An Emerging Middle Ground? An Analysis of Health Reform Positions

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Introduction

President Obama has pushed health reform to the top of the federal policy agenda during his first months in office, much as President Clinton did when he took office more than a decade-and-a-half ago. The Obama Administration, however, has approached the challenge of healthcare reform differently than the last Democrat to sit in the White House. Although the Obama Administration has made it a top priority to reform the system and has articulated principles for doing so, it is deferring the details to Congress and the legislative process. In contrast to 1993, when the Clinton Administration presented a detailed plan to Congress, the Obama Administration has worked collaboratively with Congress and engaged leading healthcare industry stakeholders and advocates.

Congress has responded in kind, with leadership committing to enact significant reforms this year. Five congressional committees are actively working to develop legislation to expand coverage to the uninsured and improve the quality and efficiency of healthcare. Over the last year, policymakers have begun to build a policy framework for a set of health reform proposals with a goal of broad bipartisan support in both the House and the Senate. Purchasers, patients, and providers have each offered their perspectives on reform, conveying a nearly unanimous sentiment on the need for reform, and their interest in playing a constructive, supportive role in designing and implementing new policies on access, cost, and quality. This supportive, pro-active "pre-legislation" environment stands in contrast to previous efforts, when the pre-legislation chorus tended to harbor caveats and controversy. Importantly, as details of specific proposals emerge, it is becoming more difficult to continue this initial state of apparent collaboration. However, most agree that the political and policy environment has never been more favorable for systemic changes to our healthcare system.

Even though it is early in the legislative process, a broad spectrum of political and business interests seem willing to compromise to meet the shared goals of reform. While areas of strong disagreement remain among stakeholders, the initial positive momentum and spirit of cooperation bodes well for advocates of reform. A number of core reform concepts appear to have garnered general, bipartisan, and multi-stakeholder support, including:

- Providing premium assistance to low-income individuals and families to purchase health insurance;
- Expanding access to, and coverage of, high-quality prevention services;
- Promoting wellness and healthy patient behaviors;
- Increasing primary care physician payments to address workforce shortages;
- Restructuring provider payments to reward for high-quality care, not for the volume of services provided;

- Encouraging chronic care coordination among providers and across various points of care to treat patients holistically;
- Accelerating health information technology (HIT) adoption and use; and
- Encouraging transparent dissemination of information about healthcare quality and costs.

The emerging consensus on these points is noteworthy, in that these issues span the spectrum of cost, quality, and access goals. However, there are a number of key issues where consensus remains an aspirational goal – issues characterized by lively, well intentioned debate among stakeholders and policymakers. Such yet-to-be resolved issues include: whether to offer the option of a government-sponsored plan; whether all Americans should be required to obtain health insurance and if employers should be required to contribute to the costs of coverage for their workers; and the authority and scope of a potential new entity to conduct research on which treatments are most effective. Also unresolved is the decision about how best to finance the costs of expanding access. Policymakers and industry leaders have proposed several and often conflicting sources of offsets, most notably taxing employer-based coverage or requiring employers to contribute to the cost of coverage or be subject to a tax penalty, but the critical decision about how to pay for health reform remains unsettled. Policymakers will need to address these core issues in order for reform to move forward.

After more than a year of discussion on these and related issues, policymakers and stakeholders are reaching the point at which each stakeholder must decide whether and how to reach a middle ground, to accomplish the common professed goal of timely action on reform. Outlines of a "centrist" point of view are beginning to emerge on several of these contentious issues. Politicians from across the aisle and a broad array of industry stakeholders are listening to each other's perspectives and attempting to find a compromise. In mid-June, the Bipartisan Policy Center (BPC), a collaborative policy organization led by former Senate Majority Leaders Daschle (D-SD), Dole (R-KS), and Baker (R-TN), released a compromise proposal for comprehensive healthcare reform that is illustrative of stakeholders' commitment to reaching a middle ground. Among several other provisions, BPC would expand both private and public funding for CER, enact federally defined, state-enforced market reforms, and allow states to create state-based or regional Health Insurance Exchanges that would adhere to federal standards and would have the option to offer a public plan within their exchange. In addition, six industry groups, some of which were the most vocal opponents to a system overhaul in 1993 (e.g., America's Health Insurance Plans and Pharmaceutical Research and Manufacturers of America), recently acknowledged support for the administration's goal to cut annual healthcare spending by 1.5 percentage points of current expenditures.

