The Health Care Debate: What Will It Mean For You?

The changes proposed in Congress could mean big changes to your practice. We take a look at how things could play out.

By Zac Haughn, Senior Associate Editor

In November of 1932 the Wilbur Commission found that adequate medical attention was not within reach of millions of Americans. With this, they recommended the expansion of group medical practices and group prepayment systems to spread financial hazards. Critics of this group insurance, notably the American Medical Association, denounce the idea as “socialism.” Whether or not this is parallel to today’s debate, it is a whimsical addition to the story whose moral is the more things change, the more they stay the same.

Today’s physicians find themselves on the frontline of an equally important turning point in the way we pay for health care in this country. And like those who charged socialism in the fall of 1932 and those pressing for change, there is a wide gulf between ideas today.

Historic Developments

Among all the red-faced town hall rants, one of the few places both sides have shared common rhetoric has been when each side has accused the other of not reading the bill. While that wouldn’t be a first in Washington, the fact that there is a bill to read might be significant in itself. Just before adjourning for summer recess three separate House committees — Energy and Commerce, Ways and Means, and Education and Labor — came together on one bill. While all the party infighting between Democrats and so-called Blue Dog Democrats and accusations of who was going to “kill grandma” received significant attention, lost was the historical context of this compromise: during President Clinton’s ill-fated 1994 reform attempts, no bill came within spitting distance of true
One committee passed a single-payer version, another a variation of Bill Clinton’s reform, another a more politically conservative. The Public Plan. The plan — which amounts to three, maybe four, insurance plans — would pay “Medicare rates to hospitals and Medicare rates plus five percent to physicians for the first three years and then begins negotiating on its own and is open to anyone with access to the Health Insurance Exchange.” Concerning provider payments and participation, the bill will:

- Initially utilize rates similar to those used in Medicare with greater flexibility to vary payments.
- Allow immediate integration of delivery reforms also contained in the bill.
- Have voluntary provider participation - Medicare providers are presumed to be participating unless they opt out.

The Benefit Packages. This section of the bill lays the foundation for the three-to-four public options. “Within the Health Insurance Exchange, the basic plan that everyone needs to offer is, well, the "basic plan." It has to be equal in value to the prevailing employer-based insurance in the area. Cost-sharing cannot exceed $5,000 for individuals or $10,000 for families in the first year [it can then grow by the rate of inflation each year after that] and is heavily regulated. After this, the bill delivers three more plans:

Enhanced Plan: Includes the core set of covered benefits with more generous cost sharing protections than the Basic plan.

Premium Plan: Includes the core set of covered benefits with more generous cost sharing protections than the Enhanced plan.

Premium Plus Plan: Includes the core set of covered benefits, the more generous cost sharing protections of the Premium plan, and additional covered benefits [e.g., oral health coverage for adults, gym membership, etc.] that will vary per plan. In this category, insurers must disclose the separate cost of the additional benefits so consumers know what they’re paying for and can choose among plans accordingly.

The Health Insurance Exchange. While it’s run nationally, states can choose to opt out and proceed with their own plan if they follow federal regulation. In the first year, the exchange accepts those without health insurance, those who are buying health insurance on their own, and small businesses with fewer than 10 people (expanding to small businesses with fewer than 20 people in the second year). Following this, it will open to “larger employers as permitted by the Commissioner.” Only the people on the exchange will be able to access the public plan in the early years, and the exchange will be, relative to the population, fairly limited—“So the public plan will be limited, and so too will any anticipated savings.”

The exchange aims to help reduce the growth in health care spending by encouraging competition on price and quality, not benefit manipulation or efforts to exclude needy patients. This is also the part of the bill that includes a cap on premiums and out-of-pocket spending. "Regardless of income, everyone will be protected, so no one will face bankruptcy due to medical expenses," reads the committees’ summary.

To ensure that health care is affordable to people of all incomes, new subsidies will be available for people purchasing through the Exchange. They will assist people with incomes up to 400 percent of the federal poverty level (equivalent to $43,000 for individuals or $88,000 for families of four) and phase-out on a sliding scale basis.

CBO Figures. Within 10 years, the bill would cost $1 trillion and cover 97 percent of the legal population.

Progress Ahead?

Passage of a House bill now puts the ball in the Senate’s hands, namely the Senate Committee on Finance, which was the only one of five congressional committees with authority over health care that didn’t produce a bill by Labor Day. Ted Kennedy’s former Senate committee, the Health, Education, Labor and Pensions, passed “The Affordable Health Choices Act” (a section-by-section summary can be viewed at practicalneurology.net) by a 13-10 party-line vote. While differing in some places from the House version, the HELP committee bill includes a key component: the public option — a new government program created to compete with private health insurers. Recent comments on health care from the White
House reflect the Obama administration’s acknowledgment that the more liberal House will not pass a bill without a public insurance option — while the Senate will not pass one with it.

**We Are Here**

President Obama has been fond of saying in his recent speeches that the price of doing nothing in the health care field is too high. And while the differences between a public-option-supporting senator from California and a government-wary representative from Alabama may be as vast as the geography between, few observers of the health care map will say our current “You Are Here” arrow is in the right place.

Trying to pin down what exactly will happen with the health system may not be feasible, but Chernew, Hirth and Cutler attempt to “illustrate the burden that health care spending will have on the economy if spending growth continues to exceed GDP growth” in the September/October issue of *Health Affairs*, an update on their 2003 piece. That earlier paper assumed a one-percentage-point gap between real per capita national health care spending growth and real per capita growth in gross domestic product (GDP). They now assumed a two-percentage point gap.

