≠ adding clinical value
  - Raise approval bar in exchange for longer period of exclusivity
  - Set cost-sharing according to value added

Promising Examples

- Medical Home in NC Medicaid
- Clinic/MA plan in TN
- Integrated Health System using information and protocols in UT
- Virtual group (IPA) using information systems and "educators"

Vision

- Electronic information infrastructure
  - eHRs, decision support, data exchanges for care coordination and research base
- Incentive re-alignment
  - Shared savings with providers
  - Evidence-based cost-sharing
  - Malpractice reform
- Comparative Effectiveness Infrastructure
  - Turbocharge production of evidence base
- Some/most/all of cost of coverage expansion can be financed this way in the long run

Very Concrete Next Steps

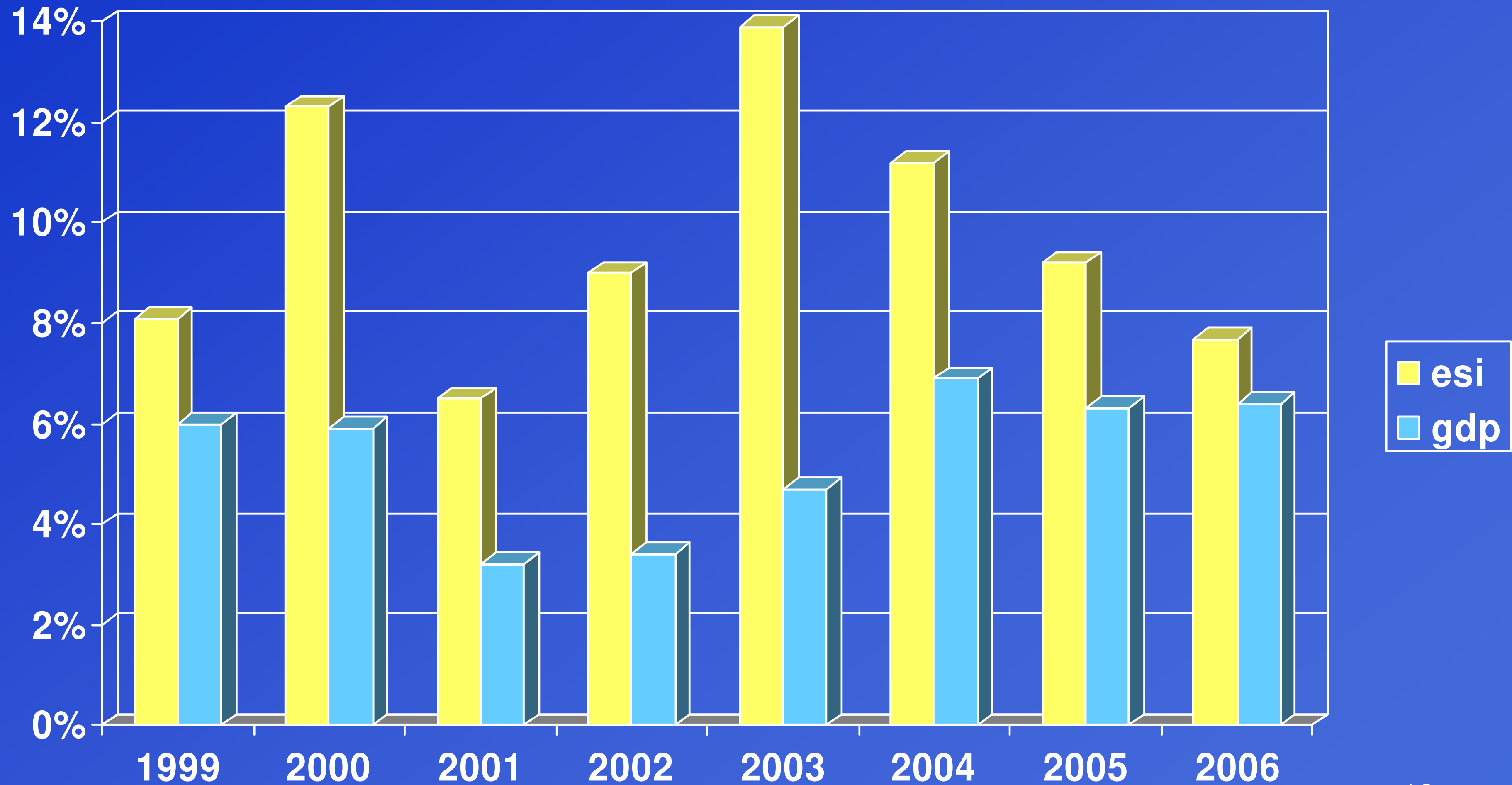
- Medical Homes in Medicaid
  - Payment reform + integrated chronic care management
- Shared savings/payment protocol experiments in Medicare, Medicaid, state employee plans and/or private sector
- Require price transparency for all, price and quality
  - PA and CMS now stopping payment for “never” events
- Create interoperable eHRs + data exchange to facilitate evidence base

