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# HEALTH-CARE REFORM: THE BEGINNING OF A JOURNEY

by

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## INTRODUCTION: HEALTH-CARE AND LONG ISLANDERS

It is clear that health-care in the United States has reached an unsustainable growth curve, where it has become unaffordable for 30 million poor and lower middle class Americans and has also reached proportions where medical costs are straining middle class household budgets.

Illustrating this is a recent report from the federal Centers for Medicare and Medicaid Services, which indicated that Americans spent nearly $2.3 trillion in 2008 for health-care. This amounted to 16% of the Gross National Product, $7,681 per person or $23,043 for a three-person household. To draw a Long Island perspective, the $23,043 represents 26% of Long Island's median family income of $87,022, and the $7,681 is 19% of a single Long Island family. While these costs would not necessarily be borne by those families and individuals with health insurance, those without insurance or high deductibles would have to make some difficult choices about health-care.

The conflicting views of Long Islanders regarding health-care reform were clearly visible in a December 2009 *Newsday*/*News* 12/*Sienna Research Institute* poll. While 94% of Long Islanders said that health-care costs were important to them, 47% supported the health-care proposals outlined by President Obama and 43% were opposed. Then, while nearly three-quarters of the respondents favored a public option, support dropped off when asked for their specific views on health-care. Fifty-one percent said that the free-market system, competition, and choice are the best way to solve the health-care dilemma and that government should stay out of the health-care solution, while 45% favored more involvement in managing the health-care system. Long Islander's divergent opinions continued when 77% of respondents favored making it illegal for insurance companies to deny coverage for pre-existing conditions and 75% agreed with setting limits for malpractice lawsuits. Yet, when respondents were asked if they favored a requirement that all Americans have proof of health insurance or face a penalty, only 22% agreed. Likewise, only 12% favored imposing a tax on high-benefit health insurance policies. Finally, when asked if Medicaid should be extended to the poorest of Americans, only 62% agreed. What Long Islanders appeared to be saying, is that the more they know about the specifics of health-care reform, or the more they learn about how health-care reform could impact their pocket books, the less they like it.

## LONG ISLAND HEALTH CARE COSTS: BY THE NUMBERS

While we applaud Congress and President Obama for addressing this critical economic and social issue, what is troubling is that, what we know about health-care reform doesn't seem to address the cost implications in the current health delivery system. It is, thus, reassuring that comments from federal officials are that there is more work to be done with health-care reform.

Illustrating the hard work ahead is that, from 2002, Long Island health employer premiums for families increased by 40% (80% since 1999), while median household income increased by 4%. Single persons saw their employer-provided health insurance premiums increase by 39%, while median income for single individuals increased by 5.5%. Furthermore, individual health-care out-of-pocket costs for New Yorkers increased by 86%, from $1,406 in 1987-88 to $2,607 in 2005-2006. Providing a broader perspective is that, between 1999 to 2005 median household income increased by 11%, from $74,045 to $82,137.

Then, there are Long Island's uninsured, totaling 352,842 in 2006, or 17% of the 2,069,104 insured Long Islanders. While U.S. Census estimates that for 2008 the region's uninsured dropped to 269,059, these estimates appear too low and may be underestimated since the economy went into recession in 2007, and worsened during 2008, leaving additional people without jobs and the health insurance that was provided to them by their employers. While COBRA coverage will help these individuals, the coverage does not last indefinitely.

If private insurers, both not-for-profit and for-profit, lose these uninsured to a federal public-option program passed by the House of Representatives but opposed by the United States Senate, past history suggests that insurance rates will surely go up.

In New York State for example, in 1997 there were five not-for-profit HMO insurers insuring 1.9 million people with net premium income of $2.9 billion. By 2005, the number of HMO's had dropped to three and insured individuals decreased by 5.2% to 1.8 million, while net premiums increased 127.2% to $6.6 billion. The New York State for-profit insurers reported similar results between 1997 and 2005. The 32 insurers decreased by 35%, from 32 in 1997 to 21 in 2005 and their insured decreased by 32% from 4.7 million in 1997 to 3.2 million in 2005, while net premium income increased 43%, from $8.4 billion in 1997 to $12.1 billion in 2005. As noted before, during the same period median Long Island household income increased only 11% from $74,045 in 1997 to $82,137 in 2005.

The presented data suggests that the insurance and health delivery market created the problem and for any health-care reform to be successful, that market must be involved in the solution. Expanding the insured base is only one alternative to bringing insurance rates down, and that can't be guaranteed, as President Obama suggests, because the free-market is an unpredictable institution.

That unpredictability was illustrated in a health insurance industry funded report issued by insurers in late 2009, which indicated that rates increases could occur and that current legislation does nothing to change the structure in which health-care is delivered and paid for. That report has an important point to make in that there is no structural change in delivering health-care, only a financial plan on how to pay for it. And, paying for it will come from taxes on insurance companies and pharmaceutical and medical technology companies who will pass along these taxes to those purchasing insurance, including the federal government to cover the uninsured.

The last item to recognize is the impact of the costs that hospitals must bear for caring for the uninsured. These cases are the Bad Debt and Charity Care patients which have cost Long Island hospitals $161,761,338 and New York State hospitals $1.7 billion. New York State reimburses only half of these costs, with those covered by insurance paying the rest through their premiums. This happens because hospitals, to remain financially solvent, must recover the un-reimbursed costs through higher billing rates to New York States insurance companies who, in turn, recover these costs from the insured through increased premiums. Are hospitals to turn away those without insurance under health-care reform? And, if hospitals are loathe to turn away those in need of medical care, are the hospitals' costs not to be reimbursed? If not, how are hospitals expected to financially absorb these costs and remain financially viable? These are critical concerns.

While a market-driven approach may not be perfect, a public-option may not be the way to go either. The goals were admirable and necessary, however, unforeseen increases in insured and premium costs in the three-year-old Massachusetts public-option, called *Chapter* 58, has made it financially unstable, since the Commonwealth, one way or another, is responsible for deficits. In this light, the discussion of *Chapter* 58 follows.

