Healthcare Reform in America: How Did We Get Here and Where Are We Going?

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Grand Rounds
Children’s Hospital of New Orleans
January 30, 2013
Introduction

- History of health insurance in America
- Flaws of the Employer-Sponsored system
- ACA
  - Medicaid Expansion
  - Health Benefit Exchanges
    - Individual mandate
  - Medicare IPAB
- Projected impact of Supreme Court Ruling
Current System

- Employer-sponsored health insurance plans (ESI)
- Unemployed, impoverished, and children use Medicaid
- Seniors use Medicare
- Some states with “county” and “charity” systems
History

- 1798: U.S. Marine Hospitals
- AD&D policies in 1850s
  - Franklin Health Assurance Co.
  - Travelers
- Industrial clinics of 1870s and 1880s
  - Benefited employer more than employee
History

- 1899: First “health” insurance
  - Aetna and Travelers
  - Insured wages if disabled due to illness

- Insured:

  against “loss due to temporary total disability occasioned by all diseases except tuberculosis, venereal disease, insanity, or disabilities due to alcohol or narcotics.” This coverage was issued to select

  Scofea, Monthly Labor Review 1994
History

- 1910: First group health policy
  - Montgomery Ward
  - Workplace illnesses

- Embraced by Unions
  - Begin to benefit employee more than employer
  - Used for recruitment
History

- 1900-1920: “Compulsory” health insurance movement
- Supported by policy makers
- Opposed by labor (AFL), physicians, and insurance companies
The Depression - HMOs

- 1929: Ross-Loos clinic
  o The first HMO
  o Operated until 1980

- 1929: Blue Cross/Blue Shield
  o Baylor teacher’s alliance
  o California Physicians Service

- 1932: Kaiser Permanente
  o Henry Kaiser and Dr. Sidney Garfield
World War II

- Stabilization Act of 1942
  - Substitute salary with benefits

- 1949: Liberty Mutual
  - “Major Medical”

- Employer-sponsored care nearly universal by 1949
  - 1940: <10% national coverage
  - 1950: 50% national coverage
The Current System

- Continued expansion
- 1954: Compelling tax benefits
- Health Maintenance Organization Act of 1973
- 1979: 97% of all FTEs covered by health insurance with 5.6% unemployment
Successes of ESI

- Covered a large portion of population
- Value based purchasing
- Large risk pool
- Economy of scale
- Helped maintain a competitive job market
- Encouraged employment and loyalty
- Encouraged wellness
Problems with ESI

- Not portable
Problems with ESI

- Not portable
- Ties cost of healthcare to the cost of goods and services and yield of dividends
- Shields employees from the true cost of care
- May be misleading to employees
- Unusual from a global perspective
Cracks in the Armor

- 1971-1991:
  - CPI rose 235.5%
  - Medical care price index rose 398.9%

<table>
<thead>
<tr>
<th>Year</th>
<th>Consumer Price Index</th>
<th>Medical CPI</th>
<th>Percent Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>25.4</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>1971</td>
<td>41.1</td>
<td>36.6</td>
<td>-11.6%</td>
</tr>
<tr>
<td>1988</td>
<td>120.5</td>
<td>142.3</td>
<td>16.6%</td>
</tr>
<tr>
<td>1991</td>
<td>137.9</td>
<td>182.6</td>
<td>27.9%</td>
</tr>
<tr>
<td>2001</td>
<td>176.7</td>
<td>277.3</td>
<td>44.3%</td>
</tr>
<tr>
<td>2011</td>
<td>225.672</td>
<td>405.629</td>
<td>57.0%</td>
</tr>
<tr>
<td>2012</td>
<td>231.407</td>
<td>418.359</td>
<td>57.5%</td>
</tr>
</tbody>
</table>
Growth in Cost

- Technology/Pharmaceuticals
- Chronic Disease
- Administrative Costs
- Little rise in MD fees

Growth 1971-2012

- Net cost of health insurance 6%
- Hospital care 31%
- Physician/clinical services 20%
- Other professional services 7%
- Other health, residential, and personal care 5%
- Nursing home care 5%
- Home health care 3%
- Retail - Rx drugs 10%
- Retail - Other products 3%
- Government Administration 1%

www.hetemeel.com
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2012

* Estimate is statistically different from estimate for the previous year shown (p<.05).

