

Congressional Health Care Reform Education Project
September 12, 2008

House Summary

The first in the series of educational seminars on health care reform issues began with an introduction of why the program was developed and what the interest of the Robert Wood Johnson Foundation (RWJF) was in funding the project. **Ed Howard** of the Alliance said that health care will demand some level of attention of policymakers, no matter who is in the White House or what the complexion of the 111th Congress following the November election. **Andy Hyman** of RWJF said the Foundation's interest in support of improving health care access, cost, and quality is widely known and has a long history. What they hope to learn from these sessions is where the gaps are and what is needed to go forward.

Participants were reminded that these sessions are off the record, they are not being recorded and that participants making comments or asking questions will not be quoted. They were further reminded that the session is not about resolving disputes or developing consensus. It is about having a forum for frank and honest discussion of the issues.

The first formal presentation was by **Paul Fronstin** of the Employee Benefit Research Institute. Fronstin provided an overview of health insurance coverage patterns and trends displaying a series of graphs using 2007 data, the most recent available (Refer to Fronstin presentation at: <http://www.allhealth.org/chcrep/IntroOverviewSept12.asp>). The data indicated that employment-based coverage is by far the most common source of health insurance coverage. Comparing 1999 and 2007, some erosion in employment based coverage is evident. However, Fronstin said, it is not "vanishing." He stated further that actually there was a big expansion in coverage in the mid '90s to 2000 and that there has since been some contraction back to earlier levels. He cautioned that 2008 might look a bit different because of higher unemployment, higher inflation and other economic factors that might change the coverage picture.

Comparing enrollment data from 1988 and 2007, there was a considerable change in type of plan in which people enroll. In 1988, traditional indemnity or fee-for-service was at 73 percent. It dropped to 3 percent in 2007. PPOs on the other hand increased from 11 percent in 1988 to 57 percent in 2007. A newcomer on the 2007 chart that did not exist before 2000 was account-based plans, e.g., HSAs and HRAs. About ten million people are currently in these plans – a category that is growing.

Some points he suggested keeping in mind when looking at spending data are: 1) Medicare covers older people, who use more health care services than average; 2) Medicaid covers the disabled, who use more health care services than average; and 3) the employed population is generally healthier and uses fewer services.

During a discussion of the uninsured, a question arose regarding underinsurance and who falls into that category. Fronstin responded that it is difficult to define underinsurance because of so many variables. For more information on this subject, he referred the

audience to studies by Cathy Schoen of The Commonwealth Fund. [Schoen, Collins, Kriss, Doty. (2008). How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007. *Health Affairs*. 27.4.w298]. Also available at: <http://www.allhealth.org/chcrep/IntroOverviewSept12.asp>

As to the uninsured and who they are, Fronstin said that the Census Bureau's Current Population Survey on its face counts those who were uninsured for the entire 2007 calendar year. Some analysts think it approximates a point-in-time survey. Participants were later referred to a CBO paper on the uninsured, how surveys differ, and duration of uninsurance. [Congressional Budget Office. (2003). How Many People Lack Health Insurance and for How Long? Retrieved from: <http://www.cbo.gov/ftpdocs/42xx/doc4210/05-12-Uninsured.pdf>].

The second formal presentation was by **Jim Baumgardner** of CBO (Refer to Baumgardner presentation at: <http://www.allhealth.org/chcrep/IntroOverviewSept12.asp>). He provided an overview of current health care spending patterns and trends. He said that historically (prior to 1960) health care costs were less than 5 percent of the economy. It has now grown to 16 percent.

In a discussion of "excess cost growth" in health care spending, Baumgardner referred participants to a January 2008 CBO paper on technology. [Congressional Budget Office. (2008). Technological Change and the Growth of Health Care Spending. Retrieved from: <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>]. He explained that excess cost growth represents the rate at which spending per capita grows faster than output (GDP) per capita. In citing technology as the main reason for excess cost growth from 1990 to 2005, Baumgardner clarified that technology refers to drugs, devices, and new procedures and protocols. Continuing on the subject of excess cost growth he stated that the projected growth in federal spending on Medicare and Medicaid is due more to excess cost growth than aging. CBO projections are based on a 1.8 percent excess cost growth, the same rate as the period 1990-2005.