Although there is still much to be debated and decided before proponents of reform can claim victory, it is possible to begin to see movement among the parties across several key elements of reform, including:

1. The nature of private insurance market reforms;
2. The need for, and the structure of, a health insurance exchange;
3. Whether and how a government-sponsored "public plan" should be created;
4. How best to leverage Medicaid and/or public programs to expand access;
5. Whether an individual mandate is needed;
6. The scope and authority of government involvement in comparative effectiveness research;
7. Sequencing and scope of payment reform; and
8. Whether to limit the tax exclusion on employer-based coverage as a reform financing mechanism.

For some of these issues, opposing stakeholders have begun to approach each others' positions, creating the potential for a middle ground. For other issues, the movement is less pronounced, but those with divergent perspectives continue to appear to be genuine in their quest for agreement. As Congress and the administration enter the summer, and embark on the difficult process of detailing the specifics of reform, it is useful to review the status of these issues relative to movement toward a middle ground. This paper summarizes the progress made to date in resolving oft-competing views, and identifies the areas in need of additional progress and movement if reform is to succeed. For each of the still-contentious issues listed above, we present a brief description of the opposing perspectives that have emerged during the initial phases of the current health reform discussion. These first-glance perspectives are illustrative, and not necessarily representative of any one stakeholder, but instead provide a synopsis of the prevailing pro and con views to illustrate the range of views and options. We then discuss the progression of the opposing views toward a possible consensus.

1. Private Insurance Market Reform

State insurance laws vary from state to state. Many states allow insurers to vary premium costs significantly depending on several demographic characteristics, including health status. This variation can make coverage prohibitively expensive for individuals and small employers. Many proposals suggest ways to reform the individual and small group insurance markets by increasing federal regulation or improving the current state-based system.

Perspective 1: Federal Regulation

Federal regulation of the insurance market is necessary to ensure that all Americans, regardless of health status or any demographic characteristic, have access to affordable care. A federally-regulated insurance market would improve consumer protections against denial of coverage, reduce high rates for certain classes of enrollees, prevent insurers from cherry-picking healthy patients, and increase the healthcare system's efficiency by streamlining administrative functions.

Perspective 2: State Regulation

State regulation addresses the need for local market flexibility and is best able to design solutions to reform the insurance market. The role of the federal government is to provide additional resources to states to implement or expand high-risk pool programs so that states can ensure that people with chronic conditions have access to coverage. A federal, "one-size-fits-all" approach would not account for regional market variations and would hinder private market innovation. States should decide which market segments would be required to adhere to which market rules, set definitions for the small group market, and promote consumer choice and responsibility through tools such as tax credits, Health Savings Accounts (HSAs), and high-deductible health plans.

Initial Policy Proposals

- Ensure the federal government requires guaranteed issue and renewability, and modified community rating, to secure access and affordability
- Establish a uniform benefit structure to balance demands for affordability, choice, and range of basic to more extensive covered services
- Centralize and streamline administrative processes to increase efficiency and portability, and reduce costs

- Allow states the discretion to define and regulate individual and small group markets to account for differences in market and regional behavior and practices
- Utilize tools such as HSAs to increase patient independence and reduce administrative burden

Despite initial concerns, several leading health insurance associations – e.g., America's Health Insurance Plans and the Blue Cross Blue Shield Association -- signaled a major movement from their historical positions, beginning in early 2009. Traditionally, these associations opposed any federal insurance regulation, but have since agreed to support

federally-based regulation of the insurance market, including requirements for guaranteed issue and modified community rating -- as long as an individual mandate is in place to spread risk throughout the population. In addition, a bicameral group of Republican lawmakers released the "The Patients' Choice Act" (H.R. 2052) which would create regulated state insurance exchanges that must adhere to a set of minimal federal requirements, and in which participating insurers would be required to offer a certain standard of benefits and patients would be guaranteed coverage despite preexisting conditions.

