Incremental Changes Key To Health Care Reform

BY JOYCE FRIEDEN
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WASHINGTON — Consumer-driven health care may be all the rage right now, but there's no single cure for the nation's ailing health care system, several experts said at a health care congress sponsored by the Wall Street Journal and CNBC.

"There are no silver bullets," said Douglas Holtz-Eakin, Ph.D., director of the Congressional Budget Office (CBO). "There is no single item—technology, disease management, tort law—that is likely to prove to be the answer to aligning incentives, providing high-quality care at reasonable costs, and financing it in a way that's economically viable. More likely, we'll have a series of incremental changes" that will shore up the system.

"Rising health care costs represent the central domestic issue at this time," Dr. Holtz-Eakin said. For example, over the next 50 years, if nothing is done, "the cost of Medicare and Medicaid will rise from 4% of the gross domestic product to 20%—the current size of the entire federal budget."

Because the population is aging, "we indeed may spend more than we do now" on health care, Dr. Holtz-Eakin continued. "But the key issue is to make sure we do not overspend, that the dollars per unit of high-quality care match up with our desires."

Robert Reischauer, Ph.D., a former CBO director who is now president of the Urban Institute, noted that Medicare was a particular concern, since Medicare spending is expected to grow very rapidly over the next 10 years. He listed four possible solutions for the Medicare budget crisis.

The first possibility is to reduce the scope of coverage, but "that isn't a practical course of action," he said. Another option is to restrain the growth in payments to providers, but already, Medicare is considered "not too generous," compared with private payers, since it pays on average only about 80% of the private rate. "[Payment restraint] is clearly not going to happen," he said.

The third option is to make beneficiaries pay more for care in the form of higher premiums, deductibles, and cost sharing.

"Some people think that will cause beneficiaries to purchase more rationally and cut out low-value services, but we have to remember, the vast bulk of spending is on individuals who are very sick, have many chronic conditions, and aren't in a position to comparison-shop," he said. "Moreover, the services that they're purchasing are extremely complex and confusing, and providers play a very significant role in determining the demand for and type of services received by beneficiaries.

"Before we bet the ranch on this approach," he continued, "we're going to have to see what happens to spending patterns among the under-65 population as they are faced with high-deductible plans, health savings accounts, consumer-driven health plans, and other approaches to incentivize them to purchase more rationally. If this proves to be a successful approach for the under-65 population, one can see it gradually angling into the bag of tools that Medicare has."

However, Dr. Reischauer noted, the potential for shifting more costs onto beneficiaries is limited, "because they already spend a considerable amount of their incomes on Medicare cost-sharing of one sort or another. By 2025, the average 65-year-old Medicare beneficiary will be paying more than the size of their Social Security check in cost-sharing and deductibles."

A fourth approach is to restructure Medicare in ways to generate competition among providers, Dr. Reischauer said. This would mean emphasizing technologies that improve efficiency, such as electronic health records and electronic prescribing.

He noted that researchers at Dartmouth University have looked at health care utilization across geographic areas and found that beneficiaries receiving higher volumes of services generally have poorer health outcomes, even after differences in their health status are accounted for.

"It's conceivable that as our ability to measure differences in quality and to reward quality effectively improves, the Medicare system could be transformed into one that pays only for care which is both necessary and beneficial, but this is likely to be a long and difficult row to hoe," he said.

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Gail Wilensky, a former administrator of the Centers for Medicare and Medicaid Services who is now a senior fellow at Project HOPE, in Bethesda, Md., expressed disappointment that Congress did not do more to address the issue of rising costs when it passed the Medicare Modernization Act of 2003.

That law "is a good example of eating dessert first," she said. "There was an opportunity to try and slow down spending in a significant way while a new benefit was being introduced, but primarily, what [the law] does is provide a new benefit and some additional payments to providers of services, but not very much in terms of trying to restructure Medicare for the future."

One little-known provision of the law does attempt to address the cost issue, she added. "Starting in 2007, Part B will be much more related to income. The subsidy will start declining significantly for those with higher incomes. As the baby boomers begin to retire, some of them with higher incomes and assets, this is at least one opportunity" to help with the cost problem.

Americans are going to need to rethink the entire issue of retirement, Dr. Wilensky predicted.