## Direct Impact on Workers

<table>
<thead>
<tr>
<th></th>
<th>Single Coverage</th>
<th></th>
<th>Family Coverage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employer</td>
<td>Worker</td>
<td>Employer</td>
<td>Worker</td>
</tr>
<tr>
<td><strong>1999</strong></td>
<td>$1,878</td>
<td>$318</td>
<td>$4,247</td>
<td>$1,543</td>
</tr>
<tr>
<td><strong>2012</strong></td>
<td>$4,664</td>
<td>$951</td>
<td>$11,429</td>
<td>$4,316</td>
</tr>
<tr>
<td><strong>% increase</strong></td>
<td>150%</td>
<td>200%</td>
<td>170%</td>
<td>180%</td>
</tr>
</tbody>
</table>
Crack in the Armor

- Rise in cost
- Increase in part-time, “no benefits” employees

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Full-time employees</th>
<th>Part-time employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>86</td>
<td>82</td>
</tr>
<tr>
<td>Dental care</td>
<td>60</td>
<td>54</td>
</tr>
<tr>
<td>Vision care</td>
<td>43</td>
<td>35</td>
</tr>
<tr>
<td>Outpatient prescription drug coverage</td>
<td>84</td>
<td>81</td>
</tr>
</tbody>
</table>

NOTE: All workers = 100 percent.
## Impact on Access

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility (%)</td>
<td>81.3</td>
<td>77.1</td>
<td>73</td>
</tr>
<tr>
<td>Enrollment (%)</td>
<td>69.6</td>
<td>62.4</td>
<td>54</td>
</tr>
<tr>
<td>Uptake Rate (%)</td>
<td>85.6</td>
<td>81.0</td>
<td>74</td>
</tr>
</tbody>
</table>

Source: U.S. Bureau of Labor Statistics

- Spouse plan enrollment
- Worse for low wage earners and small businesses
Crack in the Armor

- 1971-1991:
  - CPI rose 235.5%
  - Medical care price index rose 398.9%
  - Technology/Chronic Disease/Administrative Costs
  - Little growth in MD fees by comparison

- Increase in part-time, “no benefits” employees
- Rise in costs decline in coverage for FTEs
- The uninsured “gap” grows
## Growth of the Uninsured: 1999 to 2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Total People</th>
<th>Covered by Private or Government Health Insurance</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Private Health Insurance</td>
<td>Government Health Insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employment-based</td>
<td>Direct Purchase</td>
</tr>
<tr>
<td>2009</td>
<td>304,280</td>
<td>169,689</td>
<td>27,219</td>
</tr>
<tr>
<td>2008</td>
<td>301,483</td>
<td>176,332</td>
<td>26,777</td>
</tr>
<tr>
<td>2007</td>
<td>299,106</td>
<td>177,446</td>
<td>26,673</td>
</tr>
<tr>
<td>2006</td>
<td>296,824</td>
<td>177,152</td>
<td>27,066</td>
</tr>
<tr>
<td>2005</td>
<td>293,834</td>
<td>176,924</td>
<td>27,055</td>
</tr>
<tr>
<td>2004</td>
<td>291,166</td>
<td>176,247</td>
<td>27,551</td>
</tr>
<tr>
<td>2003</td>
<td>288,280</td>
<td>175,844</td>
<td>26,783</td>
</tr>
<tr>
<td>2002</td>
<td>285,933</td>
<td>177,095</td>
<td>26,846</td>
</tr>
<tr>
<td>2001</td>
<td>282,082</td>
<td>178,261</td>
<td>26,309</td>
</tr>
<tr>
<td>2000</td>
<td>279,517</td>
<td>179,436</td>
<td>26,799</td>
</tr>
<tr>
<td>1999</td>
<td>276,804</td>
<td>176,838</td>
<td>27,731</td>
</tr>
</tbody>
</table>

The Current Problems

- No individual market
- Patients with major illnesses priced-out
- Health care major burden on taxpayers, physicians, hospitals, and significant cause of bankruptcy
Health Care Reform Legislation

- Patient Protection and Affordable Care Act of 2010 (ACA)
- Health Care and Education Reconciliation Act of 2010
- Passed March 2010
- Staged enactment through 2019
What does ACA do?

