



HEALTH CARE 2009

Congressional Action on Health Care Reform — An Update

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The pursuit of health care reform continues to gather steam, as Democrats, with a nudge from President Barack Obama, set an ambitious target for action — House and Senate passage of mea-

asures by July 31. At the same time, legislators intensified their discussions about how far the government should extend its regulatory reach into the health care system, and two new reports underscored the necessity of embedding cost-cutting policies in any reform proposal. The reports document the deterioration of Medicare's financial condition and state government revenues — developments that complicate the challenges faced by Democrats, who are poised to spend hundreds of billions more to expand coverage, and by state governors, whose funds are already stretched by their Medicaid programs.

On May 14, after securing a commitment from House Democratic leaders, Obama announced

that the party had established an accelerated timetable for action on health care reform: passing a measure through the House by July 31, a time frame that matches the Senate's. Obama, who is aiming to sign a reform measure into law in 2009, said: "As all Americans know, our health care system is broken. It's unsustainable for families, for businesses. It is unsustainable for the federal and state governments. . . . The fact of the matter is that the most significant driver by far of our long-term debt and our long-term deficits is ever-escalating health care costs."

Medicare's overseers said in their annual assessment, released May 10, that the program's hospital trust fund would run out of

money by 2017 — 2 years sooner than was projected a year ago — unless its policies are changed.¹ According to another report, overall tax collections in 47 states declined by 12.6% (about \$20 billion) in the first quarter of this year, increasing the pressure on these governments to cut back their Medicaid programs and slow their health care reform efforts.² Lucy Dadayan, a coauthor of the state report, predicted that revenue collections will deteriorate further in the second quarter, given declines in the financial markets and in income-tax revenues.

Proposals taking shape under the Democratic chairmen of the five relevant congressional committees call for tighter regulation of the private insurance market, creation of a national health insurance exchange that would enable small businesses to buy more affordable insurance chosen from a variety of options, and expansion of Medicaid to cover addi-

tional low-income families. These measures, plus the creation of a public insurance plan designed to compete against private carriers, largely track the administration's vision of reform. The committees have not yet seriously grappled with the question of how to eliminate the 21% reduction in Medicare's physician fees scheduled for next January, but they recognize that they must do so if organized medicine is to support reform.

Among the five committees, Democrats who chair the three House panels (Education and Labor, Energy and Commerce, and Ways and Means) have been the most secretive about their proposals. Republicans have not participated in developing these proposals, nor have members of the House Blue Dog Coalition, 50 moderate-to-conservative Democrats whose votes on a reform measure will eventually be sought. The coalition's members complained about their lack of input in a letter to the three committee chairs — Representatives George Miller (D-CA), Henry Waxman (D-CA), and Charles Rangel (D-NY), respectively — and contrasted it with “the collaborative approach being taken by our Senate colleagues.”

The letter, and perhaps other factors, prompted Waxman to hold a briefing to discuss reform issues with his committee's Democratic members. Though it was a closed-door discussion, a participant reported that the panel's Democratic members favor health care reform requiring “shared responsibility” among individuals, employers, and government — language that also resonates with many Republicans, though they have less prescriptive ideas for implementing it. Individuals would be held responsible for obtaining coverage and, if they are em-

ployed in businesses with fewer than 10 workers the first year, 20 employees the second year, and eventually large firms, could purchase it through a new national health insurance exchange in which all insurers would participate. Federal subsidies that are scaled according to income — up to 400% of the federal poverty level, or \$88,200 for a family of four — would be available, and there would be an annual cap on out-of-pocket spending for enrollees.

The committee's Democrats reportedly support the imposition of a “play-or-pay” requirement on larger businesses, which would have to either provide coverage to full-time employees and their dependents or contribute a percentage of their payroll to an insurance-coverage pool. They also favor expanding Medicaid, which covered some 60 million low-income adults and children at one time or another in 2007; Waxman has long been Medicaid's champion in Congress.

Waxman's panel also reportedly proposes to create a public insurance plan designed to compete against private insurers, devise a public-private advisory committee that would recommend benefit packages based generally on the Federal Employees Health Benefits Plan, and increase support for the primary care, nursing, and public health workforces, as well as community health centers. Perhaps responding to Republicans' strong opposition to a public plan, the Democrats reportedly said that such an entity would be subject to the same market reforms and consumer protections as private insurers. It would also operate independently of the insurance exchange, rely on insurance premiums and copayments without federal support to cover

its costs, and “build on Medicare providers and rates, similar to the practices of private plans today.”

