The national health care policy debate is marked by a broad chasm of opinion over how to achieve the Obama administration’s goals of reducing costs and extending coverage to the uninsured. This issue of *in focus* includes commentary from five experts who shared their wide-ranging views on health care reform at FOJP’s 24th Annual Conference. They discussed what change should look like, how it could be implemented and most of all, how to pay for it in an economy reeling from financial chaos.

The More Things Change…
A century ago, President Theodore Roosevelt called for health reforms with universal care and national health insurance. Today, the cry for reform is again resonating loudly from the Oval Office and Capitol Hill to hospitals and households across the country. But as Lisa Kramer, president and chief executive officer of FOJP Service Corporation notes, restructuring the medical care distribution system is not enough. “For all the talk about health care reform, they are still ignoring the need for meaningful tort reform. Doctors are practicing defensive medicine, practices are being driven out of business, and more and more hospitals are shutting their doors. These things reduce access and drive up the cost of health care.” (See “Talking about Tort Reform.”)

…The More They Stay the Same
So how do we proceed? A common theme among experts assembled at the FOJP conference was to look backwards in order to move ahead. For Uwe Reinhardt, PhD, the James Madison Professor of Political Economy and professor of economics at Princeton University, this meant uncovering what went wrong with both our economic and health care models in an effort to address how to fund changes moving forward. Dr. Steven Safyer, president and CEO of Montefiore Medical Center, outlined how his institution defied a history of decline in the Bronx by applying some “back to basics” approaches to practicing medicine with a modern twist.

Despite the growing momentum for health policy changes in the United States, the sentiment that major reform is necessary is far from universal. Indeed, like the child who hates going to the doctor and getting his shots, there is still some real resistance toward a government-sponsored national health care system. Many providers, payers, suppliers and even the general public are wary of reform moving in a direction that may not improve quality and increase access while holding down costs, according to Dr. Mark Callahan, senior vice president and chief medical officer at FOJP.

In addressing the best path toward universal health coverage, two speakers turned to programs that have been around for nearly 45 years. Michael S. Sparer, PhD, JD, director of the Executive MPH Program and professor of health policy and management at Columbia University’s Mailman School of Public Health, proposed expanding the existing Medicaid program as a viable path to universal coverage. Meanwhile, Nancy Lee Johnson, former U.S.
Health Care Change in a Cost-Constrained World continued from page 1

Congresswoman and now senior public policy advisor at Baker, Donelson, Bearman, Caldwell & Berkowitz, PC, countered that system changes along with Medicare modernization offer the more logical choice for worthwhile reform.

Perhaps the largest acknowledgment to the past came from Dr. David Blumenthal, director of the Institute for Health Policy at Massachusetts General Hospital/Partners HealthCare System, the Samuel O. Thier professor of medicine and professor of health care policy at Harvard Medical School and former senior health advisor to Barack Obama. In his talk, Dr. Blumenthal, now the national coordinator for health information technology, outlined how President Obama’s efforts to enact new reforms would benefit greatly from the lessons learned by some of his predecessors, including former presidents Franklin Roosevelt and Bill Clinton.

Drawing from past perspectives, these experts seemed to agree that health care reform is more important today than ever before. Even in these tough economic times, the question is not whether we can afford to make health care available to all Americans, but whether we can afford not to.

A question that often arises whenever health care experts convene is “What about tort reform?” Perhaps one reason for this frequent refrain is the hope that the issue will somehow be taken up and moved to the forefront of the public policy agenda. Yet in the high-profile discussions taking place on health care reform, President Obama has all but ignored the call for changes to malpractice insurance and the tort system. One explanation is that tort reform is not really a federal issue but a state one.

As Lisa Kramer, FOJP president, noted, “We’ve been making many changes to how we manage claims and are putting our focus on quality and safety issues. But that is not enough—we need tort reform. How can health care reform possibly succeed when states need to pass tort reform?”

Could “no fault” provide an answer? In addressing the tort reform question, Dr. David Blumenthal mentioned “no fault” as a possible approach to compensate people for injuries. However, he was quick to point out that this approach would need to be paired with accountability and ways to address providers who are not performing up to par.

Dr. Steven Safer responded to the “pernicious problem of health care litigation” in a different way. He noted that with tort reform, states like Texas faced far lower malpractice expenses than New York. “In Texas, a large teaching hospital might pay one percent of expenses for malpractice costs, but here in the city the cost is easily four to five percent and growing over time. Our burden is 50 percent in obstetrics, even though our outcomes meet or exceed best practices. In our case, it’s not about the clinical care. We cannot win in front of a jury in the Bronx,” he said.