## CHAPTER 58: COMMONWEALTH OF MASSACHUSETTS PUBLIC OPTION

### *Introduction*

McDonough, Rosman, Butt, Tucker, and Howe (2008), in *Health Affairs*, analyzed the Massachusetts health reform law known as *Chapter* 58, which, since its passage in April 2006, has expanded affordable insurance coverage to 355,000 people. The organizing principle of *Chapter* 58 is shared responsibility between and among consumers, government, employers, insurers, and providers, who all confront new obligations while receiving new benefits.

There have been successes such as establishment of new coverage programs, consolidation of small-group and non-group insurance markets, creation of an insurance "Connector," determination of affordability and penalty standards for an individual mandate, and establishment of employer responsibility requirements.

However, along with the successes remain some major challenges, including full implementation of the individual mandate, cost control, long-term financing to sustain the program; and maintaining the broad stakeholder coalitions, without whom *Chapter* 58 would not have been enacted.

### *The Connector*

*Chapter* 58's implementation falls to the newly established Commonwealth Health Insurance Connector Authority (Connector) that is governed by a ten-member board consisting of experts, constituency representatives, and public officials. Policy issues are decided upon after extensive debate.

### *Medicaid/MassHealth and Chapter* 58

*Chapter* 58 expanded eligibility and benefits in Massachusetts' Medicaid program, MassHealth. Eligibility for children was expanded from 200 to 300 of the federal poverty level. Also restored, were the once-cut optional benefits for adults of dental care, dentures, and eyeglasses.

*Chapter* 58 increased MassHealth payment rates to physicians and hospitals, with a portion of the increases conditional on providers meeting "pay for performance" (P4P) standards. Standards were developed in consultation with a Payment Policy Advisory Board and a Quality Cost Council.

Subsequent to enactment of *Chapter* 58, Medicaid enrollment increased by 10%, resulting from a simplified application process, community outreach, the *Chapter* 58-enacted individual mandate, and restrictions on the availability of hospital charity care reimbursement.

### *Subsidized Insurance for Lower-Income Uninsured -- Creating Unforeseen Cost Pressures*

In order to provide subsidized insurance for uninsured adults, the Connector, under *Chapter* 58, was required to establish the Commonwealth Care Health Insurance Program (CommCare). CommCare covered inpatient, outpatient, preventive services, and behavioral health and prescription drugs. Enrollment began October 1, 2006. The average cost of CommCare, as of July 2008, was approximately $390 per month, a 10% increase from the prior year. CommCare is funded by the Commonwealth of Massachusetts through enrollee premiums and the Commonwealth Care Trust Fund.

Eligible adults are those with household incomes up to 300% of poverty who are ineligible for MassHealth or any other coverage. Those with incomes below 150 of poverty are charged no premiums, have no deductibles, and pay modest co-payments. Eligible adults with incomes between 151 – 300% of poverty have no deductibles and pay a sliding-scale income-based premium and co-payment. Those adults below 100% of poverty also have dental services.

CommCare covered over 177,000 people as of March 2008, surpassing projections and, thus, creating unanticipated financial pressure on the Commonwealth of Massachusetts. Furthermore, CommCare is not available for every uninsured person with income below 300% of poverty. Lower-income workers with access to employer-sponsored health-care insurance are also ineligible because of CommCare's fear of unforeseen fiscal consequences that would occur if eligible workers and their employers opt for CommCare.

### *Commonwealth Choice*: A *Complex System of Unsubsidized Approved Private Insurance*

For those individuals ineligible for CommCare and who do not have access to employer-sponsored insurance, Commonwealth Choice (CommChoice) was formed. CommChoice plans are administered by state-licensed private insurers, offered through the Connectors, and must meet Connector standards for quality and affordability. Creating this system has been complex, controversial, and delayed since enactment of *Chapter* 58.

### *Individual Mandate*: *Personal Responsibility and Defining Creditable* Health Coverage

*Chapter* 58 reform requires that every age-18 and older Massachusetts resident purchase affordable and creditable health insurance. The challenge has been for the Connector to define affordable and creditable for purposes of enforcing the individual mandate.

This process began in 2007, with the Connector approving a progressive premium affordability schedule costing the insured a range beginning with two percent of their income at 150% of poverty to more than nine percent at income levels 500% of poverty. The affordability threshold is $0 for those with incomes under 150% of poverty.

Affordability determination involves assessing insurance availability from either employer-provided or CommCare. If the person is ineligible for coverage with either of these two alternatives, and the lowest-price coverage costs less than the affordability standard established by the Connector, then, that uninsured person is subject to a prescribed penalty.

Creditability coverage is defined as the minimal level of coverage that satisfies the mandate, or the minimum creditable coverage (MCC). Beginning in January 2009, individuals must have insurance covering drugs and "comprehensive health benefits," as defined by the Connector. This health coverage can't place limitations on annual or per-sickness benefit maximums or fee schedules for indemnity benefits, nor have deductibles of more-than-$2,000 for individuals and $4,000 for families, with a respective $250 and $500 drug deductible. Also limited are the respective maximum individual and family out-of-pocket in-network costs of $5,000 and $10,000. To match what the private sector offers, the Connector offers creditable health insurance plans with lifetime benefit caps.

### *Employer Responsibility*: *Fair-Share Contribution and Section* 125 *Plans*

*Chapter* 58 requires that employers expand health insurance access to employees and to alter health plans benefits to comply with MCC standards and mandates. Employers with 11 or more full-time equivalent (FTE) workers who do not make "fair and reasonable" contributions to employees' health insurance costs must pay the Commonwealth a per-worker "fair-share contribution" of $295 annually. "Fair and reasonable" was determined by the Division of Health Care Finance and Policy as employers contributing at least 33% of health premiums for FTEs, or providing coverage for at least 25% of their FTEs. The prevailing Massachusetts small-group insurance market standards generally require employees to pay at least 50% of health premiums and cover at least 75% of eligible workers.

