

Health Care Reform: Issues for Neurosurgery

Georgia Neurosurgical Society
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AANS Past-President

In The Beginning: The Origins of Medicare

- National Health Insurance proposals
 - Progressives (T. Roosevelt – 1912)
 - F. Roosevelt: New Deal (Social Security Act – 1935)
 - NHI deleted from SSA to prevent defeat
 - Truman: Fair Deal (1948)
 - Defeated with virulent AMA opposition

Marmor, Ted,
The Politics of Medicare, 2000

Medicare Origins: After Truman

- Modified NHI Proposals 1950-65
 - Oscar Ewing (Federal Security Agency)– 60 day Hospital Insurance for elderly (1951)
 - Aime Forand (D-RI) bill (1958)
 - Kerr-Mills legislation (1960) – Federal aid to states for elderly poor health services
 - King-Anderson bill (1961) – 90 day HI for elderly (Kennedy's Forand successor bill)
 - John W. Byrnes bill (R-Wi) (1965) – Subsidized health insurance for elderly, including physician and drug coverage, financed by general funds

Medicare Origins: Opening the Floodgate

- Johnson landslide election 1964
 - Democratic Congress and administration
- Wilbur Mills (Ways & Means)– Medicare “3-layer cake”
 - 1965: House 307-116, Senate 70-24
 - Part A: Hospital insurance (modified 1951 Ewing proposal)
 - Payroll tax / Trust Fund (like Social Security)
 - Part B: Physician insurance (voluntary) (modified Byrnes bill)
 - Originally 50% general funds, 50% premiums
 - Medicaid (expanded Kerr-Mills - 1960)

1993 Clinton Health Security Act

- National Health Board (NHB)
- State-level Health Alliances (HA)
- Accountable Health Plans (AHP) under HA
- Mandated standard benefit package

- Employer mandate
- Individual mandate
- Global budgets → growth = CPI
 - Premium & price controls

“Managed Competition within a Global Budget”

Clinton Health Care Demise: Political Errors

- Issue postponed: OBRA 93 & NAFTA
- Assumed a political mandate
- Partisan strategy – no compromise
 - Closed Task Force / Congress excluded
- “Managed Competition” too regulative
 - Premium and price cost controls
- Insurance mandates: HIAA opposition
- Employer mandate: NFIB opposition

Ferguson, Fowler & Nichols, “The Long Road to Health Reform” & Antos, Joseph, “Lessons From The Clinton Plan”, Health Affairs, May/June 2008

Medicare Modernization Act 03: Medicare Drug Benefit

- Grassley / Baucus Senate Finance Committee compromise bill
- Compromise on delivery model design
 - Competing private PBMs vs. single regional PBM with fixed benefits & premiums
 - Final plan: competing regional plans with flexible benefits & premiums, partial risk, Federal fallback if no region plan participation
- Funded: \$400B reserve fund in 2004 budget (OMB '05 estimate: \$725B/ 10 yr.)

Ferguson, Fowler & Nichols, "The Long Road to Health Reform" H.A., May/June 08

2007 SCHIP Reauthorization: Political Test of Coverage Expansion

- SCHIP (BBA 97) - expanded child coverage
 - Kennedy-Hatch bipartisan compromise
 - Allowed state flexibility in coverage policy:
 - Parents, pregnant women, childless adults
 - Expand to recipients over 200% of poverty
- SCHIP Reauthorization 2007
 - Bush vetoed bipartisan Senate Finance Committee compromise expansion of coverage
 - Issue: Federal government role in health care
 - Republicans divided on expanding health coverage

Ferguson, Fowler & Nichols, "The Long Road to Health Reform" H.A., May/June 08

The 2008 Political Health Care Reform Landscape

- 2008 Presidential Campaign
 - Democrats (Obama)
 - Individual mandate (child)
 - Employer pay-or-play (sliding scale subsidies)
 - Low income subsidies
 - Health insurance "exchange" (like FEHBP)
 - Premium price controls / insurer profit controls
 - \$50 - 100+ B / yr
 - Republicans (McCain)
 - Premium tax credits & refunds
 - Eliminate employer tax deduction
- Long term budget: no solution

Obama Administration 8 Reform Principles (No Bill)

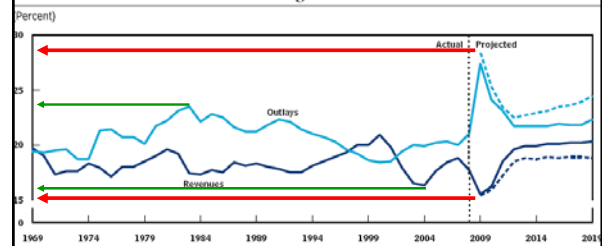
- Protect families' financial health
- Make health coverage affordable
- Path toward universality of coverage
- Portability of coverage
- Guarantee choice
- Invest in prevention and wellness
- Improve safety & quality of care
- Long-term fiscal sustainability