While California was the first state to initiate tort reforms, many cite Texas as a model for state level reforms. Texas’s changes include limits of $250,000 on non-economic damages for physicians involved in medical liability cases. Other states, such as Illinois, Georgia and Colorado, have also been successful in setting caps. In its analysis of medical liability and tort reform stud-
Is Health Care Reform Economically Possible?

In the midst of an historic economic downturn, a noted professor and leading authority on health care economics addresses implications for reform.

Listening to Uwe E. Reinhardt, PhD, James Madison Professor of Political Economy and professor of economics at Princeton University, it is clear he is passionate about the topic of health care economics. His highly engaging and often trenchantly humorous approach resonated with an audience comprised of physicians, risk managers and other senior health care professionals.

To understand some of the challenges around health care reform, Prof. Reinhardt offered a brief history of what happened to an economy long sustained by consumerism. He noted that Americans moved from a "Father Knows Best" economic model with Dad as the wage earner, to a two-earner household, to a credit card lifestyle. When that maxed out, bankers encouraged us to go after the equity in our homes. At the same time, the consumer savings profile dropped from an average of eight percent of disposable income in the 1980s to virtually nothing today (although since last year, the savings ratio has finally hit bottom and is turning positive again). He argued that even if the banking crisis had not occurred, this pattern of spending and not saving, coupled with enormous personal debt, would have put us into a recession.

In fact, Prof. Reinhardt explained that the continued on page 4

ies, the American Medical Association (AMA) concluded that premiums for internists were 17 percent lower in states with caps; rates for other specialists were even lower. It also found that state caps help reduce insurers’ claim payouts on malpractice cases while boosting the number of practicing physicians. (See Amy Lynn Sorrel, “AMA Analysis Reaffirms: Tort Reforms Work,” AMNews, March 3, 2008.)

In his President’s Message to the American Academy of Emergency Medicine (AAEM), Dr. Larry D. Weiss analyzed some of the ins and outs of tort reform. As a short-term approach, he described a number of reforms, including screening of malpractice suits, changing how various damages are paid, and changing current statutes of limitations. Despite the success with caps in states like Texas, he feels that short-term reform can limit patient rights and doesn’t focus on the real problem, “our liability crisis.”

Dr. Weiss prefers a long-term perspective, examining a number of options for changing attorney behavior and our “reckless tort system” as it operates today. He proposes swapping our "American Rule," where everyone pays legal fees, for the “English Rule,” where the losers in a case pay everyone’s legal fees. That, and eliminating the contingency fees entitling lawyers to a percentage of the “winnings,” would do much to discourage frivolous suits. He questions the need for many of the aggressive new tort actions that expand liability and add cases at every turn. And he cites the benefits of allowing defendants to countersue plaintiffs for negligent cases without having to prove malice. Finally, he joins the AMA, AAEM and others in calling for administrative health courts to hear malpractice cases.

While many reform proposals appear out of reach, Weiss recommends one approach for right now: “Education of the public has great value and has the potential to influence our political process in a more profound manner.” He encourages health care providers to share information with their patients to help increase public awareness of this “liability crisis,” for when it comes to tort reform, the most important thing to do is to keep talking. (See Larry D. Weiss, “AAEM President’s Message: Tort Reform: Our Permanent Issue,” AAEM, August 8, 2008.)
recession might have been manageable if the banking system hadn’t gone awry and done what no economist could have foreseen. The sector laid waste to the prevailing economic theory that markets were self-regulating and best left alone without government interference. Gone is that theory, taught to countless college students, embraced in Alan Greenspan’s tenure as chairman of the Federal Reserve, and celebrated in books like Ayn Rand’s Atlas Shrugged.

Reinhardt’s tale of the banking industry’s demise provided a backdrop to the current financial picture for health care, which is bleak (see http://www.princeton.edu/~reinhard/pdfs/French-to-Blame-banking-crisis.pdf). Despite pressure from the current Fed chairman, Ben Bernanke, banks simply are not lending to hospitals or other enterprises. According to Reinhardt, the banks’ attitude seems to be “Fuggedaboutit.” In the meantime, a survey of hospitals shows constrained access to capital, razor thin margins (high fixed costs to variable costs) and institutions cutting costs at a time when they should be expanding.

Citing the “American mantra ‘When the going gets tough, the tough run to government,’” Reinhardt questioned the wisdom of letting banks dump their toxic assets on taxpayers in exchange for cash (in the form of Treasury bonds). He noted that Americans have essentially become bank shareholders without voting rights. As an alternative, he suggested “letting the banks stew and using that money to create new banks that taxpayers would own” and that would be free to loan to credit worthy borrowers like hospitals.