The following issues and points were raised during the discussion of federal spending projections:

- What has been the effect of two-worker families? Baumgardner responded that labor force shifts are factored into projections. He said to expect that there would be slower GDP growth 5-10 years from now because of a decrease in the labor force (due to aging of the population). He further stated that immigration is also factored in.
- Do other areas of the economy show excess cost growth? Baumgardner explained that they do but they are offset by others in which growth is less than the economy.
- Are assumptions made about adjustments in private sector spending? Baumgardner answered that the assumption is that private players will try to control their costs and will make adjustments. They might use methods such as higher copays, higher share of premiums and other methods not yet devised. The projections do not assume SGR stays where it was. In further explaining how projections are derived, Baumgardner

said that another assumption used was that Medicare had ¼ of the slowing of private spending.

Providing an overview of prospects for reform, **Chris Jennings** of Jennings Policy Strategies said there will be health care reform. If not a major overhaul of the system there will be reform focused on costs as we are currently on an unsustainable path, he said. We are spending \$2 trillion now and it will rise to \$4 trillion in the next 10 years, if we continue on the current trend line. Listing differences now compared with '93-'94, he said:

1. The Health Security Act debate happened and it has provided many lessons
2. There is a broader constituency that believes costs are pushing budgetary limits
3. There is a broader understanding that uninsurance and underinsurance shift costs back to the insured
4. There has been an emergence of a new quality/value debate involving all stakeholders, i.e., providers, plans, labor, business, consumers, CBO
5. Stark contrasts in state experiments from earlier ones are being provided by MA and CA; and other policy options like the Wyden bill
6. Receptivity of Congress to cooperate/collaborate with the incoming president. Both candidates have a Congressional history.
7. Stakeholders are more willing and desirous of engaging in the health reform debate because they fear that the current system is not sustainable; that they will be scape-goated if they don't get involved; that they will benefit in the long run from universal coverage.
8. The second best option is no longer "do nothing."

The Bipartisan Policy Center is working with Baker, Dole, Daschle and Mitchell in hopes to push the debate forward.

Mark McClellan of the Engelberg Center for Health Care Reform of the Brookings Institution reviewed the four "pillars" or main elements of the bi-partisan project.

1. Building on strong, broad consensus in the value debate – how to get more value for the dollars we're spending on health care. Health care policy reform needs to be about how health care is delivered and getting value. There are many opportunities to do that, McClellan said. The challenge is agreeing on how.
2. Insurance market and coverage reform
3. Personal responsibility – promoting prevention and wellness; recognizing the role of individuals in making decisions about their care and playing a role in paying for their care
4. Financing reform

Chris Jennings added that the goal is a policy framework to push the discussion forward. The framing principle is affordable coverage for all. He warned that both sides need to be careful about "false dichotomies" such as cost or quality, public or private. The issue is not over or under utilization, he continued, but rather appropriate utilization.

McClellan added that there is much frustration among health professionals and consumers that they can't do the things that make sense. They feel a loss of control in the doctor-patient relationship. They want an approach that has accountability and preserves the doctor-patient relationship.

Jennings added that the physician community supports reform. We made the mistake in '94 thinking they didn't.

The session closed with a reminder from Joe Antos and Brian Biles, the "deans" of the education project, that the goal of these sessions is to provide information and a forum for discussion on important topics that will matter in the years to come. Contact the Alliance with your thoughts about future sessions and topics.

Background materials provided for each session plus additional materials referenced during the discussion will be posted at : <http://www.allhealth.org/chcrep/IntroOverviewSept12.asp>. Announcements about future sessions and the URL for materials will be made to participants by an email sent out on Tuesday morning.