In a complementary shift, early supporters of a purely-federal approach also appear open to allowing states a degree of flexibility to define small group market parameters. The Senate Finance Committee released a recommendation for new market rules in May that would require participation in an exchange (as described above) by individuals and micro-firms (fewer than 10 employees), but would allow states to set their own definitions and some market rules for the remaining small group market.

2. Creation of a Health Insurance Exchange

Several health reform proposals explore the option of creating a health insurance exchange to simplify and expand access to coverage for otherwise uncovered individuals or those who lack access to employer-sponsored coverage. An exchange would function as a marketplace for the purchase of health insurance policies. Some proposals reflect Massachusetts' recent health reform law, which created the Commonwealth Connector, an entity that facilitates the purchase of individual and small group coverage, as a potential model to expand nationally. Other ideas tend to favor a more aggressive role for the exchange, including the negotiation of premiums. Some favor a federal approach, others a state-based approach.

Perspective 1: Single, National Health Exchange

A federally administered and regulated health insurance exchange would ensure coordination and consistency throughout the healthcare system because all participating plans would be subject to the same standards, including minimum benefit standards. The exchange should require plans that offer products in the individual and small group markets in any state to participate. This would establish consistency across the current complex and variable state insurance market rules that make it difficult for consumers to compare and purchase coverage across

Perspective 2: Multiple, State-Based Health Exchanges

States should regulate health insurance, including any possible exchanges, to ensure flexibility in making decisions about developing approaches to designing coverage. For example, states may vary in their rules on which plans and individuals are eligible to participate in the exchange. New federal authority may conflict with existing state regulations and state exchanges, such as in Massachusetts. A state-based approach, with each state able to implement their own rules, best reflects the natural variation in markets.

states. It would also ensure that consumers have a wide range of options.

Initial Policy Proposals

- Allow a federal authority to determine eligibility, premium and benefit standards, risk adjustment, and other market rules to ensure uniform regulation and consumer comparison
- Allow all individuals to purchase coverage through the exchange to increase access
- Require all insurers with individual and small group market products to offer coverage through the exchange

- Grant states the authority to create exchanges, and to determine participation requirements, premium and benefit standards, and market and risk adjustment rules to best meet market needs and encourage innovation
- Allow only individuals without employer-sponsored insurance to participate to avoid "crowd-out."
- Allow the federal government to set broad objectives for the exchange but states must serve as the exchange administrator

Health reform proponents from across the political spectrum have come to support the concept of health insurance exchange(s) as a mechanism to increase consumer access and choice of health insurance products. The Senate Finance Committee's recent release of healthcare policy options includes ideas for coverage expansion, and suggests a middle ground position that grants the federal government primary authority over an exchange but also maintains some state autonomy. The recent Senate HELP Committee draft plan also provides states the option to create and manage exchanges (termed "gateways"), but is generally more prescriptive than the Finance Committee's options. Democrats in three House committees released a draft health reform bill in mid-June that would establish a national Exchange, but would give states the option to set up their own exchanges that operate under federal standards. Unlike the HELP and House bills, the Finance design would also consider permitting private entities to create regional exchanges that could compete with a federal exchange. The Finance Committee would require plans offering products to individuals and micro-firms to participate in the exchange, and would require existing state small group markets to adopt some of the rating rules of the federal exchange over time, while the HELP and the House bills appear to open the exchanges up to all employers and all individuals. Under the Finance bill, states would define the small group market, and decide whether to require insurers in the small group market to participate in the exchange.