"A couple of weeks ago, [Rep.] Bill Thomas [R-Calif.] talked about the need to think about Social Security and Medicare together. Both represent transfers from the working population to the dependent, nonworking population. To begin thinking about this as a joint issue may allow us to make more sensible decisions," she said.

For example, Americans should consider "how we can change both fiscal policies and cultural expectations so our whole concept of retirement begins to … reflect the increasing longevity and, for many individuals, the increased well-being and health status they have at age 65 relative to what 65 meant when Medicare was introduced in 1965," she said. "We need to think about fiscal policies to encourage continued labor force participation for people at 65 and 70." ■

Health Savings Accounts Engage Consumers in Care

BY MARY ELLEN SCHNEIDER
Senior Writer

Health savings accounts and other consumer-directed insurance products can help lower health care utilization and encourage better health behaviors, according to an industry expert.

Consumers "begin to recognize that the behaviors that they have can lead to a health outcome that can actually cost them money in the long run," said Doug Kronenberg, chief strategy officer for Lumenos, an Alexandria, Va.–based company that sells health savings accounts.

"And therefore they begin to think about changes in their behavior that can impact that health care," he said.

When an employer or insurer combines that with a program that also shows consumers the financial benefits of changing their behavior and offers support tools, consumers really become engaged in their health care, Mr. Kronenberg said during a teleconference sponsored by the Kaiser Family Foundation.

One of the possible pitfalls of the plans is that consumers who are facing deductibles of $1,000 or more each year may forego needed medical care.

For example, employers can create financial incentives for consumers to complete a health risk assessment.

Health Savings Accounts (HSAs) were authorized under the Medicare Modernization Act of 2003 and are portable accounts that consumers can use to pay for certain qualified medical expenses. The accounts are generally offered in conjunction with a high-deductible insurance plan, and both consumers and employers can contribute to the accounts.

HSAs and similar accounts, such as health reimbursement accounts, can also create big savings for employers, Mr. Kronenberg said. With these types of plans, consumers tend to see the money as their own, and utilization of health care services typically drops.

"That's not a bad thing, when you take a look at the environment we're in today, as long as you're getting the right kind of utilization reduction," Mr. Kronenberg said.

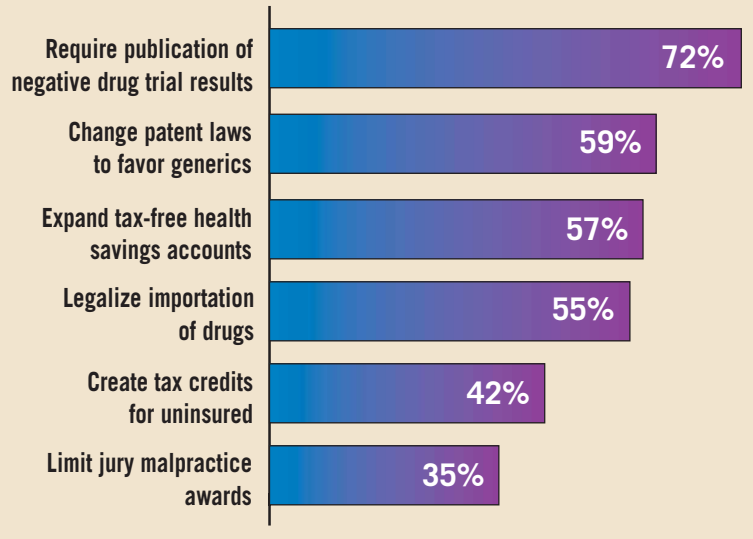
But Mila Kofman, J.D., assistant research professor at the Health Policy Institute at Georgetown University, Washington, said that HSAs coupled with high deductible plans are just shifting the cost burden for health care from the insurer and the employer to the consumer.

And one of the possible pitfalls of the plans is that consumers who are facing deductibles of $1,000 or more each year may simply forego needed medical care because they can't afford to pay for it.

Actions such as those could actually raise the cost of health care in general if consumers skip or delay screenings and other preventive care that can identify problems early. ■

DATA WATCH

Public Support for Various Health Reforms



Note: Based on a nationwide survey of 2,567 adults conducted Nov. 11-15, 2004.
Sources: Harris Interactive, Wall Street Journal Online

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