Also required for employers with 11 or more FTEs is that IRS Section 125 payroll deduction plans be established to facilitate pretax purchase of insurance for workers ineligible for group coverage. Section 125 plans can lower health insurance costs for workers and help employees avoid FICA payroll taxes on the employee contributions. Employers not establishing Section 125 plans face penalties imposed by the Commonwealth if their employees or dependents receive health-care paid for by the Commonwealth's Health Safety Trust Fund.

### *Private Insurance Market Reforms*

*Chapter* 58 also enacted market reforms intended to promote access to coverage for individuals by merging non-group/individual and small-group health insurance markets. Protections in the plans included guaranteed coverage and renewal and prohibition of medical underwriting limitations for pre-existing conditions. Individuals can choose any acceptable medical coverage available in small-employer plans (*defined as* 1-50 FTEs). Those insured under a small-employer can retain their health coverage after leaving their job.

Because individual coverage is now rated with small-group coverage, the non-group premiums have decreased, with annual premium growth between 1% –4% . Group plans covering dependent children must offer coverage to them for two years after loss of their dependent status for tax purposes, or until they reach 26-years-of-age, which ever comes first. Lastly, higher-paid employees cannot have a larger percentage of health premiums than other employees.

### *Financing Chapter* 58: *Paying for Costs/Premiums Higher than Originally Anticipated*

Funding CommCare and safety-net coverage comes from federal reimbursements, the Commonwealth's general fund, and assessments on insurers, hospitals, and employers. However, similar to the financial collapse of TennCare and the Oregon Health Plan, which faced funding shortages after years of enrollment successes, there is concern about paying for *Chapter* 58 in the years subsequent to 2008.

During Spring of 2008, *Chapter* 58*'s* funding shortfalls grew, because the unanticipated expanded enrollment in MassHealth and CommCare was much higher than forecasted, resulting in higher-than-projected costs. These discrepancies arose because the number of actual uninsured individuals was underestimated in the original projections by the Commonwealth.

As would be expected with greater enrollments, costs to CommCare have also increased, driven by increases in participating insurers' per-capita charges. This occurred because during the first contract covering the period between October 2006 and June 2008, two of the four participating insurers bid much lower than the other two. The tacit understanding between insurers and CommCare was that the lower bids were an attempt to gain enrollees through the Connector's automatic assignment process which gave health insurance plans incentives to submit low bids to build enrollment. Despite the incentives and increased premiums from new enrollees, the two plans winning the bid in 2006 received substantial increases for CommCare's second contract period beginning July 2008. The Connector responded to these increased costs by raising enrollee premiums and co-pays.

Given these unforeseen increased costs, projections of CommCare future costs remain difficult because key unknown factors of continuing medical inflation and employer-responses to reform remain uncertain. Additionally, the financial impact on CommCare of employers who have and will drop coverage for some workers, including part-time workers, to qualify them for CommCare, has yet to be determined, but must be considered a viable employer option. Lastly, critical to the financial stability of *Chapter* 58, is the willingness of the Center for Medicare and Medicaid Services of the federal government to ease existing Medicaid and Medicare spending caps, while also providing additional revenues to address the medical inflation.

### *Chapter* 58: Cost Control Essential for Sustainability

The challenge confronting the sustainability of *Chapter* 58 is how to contain premium inflation. While the original projections of cost increases were estimated to be between 1% – 4%, the actual increases for 2008 by major Massachusetts insurers averaged between 8% and 12%. Continuing increases in insurance premiums undermine the affordability of CommCare, the intent of *Chapter* 58, resulting in expanding the number of people exempt from the mandate. An unintended consequence of the *Chapter* 58 experience is that the Commonwealth of Massachusetts must formulate a financial plan that returns the promise of *Chapter* 58's affordability.

### National Implications: The Massachusetts *Chapter* 58 Experience

Lessons learned since enactment of *Chapter* 58 are that imperatives have to be met for any public-option, or government-sponsored health-care initiative to succeed. These are:

- Expand subsidized coverage to lower-income uninsured people
- Find and enroll large numbers of eligible people
- Define meaningful measures of health-care affordability for all income groups
- Enhance insurance access and affordability for all individuals by merging the small-group and individual insurance markets
- Create opportunities for consumers to compare competing insurance products on cost, benefits, and network restrictions

The Massachusetts *Chapter* 58 experience also illustrates that, even when mandate imperatives for universal coverage are initiated, the insurance and medical market pressures will impact affordability to the insured. Returning affordability to the health insurance market often falls on government, which turns to taxpayers for the necessary revenues. This might happen in Massachusetts's *Chapter* 58 and, given the uncertainties in projecting costs and enrollees, this could well happen with a federal health-care public-option. Within this perspective, the two versions of health-care reform passed by each house of congress are presented.

## THE REALITY: SENATE AND HOUSE APPROVE TWO DIFFERENT PLANS

*Prepared by Tri-Committee House staff*

*Budget and coverage data from the Congressional Budget Office or the Joint Committee on Taxation as of* 12/29/2009.

### I: *House-Senate Health Care* Bills: *Comparison of Key Provisions*

The House- and Senate-passed health reform bills are based on the plan set out by President Obama in his campaign and shaped during the legislative process. The effective date of the House bill is January 1, 2013 and the Senate is January 1, 2014. As a result, aside from the effective dates, there are substantial similarities that will greatly facilitate the final step of developing an agreement on a bill for the President's signature. Both bills:

- **Provide a comprehensive set of "early deliverables," starting in 2010**, which include: (1) initial insurance reforms and consumer protections; (2) a new insurance pool to make coverage available to individuals with pre-existing conditions or chronic illnesses who can't get coverage today; and, (3) health disclosure, review, and justification of insurance rate increases. Both bills also contain additional early investments in community health centers and the workforce, which are essential, to both ensure access when the coverage reforms that are implemented go into place and to begin to improve both personal and community wellness immediately. Additional Medicare improvements, including beginning to close the donut hole, also begin in 2010.