3. Creation of a Government-Sponsored 'Public Plan'

All leading health reform proposals include strategies to expand access to coverage for the uninsured. Most proposals would create new private insurance markets and reform current insurance market rules (e.g., guaranteed issue, eliminating medical underwriting) to improve access. Some coverage expansion proposals would create a government-sponsored health insurance plan (a "public plan option"), which the federal government would administer to compete in the new insurance market with private plans.

Perspective 1: Create a Public Plan

A public plan option based on Medicare payment rates is an essential benchmark and backstop to complement private plans in a reformed insurance market. Providing a public plan option is the only effective mechanism to ensure that individuals have a stable, affordable coverage option, especially because the private insurance market does not have a strong track record of protecting consumers. A public plan is the only way to spur competition among private plans to force them to become more efficient and affordable.

Perspective 2: Rely on Private Plans Only

A reformed insurance market should rely solely on private plans to prevent a "single-payer-option-in-disguise". Under new market conduct rules, private plans would take all comers, and compete vigorously. Negotiating payment levels is essential to avoid disruptions in the supply of physician services that may occur under a mandatory application of Medicare pricing. Managing networks and capital reserves is challenging, and best left to the private sector. Lastly, the private sector has more capacity to be responsive to consumers and innovative than the government in a reformed system.

Initial Policy Proposals

- Create a public plan to provide a stable, "fallback" option that competes with private plan options for individuals otherwise unable to obtain private coverage
- Lower prices for the overall healthcare system by paying providers Medicare rates, forcing private plans to become more efficient and affordable
- Expand access by requiring Medicare providers to participate

- Enact market conduct reforms, and let private plans compete for patients on a level playing field
- Rely on private-sector negotiations to create viable payment strategies to assure physician and hospital participation
- Depend on private market competition to create incentives to innovate and respond to consumer preferences

While deep differences remain between public plan advocates and opponents, a number of potential middle-ground proposals are emerging, even if each side of the debate has not yet embraced them. Importantly, many on each side of the issue seem to agree that the rules under which a public plan would operate must be generally consistent with the rules applicable to private plans, including benefit design, market conduct, and capital and reserve requirements. Sharp differences remain regarding the authority and process by which a public plan might set payment levels. For example, the House tri-committee draft reform bill released in mid-June would require a public plan to meet the same market and benefit rules as private plans, but bases initial payment rates on lower Medicare prices and provides incentives to Medicare physicians to participate.

Public plan proposals vary extensively. Sen. Charles Schumer (D-NY) suggested an approach in which a public plan and private plans would adhere to the same rules and regulations, including consistent underwriting rules, benefit design requirements, subsidy levels, and consistent reporting metrics. Under this approach, any federal office established to regulate the insurance market must not administer the public plan, and the public plan would have to be financially self-sustaining. Alternately, others have suggested that the public plan approximate the Federal Employees Health Benefit Program, where private plans adhere to public regulation over benefits and administration. Still others have suggested that the public plan resemble state employee plans, where the state contracts with a third-party to offer insurance, develop networks, and pay benefits for state employees and the families, on behalf of the state. Finally, a recent proposal to enable the creation of "cooperatives" that design, develop, and deploy a co-op-sponsored plan, representing the interests of local small employers and individuals, is also garnering attention.

Other proposed potential compromises suggest adopting a "fallback" option for the public plan, with the public plan introduced only if the private market fails to expand coverage and to reduce costs or premiums after a specified amount of time, and limiting enrollment into a public plan to those without access to employer-sponsored insurance.

4. Medicaid Expansion

Expanding Medicaid by setting a minimum floor for eligibility, under which all individuals up to a specified income level would be eligible, has emerged as a possible avenue for reducing the number of uninsured. Currently Medicaid serves approximately 60 million low-income, vulnerable Americans, but offers only limited coverage for adults except for the very poor, the disabled, or parents with dependent children. Proponents argue that Medicaid would be an efficient way of covering the uninsured, of which nearly two-thirds are low income, especially adults who have so far been restricted from Medicaid eligibility. Others are concerned that raising the eligibility ceiling too high will discourage some from taking personal responsibility for their insurance and healthcare.