On the demand side, there is good reason to loan money to health care institutions. Just consider the Gross Domestic Product (GDP), which equals the total amount of spending by consumers, private sources, and the government (exports minus imports of goods and services). According to Reinhardt, health care now absorbs between 16 percent and 17 percent of US GDP, a hefty slice of the GDP pie. It continues to climb, accounting for more than half of the growth in GDP between 2001 and 2002, and propping up the economy with 1.7 million new jobs since 2001.

Reinhardt believes this trend will continue. He cited a Congressional Budget Office study, “Long-Term Outlook for Health Care Spending” (November 2007), which projects spending out to 2050. While there is a subtle effect from aging populations, overall health care spending is expected to reach 38 percent of total GDP by 2050. And contrary to popular belief, the study did not find Medicare and Medicaid to be the culprits in these rising costs.

According to the Milliman Medical Index (MMI) for 2008, that projected rise in health care spending would price low- to middle-income families (earning $16.5K/year) out of the health care market. Even more disturbing, the researchers see a widening gap between wage growth and health care spending increases for wage earners in the $50K range. They will see a larger fraction of their gross wages chewed up by health care over time, Reinhardt said. It is no wonder that an ever-increasing number of middle class Americans have suddenly found themselves uninsured, according to the National Institute for Health Care Management (NIHCM)’s “Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations” (April 2008).

Is There a Solution?

There may still be cause for optimism about the health care picture. According to Reinhardt, Congress has proposed raising taxes to subsidize the middle class and offering a tax transfer program of about $125 billion a year to help finance health care for families at the bottom half of the income scale. Some countries ration prescription drugs by income class through reference pricing. The insurer pays fully for a low cost drug in a therapeutic group; if patients want a higher-priced brand name drug, they must pay the difference in price between the
two. In the years ahead, the US might apply the same idea to all kinds of health care, including hospital care. For example, people may get fully reimbursed if they have their baby or operation in a low-cost hospital, but pay out of pocket any difference between that price and the cost of a higher priced hospital. While the inequity of such an approach might run counter to American rhetoric, Reinhardt argued that we’re already rationing health care based on income. He pointed to the study “The Widening Health Care Gap Between High- and Low-Wage Workers” (2008) by Sherry Glied and Bisundev Mahato, which shows a growing gap in health care coverage among workers based on wage scale. We also know that on average uninsured Americans receive only half the health care that similar, fully insured Americans receive. “America rations in spades, by price and ability to pay,” Reinhardt said.

To address this growing crisis in health care availability, Reinhardt examined some broad reforms proposed by President Obama and Senator Max Baucus of Montana. Beyond innovative programs such as a “farmers market for health insurance” and a new public health insurance plan based on one available to federal employees, this proposal focuses on expanding existing government programs, offering tax credits and subsidies, increasing big ticket funding for areas like HIT improvements, and analyzing the effectiveness of current health care spending.

Proposing health care reform is one thing; paying for those reforms is something else. The Obama administration has proposed paying for reforms from a $634 billion fund, half of which would come from taxes raised by lowering the allowable deduction for charitable giving for those making more than $250,000 a year, Reinhardt said. Other funding sources include reducing the 14 percent extra payment now made to private health insurers for handling Medicare cases. Hospitals and home care would also face givebacks through reduced payments for readmissions and new incentive payments. While dubious that some of these ideas would work, Reinhardt praised Obama for at least trying to identify funding sources.

Finally, Reinhardt shed some perspective on the current crisis by noting that the Chinese word for “crisis” is a mix of the symbols for both danger and opportunity. The economy may be in danger and mired in the muck, but health care has proven far more recession proof. He ended with the hope that the health care industry would “seize the opportunity to do more with the resources available, to look for efficiency and to find new ways to do better,” thereby making its own reforms.

What’s Up With VAT?

While no one really wants any new taxes, there has been some talk of a possible value-added tax, or VAT, as a method to help pay for health care costs. The idea first surfaced in 1993 (and was widely opposed) as an effort to fund the ambitious Clinton health reform plan. While rare in the United States, a vast number of countries around the world apply a VAT as an upfront consumption tax on a variety of goods and services. The prospect of coordinating a federal VAT with individual states’ sales taxes is another issue entirely. But as Prof. Uwe Reinhardt noted, another way to look at a VAT is to compare it to the U.S. gas tax. No one likes the gas tax, but it has become accepted as people understand that it is earmarked to pay for maintaining our roadways. Similarly, the VAT approach could be applied to hospital and other health care services as a very visible way to pay for reforms. The city of Montreal, for example, includes a separate tax on patients’ hospital bills. As reform measures take shape, could the United States follow suit? VAT is the question.