- **Improve insurance coverage by implementing major coverage reforms** (2013 *in House bill*, 2014 *in Senate*) and providing financial assistance to lower- and middle-income families and small businesses. Those provisions include: (1) insurance reforms, minimum benefit standards, and creation of a new health insurance marketplace, called an "exchange," where health plans compete based on price and quality for individual and small-employer businesses; (2) increases in Medicaid eligibility levels for those with the lowest income, and new funding for critical safety-net services through community health centers; (3) sliding-scale financial credits to ensure affordable premiums and cost-sharing assistance for households with income above new Medicaid income levels, but below 400% of the federal poverty level; (4) individual responsibility to purchase insurance within this new framework; and, (5) employer responsibility to offer coverage or provide financial contributions to help pay for coverage.

- **Improve Medicare coverage for prescription drugs and preventive services**, and implement major Medicare delivery system and payment reforms to make Medicare more efficient and restrain future spending growth. Both bills institute numerous long-term reforms that experts have called for to enhance quality and value for Medicare beneficiaries and the entire health-care system.

- **Provide revenues** that, coupled with the program savings above, meet the commitment of the President, the Speaker, and the leaders of the House and Senate, that the bill be fully paid for. In fact, both bills actually reduce the deficit by more than $100 billion over the first 10 years, and are projected to yield savings in the second 10 years.

These similarities provide a strong platform for discussions to lead to a final agreement. However, especially on a topic as historic and sweeping as health reform, there are differences between the chambers that will need to be resolved. A brief look at some of the major differences follows.

## II: *Extending Coverage to The Uninsured*

### A: *Exchange Subsidy Levels*

**House** provides sliding-scale affordability credits, while the **Senate** provides tax credits, for those above the new Medicaid income levels, but with income less than 400% of the federal poverty level (FPL). (400% *of the poverty level in* 2009 *is* $43,320 *for an individual and* $88,200 *for a family of four.*) Those credits help make premiums more affordable and reduce the cost-sharing and maximum out-of-pocket spending by income level. The credits provide greater support at lower income levels and phase out at 400% of the FPL.

**Key differences include:** The **House** provides much greater financial support for premiums and for reduced cost-sharing for families with income at or below 300% of the FPL. The **Senate** provides greater financial support for premiums for families with income between 300% - 400**%** of the FPL and similar protections for cost-sharing at those income levels.

### B: *Payments and Reductions In Uninsured*

The **House** Affordability credits for the years 2013-2019 are $602 billion, with a reduction in uninsured by 2019 of 36 million individuals. The **Senate** tax credits for the years 2014-2019 are $436 billion, with a reduction in uninsured of 31 million by 2019.

### C: *Employer Financial Requirements*

For employers above the small-employer exception thresholds:

The **House** version requires that employers that do not offer qualified health coverage pay an 8% payroll tax on wages for all employees, including full-time, part-time, and temporary. The total employer payment, in lieu of providing coverage, to pay for health-care reform is projected to be $135 billion.

The **Senate** would require that employers that do not offer any coverage pay $750-per-employee, if even one employee receives a tax-credit in the Exchange. This flat-dollar amount equals about 1.5% of payroll for a firm with an average payroll of $50,000. The requirement applies only to full-time workers, defined as working 30-hours or more -a-week. Employers that do offer some coverage pay a penalty for employees who go to the Exchange and get tax-credits, where the employee-share of the employer-premium is more than 9.8% of income and/or the employer does not offer minimal coverage. The penalty is $3,000-per-employee going into the Exchange and getting a credit, but with a maximum penalty of $750 times the number of full-time employees in the employer's workforce. Employers also pay a penalty if they have a waiting-period for coverage. The total employer payment, in lieu of providing coverage, to pay for health-care reform is projected to be $28 billion.

### D: *Employer Contribution and Benefit Standards*

The **House** would require employers to meet benefit and consumer protection standards, and financial contribution levels of 72.5% of premiums for individuals and 65% for families. Contributions can be made on a pro-rata basis for employees who work less than full-time.

The **Senate** does not have an affirmative requirement, but employers pay a penalty (*see* C, *above*) if employer-contributions don't make the insurance affordable to full-time employees, and for employees who seek Exchange coverage and if they don't meet benefit-standards. In addition, employees with an employer-offer that is deemed "unaffordable," i.e., their share of premiums fall between 8% and 9.8 percent of their income, can convert their employer-contribution into a "free-choice voucher," which can be used to shop in the Exchange.

### E: *Employer Grandfather Provisions*

The **House** provides a five-year grace period for employers offering coverage to meet some of the requirements.

The **Senate** would permanently grandfather existing employer-plans offering any level of coverage. With few exceptions, these plans are not required to adopt insurance reforms or quality standards.

### F: *Minimum Benefit Standard*

The **House** sets a minimum standard of 70% of actuarial value (AV), which means that, on average, the health plan covers about 70% of expected costs and the individual covers 30% percent.

The **Senate** sets minimum standard of 60% AV, which results in a lower premium than under the House bill because of reduced benefits (*e.g., plan covers less*).

### G: *Insurance Reforms and Plan Standards*

The **House** bill would not have a "Young Invincibles" policy**;** sets an age-rating band at 2:1, which means that rates can vary by no-more-than 2-1 between oldest and youngest adults; not have a tobacco rating; and, contains numerous consumer protections, including requiring adequate network providers, transparency, and plan disclosure provisions, standard rules for the coordination and subrogation of benefits, and a clear grievance-and-appeals process.

The **Senate** creates a high-deductible "Young Invincibles" policy for adults younger than age-30, with an initial $5,950 deductible which would be indexed over time; set an age-rating band at 3:1; and, sets a tobacco rating of 1.5:1, meaning that rates can be increased by 50% for smokers. Subsidies do not cover the tobacco rate-up difference. (*This disproportionately affects lower-income individuals, both because of more prevalent tobacco use and the subsidy policy.*) There would also be a requirement that all insurers implement an internal-claims denial-and-appeals process as well as a requirement that States make available external-appeals processes.

### H: *Exchanges*

The **House** would create a National Exchange, with a state-option to operate an Exchange if it meets federal standards. Health-plan bidding will be based on local market areas. The Exchanges would combine individual and small-group markets into one insurance pool and one Exchange.