- How much could we save (using *all* tools)?
  - CMWF: 1.5T over 10 years, => roughly enough to cover uninsured, eventually
  - 30% waste or excess spending is common estimate
  - Enough to merit investment costs? very likely

Employer Role

- How Does It Look to Them?
  - Big vs. small
  - International competition vs. local
  - High wage vs. low wage

Premium Payments v. GDP Growth Rate



Source: NIPA, BEA/Commerce Dept.

Employer Contribution Rates and Hourly Cost of Health Benefits, Selected Top Trading Partners

Country (rank in total trade with the US, 2005)	Employer Contribution Rate	Hourly Pay, Manufacturing U.S. dollars	Hourly Cost of Health Benefits, Manufacturing US dollars
United States	11.3%		
	13.0% for Manufacturing	$18.32	$2.38
Canada (1)	4.5%*	$19.21	$0.86
Japan (4)	3.74%	$18.06	$0.68
Germany (5)	6.65%**	$25.53	$1.70
United Kingdom (6)	1.92%***	$20.91	$0.40
France (9)	12.8%****	$16.93	$2.17
Weighted avg.	4.9%	$19.79	$0.96

How States Typically Share Responsibility

- Medicaid/SCHIP
  - Leverage federal $
- New revenues
  - Tobacco taxes
  - Provider taxes
  - Sales taxes
  - Income taxes or general funds
- Maintain/expand employer system
  - Leave ERISA-firms alone
  - Increase small group market choice
  - “pay” requirements for non-offering firms

Complexities with state-based employer requirements

- Many large employers could leave state
- Multi-state employers HATE state-based variation in regulation
- ERISA prohibits simple mandates
- ERISA permits taxation, but forbids requirements about depth of package that would be exempt from taxation
- Non-offering firms are low wage, so revenue raised not that great vs. political cost
- BUT: many labor advocates consider employer requirements fair and necessary part of shared responsibility
  - Perceptions of equity matter as well as reality, e.g., MA, CA

What Some States Are Doing (or tried)

- For non-offering firms:
- Massachusetts
  - $295 per workers per year, plus §125 plans
- Vermont
  - $365 per worker per year
- California
  - Gov. 4%; legislature 1-6%
- San Francisco
  - $1.17-$1.76 per hour on health benefits or to city

Individual Mandate

- If you want all to be covered, you're gonna have to require and enforce it
  - 8-10 million uninsured are eligible for free public insurance and not enrolled
  - 20% of uninsured turn down employer offer
  - 20% of uninsured make more than 4*FPL
- Individual mandate would be required even if you had employer mandate, or if you had tax-financed system

Why Individual Mandate* Is A Good Idea

- Necessary Evil -- Only way to get all covered
- Free riders, immortals, and inert exist
  - With mandate, everyone pays their fair share
- Personal Responsibility resonates w/ center-right
- Makes insurance markets work better
  - Tight reforms with no mandate => high premiums
  - Enables reduction/end to underwriting
  - Forces insurers to seek value in care delivery, not risk selection
- Enforcement not *that* big a deal
- Signifies *commitment* to cover all
  - Forces society to address affordability for families and taxpayers at the same time