Addressing Regional Cost Variations

Reducing regional variations in beneficiary spending could help control health care costs, Prof. Uwe Reinhardt suggests. To make his point, he cited a Congressional Budget Office report that found significant variations in Medicare spending for elderly beneficiaries across the United States. He also referred to the work of Jack Wennberg, MD, a Dartmouth researcher. Wennberg’s findings suggest that Medicare spending would be 29 percent lower if all regions matched costs with low-spending regions.

Given today’s concerns about health care costs, a recent article in the New England Journal of Medicine also examined this issue. While the authors found wide variations in spending across regions, the differences could not be attributed to general health, technology or the current payment system. In fact, the article noted that quality of care and health outcomes were actually better in lower-spending regions.

The authors identified a trend for physicians in higher-spending regions to recommend more discretionary services and opt for the ICU over palliative care in “gray areas” such as end-stage decisions. A study cited by the authors concluded that physicians could effect cost controls by helping patients understand that conservative treatments are often as effective as high-cost alternatives. They also envisioned physicians fighting the “more is better” competitive growth in “over-supplied” areas. Local referral networks could be turned into integrated delivery systems linking practices, specialists and institutions. The authors noted an emerging consensus that integrated delivery systems offering strong clinical support and team based practice care offer great promise for improving quality and lowering costs.

While these steps would require legal changes, financial incentives and a shift from volume-based payments, the authors saw hope in pilot projects addressing regional variations and health care cost reforms. But the biggest incentive for change may come from estimates of Medicare growth. If we continue without any changes, the authors predict that in 2023, Medicare will be short $660 billion. However, by mirroring lower-spending regions nationwide, Medicare could end with a surplus of nearly $760 billion. (See E. S. Fisher, J. P. Bynum, and J. S. Skinner, “Slowing the Growth of Health Care Costs—Lessons from Regional Variations,” NEJM 360 (February 26, 2009): 849–52.)
Steven M. Safyer, MD, is president and chief executive officer of Montefiore Medical Center. The hospital serves as a national model for health care delivery in addressing the specific needs of at-risk populations.

It Takes a Village: A Cooperative Model for Health

With a nod to Hillary Rodham Clinton, “It takes a village …” takes on new meaning as it captures the essence of one institution’s efforts to build a new model for cooperative care.

When Steven M. Safyer, MD, walks the halls at Montefiore Medical Center, it’s hard to tell he’s president and CEO of the institution. Actually, he’s “Steve” to most everyone there—approachable and quick to shake a hand or listen to a concern. This back-to-basics approach reflects Montefiore’s mission of “transforming health and enriching lives.” The institution is entrenched in the very fabric of the community in which it resides, namely, the Bronx.

Montefiore has been nationally recognized for its quality, safety and integrative medical programs, but its history tells a richer story. The institution got its start in 1884 as a sanitarium for patients with chronic illnesses. By the 1950s, it was recognized as a significant community hospital, later joining forces with the Albert Einstein College of Medicine (AECOM) to become a teaching hospital. However, by the 1980s, the borough had started to unravel and was “rife with societal disarray, poverty, homelessness, serious health epidemics and a teetering health care system,” according to Dr. Safyer.

The Birth of an Integrated Delivery System (IDS)

At the time, the components of the medical center were disconnected. Local primary care doctors had feld, leaving a scant referral base. There was significant labor strife and other clinical and operational issues. To counteract these challenges, the organization began to expand, integrate its delivery system and build up its primary care system. By employing large numbers of primary care physicians, Montefiore extended the continuum of care provided, connected patients with primary care, and streamlined services.

Montefiore consolidated what was then a complicated two-hospital structure and built programs across the system with regional planning for more effective pre- and post-hospital care. Facing resistant tuberculosis, HIV, malnutrition, and a long list of other health issues, it became “the public health department of the borough” and established myriad programs to tackle the prevailing public health problems.

Montefiore also embraced health information technology (HIT). As Dr. Safyer noted, “By 1998 we were 100 percent computerized physician order entry (CPOE). We had a single master patient index that gave doctors access to all the systems from any of our sites and from home.”

The medical center also built expert knowledge into the system to “encourage people to do the right thing” and created a “data warehouse” to support queries and robust monitoring for improvements. Even before the Leapfrog Group for patient safety got started, Montefiore was Leapfrog compliant in multiple domains, including 100 percent CPOE and around the clock critical care attending physicians. It has adopted a “solutions not gotcha approach,” pairing high-tech methods with low-tech quality and safety measures and monthly reporting on 150 metrics. Officials have worked hard to make service their cornerstone of care and have educated staff, partnered with labor and built an atmosphere that illustrates a genuine concern for patients’ needs.