Perspective 1: Expand Medicaid Income Eligibility

Medicaid is the cornerstone for reducing the number of uninsured, especially since more than one-third of the uninsured population is comprised of low-income, childless adults. A Medicaid expansion would improve and expand affordable coverage to low-income, vulnerable individuals who cannot afford other coverage options. Also, since the federal-state structure is already in place, this would be an efficient mechanism to expand coverage.

Perspective 2: Expand Assistance for Private Coverage

Any Medicaid expansion would be very expensive and would stretch the entitlement program that is already facing soaring costs in its current form. In the face of the continuing economic crisis and state budget shortfalls, states would have to take on additional cost burdens because of the expansion. Furthermore, expanding eligibility for public coverage will likely crowd-out private coverage for those who have access to it, and standardizing eligibility by income would limit state flexibility to design innovative, targeted programs.

Initial Policy Proposals

- Set a minimum federal floor for Medicaid, such as 100 percent or 150 percent of the federal poverty level (FPL) for all individuals
- Simplify the enrollment and renewal process to increase enrollment
- Increase federal funding for Medicaid to alleviate the financial burden on states
- Offer sliding scale subsidies to low-income individuals and families who earn incomes above current eligibility
- Enact insurance market reforms, such as establishing a Health Insurance Exchange, to remove barriers to participation and facilitate enrollment of low-income populations in the private market

There is growing agreement among stakeholders that an income-based Medicaid expansion could be a viable option for reducing the low-income uninsured population. The reauthorization of the Children's Health Insurance Program (CHIP) in early 2009 marked the first major action under the Obama Administration to expand public coverage to low-income populations. More recently, the Health Reform Dialogue (HRD), a coalition of healthcare stakeholders that includes business and labor groups, released a report in May supporting a nationwide Medicaid eligibility floor of 100 percent FPL for all adults and greater federal funding for Medicaid. In addition, Families USA and PhRMA jointly released a statement that supports a Medicaid expansion to a nationwide floor of 133 percent FPL. Other stakeholders have proposed expanding and simplifying premium assistance programs to encourage low-income workers eligible for Medicaid to use subsidies to purchase employer-based coverage.

5. Enactment of an Individual Mandate

There are several reasons why people lack insurance coverage; some choose not to purchase it, while others lack insurance due to cost burdens or because of preexisting conditions, which increases the cost of covering this collective pool considerably. Without a broadly representative risk pool, insurers face market forces that incent cherry-picking and experience-based underwriting and rating. To achieve universal coverage, and to eliminate insurers' incentives to cherry pick and underwrite, many health policy experts have argued that all individuals should be required to obtain health insurance, whether through an employer, an individual plan, or a public insurance program. These proponents also argue for subsidies for low-income individuals to purchase insurance. Under this proposal, citizens who fail to obtain coverage would face a financial penalty.

Such a requirement would represent a major expansion of governmental authority; Americans face very few, if any, blanket requirements. Auto insurance, while required by most states, is only required for those who choose to drive. Filing income taxes is only required if one has taxable income. Enacting an individual mandate would mark a watershed event in U.S. domestic policy.

Perspective 1: Enact an Individual Mandate

Implementing an individual mandate is a necessary pre-condition to requiring all insurance companies to provide coverage to all applicants. Without a mandate, many individuals would otherwise wait until they get sick or injured, and only then purchase insurance when their care is very expensive. Also, an individual mandate would broaden the risk pool, which would reduce overall premium costs, especially for those with preexisting conditions. In turn, a mandate requires that we subsidize the cost of insurance for those that cannot afford it, and we must control the growth of health spending to assure the sustained affordability of insurance.

