

Health Reform Talk – January 2010

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INTRODUCTION

It is a natural human tendency to characterize complex systems according to the role these systems play in our lives. Take health care for example: Medicare recipients have one view, Medicaid another, children still a different perspective, and for those who must pay the costs themselves, health care services are often a nightmare.

On the other hand elected officials are forced to consider the effects of complex systems on groups or citizens. This dynamic between the perceptions of individuals and the requirement of government to consider “populations” is one of the factors underlying the disagreements in Congress. Add to this the reality of big league power politics, enormous sums of money, special interest groups and an ever deepening partisan divide and we have a witch’s brew that can bring almost any proposal to its knees.

So what is it that we are attempting to “reform?” Simply put, reform is addressing issues of the delivery of health care and how it is financed. And within

both of these lies a crucial question: to what extent should every resident of our country have access to the delivery of health care services?

I would like to speak for four or five minutes about the (1) delivery and (2) financing of health care here in New Hampshire before moving on to ask (3) what will happen to us if health reform efforts fail, followed by an examination of (4) where the US Senate and House agree, where the two legislative bodies disagree and (5) conclude with some reflections about the future of reform efforts. Then, I hope we can begin a dialogue, ask some questions, add to what I have said or express an opinion.

BROAD VIEW OF HEALTH CARE SERVICES IN NH

- 26 Hospitals and attendant primary practices
- 11 Community Health Centers
- 10 Community Mental Health Centers
- 68 Long Term Care facilities
- 1 State Hospital
- 50 Home Health Agencies
- Dozens of others as for example services provided by Harbor Homes in Nashua.
- Specialized organizations such as the Institute on Disabilities

HOW THIS IS PAID FOR IN NH (\$8 Billion Annually)

- About 50% and 55% of this sum is paid by tax dollars

- Medicare
- Medicaid (half federal and half state) – Significantly Underpays
- Public Employees and retirees
- Federal – State – Counties (SSI for example) State Hospital
- Employer based insurance
 - Wellpoint (Anthem)
 - Harvard Pilgrim
 - CIGNA
 - MVP
- Self Pay

Here is one example of how health insurance works and one of the reasons I suggest to you that the way we pay for health care in New Hampshire reflects a broken economic model.

- Procedure: Gall Bladder Surgery (outpatient) (Source NH Department of In Insurance Plan: Anthem - NH, Health Maintenance Organization (HMO) Within: 20 miles of 03049ⁱ Deductible and Coinsurance Amount: \$1,000.00 / 0% Source www.nhhealthcost.org/)

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity	Contact Info
THE SURGICENTER AT ST JOSEPH	\$1000	\$6305	\$7305	LOW	MEDIUM	THE SURGICENTER AT ST JOSEPH 603.882.3000
PARKLAND MEDICAL CENTER	\$1000	\$6499	\$7499	HIGH	MEDIUM	PARKLAND MEDICAL CENTER 603.432.1500
ELLIOT HOSPITAL	\$1000	\$8673	\$9673	LOW	MEDIUM	ELLIOT HOSPITAL 603.669.5300
ST JOSEPH HOSPITAL	\$1000	\$8862	\$9862	MEDIUM	VERY HIGH	ST JOSEPH HOSPITAL 603.882.3000
SOUTHERN NH MEDICAL CENTER	\$1000	\$9666	\$10666	MEDIUM	LOW	SOUTHERN NH MEDICAL CENTER

						603.577.2000
CATHOLIC MEDICAL CENTER	\$1000	\$10064	\$11064			

Surgery (outpatient) Uninsured

Procedure: [Gall Bladder Surgery \(outpatient\)](#)

Within: 20 miles of 03049

Lead Provider Name	Median Charge Amount For Procedure	Median Charge Less 15% Uninsured Discount	Typical Patient Complexity	Contact for Patient Financial Services
THE SURGICENTER AT ST JOSEPH	\$12474	\$10603	MEDIUM	<u>THE SURGICENTER AT ST JOSEPH</u> 603.882.3000
SOUTHERN NH MEDICAL CENTER	\$13089	\$11126	LOW	<u>SOUTHERN NH MEDICAL CENTER</u> 603.577.2000
DARTMOUTH HITCHCOCK SOUTH	\$13348	\$11346	MEDIUM	<u>DARTMOUTH HITCHCOCK SOUTH</u> 800.238.0505
ELLIOT HOSPITAL	\$13857	\$11778	MEDIUM	<u>ELLIOT HOSPITAL</u> 603.669.5300
PARKLAND MEDICAL CENTER	\$16445	\$13978	MEDIUM	<u>PARKLAND MEDICAL CENTER</u> 603.432.1500
ST JOSEPH HOSPITAL	\$17147	\$14575	VERY HIGH	<u>ST JOSEPH HOSPITAL</u> 603.882.3000
CATHOLIC MEDICAL CENTER	\$18654	\$15856	MEDIUM	<u>CATHOLIC MEDICAL CENTER</u> 800.437.9666

- Health Care costs in New Hampshire are the third highest in the US
- Health Care expenditures have risen to 18% of the Gross State Product (GSP)
- Health Insurance Premiums have doubled since 2000 while wages have flattened

- Livable Wage \$21,683 to \$48,625, again depending on the type of family.ⁱⁱ
- We are the 5th wealthiest state in the country.

WHAT NOW IN NH IF HEALTH REFORM FAILS?

