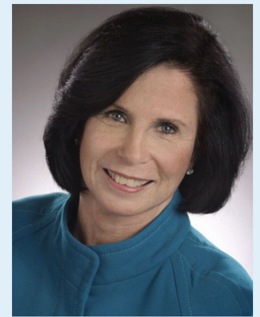
SPECIAL SECTION:
HEALTHCARE REFORM



COMMENTARY

healthcare reform version 1.0

Gail R. Wilensky

The nation has taken a significant step, if not a giant one, toward addressing the serious challenges that lie ahead for our healthcare system. But many more steps are still needed.

After a tumultuous year of proposals, negotiations, closed-door sessions, town hall meetings, and what has seemed like endless talk-shows and debates, President Obama signed The Patient Protection and Affordable Care Act into law on March 23. Although many of us who spend our professional lives focused on the issues covered in the act thought we would never tire of discussions on healthcare policy and reform, all of us in Washington and many outside the Beltway have breathed a collective sigh of relief that we would be spared further discussion of these issues—for at least a little while.

People need to understand, however, that as important and sweeping as the legislation is, it represents no more than a first step on a path to reaching universal coverage and reform of the healthcare delivery system. In part, this is because even after full enactment, there will still be 5 to 6 percent of the population who remain uncovered. More important, most of the potential reforms to the delivery system are tied to the pilot projects. Hopefully, at least some of them will be successful and provide insights into whether certain types of changes could lead to improved outcomes and lower spending. Actually implementing these changes and understanding which are more likely to be successful under what circumstances will be a challenge. That and finding ways to successfully slow spending while improving outcomes and patient safety will require many more rounds of legislation.

And then there will always be those unintended consequences that will present themselves, with the need for follow-on legislation to fix the most egregious of them. In the short term, everyone involved in Medicare, Medicaid, and any other aspect of health care will be focused on the implementation challenges of the legislation.

What the Legislation Does

It is impossible to list here all or even most of the changes included in the legislation. Several groups have produced useful summaries, such as the one available on the Kaiser Family Foundation web site (www.kff.org) and on HFMA's web site (www.hfma.org). I will do no more than summarize the most salient portions here.

The primary focus of the legislation is on reforming insurance and expanding coverage. After full implementation, there will be 32 million fewer uninsured, implying a coverage rate for the nation of 94 to 95 percent as opposed to the current 85 percent. Of these, 16 million will be on Medicaid and 24 million will be receiving subsidies to purchase negotiated insurance policies in state-based insurance exchanges. Not all of those receiving subsidies will have been previously uninsured. Some will be working for small employers who can make use of the insurance exchanges.

The total cost of the legislation is $940 billion over the 10-year budget window. Of this amount, $520 billion will come from reduced payments to Medicare providers, with most of the remainder coming from excise taxes and increased fees on various types of healthcare suppliers and manufacturers, as well as increased taxes on individuals with high incomes.

The Congressional Budget Office (CBO) estimates that the legislation will reduce the deficit by $124 billion over 10 years. As is CBO custom, the estimate assumes that all current law continues in its present form. In this case, that means assuming that current law regarding physician payments under Medicare will persist, which, in fact, no one assumes will be the case. Fixing the problems with the sustainable growth rate (SGR), CBO estimates, will cost approximately $215 billion to $250 billion over 10 years, which is approximately double the expected reduction in the deficit.

Changes over Time

The schedule for implementation of the legislation's provisions spans years, with relatively few of the changes due to be implemented immediately. Among the key provisions that will have an extended implementation timeline are those addressing coverage, financing, and quality improvement (QI).

Coverage. The primary focus of the legislation in the short term is the introduction of limited insurance reforms and the modest expansion in insurance coverage to targeted populations.

In 2010, lifetime and annual limits on polices will be disallowed, policy cancellations (rescission) in the individual market will be disallowed except in the case of fraud, tax credits will be provided for small employers with low-wage employees, adult children under 26 (not offered employer-sponsored insurance) will be allowed to stay on their parents' plans, and funding to support state high-risk pools will be increased by $5 billion.

In addition, tax credits will be provided to small employers with low-wage workers. A $250 rebate will also be provided to Medicare enrollees who reach the coverage gap in Part D—otherwise known as the "doughnut-hole." Other changes to fill the coverage gap will occur later in the decade.

Most of the coverage expansions occur in 2014. Starting in 2014, significant subsidies will be provided for individuals up to four times the poverty line who are not on public programs and who don't have access to employer-sponsored insurance, to purchase negotiated insurance through state insurance exchanges. Individuals working in firms with up to 100 employees will also be able to buy insurance in the exchanges.

Medicaid will be expanded to cover all individuals who are below 133 percent of the poverty line, although it is unclear how and whether asset limitations for eligibility will be established. States will receive enhanced matching rates to help finance the expansion.

Individuals will be required to have insurance and be assessed (small) tax penalties if they do not. Employers with more than 50 employees who have employees receiving premium credits will be assessed penalties.

Financing. Unlike the coverage expansions, which primarily occur in 2014, various funding strategies start substantially earlier.

Reductions in market basket updates for Medicare and for assumed increases in productivity for hospitals, home health, skilled nursing homes, and other Medicare providers start in 2010. Payments to Medicare Advantage plans (whose savings represent almost 28 percent of Medicare payment reductions) are frozen for 2011 and reduced to approximate Medicare fee-for-service rates thereafter. Additional fees and rebates on pharmaceutical manufacturers start in 2010. Fees on medical device manufacturers start in 2012. Fees on the insurance sector start in 2014.

AT A GLANCE

> The primary focus of the March 23 healthcare reform legislation is on reforming insurance and expanding coverage; less direct attention is given to slowing spending while improving outcomes and patient safety.