Perspective 2: Preserve Individual Choice

An individual mandate infringes on an individual's freedom of choice, and the federal government does not have the authority to require all individuals to purchase health insurance. An individual mandate could drastically increase healthcare expenses for younger, healthy consumers who would have to finance care for older, sicker consumers. Furthermore, an individual mandate could impose an undue financial burden on individuals, families, and small businesses. Health insurance premiums may be prohibitively expensive and a mandate is discriminatory unless the government can ensure that health plans are affordable, especially in the absence of other health reform cost containment initiatives. Lastly, an individual mandate would be very difficult to enforce.

Initial Policy Proposals

- Implement an individual mandate to achieve universal coverage, broaden the risk pool and protect healthcare providers and systems from catastrophic healthcare costs by ensuring coverage

- Maintain individual freedom to choose whether to purchase or forgo coverage

Many Republican policymakers, as well as large health insurers, both of whom initially opposed a mandate, now appear willing to consider such a scheme. For example, most agree that requiring insurers to cover everyone, regardless of pre-existing condition, requires either a mandate or substantial subsidies, to avoid a situation where the only people purchasing insurance are those who are sick or injured. Some patient advocacy groups have also conceded the need for a mandate but only if coverage is "affordable."

6. Scope and Authority of Comparative Effectiveness Research (CER)

Comparative effectiveness research (CER) compares the relative benefits and risks among available treatments or interventions for a given condition to assist clinicians, patients, and policymakers. Although most health reform stakeholders agree that information about the effectiveness of treatment options is valuable, stakeholders disagree on whether and how policymakers and payers should use this information to guide or dictate payment and coverage of healthcare treatments and services. Further, even among proponents of CER there is much debate about the degree of governmental oversight and direction of these research projects, with some favoring a strong governmental role, and others favoring a more private-sector orientation. Finally, the scope of the CER efforts relative to which drugs, devices, and treatment pathways is also unclear: some favor a focused approach on high-priced drugs and devices; others favor a broader approach, focusing on treatments and clinical pathways.

Perspective 1: Allow CER to Drive Coverage and Payment Policy

The United States has the most expensive healthcare system in the world, yet quality of care lags behind most other industrialized countries because this nation spends healthcare resources inefficiently. There is a need for federal investment to generate more information on which treatments are clinically and cost-effective and then to

Perspective 2: Limit CER to Clinical Recommendations

CER should focus on generating evidence on the clinical effectiveness of healthcare treatments, strategies, and delivery options. Further, they should not restrict access to treatments and services otherwise deemed safe and effective. The findings should be educational and should in no way compromise the patient-provider discussion. A private-sector organization

drive coverage decisions based on value. The government has a responsibility to improve the value of care by directing CER, and by embracing its findings in coverage and payment decisions. Finally, given the need to focus CER on low-hanging fruit, an emphasis on drug- and device-related CER is appropriate.

should pursue CER research, even if the government funds it, in order to prevent government employees from interfering in the patient-doctor relationship. Lastly, research should focus on all types of healthcare, not just one set of interventions (i.e., not just drugs or devices).

Initial Policy Proposals

- Promote the best care options by using CER to inform coverage of treatments and services
- Improve the assessment of interventions by including cost-effectiveness analyses to assess the value of various treatments studied
- House the governance and oversight of the program within the federal government to impose a meaningful impact on quality improvement and lowering costs
- Establish designated channels for public input to ensure participation and engagement without catering to private interests
- Support expanded research into the clinical effectiveness of treatments
- Limit research to clinical issues, and produce no recommendations, guidance, or policy that pertains to coverage, payment, or access of the intervention(s) evaluated in a particular study to prevent care rationing
- Assure patient choice by limiting efforts to producing accessible and useful information
- Establish a non-governmental structure that includes representation from a wide range of stakeholders to oversee the conduct and operations of the program to avoid political influence

Health reform stakeholders appear to have reached consensus that the U.S. healthcare system would benefit from increasing the volume of high-quality information about the most valuable treatments. While there is not yet agreement on how best to achieve this goal, emerging compromises between the stakeholders will likely focus around two key elements: (1) authority and structure of the program responsible for collecting and administering the data, and (2) the inclusion of cost-effectiveness in research agendas.