- Insurance reform bill
  - Increase access through regulatory change
- Expand Medicaid eligibility
- Create portable individual market
  - Emulate employer system through government subsidies
  - Individual Mandate
  - Exchanges
- Medicare Reform
Insurance Regulations

- Children covered until age 26
- Patients <19y/o may not be denied based on pre-existing conditions
- Establish temporary high-risk pool
- All new plans must cover preventive care/check ups with no co-payment
Insurance Regulations

• Loss Ratio Cap
• Strict prohibition of denials/rate increases based on pre-existing conditions
• No annual or lifetime spending caps
• Other regulations concerning denials, appeals, and earnings transparency
Medicaid Expansion

• All legal residents <65y/o at or below 133% of the Federal Poverty Level (FPL)

• Majority is federally funded
  o 100% 2014-2016
  o 95% in 2017
  o 94% in 2018
  o 93% in 2019
  o 90% 2020 and beyond

• Participation not compulsory to receive existing federal funds
Medicaid Expansion

- In: 19, Out: 10, Undecided: 21
- 11 million to 17 million new subscribers
  - Of 30 million estimated to be covered by law
- Opting out may affect ultimate success of law
Health Benefit Exchanges

- Primary goal: create individual market
- Create group rates for individuals and corporate rates for small businesses
  - American Health Benefit Exchanges (AHBE)
  - Small Business Health Options Program (SHOP)
- CBO: 24 million AHBE and 5 million SHOP consumers by 2019
The Individual Mandate

• The foundation of the individual market and the exchanges

• Penalty: Greatest of two amounts
  o 2014: 1% or $95 ($285 per family)
  o 2015: 2% or $325 ($1300 per family)
  o 2016: 2.5% or $695 ($2085 per family)
  o Annual increases after that

• Penalty capped at national average of lowest level exchange premium
The Individual Mandate

- Exemptions:
  - Religious objection
  - Health premiums would cost >8% of income
  - Those who qualify for Medicare/Medicaid
  - Incomes below the income tax filing threshold
  - Native American Tribe Members
  - Undocumented immigrants
  - Incarcerated individuals
  - Those without coverage < 3 months
Supreme Court Ruling

- 5-4 decision
- Individual mandate constitutional
- States may “opt out” of Medicaid expansion
Health Benefit Exchanges

- Available to citizens and legal immigrants
  - No access to affordable employer qualified coverage
    - 60% actuarial value
    - Premium $ 9.5% of income

- Available to Small Businesses
  - 50 or fewer workers through 2016
  - Then, 100 or fewer workers

- Able to operate in multiple states
  - Regional Exchanges
Health Benefit Exchanges

Essential Benefits

• Ambulatory services
• Emergency services
• Hospitalization
• Maternity and newborn care
• Mental health benefits/substance abuse treatment
• Prescription drugs

• Rehabilitative and habilitative services/devices
• Laboratory services
• Preventive and wellness services
• Chronic disease management
• Pediatric services including oral and vision care
Health Benefit Exchanges

• Premium structuring
  o Guarantee issuance and renewability
  o Rating may be based on:
    • Age (maximum rating ratio 3:1)
    • Geography
    • Family composition
    • Tobacco use (maximum rating ration 1.5:1)

• Four benefit tiers
## Health Benefit Exchanges

**Premium structuring**

**Guarantee issuance and renewability**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Actuarial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
</tr>
</tbody>
</table>

- Catastrophic plan for <30y/o
- Out-of-pocket maximums
### Health Benefit Exchanges

- Tax credits up to 400% FPL

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as Percent of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-133% of FPL</td>
<td>2% of income</td>
</tr>
<tr>
<td>133-150% of FPL</td>
<td>3-4%</td>
</tr>
<tr>
<td>150-200% of FPL</td>
<td>4-6.3%</td>
</tr>
<tr>
<td>200-250% of FPL</td>
<td>6.3-8.05%</td>
</tr>
<tr>
<td>250-300% of FPL</td>
<td>8.05-9.5%</td>
</tr>
<tr>
<td>300-400% of FPL</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation *Focus on Health Reform*