Dr. Safyer spoke of the innovation that has turned managed care on its head: “We saw managed care coming to the Bronx and felt we could do better. We knew we could manage care, but we also wanted to keep the money in the system. So we created a risk transfer process that now has 150,000 globally capitated lives and $750 million in annual revenues. This allowed us to live within the insurance cap and funnel savings back into the healthcare system to improve patient care.”
This integrated approach has helped the organization achieve growing recognition as an academic medical center that takes meaningful responsibility for its patients. Partnering with AECOM, Montefiore has been able to recruit premier faculty that provide cutting edge care. With its network of four hospitals, Montefiore provides access to specialist care, including increasingly complex heart care, pediatrics and cancer services. Montefiore’s extensive primary care network offers expertise in the management of chronic diseases and disease prevention.

Dr. Safyer was quick to point out that Montefiore, while lean and efficient, has “razor thin margins.” He attributed this to a high percentage of patents insured through Medicaid and Medicare and limited negotiating leverage with those agencies as well as having to live under the current tort system and pay extremely high medical malpractice costs.

Reflections on Lessons Learned

Successes aside, the real point here is to identify methodologies that extend beyond the institutional “village” and can be applied to the health care world at large. Indeed, this health care model for an “at risk” community has implications far beyond the Bronx.

Dr. Safyer outlined “five lessons learned” and how they can make an impact in wider settings. The first component, INTEGRATED SYSTEM CARE, is the “Holy Grail” of health care. The idea of creating “systemness” or integration is vital to eliminating health care fragmentation. The key is to determine what needs to be done to enable this type of integration. It is an ongoing process of improving access and transitions to help patients navigate the health care network and get the care they need.

Next is ESTABLISHING AN EMPLOYED PHYSICIAN MODEL. Dr. Safyer noted that in most areas, only about 13 to 14 percent of doctors practicing in a community are employed. Doctors are individuals, and it can be challenging to bring this cohort into the model. However, with employment, they can be “incentivized properly,” and institutions can move money around to nurture what is being accomplished and move it forward.

“It IS ALSO KEY,” Dr. Safyer observed. “I still find it stunning that we can travel the world, use an ATM and conduct transactions just about anywhere, but we can’t do that with health records, which are far more important. There are some positive signs of change. And I am a believer in the power of IT when you use it creatively, not just out of the box.”

In calling for GLOBAL PAYMENTS AND SOME FORM OF BUNDLING, Dr. Safyer conceded that “managed care has so blackened the eye of the American people that it might not fly.” Still, he sees value in a bundling of payments that transcends the episode of hospitalization such as the discussion about 30-day inclusion after hospitalization.

“Patients are not about hospitalization but about health and wellness, and sometimes chronic diseases,” he noted. “Bundling starts to get the system more responsive and working the way it should.”

Then there is the increasing importance of DEVELOPING REGIONAL PARTNERSHIPS. He acknowledged how competitive health care institutions have grown over the last 10 years, especially in New York. But the system is not one monolith, and forming regional partnerships encourages a real synergy that can be leveraged to benefit health care. As an example, he cited his involvement with the Bronx Regional Health Information Organization (Bronx RHIO), a highly successful integrated regional health care initiative.

Whether you take a regional or localized view, it is clear that the value of health care extends far beyond simply providing care. Amid the current economic crisis, health care growth continues to be strong. Because of the dollars health care represents, the view among many is that it offers the perfect stimulus for the economy. (This is especially true given the money pledged to health care through the president’s economic stimulus package.) Dr. Safyer emphasized that the financial contributions health care organizations bring to a community cannot be overlooked: “Montefiore employs 16,000 people. We are the stimulus, the economic engine of the Bronx.”

It may well “take a village” to achieve health care reforms, but ultimately it is about the patient. Dr. Safyer concluded, “Putting the patient and community at the center is what’s best for the patient. It may not always be what is best for the hospital, but it has led to good things for Montefiore and helped us to become the best hospital we can be.”

Meet the Massachusetts Health Insurance Exchange

Dr. David Blumenthal pointed to the Massachusetts health insurance exchange as one plan that seems to be working. This exchange, known as Connector, was created in 2006 as part of a state law mandating health insurance coverage for every resident. Under the plan, employers must offer coverage to workers or pay into a state fund; individuals and families must also purchase coverage or pay penalties. The Connector health insurance exchange provides support by enabling individuals and small businesses to purchase coverage at an affordable rate from a number of competing insurers and plans. To make this happen, the state allowed private insurers the flexibility to offer different “flavors” of plans based on tiered provider networks, higher deductibles and copay amounts, annual

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Health care reform emerged as a key issue during the 2008 presidential campaign and continues as a priority for the Obama administration today. This expert blends his insights with an historical perspective to shed new light on the debate.