While the American Recovery and Reinvestment Act (ARRA) housed the CER program within the federal government, legislators in both the House and the Senate are considering introducing (or already have introduced) proposals that would create a non-governmental body to oversee the CER program. However, comprehensive draft reform bills released by the Senate HELP Committee and Democratic members of the three

health-focused House committees would establish a new CER Center in the Agency for Healthcare Research and Quality (AHRQ), but neither stipulates that recommendations would guide coverage or reimbursement policy. Given the difference between the ARRA language and recent proposals in the Senate and House, the particulars of a compromise are unclear, but a federal program may have more private stakeholder participation or another independent entity may form.

With respect to the consideration of cost-effectiveness, there are also signs of some coalescence. ARRA neither required nor prohibited the pursuit of cost-effectiveness research in the CER context. More recently, the Patients' Choice Act (H.R. 2052) called for a report on cost-effectiveness methodologies within two years of enactment. The combination of the ARRA language and the recently introduced House bill suggests that policymakers are looking (and will continue to look) for ways to find a compromise on this issue.

7. Sequencing and Scope of Payment Reform

Healthcare payment reform is a critical lever for improving the quality of care delivery, slowing cost growth, and promoting system integration. Reform options promoted by individual groups or sectors of the healthcare system have now converged into a more cohesive and comprehensive reform platform. Stakeholders generally agree that payment reform should promote primary care, system integration, provider collaboration, and greater accountability, although there is still some disagreement on how best to implement these goals.

Perspective 1: Comprehensive Reform

Repairing the healthcare payment system should happen through an integrated approach that would coordinate various components of the fragmented delivery system and promote provider collaboration by incorporating many incremental changes into one comprehensive package. This approach would increase the potential to generate real change if reform options are integrated, cohesive, and comprehensive and remove incentives inherent in fee-for-service to provide *more* care, not *better* care.

Perspective 2: Incremental Reform

Repairing the healthcare payment system should happen incrementally through reforms aimed at individual sectors in the healthcare system (e.g., Sustainable Growth Rate (SGR) fixes for Medicare physician payment). Incremental reform policies would generate sufficient buy-in from the providers it would affect as well as promote gains in efficiency and quality.

Initial Policy Proposals

- Implement the medical home model to improve care coordination
- Rebalance physician payments to lessen the gap between primary care providers' and specialists' incomes
- Incentivize better care transitions by reducing payment for avoidable hospital readmissions
- Establish accountable care organizations (ACOs): providers networked together, reimbursed as a unit, and accountable for quality and overall spending for their patients
- Allow connected providers to share in any savings generated from efficiency and productivity gains
- Authorize large-scale demonstrations, with minimal congressional oversight, and grant the Centers for Medicare & Medicaid Services (CMS) the authority to implement proven concepts more easily

- Increase payments to primary care providers
- Pay bonuses for improved or high performance
- Bundle payment for related services (e.g., heart surgery and post-acute care, end stage renal disease services and physician care)

For now, most policymakers and stakeholders appear to favor more holistic reforms, implemented though large-scale pilots, and overseen by a CMS office with additional authority to start, stop, or expand these demonstrations and pilots. Almost all stakeholders agree that payment reform should target primary care, provider collaboration, and system integration. How to implement the reforms, however, still drives debate and disagreement.

The Senate Finance Committee options for healthcare payment and delivery reform incorporated at least one option in each of these three areas. On primary care reform, options included enhanced payment levels for primary care services, modifications to the SGR formula, and additional investment in graduate medical education for primary care. For system integration and provider collaboration, the committee signaled its intent to explore options around bundling hospital and post-acute care services, paying for care coordination services, creating ACOs, implementing shared savings programs, and establishing a hospital readmissions policy. The House tri-committee draft health reform bill proposes to implement these options as well, and includes provisions to increase Medicaid primary care payments.

