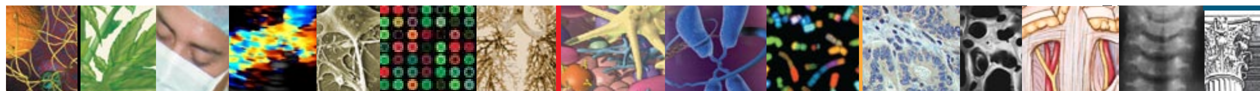

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Perspective

Health Care Reform — Where Do We Go from Here?

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For most of 2009, the conventional wisdom inside and outside Washington was that a significant health care reform bill would be signed into law no later than February 2010, the start of the primary season for the 2010 elections. Although there was always some question about final passage of a bill — whether the Senate's Democratic leadership would be able to retain support for the legislation among more conservative party members and whether the more liberal House would accept most of the Senate's provisions — most observers, including me, assumed that a signing ceremony would take place early this year. Then Massachusetts elected a Republican senator, and now nothing is certain, despite the public optimism of President Barack Obama and Democratic congressional leaders.

As Democrats assess paths forward, only a few options seem remotely realistic: changing some provisions in the Senate bill to attract at least one Republican vote; using the budget-reconciliation process, which requires only a simple majority for passage; crafting a new, more circumscribed bill; or passing either minor pieces of health care legislation or nothing. This last option seems the most likely outcome.

Democratic Senate leaders tried to find ways to attract one or two Republican votes early in 2009 but could not do so. Given the ill will generated over the past year, it seems unlikely that they could do so now. Adding or deleting provisions to attract some support from the opposing party sometimes works, as it did with the stimulus bill, but is different from crafting bipartisan legislation. That requires working with members of both parties to develop a joint legislative package, like the bill proposed by Senators Ron Wyden (D-OR) and Robert Bennett (R-UT) in 2007.

The use of the budget-reconciliation process continues to be raised as a possibility. The attraction of this approach is that if a reform package were cast as a budget bill, it would require only a simple majority for passage in the Senate, the time allowed for debate would be limited, and the bill would not be subject to filibuster. However, there are at least two major drawbacks: any provisions that were not directly related to the budget, such as insurance reforms or changes to the delivery system, could be challenged as not being germane; and the use of reconciliation would probably further inflame a public that

already believes this Congress cuts too many special deals. It thus seems a political nonstarter to me, but Democrats continue to discuss it as an option, so perhaps it's a viable strategy.

The third option is to create a new, more limited bill, which essentially means starting over. This strategy seems unlikely to be acceptable to Democrats, and it's hard to know whether Republicans really want a new bill, either, though they say they do. In reality, there seems to be little inclination on either side to change the positions already staked out. Republican support has coalesced around two different bills: the Common Sense Health Care Reform and Affordability Act developed by the Republican House leadership last July and the Coburn–Burr Patient Choice Act of 2009 sponsored by Senators Tom Coburn (R-OK) and Richard Burr (R-NC) and Congressmen Paul Ryan (R-WI) and Devin Nunes (R-CA). However, as happens too often with Republicans and health care, neither proposal was pursued with the single-mindedness and passion that characterizes the Democratic pursuit of health care reform.[1]

Furthermore, Democrats believe that they won the election in part on the promise of major health care reform and seem uninterested in fundamentally changing their legislation despite polls suggesting that at least a plurality of the population doesn't want what has been passed.[2] The drive to move forward is particularly forceful in the House, where rules strongly empower the majority and where Democrats enjoy a 77-vote margin. Even so, it took intense pressure from the leadership to get a majority vote (220 to 215) on the House reform bill — a reminder that there can be almost as much difference within parties as between them when it comes to health care reform.

Thus, the fourth option — no significant reform — seems the most likely outcome.

The issues that drove health care reform — unsustainable increases in health care spending, unacceptable levels of patient safety and delivery of clinically appropriate care, and 15% of the population without insurance coverage — will not disappear just because there's a political impasse. So as frustrating as legislators found the experience of 2009, they will still need to find ways to make progress on these issues.

The President can legitimately claim to have already passed the first round of health care reform in 2009, with the renewal and expansion of the Children's Health Insurance Program and the health-related provisions in the stimulus bill, which included increased funding for Medicaid, COBRA subsidies, health information technology, and comparative-effectiveness research.

Next steps should continue the two-pronged approach of expanding coverage and beginning to reform the delivery system. For example, coverage could be extended to all uninsured people with incomes below the federal poverty line, either through Medicaid or through some type of negotiated insurance-purchasing process. Since approximately one third of the uninsured live below the poverty line, this expansion would require additional funding, but far less than what was being contemplated under the House or Senate version of reform.

A second step could be an evidence-based strategy for medical liability reform, an issue of great importance to physicians and hospitals and an important enabler of cost containment. I would propose that physicians and institutions that agree to adopt a set of patient-safety measures developed by the Institute of Medicine and that follow the clinical guidelines and protocols developed by the relevant medical societies or by a group of clinical representatives convened for that purpose should be granted immunity from liability unless there are provable charges of criminal negligence. This strategy of pairing liability reform with evidence-based medicine rather than relying on arbitrary caps on malpractice awards might appeal to Democrats as well as Republicans.

Third, some of the current legislation's interesting pilot studies involving delivery-system reforms should be included in future legislation. Examples include bundled-payment programs, in which a single payment covers all services for an episode of care, and programs that encourage the formation of accountable care organizations, which allow physicians and hospitals to share the cost savings resulting from better care management.

Fourth, changes must be made to the way Medicare pays physicians. It is hard to imagine reforming the delivery system without reforming physician reimbursement. The current system, in which physicians bill Medicare using more than 8000 diagnostic and procedural codes, encourages the delivery of fragmented care and makes it impossible to reward physicians who provide integrated, high-quality care at a reasonable cost. Pilot programs

testing new reimbursement systems must be started as soon as possible.[3] Until Congress is prepared to replace the current payment system, it should provide no more than short-term relief from the sustainable growth rate's pressures on fees. Otherwise, change will never occur.

It may be premature to draw conclusions from the past year, but one lesson already seems clear. When it comes to social legislation, Americans prefer incremental reform. Twice in recent memory, the United States has attempted "big bang" health care reform, with massive changes in many dimensions of health care. Although there are many important differences between current proposals and those of 1993, including how the legislation was developed, it is hard not to conclude that the amount of change being contemplated exceeds the comfort level of many Americans. This shouldn't be surprising, given that almost 75% of Americans report being satisfied or very satisfied with their own care and insurance.

This resistance to major overhaul means that we need to think about health care reform in terms of discrete blocks of change — though not necessarily small ones. Yes, this approach will make reform more complicated: many of the pieces are interconnected. Some would argue that the current bills are in fact incremental — focusing primarily on expanding coverage over several years, while doing little to address health care's other challenges — but any bill that costs about $1 trillion and includes as much change as these do is not incremental. And truly incremental reform seems to be the only viable strategy. This fact and the realization that the United States has to get serious about slowing spending may be, to borrow a phrase from Al Gore, health care's inconvenient truths.

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From Project HOPE, Bethesda, MD.

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