Congressional Health Care Reform Education Project
September 12, 2008

Senate 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. **John Lumpkin** 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 information and analysis is needed to go forward.

Participants were reminded that these sessions are off the record, they are not being recorded and that persons 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.

Providing an overview of prospects for reform, **Chris Jennings** of Jennings Policy Strategies said there will be health care reform. The Bipartisan Policy Center (BPC) hopes to contribute to "those of you who are players" in health care reform with the hope that every American will have affordable coverage. Jennings provided eight reasons in '08 for optimism

1. The Health Security Act debate happened and it has provided many lessons informing the current debate
2. There is a broader constituency that believes costs are pushing budgetary limits. Businesses that are looking at their ability to compete internationally and nationally are at the table.
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 discourse involving all stakeholders, i.e., providers, plans, labor, business, consumers, CBO
5. Examples of bipartisanship providing stark contrast in efforts in state experiments such as MA and CA; and other policy options on the federal level like the Wyden bill
6. Both candidates have a Congressional history and a relationship with the Hill.
7. Stakeholders are more willing and desirous of engaging in the health reform debate in Washington 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. Do nothing is no longer a choice – there is more willingness to compromise.

The BPC's Leaders Project on health care is conducting a series of forums. A report and recommendations will come out after the election.

Mark McClellan of the Engelberg Center for Health Care Reform of the Brookings Institution reviewed the four pillars or main elements of the Leaders 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.
2. Insurance market and coverage reform. There need to be standards for coverage while enabling flexibility.
3. Personal responsibility – promoting prevention and wellness; recognizing the role of individuals in making decisions about their care and having an appropriate role sharing in the cost.
4. Financing reform with the goal of having a more financially sustainable path for our health system.

When asked about his optimism on bipartisan support, Chris Jennings remarked that he sees comity, collaboration and commitment to get something done. They are holding broad based forums, and having hard conversations and good honest discussions. He further remarked that trust is important.

When asked what they did right in '93-'94, Jennings listed a president who cared, technology support, and a sense of timing. Jennings further advised:

1. There is a window of opportunity early in the administration
2. Desire/willingness to make a bi-partisan effort is critical. This engenders greater public trust for the product
3. Don't make the mistake that small and incremental is easier than bigger reform. Incremental doesn't bring everyone to the table. Don't get bogged down in something small early on.
4. Packaging is important

Jennings went on to say that health reform is a balancing act. You can't do it well unless everyone is in the system. But, you can't get everyone covered unless you improve the system and get costs under control.

On the subject of communication Jennings advised that keeping the message simple is important and part of building trust with the public. He suggested using words the public understands such as: affordable, choice, quality.

Next, **Paul Fronstin** of the Employee Benefit Research Institute provided an overview of health insurance coverage patterns and trends displaying a series of graphs using 2007 data (Refer to Fronstin presentation at: http://www.allhealth.org/chcrep/IntroOverviewSept12.asp). The most recent available. 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 from 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 enrolled. 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 Technology. [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].

When asked for an explanation of the employer tax exclusion, Fronstin explained that employers can deduct health benefits to employees as a business expense; and the benefit is not included as taxable income on the worker's W-2. He further explained that individuals don't get a tax break for buying their own insurance and that they can only deduct that portion of their medical expenses that is above 7.5 percent of their annual income. Fronstin believes the impact of changing the tax exclusion to a tax credit or standard deduction would mean the end of employer-sponsored coverage over time. He explained that initially the young and healthy would opt out, leading to adverse selection and what he calls the "death spiral." At some point enough employees have left the market that it affects premiums and ultimately employers see it as having less value. He said this might take 10 years.

The final 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 that 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 explained 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:

- Are assumptions made about adjustments in private sector spending? Baumgardner answered that the assumption is that the private sector will look to slow their rate of cost growth and will make adjustments.
- In further explaining how projections are derived, Baumgardner said the projections are based on the assumption that current laws remain unchanged for Medicare and Medicaid.
- Growth in the non-health economy has to be factored in. The '90s had strong growth in the economy.

The session closed with a reminder by Joe Antos and Brian Biles, the "deans" of this 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. Participants should contact the Alliance with their 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.