- Current number of uninsured residents (currently 157,000 of whom at least 70% are employed) will continue to grow.
- The growing number uninsured (and underinsured) will, by virtue of cost shifting, drive premiums steadily higher.
- Wages will continue to be flat as premium growth outstrips wage growth.
- As a consequence of rising premiums, local taxes will increase as negotiated health benefits come due. There will be increasing divisiveness between citizens and teachers and public servants.
- Hospitals will increasingly struggle to stay afloat.
- Health care expenditures will continue to consume more of the GSP until the economy revives.
- Continued reductions in Medicaid payments will decrease the volume of care for those with severe and persistent mental illness.
- Primary care resources will continue to diminish.

WHERE BOTH HOUSE AND SENATE AGREE ⁱⁱⁱ

- Where the Senate and House Agree
 - Subsidies for lower-and middle-income people to buy insurance.
 - Expansion of Medicaid (Hotly contested by governors). **House^{iv}** - Expand to 133% of Federal Poverty Level FPL. Fully financed by Federal Gov beginning in 2014 through 2016. Beginning in 2017 States the present formulas resume. **Senate^v** – Expand to 150%. Federal match through 2014 then 91% financing beginning in 2015.
 - Creation of “Exchanges.” House^{vi} Senate^{vii}
 - Mandate that Americans must carry health insurance or face a fine

- Cuts in Medicare to finance expansion (Medicare Advantage)
- Eliminate pre-existing conditions and caps on coverage

WHERE BOTH HOUSE AND SENATE DISAGREE ^{viii}

- Where the House and Senate Disagree
 - Public Option – Now deceased
 - Abortion
 - **Taxes: House** 5.4% income surtax on individuals making more than \$500,000 or couples earning more than \$1,000,000; **Senate** 40% excise on “Cadillac” plans valued at more than \$23,000 (open to negotiation) for a family or \$8,500 for individual
 - **Employer Requirement:** (Crucial for NH) **House:** employers with greater than \$750,000 in payroll must provide health insurance or pay a fine of 8%. Smaller employers pay a fine based on size; some pay none. **Senate:** Employers with more than 50 employees pay a fine of \$750.00 per employee and employees get federal subsidy to buy insurance.
 - **Medicare Board: House:** No. **Senate** Independent board empowered to recommend changes to Medicare spending
 - **Tax on medical-device makers: House:** 2.5% tax on medical-device makers beginning in 2013. **Senate:** \$2-billion a year tax beginning in 2011.

Senate Components – not sure about House

- Medical Home Pilot projects
- Accountable Care Organizations Pilots (ACOs)
- Expansion of Primary Care Providers
- Increased payments for Primary Care Providers
- Small Business Tax Credits (Senate)^{ix}
- Expanded Medicaid for people with disabilities (Senate)

- Medicare Part D “Doughnut Hole” will be halved
- Comparative Effectiveness Research^{x xi}

It is very difficult at this point to see the response of the opposition to these sections of the bills as they stand today. It seems to me, however, in looking at the current Senate and House versions of reform that there is ample opportunity for compromise.

FUTURE OF REFORM

Here in New Hampshire there is reason to hope that we can control the rise in the cost of health care by a number of pioneering efforts. These include:

- Patient Medical Home Pilot Project
- The Medical Home Project
- The initiative by the city of Keene to become the healthiest city in America by 2020.
- The Heal (Healthy Eating/Active Living) Project
- An evolving discussion along the lines of the Public Utilities Commission but related to health care pricing.
- The development of new health care “Systems” such as the planned “Affiliation” between the Dartmouth Hitchcock Medical Center and the Catholic Medical Center in Manchester.

References

ⁱ New Hampshire Depart of Insurance “New Hampshire Health Cost: <http://www.nhsbdc.org/LW2006/index.html>

ⁱⁱ <http://www.nhsbdc.org/LW2006/index.html> 2006 Study New Hampshire Small Business Development Center.

- Basic needs are defined as:
- _ food
- _ rent

- _ utilities
- _ basic telephone service
- _ clothing and household expenses
- _ transportation by automobile
- _ child care
- _ health care
- _ a small allowance for personal expenses

ⁱⁱⁱ Hitt G., and Adamy J. *The Health-Care Overall. Senate, House to Haggle over Differences.* Wall Street Journal. Saturday/Sunday, December 26-27, 2009 pg. A4

Note – The following notes are taken from
<http://www.healthreform.kff.org/>

^{iv} **House** Provide refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to 2.8% of income for those at 100% FPL to 9.8% of income for those between 300-400% FPL, except that for those with incomes between 100 and 133% FPL, the premium contribution is limited to 2% of income. (These are the provisions as drafted; however, individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.)

- Increase the premium contributions for those receiving subsidies annually by the rate of premium growth from the preceding year.
- Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.

^v **Senate** Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers:

133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 – 5.5% of income 200-250% FPL: 5.5 - 8% of income 250-300% FPL: 8 - 10% of income
 300-350% FPL: 10 - 11% of income 350-400% FPL: 11 - 12% of income (Effective January 1, 2013)

- Index the affordability premium credits after 2013 to maintain the ratio of government to enrollee shares of the premiums over time.

^{vi} **House** Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)

- ^{vii} • **Senate** Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option.
- Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.

^{viii} Hitt G., and Adamy J op.cit

^{ix} Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit for up to two years. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than \$80,000 per year. (Effective January 1, 2013)

^x **House** Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)

^{xi} **Senate** Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. (Effective FY 2010)