Between 1999, when their data ended in the previous paper, and 2007, the last year for which they were able to get data, real per capita health care spending grew an average of 2.2 percentage points faster than GDP per year. As a result, between 1999 and 2007, health care consumed 35.7 percent of the real increase in per capita income, and the share of GDP devoted to health care rose from 13.7 percent to 16.2 percent. Offsetting these more negative base values is an increase in the assumed rate of real per capita GDP growth. Their base was 2007 per capita national health expenditures ($7,421) and GDP ($45,722).

Under the one-percentage-point gap assumption, spending on non-health care goods will continue to increase through 2083, although at an increasingly smaller rate, which was consistent with results published in their 2003 paper. They write that the percentage of per capita income growth directed to health care is predicted to be about 54 percent in this 75-year period (compared to the figure of 54.8 percent from 1999 to 2075 that they previously described). “We now predict that 40.1 percent of income growth will be devoted to health care between 2010 and 2050, as opposed to 45.5 percent in our earlier work. These somewhat less dire estimates reflect faster assumed income growth.” They also say that under the two-percentage-point gap assumption, non-health care spending growth will continue to increase through 2050.

**Neurological Diagnosis**

A major issue for all neurologists is concern over Medicare reimbursement rates. The payment philosophy of paying higher rates for procedures than for the time spent in the office evaluating and managing patients irks physicians and gives weight to claims that we will see a shortage of neurologists as the baby boomers age. At a public discussion on health care reform in May, Stephen L. Hauser, MD, chair of the department of neurology at the University of California-San Francisco, cited stroke-prevention practices as an example of how the payment system encourages physicians to run up the nation’s health care check. Although prescribing a daily regimen of baby aspirin is appropriate for many patients at risk of stroke, the payment system rewards physicians who perform invasive carotid procedures. The economic incentives are so aligned towards invasive therapies that some estimates say 100,000 more carotid procedures are preformed than are necessary based on the evidence, according to Dr. Hauser.

So in our current health care debate, one undoubt-edly bright spot for doctors who typically deal with older patients was a provision that would allow Medicare to pay physicians for voluntary counseling sessions that address end-of-life issues. These conversations between doctor and patient could have covered “living wills, making a close relative or a trusted friend your health care proxy, learning about hospice as an option for the terminally ill, and information about pain medications for people suffering chronic discomfort.” Such conversations would have been covered every five years, or more frequently if a patient became gravely ill.
### Senate Finance Committee Policy Options

- Strengthen primary care and chronic care management by providing bonus payments to certain primary care providers and providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition.
- Establish a framework to set national priorities for comparative clinical effectiveness research.
- Create a Chronic Care Management Innovation Center within CMS to disseminate innovations that foster patient-centered care coordination innovations for high-cost, chronically ill Medicare beneficiaries.
- Bundle payments for acute, inpatient hospital services and post-acute care services occurring within 30 days of discharge from a hospital.
- Establish a hospital value-based purchasing program to pay hospitals based on performance on quality measures.
- Develop a strategy for the development, selection, and implementation of quality measures that involves input from multiple stakeholders. Improve public reporting of quality and performance information that includes making information available on the web.
- Require enhanced collection and reporting of data on race, ethnicity, and primary language. Also require collection of access and treatment data for people with disabilities.

### House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)

- Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. [E&C Committee amendment: Prohibit use of comparative effectiveness research findings to deny or ration care or to make coverage decisions in Medicare.]
- Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers, providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas).
- Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments, and conduct pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing patient-centered medical homes. [E&C Committee amendment: Adopt accountable care organization, bundled payment, and medical home models on a large scale if pilot programs prove successful at reducing costs.]
- Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments, and conduct pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing patient-centered medical homes. [E&C Committee amendment: Conduct accountable care organization pilot programs in Medicaid.]

### President Obama Principles for Health Reform

- The plan must ensure the implementation of patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.
- To lay the foundation for improving the health care delivery system and quality of care, the American Recovery and Reinvestment Act invests $19 billion in health information technology, including $17 billion in incentives to providers to encourage their use of electronic medical records, and provides $1.1 billion for comparative effectiveness research.

While serving as a step in the right direction to both billing fairness and patient education (Medicare currently provide limited reimbursement based on time), the provisions caught more than a handful of people off guard when these conversations became known as “death panels”—ways to kill off grandma for draining the system of health care dollars. That the claim got so much attention from the mainstream media was especially curious, since the federal government already involves itself with living wills and end-of-life questions by requiring hospitals to ask adult patients if they have a living will, or "advance directive."6

Explaining their decision to drop the provision, Sen. Chuck Grassley (R-Iowa) said in a statement: "On the Finance Committee, we are working very hard to avoid unintended consequences by methodically working through the complexities of all of these issues and policy options. We dropped end-of-life provisions from consideration entirely because of the way they could be misinterpreted and implemented incorrectly."

And as neurologists who have spent time with patients of limited financial means know, the current Medicare payment system can just as easily shortchange patients, as well. Robin Elliot, Executive Director of the Parkinson’s Disease Foundation, describes in one piece: “[T]here’s the matter of home health care. Currently, Medicare pays only for such care that is required for only short stints of time during an ‘episode of care’ – usually illness, injury and/or rehabilitation. The benefit is only temporary and available for those cases where further improvement is expected.”7 He goes on to say that while this level of care is necessary on a regular basis by many of those who live with advanced PD — and costs much less than a hospital stay— it is simply not available to most people unless they are in a position to pay the substantial costs from their own pocket. ■