The Washington Environment 2009

- Forces aligned on health system reform
 - Most stakeholders echoing similar core principles and goals
 - Breaking points center on financing issues & public plan
- Democrats in charge
 - Shift in ideology away from insurers & private market solutions
 - They will reach as far as they can
- Posturing is positive, collaborative
 - Concerns about avoiding previous mistakes
- Economic downturn is not a distraction
 - Policymakers and stakeholders are drawing connections between reform and economy

Projected Federal Revenue and Expense through 2019

Total Revenues and Outlays as a Percentage of Gross Domestic Product in CBO's Baseline and the President's Budget



Note: Dashed lines represent CBO's estimate of revenues and outlays as a share of gross domestic product in the President's budget.
CBO: A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook, March, 2009

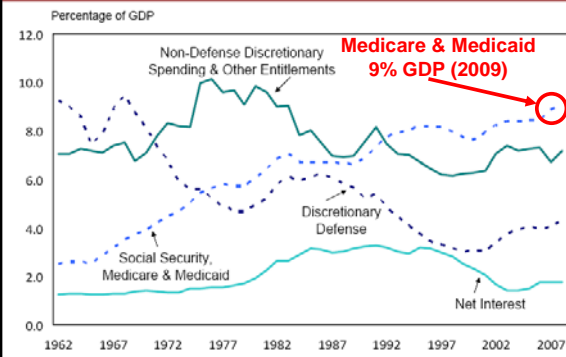
Key Elements of the President's Budget as Estimated by CBO (2010 to 2019 totals)

- Revenue reduction: \$2.1 trillion.
 - Extend elements of 2001/2003 tax cuts: \$1.9 trillion.
 - Index AMT: \$450 billion.
 - Other proposals: \$250 billion *increase*.
- Programmatic outlay increase: \$1.7 trillion.
 - Refundable tax credits: \$500 billion.
 - Adjust Medicare physician payments: \$300 billion.
 - Defense discretionary: \$150 billion.
 - Other (about half nondefense discretionary): \$800 billion.
- Resulting net interest increase: \$1.0 trillion.

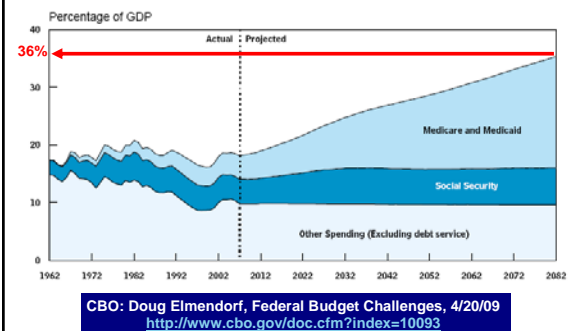
President's Budget (as Estimated by CBO) in Historical Context

- In 2019, revenues close to pre-recession share of GDP and historical average share of GDP.
- In 2019, spending on all programs except Soc. Sec., Medicare, and Medicaid below pre-recession share of GDP and historical average share of GDP.
- But spending on Social Security, Medicare, and Medicaid continues to rise rapidly as share of GDP.
- Result: Budget deficits large and rising (and self-reinforcing through rising interest burden).

Federal Outlays by Category



Federal Spending Under CBO's Alternative Fiscal Scenario



First Salvo: SCHIP Reauthorization

- Joint Federal/State health care program
 - States determine design of program, benefit packages, eligibility, provider reimbursement, etc.
- HR 2, "Children's Health Insurance Reauthorization Act of 2009" Feb. 4, 2009
 - Extends program for 4 ½ years; total funding \$69B paid for by tobacco tax and ban on specialty hospitals
 - Expands coverage/eligibility up to 300% of poverty level (\$63,600 for family of 4); covers 11m kids (up from 7m)
 - Eliminates 5 year waiting period for legal aliens

Economic Stimulus Package

- American Recovery and Reinvestment Act (HR 1) – Friday, February 13th, 2009
- Key Health Provisions:
 - Health Information Technology = \$20B
 - Comparative Effectiveness Research = \$1.1B
 - COBRA health insurance coverage = \$30.3B ('08-'09)
 - Scientific Research support (multiple agencies, including NIH, CDC, others) = \$8B
 - Primary Care Improvements = \$6B
 - Medicaid '08 – '10 = \$87B

Passage of this legislation may slow momentum for larger health system reform

Potential Sources of Proposed Health Care Reform Financing

- Expected cost: \$1 – 2 Trillion / 10 yrs.
- ? Savings:
 - HIT, primary & preventive care, “medical home”, P4P
 - Medicare hospital \$ reductions: 1% annual update cut, high \$ geographic area cuts
 - Reduced Medicare Advantage payments by competitive bidding (\$177B/yr)
- “Sin taxes”: tobacco, alcohol
- Eliminate employer-sponsored health benefit tax exemption (\$246B / yr.)
- Employer / individual mandates