> Many of the key provisions regarding coverage and financing will unfold during the period of now through 2014.

> The primary strategies proposed for "bending the cost curve" in the House and Senate versions of reform—the tax on high-cost plans and the new advisory board that could fast-track payment changes in Medicare that would reduce spending—are also included in the final legislation, but in muted form.

Starting the financing before the majority of benefits begin has the obvious advantage of making it easier to cover the costs of the program for the first 10 years. It also recognizes that increasing taxes and other fees is easier and can be accomplished faster than starting new benefits. Both the strategy and the rationale were used when Medicare Part D was introduced and are hardly new to Congress, regardless of which political party has the majority.

QI. The legislation contains a variety of QI strategies. These include a new center to support comparative effectiveness research, health homes for Medicaid enrollees with multiple chronic conditions, development of a national quality initiative, and a new CMS office to integrate care for dual eligibles. Like the other changes, the QI strategies will be implemented over time: a new not-for-profit center for comparative effectiveness research in 2010, a national QI strategy in 2011, enhanced data collection in 2012, and financial relationship disclosures in 2013.

Bending the Cost Curve ...

Expanding coverage to universal or close to universal coverage has been a major goal of healthcare reform, but two other goals have been of equal importance: slowing spending and improving patient safety and clinical outcomes. Although the legislation will make substantial progress in reducing the number and percentage of the population without insurance coverage, its effect on slowing spending and improving clinical outcomes is more questionable.

The primary strategies that were regarded as having the potential to "bend the cost curve" in the House and Senate versions of reform were the tax on high-cost plans and the new Independent Payment Advisory Board (IPAB) that could fast-track payment changes in Medicare that would reduce spending—the so-called "MedPAC on steroids." However, both of these strategies are included in the final legislation in muted forms for at least the current decade.

The 40 percent excise tax on high-premium insurance plans doesn't take effect until 2018 and applies only to plans that exceed $10,200 for an individual and $27,500 for a family, but even these high values are to be upwardly adjusted for retirees under the age of 65 and people in high-risk professions, and if costs increase "more than expected." If current law remains unchanged, the tax could affect the purchase of high-cost insurance plans over time because the threshold will increase at the Consumer Price Index for urban areas (CPI-U), which grows more slowly than the CPI for medical goods and services.

Similarly, the IPAB has the authority to fast track recommendations to Congress to slow Medicare spending, but its effect will be meaningful only if it survives (and is actually used) after 2020. Before then, hospitals are exempt and physicians are being treated separately. In principle, the IPAB could force Medicare spending to stay at gross domestic product (GDP) plus one. However, our experience with the SGR and physician payments under Medicare, suggest that having authority and being willing to exert that authority are not the same.

Reforming the Delivery System

Reductions in Medicare payment rates should not be confused with reforming the delivery system. The reduced payments just continue the same dysfunctional incentives that reward more and more complex rather than high-quality outcomes at efficiently produced prices. The real reforms depend on the pilots described in the legislation, in particular regarding development of *accountable care organizations* in which physicians and hospitals team together to share resulting savings, and bundling of payments across all providers involved in an episode of care.

These congressionally mandated pilots are intriguing and could help drive the current delivery system, where most physicians practice in small single-specialty groups unaffiliated with the hospitals where they practice, to a more functionally integrated system. However, it would be difficult to overestimate the challenges involved in getting pilot projects up and running in a timely way, making midcourse corrections where needed, validating the results, and then implementing those that prove successful wherever such implementation makes sense.

And Don't Forget About the Physicians

Despite all of the changes included in the healthcare reform legislation, what for me remains unfortunate and inexplicable is that it includes neither funding to fix the SGR nor pilots designed to explore alternatives to the current dysfunctional relative value system, which reimburses physicians using some 8,000-plus codes.

The notion that reforming physician payment could be accomplished separately from healthcare reform might have been plausible if the legislation had not identified the reduction in Medicare payments to providers as the single largest funding source for expanded coverage and if other changes affecting Medicare, such as the filling in the coverage gap in Part D Medicare, had not been included. Now, there is neither an obvious funding source available nor as much focus as would be desirable on alternative physician payment strategies, particularly for reimbursing physicians who treat Medicare patients with multiple chronic conditions.

And finally, it is difficult for me to imagine a delivery system where physicians and institutions have incentives to produce high-quality care at efficient costs that does not also include a reformed liability system. So given these significant omissions, even with 2,400 pages of legislation and the bruising battle that has just been concluded, it would be a mistake to regard the act as anything more than healthcare reform, version 1.0. ●

about Gail R. Wilensky, PhD

Gail R. Wilensky is an economist and a senior fellow at Project HOPE, an international health foundation. Her focus has been on strategies to reform health care, with particular emphasis in recent years on Medicare, comparative effectiveness research, and military health care. Wilensky serves as a trustee of the Combined Benefits Fund of the United Mine Workers of America and the National Opinion Research Center, and is on the Board of Regents of the Uniformed Services University of the Health Sciences (USUHS) and the Visiting Committee of the Harvard Medical and Dental Schools. She recently served as president of the Defense Health Board, a federal advisory board to the Secretary of Defense, was a commissioner on the World Health Organization's Commission on the Social Determinants of Health, and co-chaired the Department of Defense Task Force on the Future of Military Health Care. She was the administrator of the Health Care Financing Administration (now called CMS) from 1990-92 and the chair of MedPAC from 1997-2001.

She is an elected member of the Institute of Medicine and has served two terms on its governing council. She is a former chair of the board of directors of Academy Health, a former trustee of the American Heart Association, and a current or former director of numerous other not-for-profit organizations. She is also a director on several corporate boards. She received a bachelor's degree in psychology and a PhD in economics at the University of Michigan and has received several honorary degrees.

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