When it comes to perspectives on health care reform, David Blumenthal, MD, MPP, has much professional experience to draw on. As director of the Institute for Health Policy for Massachusetts General Hospital/Partners HealthCare System; the Samuel O. Thier professor of medicine & professor of health care policy, Harvard Medical School; and former senior health advisor for the Obama campaign, he is connected to the academic, clinical and political worlds.

However, Dr. Blumenthal was quick to emphasize how difficult it is to be pinned to a perspective. Joking that he would “deny all quotes,” he noted, “This topic is in motion as we speak. Pick up a newspaper, go online to the latest blog and you’ll see how fluid this discussion is.”

Framing the topic, he focused on four areas: policy, politics, process and product. With policy, the issues are debated on two fronts: coverage and system reform. The president’s budget commits $600 to $700 billion to jumpstart the process toward universal health coverage. Dr. Blumenthal outlined a “toolbox of opportunities” for extending coverage to the uninsured and underinsured. These coverage opportunities range from employer or individual mandates and employee tax exclusions to new plans such as the government plan currently in place for federal employees and the health insurance exchange introduced in Massachusetts.

When it comes to system reforms, Dr. Blumenthal acknowledged, “What is more complex and uncertain is how to actually reform the delivery system. We know a lot more about how to cover people than we do about how to implement changes to care.” He discussed potential changes in the areas of payment, organization and infrastructure. And the current skepticism about executive bonuses is bound to have a ripple effect, which he expects will put more focus on pay-for-performance (P4P) efforts. Other viable areas of payment reform include bundling related services for more efficient patient care and rebalancing the overuse of specialists at the expense of primary care.

“There’s a growing consensus that integration is preferable to fragmentation,” he noted. “We’ve made it harder for individuals and doctors to organize care because of these silos of specialties.” The move toward more integrated care has also renewed interest in a “medical homes” approach, where traditional primary care is surrounded by resources to integrate care overall.

Finally, there is the infrastructure, which provides a viable tool for change, especially with the big “down payment” of stimulus funding for health information technology (HIT). In addition to the “electronification” of health information, funding has been earmarked for research on comparative effectiveness of care, preventive care models, and efforts to build up the primary care workforce. Dr. Blumenthal will play a leading role in the future of guiding these HIT and infrastructure improvements since he has joined the Obama administration. (See “Speaker Named HIT National Coordinator.”)

The Politics Seem Right

Dr. Blumenthal was quick to emphasize that the views he presented were his own and not representative of any particular political agenda. Nonetheless, politics are central to health care reform, and today’s circumstances may well offer a “golden moment” for change. The financial collapse and rising unemployment have left people feeling vulnerable and more accepting of “big government” assuming a bigger role in our lives (quite the opposite of what Clinton faced in trying to launch reforms during the economic resurgence in the 1990s). Today the U.S. has a popular president who grasps historical precedents and has a strong health care focus. There’s also single party control and new amity among congressional power groups as well as flexibility among the interest groups.

“The bottom-line is that health care reform has moved from impossible, three to four years ago, to
possible right now,” Dr. Blumenthal explained. “It’s not guaranteed, but many things are aligned that haven’t been since the Great Depression. A skillful president could make changes happen.” If this seems like déjà vu, it is. Health care reform efforts have a long, rich tradition in the political mainstream. Dr. Blumenthal stressed the importance of keeping that historical perspective in mind when guiding the health care reform process. He previewed some basic strategies for leveraging political experience from a book he co-authored, The Heart of Power: Health and Politics in the Oval Office (recently published by the University of California Press). The book examines the history of leadership on the part of presidents who were deeply vested in health care reforms, including FDR, Eisenhower, Johnson, Reagan and Clinton.

A Historical Process for Change

The political climate may seem right, but what are some ways the Obama administration can effect change? Based on his historical research, Dr. Blumenthal offered “lessons learned on health care reform.”

First, he noted the importance of truly caring about health care: “It is an extraordinarily complicated and risky issue under the best of circumstances. … Even Roosevelt shied away from the process. Those who care about it are the most successful.” Along those lines, a president should also campaign on the issue, work to mobilize public support and hire like-minded staff. Dr. Blumenthal emphasized the need to initiate reforms early on and leverage the transition team and time to do it. For example, Lyndon Johnson (who signed both Medicare and Medicaid into law) used this approach to ride the wave of post-election popularity and enact legislation before the “honeymoon” was over. Bill Clinton, on the other hand, initially moved forward on tax initiatives; later his reform plans faced strong opposition and lost momentum.