8. Employer Tax Exclusion

Experts have identified the employer-sponsored health insurance tax exclusion as a potential major source for financing health reform, citing two primary rationales. First, the current unlimited exclusion incents richer insurance plans than would be the case with a limited exclusion; second, the potential revenues associated with adjusting the exclusion are significant. More than 60 percent of the working-age population gets their health insurance from their employers, but neither these individuals nor their employers pay income or payroll taxes on this income. Currently, employer-provided health insurance is excluded from taxable income and is considered the largest single subsidy in the tax code. According to some estimates, this tax exclusion reduced tax revenue by approximately $246 billion in 2007.

The cost of overhauling the healthcare system is massive, estimated around $1.2 trillion over the 10 years, potentially adding to the already enormous budget deficits. In addition, those working on reform proposals have expressed a desire for reform to be budget neutral. Although many other financing methods are under consideration, including so-called sin taxes on tobacco, alcohol, and sugary beverages, and payment and delivery system reforms, many believe the elimination or capping of the tax exclusion for employer-sponsored health insurance is the most logical way to finance health reform.

Perspective 1: Eliminate or Cap Tax Exclusion

The current tax exclusion is the single largest tax subsidy and it provides regressive benefits. In other words, the benefits of the tax exclusion disproportionately accrue to those with higher incomes, which do not help low-income people most in need of assistance. Moreover, the tax exemption excludes those without employer coverage. This system also incentivizes greater healthcare spending and encourages overuse of insurance, which contributes to higher health spending. Eliminating or capping the tax exclusion could be a major source of financing for health reform.

Perspective 2: Maintain Tax Exclusion

Curbing the tax exclusion would erode employer-sponsored coverage, which is the source of health insurance for most Americans. The employer-based system encourages risk pooling, and changing the tax exclusion would eliminate protections for high-cost groups and may push them into the non-group insurance market that excludes people with preexisting conditions. Changing the tax exclusion may hurt workers who reside in high cost regions and may even contribute to increasing the number of uninsured if workers or employers simply drop their coverage. Limiting the exclusion may also result in higher deductions or less generous benefits, further making health insurance unaffordable for many Americans.

Initial Policy Proposals

- Eliminate the tax exclusion and replace with a tax credit or a limit on the deductibility of health insurance premiums.
- Maintain the current tax exclusion for employer-sponsored coverage.

Although opposition to capping or eliminating the tax exclusion for employer-sponsored coverage remains, there are indications of a growing willingness to compromise on this issue. In recent months, proposals have emerged that strike a balance between protecting workers who may be harmed by changing the tax exclusion and the need for reforming a system that, some say, encourages overuse of insurance and skews toward high earners. Most notably, Senate Finance Committee Chairman Max Baucus (D-MT) has indicated that President Obama is willing to consider changes to the tax exclusion despite his earlier opposition. White House Director of the Office of Management and Budget Peter Orszag has said that all proposals for health reform are on the table, which suggests a tacit acknowledgement that they will still consider this issue as a financing mechanism. Some policy proposals, including reports from the Senate Finance Committee, recommend limiting the tax exclusion based on the value of insurance, type of insurance policy, or income of the recipient, or based on a combination thereof. In addition, some labor groups may support limiting the tax exclusion based on income.

Conclusion

Health reform activity will continue to accelerate in 2009 as Congress strives to meet President Obama's goal of passing a comprehensive reform bill by the end of the year. Concurrently, healthcare system stakeholders have and continue to propose several mechanisms and to make attempts to engage in dialogue to discuss ideas for compromise to expand coverage, improve quality and financing, but it remains to be seen if the dynamic negotiations and discussions over recent months will surmount the key tension points that are barriers to reform. However, as illustrated in this paper, healthcare stakeholders and policymakers have made considerable progress in finding a common ground on which they can collaboratively improve the U.S. healthcare system.

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