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The Good News

MARCH 22, 2010

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The Good News

After a feisty year of debate, Congress has passed health care reform legislation. Once enacted, it will increase the numbers of Americans with health insurance as well as both the size and scope of government. There's plenty to understand and argue about – but the first thing we need to understand is that it presents some wonderful opportunities … if we understand where they are and can develop the tools to exploit them.

So here's the good news – the most powerful tool to improve both access to and quality of American health care is innovation.

We have to embrace innovative technologies for medical records and prescribing. We need innovative clinical trial designs and molecular diagnostics so that we can develop better, more personalized medicines faster and for far less than the current $1 billion plus delivery charge. We need innovation in access and reimbursement policies that rewards speed-to-best-treatment rather than more lower-cost patients per hour.

Will more people have access to health insurance? They will and that's a good thing. But, let's be honest, we're not talking about erasing the word "uninsured" from the American health care dictionary – we're just redefining what it means.

WHAT WILL IT REALLY COST?

We have to embrace the likely reality that we will all pay more in taxes (yes, all of us) eventually. And, ultimately, we will be okay with that. Americans are always willing to do what's right for their fellow citizens. As Winston Churchill said, "Americans always want to do the right thing – after they have tried everything else." Even so, many of our fellow Americans will receive less comprehensive health care benefits than they are receiving now.

That being said, let's look at the numbers.

The Congressional Budget Office estimates that health care reform will, over the next 10 years, cost about $950 billion, but because it would raise some revenues and lower some costs, it would also lower federal deficits by $138 billion.

Yet according to Douglas Holtz-Eakin (director of the Congressional Budget Office from 2003 to 2005), if you strip out all the gimmicks and games and rework the calculus, a wholly different picture emerges: The health care reform legislation would raise, not lower, federal deficits, by $562 billion. Now that the politicking is over (at least hopefully), we need to take off our partisan blinders and have a hard look at the budgetary assumptions.

The first issue is that the bill front-loads revenues and back-loads spending. The taxes and fees it calls for are set to begin immediately, but its new subsidies would be deferred so that the first 10 years of revenue would be used to pay for only six years of spending.

Some costs are left out entirely. To operate the new programs over the first 10 years, future Congresses will need to vote for $114 billion in additional annual spending. But this so-called discretionary spending is excluded from the Congressional Budget Office's tabulation.

Then there's the $70 billion in premiums expected to be raised in the first 10 years for the legislation's new long-term health care insurance program. This money is counted as deficit reduction, but the benefits it is intended to finance are assumed not to materialize in the first 10 years, so they appear nowhere in the cost of the legislation.

Also included in the health reform legislation is a government takeover of all federally financed student loans is rolled into the bill because it is expected to generate $19 billion in deficit reduction.

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The legislation proposes to trim $463 billion from Medicare spending and use it to finance insurance subsidies. But Medicare is already in the red, and the health care bill has no reforms that would enable the program to operate more cheaply in the future. Instead, Congress is likely to continue to regularly override scheduled cuts in payments to Medicare doctors and other providers.

The legislation will use $53 billion in anticipated higher Social Security taxes to offset health care spending. Social Security revenues are expected to rise as employers shift from paying for health insurance to paying higher wages. But, according to Holtz-Eakin, if workers have higher wages, they will also qualify for increased Social Security benefits when they retire. So the extra money raised from payroll taxes is already spoken for and cannot be used for lowering the deficit. The day the President signs this into law could be viewed by a near-future generation of Americans as a day of financial infamy -- if we let it.

But, let's be honest, we're not talking about erasing the word "uninsured" from the American healthcare dictionary – we're just redefining what it means.

CHANGE IS HARD

Woody Allen said that we should always expect change –except from vending machines. But a more germane thought comes from W. Edwards Deming who said that "Change is not required. Survival is not mandatory."

That being the case, we'd better start taking innovation – both incremental and discontinuous – seriously. That means spending more on harder developmental R&D (with concomitant higher investment risks). In this regard, the new legislative language on the development of FOBS (follow-on biologics or, if you prefer, biosimilars) is a good thing. (And don't ever call them generic biologics!) Twelve years of patent exclusivity both protects investment and incentivizes innovation.

The bill pays lip service to the need for more robust comparative effectiveness – although this is a battle yet to be either defined (comparative effectiveness or cost effectiveness or clinical effectiveness?) or fought (do we need a U.S. version of NICE?). And a battle royal it will be. In addition, there's as yet-to-be reconciled language on a Medicare advisory board that could very well morph into a national formulary body. L'audace, l'audace, toujours l'audace. This isn't even the end of the beginning.

Of course we bid adieu to the infamous Medicare Part D Doughnut Hole. Pax vobiscum. The Medicare prescription drug benefit is coming in hundreds of millions of dollars under budget already and consistently has 90 percent plus approval ratings by America's savvy seniors.

DEATH PANELS. REALLY?

Over the past year, we spent a lot of wasted time throwing around terms like "death panels" but, at the end of the day, we didn't even begin to address the elephant-in-the-room issue of how much of our national treasure we spend on end of life care. We will have to address this highly volatile and divisive issue – and sooner rather than later.

