

Health Care Reform: A Political and Policy Balancing Act

*Finding Middle Ground on Three Hot-Button Issues
Will Determine if New Comprehensive Legislation is Enacted*



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Although perspectives differ widely on how to fix the nation's health care system, as well as on the root causes of its problems, most agree on the need for reform. Its by now well-known justifications include the need to cover the more than 45 million uninsured, the lack of affordable insurance, the increasing expense of health care insurance for businesses, the double-digit growth of medical costs, and the need to improve the quality of care and patient outcomes.

Some believe successful change can result from fixing only one aspect of our current system, while others believe each problem area needs to be addressed.

Achieving intended policy goals without igniting additional opposition in one or another sectors is the balancing act policymakers face. For example, consensus exists for maintaining our current employer-based system for providing health care insurance. However, as policymakers strive to design around that system, they must strike a balance between ensuring that employers continue to provide benefits and employers' opposition to requiring them to do so — a requirement that many employers vocally oppose. Strong opposition from employers — obviously a key sector of the U.S. economy — could end the possibility of reform.

Other hot-button issues, each explored in this article, include a public insurance plan, bending the cost curve, and abortion. Finding middle ground on these is the make-or-break point for health care reform, and time is short. All must be resolved within the next few months if comprehensive reform is to be achieved. As high-pressure rhetoric escalates, the window of opportunity is quickly closing.

PUBLIC INSURANCE OPTION

At issue here is whether or not to include a public insurance plan that would compete with private

insurance. Proponents of a public insurance option argue that it would ensure access to affordable health insurance and create competition in the private market, which would drive down the price of premiums. For instance, a government-run public plan is expected to save on administrative costs and overhead, both of which contribute significantly to the high cost of health insurance in the individual market. In that market, according to Families USA, an estimated 25 to 40 percent of premiums are consumed by claims administration, underwriting, marketing, profits, and administrative costs, compared with 10 percent in employer group markets and 2 percent in Medicare. And those costs are rising rapidly. Nationally, insurance administration is one of the fastest-growing components of health expenditures.

Further, a public insurance plan could have the ability to set provider rates at levels equal to those of Medicare, making the cost of coverage cheaper for the consumer.

Opponents of a public plan argue that mandating provider reimbursement rates at Medicare levels would create unfair competition for private insurers as well as inadequate reimbursement rates for providers. Opponents contend that if a public plan option were made available to everyone, both individuals and employers would be attracted to its lower cost, thereby prompting large employers to move employees from private to public coverage, a situation known as "crowd out." Such concerns lead opponents to regard a public insurance option as a step toward a government-run single-payer system, with the ultimate consequence of eroding private insurance.

Key questions related to finding middle ground on a public plan include how providers would be reimbursed and whether they would be required to participate, whether the public plan would play by the same rules as private plans, whether a public plan would be required to be

self-sustaining through premiums, and who would be eligible to purchase insurance through a public plan. Some policymakers, such as the Blue Dogs, a coalition of conservative Democrats in the U.S. House of Representatives, are attempting to find middle ground by allowing providers to negotiate payment rates and to opt out of participation in a public plan. (According to a study by the Lewin Group, a health care policy research and management consulting firm, limiting a public plan's enrollment to small employers, individuals and the self-insured, and setting its hospital reimbursement rates equivalent to Medicare, would result in increased income for hospitals of \$11.3 billion per year.)

Other proposals include limiting availability of a public insurance plan to individuals and small employers, which would address a potential "crowd out" of private coverage and potentially diminish providers' concern about a Medicare standard for rates.

BENDING THE COST CURVE

Reducing the growth of medical spending is one of the main drivers for supporters of health care reform. Current estimates anticipate total health spending in the United States to double by 2020 to \$5.5 trillion, or 21 percent of the gross domestic product. According to the Congressional Budget Office, federal outlays for Medicare and Medicaid will exceed 6 percent of the GDP in 2019 and about 8 percent in 2029. Momentum is building for realignment of payment incentives, fueled by a commitment to improved patient outcomes through greater efficiency and quality in health care, a desire to lower costs for patients and payers, including Medicare, and the potential to use the resulting savings to fund coverage expansions. It is when improving quality and efficiency are used as a justification for large up-front reductions in federal reimbursement levels that provider groups recoil.

A number of payment and delivery system reforms in the Medicare program are being considered. These include a value-based purchasing program that reimburses hospitals based on improved quality of care, targeted policies to reduce preventable hospital readmissions, and a program to test different models that could ease a transition to bundled hospital payments. These were all originally proposed with projected payment reductions and savings targets beyond those which policy changes were likely to achieve. Providers note that it is one thing to propose policy changes aimed at generating savings by improv-

ing quality and efficiency, but another to make major policy changes and then arbitrarily reduce reimbursement rates as part of those changes.

Legislators have moved away from extracting extra funding reductions through such policy provisions. But they are still faced with demands from budget-conscious Congressional members, as well as from economists, to bend the cost curve in health care. This has led to the recent push for the "Super MedPAC," a proposal to make the Medicare Payment Advisory Committee (MedPAC) an independent agency under the executive branch rather than an advisory panel under the legislative branch. The "Super MedPAC" agency would be given authority to determine payment rates for items and services furnished under Medicare — and some Congressional proposals have suggested that it be charged with reducing Medicare spending by \$35 billion over 10 years. Providers, however, generally oppose "Super MedPAC" as too far-reaching, given that numerous Medicare and Medicaid policy changes are already likely to be included in health care reform. They argue that the goal of payment and delivery system reforms must be to improve quality and effectiveness so that patients receive safe and effective care, not merely to produce federal savings.

ABORTION COVERAGE

One highly controversial area which, if not resolved, could truly bring down health care reform is coverage and funding of abortion. Congress will need to ensure that a reform bill is "abortion neutral," furthering neither the pro-choice nor the pro-life position. From a pro-life point of view, "abortion neutral" means continuing longstanding and widely supported conscience protection policies, and prohibiting both federal abortion funding and mandated abortion coverage, thus maintaining the status quo in the context of health care reform while continuing to work against abortion in other arenas. This will be a difficult compromise to reach and may not satisfy everyone on either side of the abortion debate. However if such a neutral balance can be reached, then it may prevent the ultimate demise of health care reform and allow our nation to finally achieve the goal of health care for all. ■



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