The **Senate** would allow for a State Exchange with federal back-up; health-plan bidding based on local market areas; Exchanges that would maintain separate insurance pools for individual and small-group markets; separate individual- and small-group Exchanges in each state; and, permits states to set up additional Exchanges within the state. States can also apply for a block grant to provide health insurance for families with income below 200% of the federal poverty level, rather than permitting those individuals to qualify for their federal tax-credits and coverage in the Exchange.

### I: *Public Option*

The **House** would establish a National public option administered by the Department of Health and Human Services and negotiated rates to pay providers.

The **Senate** would not have a public option.

### J: *Office of Personnel Management* Plans (OPM)

The **House** provides that the National Exchange has responsibility for overseeing plan availability and has authority to negotiate with budding plans, but has no provision for OPM involvement.

The **Senate,** in lieu of a public option, provides that the Office of Personnel Management has an obligation to make sure that there are two multi-state qualified plans, with at least one being a non-profit, in each State Exchange.

### K: *Individual Mandate Requirement*

The **House** would provide that the uninsured contribute 2.5% of income above the filing threshold (e.g., ~$20k), capped at the amount of the average premium. There would be an exemption for those for whom the contribution would constitute financial hardship.

The **Senate** would have the uninsured contribute fixed-dollar amounts per-person, coupled with income-related contribution: phases up from $95 in 2014, to $495 in 2015, to $750 in 2016; 50% for children; $2,250 family maximum; or, if higher than these flat-dollar amounts, a contribution phasing up to 2% of income in 2016, capped at the average premium level. There would be a hardship exemption for those unable to afford any level of payment.

### L: *Immigration and Undocumented Aliens*

The **House** would provide no affordability credits for undocumented aliens, but would allow undocumented aliens to purchase any Exchange-regulated product with their own funds. This is preliminary and additional information is being developed for review.

The **Senate** would not allow for any affordability credits for undocumented aliens and would not allow them to purchase any Exchange-regulated product with their own funds. Similar to the House, the Senate is developing additional information for review.

### M: *Abortion*

The **House** has the Stupak Amendment and the **Senate** has the Nelson Amendment. The Senate version places more restrictions on funds being used for abortion.

## III: *Financing Health Care Reform: Primary Revenue Sources and Health Industry Fees*

The two versions of the health-care proposals generate different revenue streams. The **House generates $564.5 billion**, while the **Senate generates $460.3 billion**. The primary revenues sources funding each version of health-care reform are illustrated in the following analysis.

### A: 5.4% *Surcharge-On-Income In Excess of* $500,000 ($1 *million for joint returns*)

The **House** version, effective in 2011, would raise $460.5 billion. The **Senate** has no provision for any surcharge.

### B: 40% *Excise Tax on Group Health Coverage In Excess of* $8,500/23,000

The **House** has no provision for an excise tax. The **Senate** has an excise tax provision, beginning in 2013, which will generate $148.9 billion.

### C: *Additional* 0.9% *Medicare Health Insurance Payroll Tax on Wages In Excess of* $200,000 *for an Individual and* $250,000 *for a Joint Return*

The **House** version has no provision for an additional Medicare payroll tax. The **Senate** bill has an additional Medicare tax that will be effective in 2013 and generate $86.8 billion.

### D: *Impose Annual* $2.3 *billion Fee on Manufacturers and Importers of Branded Drugs*

This annual fee will be allocated based on proportional market-share. The **House** has no provision to enact this fee. The **Senate** proposes to enact this fee on manufacturers and branded-drugs that will begin in 2010 and generate $22.2 billion annually.

### E: *Medical Devices*

The **House** would raise $20.0 billion, beginning in 2013 from a 2.5% excise tax. The **Senate** would enact a $2 billion industry fee based on market-share which, between 2011 and 2017, would generate $19.2 billion; beginning with 2018, the industry fee would increase to $3 billion.

**F: *Impose Annual Fee on Health Insurance Providers***

This annual fee on health insurance providers would be allocated based on proportional share of total health insurance premiums, excluding self-insured plans. The **House** does not have such a provision. The **Senate** would generate $59.6 billion, with a $2 billion industry fee beginning in 2011; increasing to $4 billion in 2012; $7 billion in 2013; $9 billion between 2014 and 2016; and, increasing to $10 billion for 2017 and later.

**G: *Fee on Insured and Self-Insured Plans***

For comparative effectiveness research, effective 2013, the **House** version would raise $2.0 billion and the **Senate** bill would generate $2.6 billion

**H: *Raise 7.5% AGI floor on Medical Expenses Deduction to 10%***

The **House** version does not contain this provision. The **Senate** bill would increase the AGI floor to 10% . effective in 2013, which would generate $15.2 billion.

**I: *A 10% Excise Tax on Indoor Tanning Services***

The **House** version contains no provision. The **Senate** has such a provision which would become effective July 1, 2010 and would generate $2.7 billion.

**J: *Anti-Trust Exemption***

The **House** repeals the anti-trust exemption, while the **Senate** retains the anti-trust exemption. Repealing the exemption is important to creating competition within the health-care insurer market.

## COMMENTS, DISCUSSION, AND OBSERVATIONS

### *Introduction*

The President and the Congress have come a long way toward enacting health-care reform, something that has eluded government for over a century. They properly recognize that, in a country as wealthy as America, there should not be anyone unable to receive medical care because of the cost.

The two separate versions of health-care reform enacted by the House of Representatives and the Senate, will be negotiated into the one version ultimately to be passed by the Congress and signed into law by President Obama. However, this should not signal the end of health-care reform efforts, but should be regarded as a new beginning. As most involved in developing this reform have said, the legislation is not perfect and can be improved upon as the impact of the reform are determined.

The fact is, focus on health-care should be continuous because, as the Massachusetts *Chapter* 58 program has shown, unforeseen problems, such as higher costs and more enrollees than anticipated, materialize.