The legislation doesn't do anything really significant about driving young, healthy people into the insurance pool. The penalties (which don't even kick-in right away – the demographics and politics aren't too hard to figure out) actually disincentivize youthful participation. After all, why not pay the monthly penalty (which is less than even a very affordable monthly insurance premium) if, when you do face a medical emergency, you can't be turned down or charged more? Nor does the bill create any sort of national insurance pool – where we can all benefit from a 50-state economy of scale insurance marketplace.

Some of the best things about the bill are what is does not do. No drug importation. And the Non-Interference Clause remains the law of the land. When originally drafted (wisely by then Senators Daschle and Kennedy), we knew then what we need to remember now, that (1) direct government negotiations for Medicare drug prices won't (according to numerous government studies and leading economists) lower Medicare drug prices and (2) it is the next slippery step towards even broader price controls. And price controls equal choice controls.

WHO WINS?

Cui bono? As The New York Times reports, "With a sweeping overhaul of the nation's health care system, Congress would be giving the health care industry as many as 32 million additional paying customers in the next few years. That would mean millions more Americans buying private health insurance and better able to pay for their hospital stays, doctors' visits, prescription drugs and medical devices."

About 16 million of the newly insured are expected to enroll in private insurance plans and this newly insured population is expected to decrease significantly the amount that hospitals now lose each year when they provide care to people with no means to pay.

But, according to the Times, "The expanded enrollments in the low-income Medicaid program could be a mixed blessing, analysts say, because Medicaid typically pays hospitals less than the actual cost of care. So the question becomes whether hospitals were already treating many of these patients without any reimbursement at all, or whether they will now see an influx of new money-losing Medicaid customers."

(Hospitals agreed to help defray the costs of the legislation by agreeing to contribute $155 billion over 10 years, largely by accepting lower payments under the Medicare program for older Americans.)

Pharmaceutical companies will contribute $85 billion toward the cost of the bill in the form of industry fees and lower prices paid under government programs over 10 years, but can look forward to tens of billions of dollars in additional revenue as more people with insurance visit doctors and fill prescriptions.

FOCUS ON THE POSITIVE AND THE PRAGMATIC

But let's not focus on commercial winners and losers. Let's keep our eye on the prize. No, not the November elections – the real prize: better access to health care for all Americans. Innovation that focuses on creating a chronic health care culture that embraces prevention and prophylactic care. We will not survive as a nation of obese, hypertensive diabetics. Rather than wasting time on spin, let's redouble our efforts on innovation. Then, when we succeed through brainpower and teamwork (and, hopefully some civil bipartisanship), the circus surrounding this vote and the past year's partisan political warfare will be but a footnote in American political history.

Yes we can.

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Healthcare Reform Highlights*

COVERAGE

- Subsidies begin for small businesses to provide coverage to employees.
- Insurance companies barred from denying coverage to children with pre-existing illness.
- Children permitted to stay on their parents' insurance policies until their 26th birthday.

COVERAGE

- Set up long-term care program under which people pay premiums into system for at least five years and become eligible for support payments if they need assistance in daily living.

TAXES AND FEES

- Drug makers face annual fee of $2.5 billion (rises in subsequent years).

TAXES AND FEES

- New Medicare taxes on individuals earning more than $200,000 a year and couples filing jointly earning more than $250,000 a year.
- Tax on wages rises to 2.35% from 1.45%.
- New 3.8% tax on unearned income such as dividends and interest.
- Excise tax of 2.9% imposed on sale of medical devices.

COST CONTROL

- Medicare pilot program begins to test bundled payments for care, in a bid to pay for quality rather than quantity of services.

COVERAGE

- Create exchanges where people without employer coverage, as well as small businesses, can shop for health coverage. Insurance companies barred from denying coverage to anyone with pre-existing illness.

- Requirement begins for most people to have health insurance. Subsidies begin for lower and middle-income people. People at 133% of federal poverty level pay maximum of 3% of income for coverage. People at 400% of poverty level pay up to 9.5% of income. (Poverty level currently is about $22,000 for a family of four.)
- Medicaid, the federal-state program for the poor, expands to all Americans with income up to 133% of federal poverty level.
- Subsidies for small businesses to provide coverage increase. Businesses with 10 or fewer employees and average annual wages of less than $25,000 receive tax credit of up to 50% of employer's contribution. Tax credits phase out for larger businesses.

TAXES AND FEES

- Employers with more than 50 employees that don't provide affordable coverage must pay a fine if employees receive tax credits to buy insurance. Fine is up to $3,000 per employee, excluding first 30 employees.
- Insurance industry must pay annual fee of $8 billion (rises in subsequent years).

COST CONTROL

- Independent Medicare board must begin to submit recommendations to curb Medicare spending, if costs are rising faster than inflation.

TAXES AND FEES

- Penalty for those who don't carry coverage rises to 2.5% of taxable income or $695, whichever is greater.

COVERAGE

- Businesses with more than 100 employees can buy coverage on insurance exchanges, if state permits it.

TAXES AND FEES

- Excise tax of 40% imposed on health plans valued at more than $10,200 for individual coverage and $27,500 for family coverage.

**Courtesy of the Wall Street Journal, March 22, 2010*