

Gail R. Wilensky

## last throes of healthcare reform 1.0

After focusing on healthcare reform for most of 2009, the House and the Senate are in the final stages of reconciling the differences among their various bills both within and between the two houses of Congress.

Although it is too early to begin the post-mortems that will surely follow the final bill's passage, a few observations are worth making even now.

### The Good

Healthcare reform in 2009 has focused primarily on reforming health insurance. Many of the changes relate to the types of insurance benefits that must be provided, where and how people can purchase insurance, the subsidies that will be provided to them, how Medicaid will be expanded, and which populations it will cover in the future. Settling these types of issues is clearly important if coverage is to be expanded to most of the 47 million currently uninsured.

Many of the issues are interdependent, and how they are resolved ultimately will determine just how many individuals are likely to become insured. Having all or almost all individuals covered makes it easier to require insurance companies to guarantee that any insurance will be issued and renewed, regardless of an individual's health status or the existence of any preexisting conditions.

But having everyone covered could mean individuals who are currently uninsured might be required to obtain coverage. Since most people would consider it unfair and unrealistic, practically speaking, to require individuals with lower incomes to buy insurance that costs thousands of

dollars without substantial subsidies, getting to full coverage will mean substantially subsidizing most of the currently uninsured.

Mandating insurance coverage is important and necessary to avoid problems with only partially subsidizing insurance for the uninsured—especially if people know that they can buy insurance at any time and cannot be denied or penalized for having waited until a medical need arises. Not having a mandate runs the risk of selection, wherein people who expect to have significant health expenditures are more likely to buy insurance than those who do not have that expectation—a problem that only drives up the cost of insurance.

### The Frustrating

Clearly, insurance reform and getting as many people covered as possible are important goals. But it is frustrating that so much of the focus and effort of the legislation is on insurance reform, and so little is on reforming the delivery system. There is widespread agreement that the current growth rates in spending are unsustainable and that quality of care and patient safety are still beleaguered with significant problems.

Reforming health care will require many changes in how and what we reimburse. It will also require moving away from a delivery system dominated by physicians who receive a la carte fee-for-service reimbursement and who deliver care in small, single specialty groups with little or no integration with other parts of the delivery system.

Instead of focusing on strategies to reform the delivery system, much of the current controversy is on whether to include a public plan and, if so,

whether to permit it to use Medicare payment rates or negotiate with providers. The former option is the only way a public plan would save much money, but not because it leads to lower costs. If the plan were to use Medicare rates, which are below average costs for hospitals and physicians, the unreimbursed costs would likely be shifted to the private sector—just as unreimbursed Medicare costs are currently. And, again, although this is an important issue, it has distracted attention from strategies that would lower costs or improve quality.

In fairness, there are a variety of proposals and pilot programs included in the bills that are geared toward improving quality and health system performance. The bills include strategies to disseminate best practices, improve performance measurement, and coordinate care for dual-eligible populations, as well as requirements to adopt value-based purchasing for various types of institutional providers. There are also several interesting pilot programs that encourage the development of bundled payments for physicians and hospitals and for hospitals and postacute care facilities, and that encourage the development of accountable care organizations—i.e., groups of providers charged with responsibility for managing the cost and quality of health care for a given Medicare patient population.

### The Challenges

Because many of the strategies to slow spending or improve quality are linked to pilot projects, it is important that the Secretary of the Department of Health and Human Services not only be allowed to make midcourse corrections to the pilot projects if needed, but also be able to fully implement—without the need for new authorizing legislation from the Congress—those projects that improve quality and/or lower costs while also avoiding significant adverse outcomes.

The most serious challenge is the delay in reforming how physicians are reimbursed. Physicians currently face a reduction in their fees of more than 20 percent when the latest one-year patch expires in 2010. (Congress has

been compelled to intervene with a series of one-year patches to prevent physicians from experiencing reductions in their fees based on the sustainable growth rate [SGR] formula, which Medicare uses to calibrate the physician fee schedule). Eliminating the cost of past one-year fixes is estimated to run about \$250 billion over 10 years. Wisely, the Senate defeated a motion to ignore this \$250 billion charge. Not only would this motion have added significantly to a deficit that has already tripled over the past year, but it also would have done nothing to eliminate the fundamental problem—the SGR combined with a disaggregated fee schedule.

Some have suggested just eliminating the SGR, but that would invite the return to the experience of the 1980s, where physician spending grew faster than any other component of Medicare. Again, the real problem is that the SGR is used with a disaggregated fee schedule that allows physicians to bill for more than 7,000 services. This system rewards physicians who charge for more and more complex services and punishes those who practice conservatively, because the fees are set on the basis of what physicians do in the aggregate and not on what any individual or group of physicians do.

Fixing this problem will require a new payment system—either one that bundles reimbursement for providing care for the treatment of one or multiple chronic diseases and for the care of acute, complex interventions, or one that moves toward a capitation payment, modified perhaps by productivity or other measures of performance.

Finally, as we contemplate the passage of major healthcare legislation, we need to be prepared for significant unintended consequences and, more important, to be responsive as they develop. It is impossible to conceive of a bill affecting one-sixth of the economy that is also completely devoid of serious unintended consequences. To pretend otherwise is just folly. ●

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