Additionally, change shouldn't only be defined in terms of money thrown at a chronically ill health-care system. It should also include investigating what is the highest and best use of the health-care dollars invested by government, individuals, and employers, and the structure delivering that care. The House and Senate versions of health-care reform offer detailed discussion on raising the funds for health-care reform, but are silent as to how to improve the structure of health-care delivery. Finally, if the President is to deliver on his a zero-sum budgetary impact, something has to give if costs and enrollees increase beyond projections, as was the case with *Chapter* 58. The impression, based on the financial structure, is that the taxes and fees will be increased to meet any increased costs.

As for injecting competition into the health-care delivery market-place that the House version offers, with the intended benefits to consumers, the following discussion of competition is provided.

## ***True Competition, the Public Option, and Eliminating the Anti-Trust Exemption***

### *Introduction*

In developing his theory on competition, classical economist Adam Smith explained that participants in an economy tend to pursue their own personal interests. Competition is driven by the natural tension that exists between an entrepreneur pursuing profit, a consumer seeking the lowest price, and a worker wanting to find the highest wages.

The action of each producer and merchant attempting to make a profit from offered goods and services is further restrained by other producers or merchants who are similarly attempting to make money on equivalent goods and services. This economic and market pressure is the competition which drives down the prices of these goods and services, often resulting in lower profits accruing to each producer and merchant.

Competition also prevents a single producer or merchant from making extraordinary profits because extraordinary profits attract new competitors to that market. These new competitors increase the supply of goods and services in an attempt to garner market-share and profits from the single merchant. Likewise, employers compete for the best workers and workers compete for the best jobs and for the right to purchase and consume goods and services.

These naturally conflicting economic pressures result in allocation of resources to their highest valued uses, resulting in economic efficiency. Another result is that entrepreneurs, in their own self-interest, invest their profits in their businesses. Thus, restrained by self-interest and competition, capital accumulates, goods and services grow, and the economy expands.

Smith called this structured differing economic interests the "harmony of interests," and further concluded that, for this natural give-and-take between these economic interests to be most efficient, government, which can be wasteful and inefficient, is not needed, is undesirable and, because of granting monopoly privileges, by way of contemporary anti-trust legislation, is a detriment of society. In the interest of fostering competition, the House version repeals that anti-trust exemption. The Senate version does not.

### *The Public Option*

Within this perspective, the health-care proposals that promote the public option inject government into the process, offsetting the competitive equilibrium in the health insurance market-place. While government's goals of providing health insurance for America's uninsured and for reducing health costs to America's middle-class are laudable, the House's approach is to provide an alternative to private health insurance, with taxpayers ultimately bearing the responsibility of providing the financial margin necessary for achieving President Obama's directive that health-care reform not increase the deficit.

The public-option, funded by taxpayers, (*as is Medicaid, Medicare, and Social Security*) relies on taxes paid by Americans. It is true that mandating every American purchase health insurance would add 35 million uninsured Americans into the market, however, if the importance of profits to health insurers are underestimated as it was in Massachusetts' *Chapter* 58, then those new-insured may not find themselves insured by private insurers and may have to find health insurance in the public-option funded by taxpayers. If the public-option is not available, then, as was the case with *Chapter* 58, some insured will drop out of the market.

For a public-option to be fair and competitive, an important issue that needs to be resolved is how government can function as a regulator of the health insurance industry, a competitor with private-sector health insurers, and a health-care provider. There is an inherent conflict of interest in assuming that government can function as a regulator, competitor, and provider of health-care.

### *Eliminating the Anti-Trust Exemption*

That is why the House's intent to eliminate the anti-trust exemption is important — because it allows more insurers to enter state market-places and provide alternatives to existing health insurers. These new insurers will provide competition to existing insurers and should reduce health premiums.

A further unintended consequence may be the health providers, doctors, and hospitals not willing to provide health-care for the price that the public-option may require. Illustrating this are the constantly increasing health-care insurance premiums for individuals and businesses that ultimately cover the uninsured and underinsured who use public and private hospitals. Additionally, taxing pharmaceutical companies, medical technology firms, and health insurance firms will only transfer those costs to Americans choosing to remain with private insurance companies. The imperative to prevent this is for the public-option to provide the same health insurance coverage at lower costs to attract insured from private companies to the public-option.

Without this influx of capital from those who can afford the health-care premiums, the only option that government will have to sustain the public-option will be taxes. This is not true completion as envisioned by Adam Smith.

## *Changing the Role of Health Insurance Companies and the Structure of the Transaction*

### *Changing the Role of Health Insurance Companies*

Insurance companies have become the dominant players in the health-care industry, eclipsing the role of patients and health-care providers. To achieve structural health-care reform, the insurance companies need to be more consultative with employers, instead of the dictating to employers, doctors, hospitals, employees, and the insured, about what the health insurance coverage will be and how much that coverage will cost.

Rather than health insurers being the dominant participant in the health-care delivery system, the dominant parties should be the buyer(s) and seller(s) of health-care, i.e., patients, hospitals, doctors, and pharmacists.

There is an inherent conflict between insurers and their mission. Who do insurers work for? Is it for the patients, doctors, hospitals, and pharmacists *or* for their stockholders and Wall Street? This raises other questions as to what the components of insurance premiums are: are they profits, stockholders' dividends, and administration costs?

What has become clear during the process of developing health-care reform is that the insurance companies have alienated themselves from Congress and the White House. This is because insurance companies have become so dominant in the process that they can dictate the actual market-driven results of health-care reform, as they did with Massachusetts' *Chapter* 58, ultimately causing costs to increase.

The reform initiative presents us with an excellent opportunity to redefine the role of the insurer in health-care. The dominance they have come to enjoy needs to be modified so as to return them to a reasonable component in the health-care transaction. In exchange, the insurers get the opportunity to expand their risk pools substantially. The employers need to become convinced that they have a vested interest in cooperating with the reforms. This will not happen if it seen as simply a major tax or redistribution of wealth.