Meanwhile, on May 14, the Senate Finance Committee met behind closed doors for a full day to review a new set of policy options put forward by chair Max Baucus (D-MT) and ranking Republican Charles Grassley of Iowa. Although this committee operates in a far more bipartisan fashion than do most others, its discussions reflected some serious differences of view, particularly regarding the creation of a public plan. But the potential for compromise on this most contentious issue may well take root between Baucus and Grassley, who have a history of striking bargains on thorny questions. Baucus is not entirely sold on the need for a new public plan, though many of his Democratic colleagues will press him to embrace the idea; Grassley opposes it. The compromise could take the form of tightened regulation of private insurers in lieu of a new public plan — an approach that might allow a reform proposal to emerge from the Finance Committee with some Republican support.

Two days before the May 14 marathon discussion, the panel held its third public roundtable on health care reform, this one on financing. One major issue under discussion was whether Congress should eliminate the exclusion of employer-sponsored insurance spending from individual income taxation. The exclusion is the government's third-largest health insurance expenditure (after Medicare and Medicaid) — about \$250 billion per year. To a person, the health economists participating in the discussion agreed that, as Jonathan Gruber of the Massachusetts Institute of Technology

put it, the exclusion is “a regressive entitlement, since . . . about three quarters of these dollars go to the top half of the income distribution.” Baucus opposes eliminating the exemption but would consider capping the benefit’s value to individual taxpayers. Congressman Rangel, chair of the House Ways and Means Committee, has said there is “no way” he would support taxing employer-provided health benefits.³

On May 18, Baucus and Grassley released a 41-page paper outlining “proposed health system savings and revenue options” the committee will consider for financing reform.⁴ The paper served as the basis for a closed-door meeting of committee members on May 20, at which they were scheduled to discuss how to raise the estimated \$1.2 trillion that reform will cost over a decade. It set out as options proposed new taxes on an array of items and organizations, including employer-sponsored health insurance benefits, nonprofit hospitals, and alcohol and sugar-sweetened drinks. It also proposed a variety of op-

tions for reducing Medicare and Medicaid expenditures.

The discussions in Congress suggest that finding the money to finance reform is the most formidable hurdle facing Democrats. Though Republicans have been largely silent to date, once Democratic reform bills are introduced, the GOP will undoubtedly attack them for adding untold billions to the mounting federal deficit and leading down a road to socialism. Recognizing this inevitable onslaught, Obama took full advantage of a pledge made by major organizations representing U.S. physicians, hospitals, health plans, and medical suppliers to do their part to reduce the growth of health care spending by 1.5 percentage points annually — saving an estimated \$2 trillion over the next decade. Though the importance of the pledge was interpreted in various ways, Peter Orszag, the director of the president’s Office of Management and Budget, took it to mean that “even doctors and hospitals agree that substantial efficiency improvements are pos-

sible in how medicine is practiced.”⁵ And there is no question that the administration will take every opportunity to hold these key stakeholders accountable for their pledge.

This article (10.1056/NEJMp0904517) was published on May 20, 2009, at NEJM.org.

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The Signature Features of Influenza Pandemics — Implications for Policy

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Vast amounts of time and resources are being invested in planning for the next influenza pandemic, and one may indeed have already begun. Data from past pandemics can provide useful insights for current and future planning. Having conducted archeo-epidemiologic research, we can clarify certain “signature features” of three previous influenza pandemics — A/H1N1 from 1918 through 1919, A/H2N2 from 1957

through 1963, and A/H3N2 from 1968 through 1970 — that should inform both national plans for pandemic preparedness and required international collaborations.

Past pandemics were characterized by a shift in the virus subtype, shifts of the highest death rates to younger populations, successive pandemic waves, higher transmissibility than that of seasonal influenza, and differences in impact in different geographic

regions. Although influenza pandemics are classically defined by the first of these features, the other four characteristics are frequently not considered in response plans.

Yet the second feature, the shift in mortality toward younger age groups, was the most striking characteristic of the 20th-century pandemics.^{1,2} Exposure to influenza A/H1 subtypes before 1873 may have offered some pro-

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