It is important to give away credit, for example, to let Congress draft reform measures and own the process. Johnson took this approach with Senator Wilbur Mills, and the “Mills bill” enacting Medicare and Medicaid was successful; Clinton did not and failed. Dr. Blumenthal advised presidents to “manage the Congress and the economists” to gain their support and “stay out of the weeds” by leaving the reform details to others. By example, he cited Richard Nixon and Ronald Reagan (among others) as being successful in just “getting it done.” Conversely, Jimmy Carter endlessly notated health care policy details but lost sight of his leadership role in the process.

According to Dr. Blumenthal, “The one job a president needs to do is to communicate what health reform is all about to the American people and build the political coalition that is needed to support it.” So how does President Obama measure up? Dr. Blumenthal gave the president high marks for his caring, commitment, early momentum and enabling of a Congress-drafted bill. He also cited the significant commitment of $650 billion in stimulus funds for health care reform. Using a baseball analogy, he joked that the president has had a “great off-season and is doing well in spring training. We’ll see if he’s going to show up in October for a World Series of health care reform played out in the House and Senate.”

Potential Products for Reform

The politics and process seem aligned, there’s impetus at government levels and some startup funding—so what’s next? If this year’s conference has revealed anything, it is the absolute variety of approaches to health care reform. Dr. Blumenthal considers it “a guessing game” as to how everything will play out. However, he did share his picks for some viable “products” for reform, starting with a serious extension of coverage for the uninsured. Cheering recent expansions to both the State Children’s Health Insurance Program (SCHIP) and COBRA, he anticipates extended employer and individual coverage with reasonable exclusions for small businesses and economic hardship. Citing the success of Massachusetts’s experimental program, he called for similar subsidies to purchase private insurance through national, regional or state-based exchanges. (See “Meet the Massachusetts Health Insurance Exchange.”)

From a system perspective, Dr. Blumenthal expects significant reform through “bundled payment experiences” that may evolve into “episode-based payments.” He also sees “a simplified, more consistent performance-based payment regime with more money at risk for providers.” Finally, change is likely through key organizational reforms in areas such as “bonuses for integration, care coordination, disease management, medical homes and HIT.”

He added, “In addition to improving compensation for primary care, I suspect we’ll see some way to change the rules of care so that primary care becomes a viable specialty once again in our country. We need to change to complementary teams of people coming together for patients with the primary care provider at the core, balancing specialist care. After all, medicine is really a team sport.”
FOJP’s 24th Annual Conference

The Road to Universal Health Coverage: Medicaid versus Medicare

Will 2009 be the year for comprehensive health care reform and universal coverage? Applying their respective expertise in health policy, two speakers looked at leveraging current programs but followed divergent paths to universal coverage.

Expanding Medicaid Is a Viable Choice

According to Michael S. Sparer, PhD, JD, director of the Executive MPH Program and professor of health policy and management at Columbia University’s Mailman School of Public Health, our current system is “fraying,” particularly for the “40 to 50 million uninsured low-wage, middle class workers who have been priced out of health care.”

To improve health care access, he reviewed a number of options, including expanding government insurance programs to reach the “eligible but not enrolled,” “imposing the hammer” of mandates for employer or individual coverage, and building up private health insurance through tax incentives and competitive markets. Looking at general sources of funding, he ticked off the typical sources of raising taxes, cutting prices and rates, regulating diffusion of and access to new technology and reducing administrative costs.

While recognizing the value of health information technology (HIT), primary care prevention, care management and other improvements, he felt that rather than saving money, these programs could actually cost more.

Beyond cost, Dr. Sparer saw politics as a big roadblock: “Interest group politics—employers, private insurers, pharmaceuticals, unions, doctors and hospitals—have been arrayed against proposals to universal coverage for more than 60 years. The only way to pay for expanded access in a $2.3 trillion industry is out of those groups. Considering that the uninsured are not organized, particularly political or influential, it is no surprise who wins out.”

Some groups have a real interest in expanding Medicaid, he said. It is the “lifeblood to much of our medical safety net.” Private insurers benefit through managed care, powerful constituencies push eligibility benefits reimbursements and states have a “love-hate relationship where they can’t live with it and can’t live without it.” Even the fragmented nature of our political system and the way it is financed create this “catalytic federalism,” where mostly federal dollars are managed by state programs. He concluded that Medicaid expansion offers the most viable route to national health insurance.