### *Changing the Structure of the Transaction*

It comes as no surprise that, a little over two years after the enactment of health-care reform in Massachusetts, a state-wide advisory body has asserted that fee-for-service-medicine should be replaced with a new financing mechanism over the next few years. There has been a realization in which all of the vested interests, including payers, providers, and government, conclude that they need to change the structure of how health-care is transacted in their state. There can be no better example of function following form.

The health reform debate occurring today in Washington runs the risk of following the same course as Massachusetts. The House and Senate bills are less about health-care reform and more about health-care insurance reform. There has been some talk of demonstrations around bundled-payments; however, these concepts will play themselves out over multiple years. Meanwhile, there will be a significant influx of new-insured entering a broken health-care system that will drive utilization and subsequent health costs significantly higher, as happened with *Chapter* 58.

Common sense dictates that, if you are attempting to confront any operating system that is known to be chronically flawed, you must address the dysfunction before adding more demand on the system. The risk we run for runaway cost escalation is tremendous.

So, here we are. Congress is working its way to a compromise bill. While we would be misstating the obvious to label the legislation sweeping reform, it should be seen for what it accomplishes at this time. The bill will succeed in creating a road-map for the coverage of between 94% and 96% of Americans residing in our country. It provides subsidies to those individuals requiring them to purchase coverage while also setting individual- and employer-mandates. This may result in more consumers seeking subsidies and more states required to offer Medicaid coverage to those individuals with incomes between 133% and 150% of the federal poverty level.

There is a lesson to be drawn from the process we have witnessed during the past six months. It is tedious to enact substantial public policy reform through a partisan political process. The compromise that is required, and the hundred-million dollar sweeteners to buy votes, such as was the case of Senator Nelson of Kansas and Senator Landreaux of Louisiana, is such that, sometimes the parties lose sight of the stated intent. In this case, we see meaningful progress in addressing the problem of the uninsured.

Despite the vagaries of the political process, the House and Senate versions of health-care reform should not be minimized, as they are major turning points in what has been a national embarrassment for decades —that in the wealthiest country in the world, there are those without health-care.

This, however, is only part of what was originally conceived to be the goal of reform. Remember the cost-curve? The cost-curve issue relates to Congressional Budget Office projections that, if we were to do nothing to change our ways, the Medicare Trust fund will be rendered insolvent by FY 2017. We must find ways to slow the growth in the expenditure rate. Our current method of payment rewards volume with very little management of care and outcome. Since we know that demand will increase as the baby-boomers age, the only choice we have is to re-engineer the transaction and, therefore, the delivery of care

Part of this reform was to find ways to bend the curve**.** In fact, unknown aspects of the House and Senate versions rests in assumptions that cost-reduction targets, which are required to cover the coverage expansion, will be achieved by way of a number of cuts and other new initiatives. The cuts are relatively easy, but the new initiatives around changing the provider reimbursement system are not.

Both bills call for a series of initiatives that would be voluntary on the part of provider groups interested in experimenting in a new paradigm of financing. While this may sound promising, these initiatives must be structured with monitoring that allows for appropriate measurements to determine what works and what does not. They need to be offered in disparate regions so that local issues, such as socio-economic status, are taken into consideration. Most important is that they need to be time-limited ,so as to parallel the new enrollment activity that begins in 2013. We must ensure that the added cost that expanded coverage brings is offset by a structural change in the financing of health-care. One cannot follow the other. What is more important is to get the structure right, not the date to begin the federal health-care initiative.

It is more cost-effective to insure that what is implemented meets all the health-care reform goals before money is spent. It is more expensive to amend reforms after implementation than to wait until we get health-care reform right. The challenge is for all vested interests in the health-care delivery system to recognize that we are far from done in achieving overall reform. We must bring real focus to finding structural change that will bring about systemic cost-reduction.

## *Achieving Structural Change, Health-Care Cost Containment and Transparency*

Building upon the enacted health-care reform legislation, we suggest that initiatives for structural change begin with health-care providers. Because they have patient contact, they are in the best position to identify process improvements and resource realignment. Employers need to see the providers as their business partners with whom they interact with various exchanges and transactions. Health-care Insurers will have to recognize that the dominance they now enjoy in the health-care delivery system will be modified. Government has a role to play — as expeditor, monitor, and protector of the indigent, as well as encouraging changes in the dominant position that the health-care insurers enjoy. The dominant position needs to return to the patient, doctor, and hospital.

Incentives that encourage spending less for health-care have to be implemented, with those savings reflected in rebates and lower premium costs to the insured, and better reimbursement rates for doctors and hospitals. Doctors, hospitals, and patients have to work together in reducing costs. For this to work, patients, hospitals, and doctors need to benefit from their efforts to reduce medical care cost-savings through rebates to the insured from their insurance companies for spending less money. It all begins with the patient.

Transparency is a term that gets thrown around quite a bit with regards to reporting health-care quality outcomes. While it is wholly appropriate to expect and demand quality health-care, transparency needs to extend to the nature of the transaction itself. Employers need to be enabled to make prudent business decisions regarding the health-care they wish to purchase on behalf of their employees and their families. When an employer decides to offer health-care, it does so with a great deal of risk because of the uncertainty of future health-care costs. It is for this reason that an insurance vehicle is used to finance the transaction and theoretically provide some protection to the purchaser.

The dysfunction exists in the separateness that exists between buyer and seller. The buyer (employer) needs to become better informed about what it is they are getting for their money and the best way to learn that is from the sellers. This is no different than in any other purchase decision that business makes. This does not suggest that the insurers no longer have a role in the transaction, because they do. There will still be a need to insure the purchase, but the employer needs to be better informed about the value they are getting.

If we are to encourage employer-sponsored health-care, then we must re-examine the role of the employer as purchaser and hospitals, physicians, homecare, et al. as sellers. This calls into question the role of the insurers who have managed to gain a position of dominance in the transaction that clearly was unintended.

Another aspect is tort reform, which we don't address. However, this is an important element in lowering health-care costs. Common sense tells us that health-care providers authorize tests that will totally support diagnosis and treatment, so as to avoid malpractice litigation. The system forces them into that position. Patients will go along with the prescribed treatment because they won't disagree with their doctor. While no person should ever be legislatively put in a position not to exercise their rights, tort reform does play a roll in the rising costs of health-care.

