By mid-June, the shapes in the fog have been emerging in the Senate Healthcare Reform proposals. The stakeholder coalition of providers, insurers, consumers, and employers that were all on stage at the White House “photo op” is starting to fray. One after the other, the list of “must haves” is spooling out. With partisan tensions high and interest group organizing mounting, the art of compromise is going to be very difficult on this massive bill. President Obama is directly engaged in the process, saying that reform is central to the economic recovery, as it will affect one-sixth of the federal budget and 1 of 10 jobs in the US economy.

**How Much Reform?**

The question everyone is asking is, “Will healthcare reform be enacted?” It must, and it will. The real question is how much reform and coverage of the uninsured we will get.

By the third week of June, the Senate Committee on Health, Education, Labor, and Pensions proposal—still thin in its details—was dealt a blow in Congressional Budget Office (CBO) scoring of $1.3 trillion, to only cover 16 million to 19 million of the 46 million uninsured Americans. The US Senate Finance Committee went back to the drawing board, postponing a markup until after the July 4 holiday, and slowing the momentum of the effort.

Some form of healthcare reform legislation will pass in 2009. The new administration and the Democratic majority in Congress have placed too high a priority on getting a bill done this year to fail to act.

The president has set aside a reserve fund of more than $900 billion that involves large cuts to Medicare and Medicaid payments, which can be used to fund some form of coverage expansion. Tax reform offers another payment option. The president opposed tax changes during the campaign but has softened his opposition in view of the increasing cost estimates for comprehensive healthcare reform and the large amount of tax dollars that could be available by capping or repealing the deduction for employer-provided healthcare benefits. And as a last resort, the budget resolution includes a fallback option that could use a budget reconciliation process requiring only a majority vote in Congress to reduce the ranks of the uninsured.

One issue complicating the healthcare reform effort is the proposal for a public plan option. The White House is trying to calm the fears of the insurance and the pharmaceutical industries, who are concerned that a public plan will have a competitive edge to attract large enrollments, by paying providers discounted rates (eg, Medicare fee schedules) and operating at lower administrative costs, without the need to market its products or to generate a profit. In addition, both industries fear that large enrollment in a public plan would enable the government to negotiate substantial discounts on drug prices.

A number of compromises are being discussed, such as setting a “trigger” for the public plan, not unlike the fallback plan originally contemplated for Medicare Part D. Other options include regional cooperative plans run by members rather than by the government, or plans run by states and meet the same solvency requirements and pay providers the same as private-sector plans. We do not view a public plan as an essential part of healthcare reform, and we expect that there will be a solution that few will be happy with.

**Medicare Part D Issues**

The discussion of a public plan has temporarily taken the heat off 2 Medicare Part D issues that were discussed in the last Congress—(1) closing the Medicare Part D coverage gap, and (2) providing the government with authority to negotiate the price of Part D drugs. Closing the Part D coverage gap seems like a dream, with a price tag of $134 billion over 10 years, but the US House of Representatives has included it on their healthcare reform list.

The broader public plan issue in the overall healthcare reform debate seems to have replaced the discussion on a government-run Part D plan. Since CBO scored no savings for a Part D government negotiating authority last time, the Democrats have been discussing several other ways to reduce Part D costs, including ensuring that Medicare Part D pays no more than Medicaid for drugs for beneficiaries eligible for Medicare and

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**The View from Washington: Healthcare Reform**

John Gorman, Chief Executive Officer, Gorman Health Group
Medicaid, or providing Medicare Part D with the same minimum rebate—of 15%—as Medicaid for brand-name drugs.

**PhRMA's Surprise Move**

In a surprise move, the Pharmaceutical Research and Manufacturers of America (PhRMA) just announced that its member companies would voluntarily provide a 50% discount to most beneficiaries using brand-name drugs purchased during the Medicare Part D coverage gap. In addition, the full cost of these drugs, without discounts, would be counted toward the beneficiary's out-of-pocket spending cap, thus further reducing beneficiary costs. Although the PhRMA proposal may not produce as many savings as CBO scored for extending the Medicaid rebate throughout the Medicare Part D benefit ($143 billion over 10 years), this may present a win-win compromise.

**Medicare Advantage**

One issue on which everyone seems to agree is the inevitability of Medicare Advantage (MA) plan payment cuts. There are 2 major proposals on the table—a competitive-bidding approach that was included in the president's budget, and a modification of the current administrative pricing formula. The goal is to reduce MA payments to 100% of Medicare fee-for-service levels over several years. The cuts range from $159 billion for competitive bidding over 10 years to $79 billion for a gradual phase-down. One proposal would provide bonus payments to plans that implement care coordination programs and quality improvement mechanisms. We expect that the competitive-bidding option, which CBO estimates will cut MA enrollment by 30%, will be perceived as too draconian and too problematic to administer, so that Congress will adopt a more moderate plan, such as a phased reduction to parity, which will allow efficient MA plans to remain in markets where they can compete with fee-for-service and Medigap.

It is important to remember that the strengths of the MA program are the cornerstones of reforming the Medicare fee-for-service program, and even as the building blocks of healthcare reform; these include:
- Coordinated care
- Quality improvement programs
- Chronic care management
- Capitated payment.

All these functions will receive greater regulatory attention, regardless of the outcome on Capitol Hill, and will provide a framework for regulating a reformed commercial market in a health insurance exchange.

**Means-Testing Premium**

Another Medicare issue that is expected to pass is means testing of the Medicare Part D premium. This proposal was included in the president's 2010 budget and is supported by Democrats and by Republicans. Congress has already enacted a means-tested premium for Medicare Part B. Under this proposal, Congress would be expected to use the same premium formula currently used for Medicare Part B, which includes adjustments for inflation. For example, beneficiaries who have income of more than $213,000 would pay a Part D premium of 80% of Part D's projected per-capita costs. If the formula does not adjust for inflation, more Medicare beneficiaries would be affected, and the 10-year savings will be $10 billion. The CBO estimates that approximately 6% of Medicare beneficiaries would be affected, and that about 1% of beneficiaries would decline to enroll or delay enrollment in Medicare.

**Physician Fee Schedule**

The final overarching Medicare issue on the table is to find a permanent fix for the Medicare physician payment fee schedule. Under the sustainable growth rate formula, if total Medicare payment to physicians does not meet certain targets, then fee schedules need to be reduced. Last year, Congress was able to find the funds to avert a 10% cut in physician payments, but next year the cuts are scheduled to reach 21%. The cost of this fix is very high, estimated at $318 billion over 10 years to freeze physician payment and $556 billion to provide an annual update.

These costs are substantially higher than the worst case scenario for MA payment cuts. But Congress does not want to revisit this issue every year, and it has created a backlash in the physician community, with physicians starting to turn away Medicare beneficiaries. Fixing the Medicare fee schedule is essential for assuring provider support of healthcare reform.

The path to enactment is likely going to be decided by pay-as-go enforcers in the middle, including a handful of Republican Senate votes. This will inherently limit the size of the package. The “pack psychology” here seems to be coalescing around a bill costing $1 trillion that would be paid for with cuts to other programs or providers. Public clamor for the issue seems stale, but the president is insistent, and the majority in Congress wants to deliver—for the legacy of Senator Ted Kennedy as much as for anyone else. At his core, President Obama is a pragmatist, and he will go as far to the left as he can to still win. So again, the question is how much reform we will get. It seems certain we will know this year.