Birthing a New Health Care System

Nancy Lee Johnson, former congresswoman for the 5th District of Connecticut and now senior public policy advisor for Baker, Donelson, Bearman, Caldwell & Berkowitz, PC, agreed that there is no taking politics out of health care. But she argued that health care is also “tactile,” touching real life, community and relationships. Reform is happening because it needs to. “There is going to be change, but two things we want to preserve as we go through reforms are the inventive vitality of our society and the power we have to advance medicine and bring it to the service of patients.”

But solving problems through price and a Medicaid approach could put those values at peril, she warned. As a legislator, Johnson watched costs rise and the methodical effort to control health budgets stall because no one wanted new taxes. Today with Medicaid creeping to one-half of some states’ budgets, she questioned how we could even afford to expand the program.

“As medical knowledge is exploding, and that drives up costs. We want access to all the treatment options.
Link that with system incentives to buy regardless of need or quality and we see costs rising beyond what we can afford. The public sector has little power to change; only big employers seem to be able to control costs.” As a result, in looking at solutions, Johnson prefers to “birth a new health care system” with some lessons learned from Medicare modernization.

Medicaid and More
While agreeing that system changes are necessary, Dr. Sparer observed that as a state-administered program, Medicaid is not tagged as a big national bureaucracy like Medicare, making it more palatable to the public as a national health insurance plan. However, Medicaid could use a “name change and some marketing spin,” as it is vastly different from the system introduced in 1968. He acknowledged that the stigma attached to Medicaid might explain why nearly eight million eligible people opt not to use the program today. Other critics question the wisdom of turning a tested, welfare-type program into a universal program. There’s also Medicaid’s reputation in some states as “the plan doctors love to hate” because it can be low and slow with reimbursements.

Despite these critiques, Dr. Sparer sees hope for his proposal: “We would have to follow systems like North Carolina, where more than 90 percent of doctors are enrolled because it pays fast and well. But per capita, as it treats high-risk and highly vulnerable people while containing costs, Medicaid is actually cheap.” He has found that Medicaid directors across the country support an expanded approach and claim to have the necessary infrastructure to make it work. As to the issue of eligibility variations being leveled nationally, he feels states are better equipped to be responsive to local markets and delivery systems.

“We need to convince folks that expanding Medicaid for universal coverage is not the first step towards a single-payer system. No country in the world has that. Similar to systems in other countries, ours would be a two-tier mix of public and private financed systems. There would be options for private supplemental coverage, and the middle class and above would continue with employer-based private coverage.”

Sea Change: Lessons Learned from Medicare
With the Medicare Modernization Act, Johnson and others looked at fee-for-service Medicare and opted to focus on preventive care and wellness. Acknowledging that chronic illness represented 80 percent of the dollars and 20 percent of the people, they developed different benefits for groups based on their chronic and other special treatment needs. She noted, “By moving from the structure of an illness treatment system to an integrated health, wellness and illness treatment system, we could define illness sooner and keep people out of treatment areas. This resulted in people leading “healthier, happier lives at a far less costly medical existence.”

Now “we must reform the current structure of public and private sector insurance programs to realize the ultimate value and capability of electronic health records (EHR) for delivering evidence-based protocols and new integrated information to care for patients,” Johnson said. The groundwork for reform has been laid, including Medicare modernization and the “80/20 challenge,” with demos focused on integration, chronic care management, physician group practices, care coordination, medical homes and gain sharing. She sees “the medical home policy zooming along,” because family practice doctors are anxious to restore their family support role with fair compensation to raise reimbursements. Gain sharing offers incentive for doctors and hospitals to work together and achieve “continuous, efficient, non-duplicative, error-free diagnosis through recovery.”

The Necessity of Payment Reforms
Getting our health care systems to focus on preventive care requires reforms to our current payment systems, she said. “Payment systems include bundling and there are rules for nonpayment for errors and preventable complications, with bonuses for quality. The private sector is redesigning insurance to reward patient responsibility and basing premiums on preventive care, treatment adherence and lifestyle choices.” Paying for quality and pay-for-performance (P4P) initiatives are also part of the reform picture, she added.

Moving Toward Change
The good news is that the government and policymakers seem to agree that something must be done to ensure that everyone can afford insurance. “We have to fill the gap by bringing Medicaid up to 100 percent of poverty level but then relieve state governments of that burden and have the federal government and society subsidize premiums and provide a level of choice.”

From a long-term perspective, she agrees with the Obama administration’s calls for HIT, comparative effectiveness, restructuring and integrating care as the “best shot at getting the savings we need.” For now, there is plenty of work to be done in saving money and improving care. “If we give up and just do it through price and public plans, we will fail in long run.”
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