### *Immigration Reform*

While the House and Senate versions of health-care reform exclude coverage for undocumented immigrants, it is unsure that they will not receive health-care coverage in hospital emergency rooms. One of the unintended consequences of the Massachusetts C*hapter* 58 public-option was that there were many more emergency room visits than expected.

Until we are able to accomplish immigration reform, the hospital emergency room will continue to function as the primary provider of care to undocumented immigrants. If we are successful in covering the majority of those legally residing in our country, then we should be able to quantify one of the costs associated with not reforming our immigration policies.

States will need to be directed to offset some of those costs until immigration reform is enacted. The Bad Debt and Charity Care pool in New York might serve as a model. The pool, which is funded in part by a payer-surcharge , generally reimburses hospitals 50% of the cost associated with uncompensated care.

While it can be said that the health reform mandate that all Americans must have health insurance coverage will reduce the financial pressures faced by hospitals in providing health-care to the uninsured, what is obvious is that hospitals will continue in their mission of providing health-care to those without insurance or the means to pay for their health-care.

## CLOSING THOUGHTS

We applaud the effort to raise the discussion about a health-care system badly in need of reform. It is pretty clear that we, as a society, have a moral obligation to bring about meaningful change. Our conclusion is that, to reform the system, we must shift incentives to more efficiently manage care and improve outcomes. All vested interests should be held accountable, but also should be asked to participate in the change. As anyone who has tried to bring about process improvement will attest, you will fail unless you engage those that touch the process along the way. Our government leaders must understand that whatever they enact now is a first step in what promises to be a long journey.

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## ABOUT KEVIN DAHILL,
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Kevin Dahill assumed the leadership post of the Nassau-Suffolk Hospital Council in 2002. Under his direction, the association, which represents Long Island's not-for-profit and public hospitals, has dramatically enhanced its presence among lawmakers, the media, and the public and is truly the collective voice of Long Island's hospitals. Mr. Dahill is routinely sought for his expertise on a variety of health-care issues such as: hospital economics and finance, health services planning, hospitals and community benefit, workforce issues, corporate compliance, quality and performance improvement issues, and managed care practices.

He imparts his health care administrative knowledge to numerous organizations and sits on a variety of health-care task forces, including *Action Long Island*, the *Long Island Association*, and the *Hauppauge Industrial Association*. In addition, he often serves in an advisory capacity to local, state, and federal elected officials on matters related to health-care legislation and policy development.

Kevin Dahill served as chairman for the *National Conference of Metropolitan Hospital Associations* (CMHA) in 2006. Currently, he sits on the boards of the *New York Organ Donor Network* and the *Urban League of Long Island*.

Prior to his appointment at the NSHC, Mr. Dahill served as President and CEO of the New York United Hospital in Port Chester, New York. Previously, he held a variety of administrative positions that spanned 25 years at Columbia Presbyterian Medical Center in New York City, before departing as Senior Vice President and General Manager in 1994.

Mr. Dahill holds a bachelor of science degree in health care management from St. Peter's College (Jersey City, NJ) and a master's in business administration from Fordham University (New York, NY). He is a member of the *American College of Healthcare Administrators* and the *American Association of Association Executives*. He serves as adjunct professor of management at St. Peter's College and St. Joseph's College on Long Island. He resides on Long Island with his wife, Eileen.

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Martin R. Cantor has a Bachelor of Science Degree in Accounting from Brooklyn College of the City University of New York, and a Master of Arts Degree in Interdisciplinary Studies from Hofstra University, and is currently enrolled in the doctoral program in Educational Administration, Leadership and Technology at Dowling College.

He is Director of the Long Island Economic and Social Policy Institute at Dowling College, a Certified Public Accountant in private practice, an adjunct associate professor of economics, a consulting economist providing services to counties, towns, villages, industrial development agencies, and Chairman of the Suffolk County Judicial Facilities Agency.

Mr. Cantor has served as Suffolk County Economic Development Commissioner, Chief Economist, New York State Assembly Subcommittee for the Long Island Economy; Senior Fellow at the White Plains, New York-based Institute for Socio-economic Studies, Chief Economist and Chair of the Long Island Development Corp; a building trades labor/management arbitrator; a consultant to the Nassau Interim Financial Authority; an advisor to the Suffolk County Executive and Chair of The Suffolk County Downtown Revitalization Advisory Panel, faculty member in the Brooklyn College Department of Economics; Executive Director of the Patchogue Village Business Improvement District; and, most recently, as Director of Economic Development and Chief Economist for Sustainable Long Island and the Long Island Fund for Sustainable Development.

His work is included in the *National Tax Rebate-A New America With Less Government*, and has prepared downtown revitalization plans for Long Island and New York City neighborhoods featuring art districts, economic restructuring, waterfront projects and community organizing. He was the architect of the Nassau County Comptroller's debt restructuring plan for resolving Nassau County's fiscal crisis; has been a columnist for *Long Island Business Journal*; and has authored federal, state and local legislation; economic impact analyses; socio- economic profiles of the New York City and Long Island economic, employment and educational bases; and, annual reports on the State of the Long Island Economy.

Mr. Cantor provides economic and business commentary on television and radio; is a columnist for the *Long Island Business News*, Long Island's largest business weekly, and the LI *Pulse*; has appeared in *The New York Times* and *Newsday*, and has been syndicated nationally by *Newsday*, *Bridge News* and *Knight- Ridder/Tribune News Service*. He is an Honorary Member of Delta Mu Delta - The National Honor Society in Business Administration, and has been recognized by the National Association of Counties for innovative uses of Industrial Revenue Bonds, international trade promotion initiatives, and downtown revitalization. He was invited by Dr. William Julius Wilson of Harvard University's John F. Kennedy School of Government to present his paper entitled *Race Neutral Sustainable Economic Development*. He is the author of the recently published *Long Island, The Global Economy and Race: The Aging of America's First Suburb*. (www.martincantor.com)