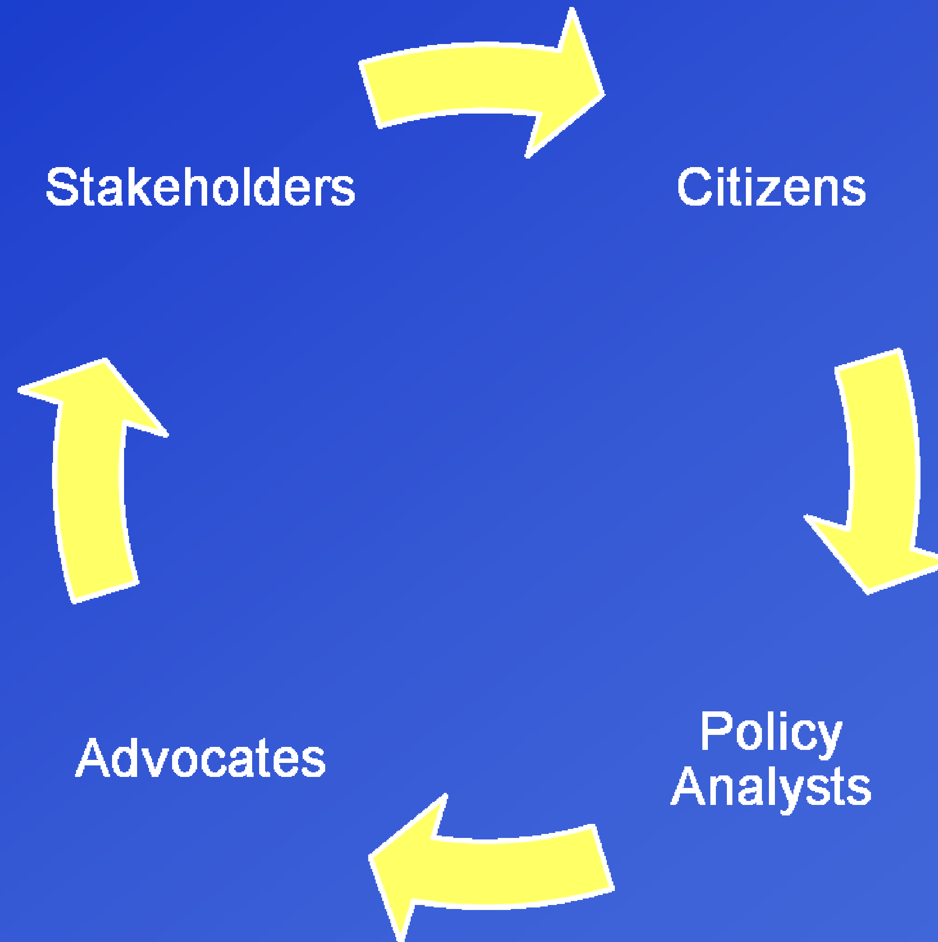
What All States Should Do

- Pursue efficiency in delivery system reform on all fronts
- Meld reformed individual + small group insurance markets, add mandate (if you can offer subsidies) to lower admin/underwriting costs
- Agitate for federal reform to improve leverage for accountability, efficiency, information infrastructure and coverage expansion in the long run

Common Themes To Expect

- We Cannot Afford It (whatever “IT” is)
- Trust, but Verify
  - Transparency of price and comparative quality info
  - Market outcomes will need to be monitored
  - Government programs will need to be evaluated
- Shared Responsibility *is* the American Way
  - Individual responsibility is central
  - Community responsibility is to make it possible for each individual to take responsibility for himself or herself
- Economic cost of doing nothing is high
- Moral cost of doing nothing is possibly higher

Why Health Reform Is Hard



How To “Break The Chain”

- Pursue Bi-Partisan Reform
  - Not milquetoast, but real reform
  - Both parties’ values must be reflected
  - 60 votes really means 70
- Work to PROTECT the Debate from Saboteurs
  - Inside-outside strategies
  - Collaborations
  - Develop credible policies that can earn (divided) stakeholder support