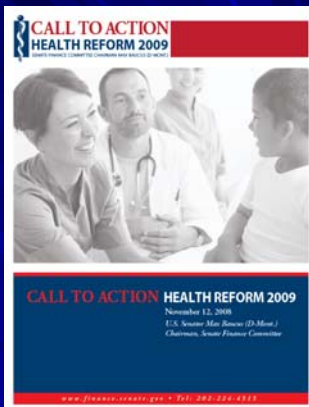
Oberlander, Jonathon, “Picking the Right Poison – Options for Funding Health Care Reform. NEJM 360: 2045 – 2048, May 14, 2009

Key Congressional Committees with Jurisdiction in Health Care

- Senate
 - Finance (Max Baucus – chair)
 - HELP: Health, Education, Labor, and Pensions (Edward Kennedy – chair)
- House
 - Ways & Means (Chas. Rangel – chair)
 - Health Subcommittee (Stark – chair)
 - Energy & Commerce (Henry Waxman – chair)
 - Health Subcommittee (Frank Pallone – chair)

Senate Finance Committee Frames Health Care Reform Debate

Released November 12, 2008



Baucus – Senate Finance Committee

- “Call to Action: Health Care Reform 2009”
 - Health Insurance Exchange – insurance pool (FEHBP model)
 - Guaranteed issue
 - New public plan option
 - Medicare buy-in: age 55-64
 - Phase out 2 year waiting period
 - Medicaid expansion – for all below 100% FPL
 - SCHIP – all children up to 250% FPL
 - Employer mandate – except small employers
 - **Primary care expansion - budget neutrality**
 - **Comparative effectiveness research**
 - Independent Health Coverage Council

Strengthening primary care and chronic care management

1. Ensuring Accurate Payments for Primary Care Services
 - a. Payments for PCP visits undervalued compared to surgical services
 - b. Rapid growth in volume is evidence that RVUs should be reviewed – = **Reduce Surgical Fees**
 - E.g. Spine codes 22214, 22533, 22843, 22849, 22851, 63056
 - c. PCPs disadvantaged at RUC – **READ More seats**
 - d. Fee schedule rates must accurately reflect health care system priorities – = **More \$ for PCP; less for Surgeons**

Strengthening primary care and chronic care management

2. Additional Payments for PCPs
 - a) Increase value of primary care E&M services
 - b) PCP bonus payments

MUST BE BUDGET NEUTRAL
3. Patient Centered Medical Home
 - a) Expand demos to private payers & Medicaid
 - b) Financial assistance to PCP practices to adopt HIT

Refocusing Payment Incentives Toward Quality

1. Physician Quality Reporting Initiative (PQRI)
 - a) Expand support for clinical data-outcome registries
 - e.g. AANS/CNS Neuropoint Alliance
 - b) PQRI should work w/certification boards to encourage more frequent and more aggressive recertification processes
 - Not just quality reporting, but focus on actual MD performance
 - c) Current positive PQRI bonus payments eventually will **"be matched with payment penalties for those who do not report"**

Refocusing Payment Incentives Toward Quality

2. Provider Feedback and Episode Groupers
 - a) Evaluate resources used to treat a patient during specific episode of illness
 - b) Feedback on resource use compared to benchmarks
 - c) Ensure that episodes of care are both necessary and efficient

E.g. back pain – evaluate all resources from time patient sees PCP, imaging, PT, injections, surgery, rehab, etc. to see what is necessary and what is not

Promoting Collaboration and Accountability

1. Reducing Hospital Readmissions
 - a) Cost to Medicare \$15 billion; \$12B avoidable
2. Bundled Payments – global payment made to hospital and doctors to split
 - a) Includes first MD visit that determines surgery is necessary, all hospitals costs and all post-op costs
 - b) Who gets the check? How is it divided?

Promoting Collaboration and Accountability

3. Large Multi-Specialty Group Practices and Accountable Care Organizations
 - a) Integrated delivery systems for better efficiencies and improved coordination of total care
4. Gainsharing
 - a) Need changes to Stark and anti-kickback laws
 - b) Concerns that hospitals and providers will use lowest costs devices to save money and increase their own reimbursement from those savings

Other Elements: Financing a More Efficient Health Care System

1. Eliminate fraud, waste and abuse
2. Increased transparency
 - a) Disclosure of Physician-Industry relationships
 - b) Physician Self-Referral – disclosure of MD ownership of hospitals, ASCs, imaging
 - c) Public reporting of costs and quality -- more educated consumers will consume more cost effectively
3. Medical malpractice reform – health courts, early offer, administrative compensation system
4. Reduce payments to Medicare Advantage Plans

Predictions

1. **LOTS** of activity – hearings, speeches, debates, lobbying, PR campaigns, etc. in 2009; no action
2. Late in 2009 – temporary Medicare physician payment "fix" to prevent 21% cut passes
 - **WITH POISON PILLS**