- Based on premium income of 100-400% FPL cost silver plan
### Health Benefit Exchanges

- **Cost Sharing Subsidies**

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Actuarial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150% FPL</td>
<td>94%</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>87%</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>73%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation *Focus on Health Reform*

- Based on premium of silver plan
- *Do not apply to income <100% FPL*
Health Benefit Exchanges

- Cost Sharing Subsidies

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Reduction in Out-of-Pocket Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-200% FPL</td>
<td>Two-thirds of the maximum</td>
</tr>
<tr>
<td>200-300% FPL</td>
<td>One-half of the maximum</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>One-third of the maximum</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation *Focus on Health Reform*

- Based on premium of second lowest cost silver plan
- *Do not apply to income <100% FPL*
Health Benefit Exchanges

- States have until December 14, 2012 to declare intention to participate
  - State Run
  - State/Federal Partnership
  - Federal Exchange

- Blueprint due early February 15, 2013
- Open enrollment in Oct 1, 2013
- Start January 1, 2014
Health Benefit Exchanges

- 19 states are default to Federal Exchange
- 25 states are out of exchange
- 7 states have partnerships

Map of the United States with states color-coded:
- Yellow: Default to Federal Exchange
- Blue: Declared State-based Exchange
- Light blue: Planning for Partnership Exchange

Source: statehealthfacts.org
How is it paid for

Cost-Saving Measures

- Individual mandate penalty
- Medicare taxes on “high-income” brackets
- Tax on indoor tanning
- Cuts to Medicare Advantage program
- Fees on medical devices and pharmaceutical companies
- Tax penalty for not having health insurance
- Fees on insurance companies
- Excise tax on “Cadillac” insurance plans
- Adjust the medical deduction
- Changes in HSA and FSA rules
- Investment income surtax
- Change medical deduction rules
- Reduce DSH payments
Independent Payment Advisory Board (IPAB)

- 15 member panel
  - Appointed by the President with Senate confirmation
  - Tasked with finding “savings” in Medicare
- Recommendations become law absent Congressional action
Problems with IPAB

- Physicians only target until 2016
  - Laboratories in 2016
  - Hospitals in 2020

- Prohibitive restriction on members

- Potentially unrealistic spending targets and restrictions

- Does not address SGR
Problems with IPAB

- Savings may simply mean paying less
  - May jeopardize access

- MedPAC would still exist

- 2014. Must be “triggered” by overspending
  - First recommendations estimated 2023-2025

- HR 452- IPAB Repeal bill
Projected Impact of ACA

- **Money:**
  - Cost: CBO projects $1.168 trillion 2012-2022
    - $923 billion between 2014-2019
  - Reduce deficit by $150-200 billion in first decade and $1.2 trillion in second decade

- **Uninsured**
  - Decreased from 55 million to 23-27 million
    - Those exempted from mandate
    - Those caught in “gap” between Medicaid and Exchange subsidy availability

Sources: Kaiser Family Foundation and 2011-2012 Congressional Budget Office Projections
Problems with ACA

- Financial solvency is uncertain
- Independent Payment Advisory Board
- No medical liability reform or SGR fix
- Industry taxes may slow innovation
- Resistance by states to enforcement
- Still leaves a lot of people out
- Employers dropping healthcare
Problems with ACA

• Many rules left to be determined
  o Over 100 different commissions and boards (i.e. Center for Medicare/Medicaid Innovation)

• States run exchanges
  o Success of the bill will largely depend on success of exchanges
  o States have considerably less bargaining power than does the federal government

• Concerns for over-regulation
Summation

- The United States’ employer-sponsored health insurance system (ESI) is unique/unusual and arose out of necessity and remains, in part, out of tradition

- Rising costs threaten the sustainability of ESI

- The lack of an individual market is a major impediment to universal coverage
Summation

- The primary goals of ACA are:
  - Provide care to indigent population through Medicaid expansion
  - Create individual market through individual mandate and health benefit exchanges
  - "Reform" Medicare

- Ultimate financial impact of bill is unknown
What will ACA mean for us?
Thank You