Health Reform '09: Major Overhaul—Or Not

BY JOYCE FRIEDEN
Senior Editor

WASHINGTON — Can President-elect Barack Obama really shepherd through major health reform? Not until the Medicare physician payment system gets fixed, according to Robert Laszewski.

"How do you plan a health care budget in Medicare and the private sector for years on out if you haven't agreed on how you're going to pay the doctors?" Mr. Laszewski said at a conference on the impact of the November elections sponsored by Congressional Quarterly and the Public Affairs Council.

Many obstacles lie ahead before the payment system can be fixed, said Mr. Laszewski, president of Health Policy and Strategy Associates, a health care consulting firm. "The primary care physicians are clearly underpaid, and a lot of people think that the specialists are overpaid."

Although everyone agrees that the Medicare payment system needs to be reformed and costs need to be trimmed, "the problem is, who's going to give up the money?" he continued. "The definition of physician payment reform is to pay the primary care physicians more and pay the rest of us more, and that's not going to fly."

Congress can't keep making temporary fixes, Mr. Laszewski said, because a fix that lasts for, say, 3 years will be followed by a 36% fee cut because of the way the Sustainable Growth Rate (SGR) payment formula works.

In the meantime, analysts and legislative aides are considering whether smaller health reforms might be possible.

Policy makers have to be clear about what their overall goals are, said Christine Ferguson, J.D., of the department of health policy at George Washington University, Washington. "There is a group of people who want to use health reform to improve health outcomes; another group that wants to control costs [in terms of] the percentage of gross domestic product that goes to health care; and a third group that wants to protect people from high [out-of-pocket] costs," she said. "So it's very important we're very clear about which of those goals we're trying to achieve."

Rather than passing a major health reform bill right away, the panelists suggested that President-elect Obama could urge Congress to pass a package of smaller reforms, which could include less-controversial items as expanding the State Children's Health Insurance Program (SCHIP), setting up a cost-containment board to come up with ideas for reducing health spending, and helping individuals and small businesses buy health insurance—possibly by giving them subsidies to help pay for it.

But some Senate Democrats are looking to take a more aggressive approach. Sen. Edward M. Kennedy (D-Mass.), who chairs the Senate Health, Education, Labor and Pensions Committee, wants to craft comprehensive health reform legislation that follows the framework of the Obama plan, said Michael Myers, staff director for the committee.

"With the Obama victory, the question is no longer whether we'll pursue comprehensive health reform but when and exactly what form," Mr. Myers said during a postelection briefing sponsored by the advocacy group, Families USA.

While there are many health reform proposals circulating on Capitol Hill, the best chance for success is a single-bill strategy, Mr. Myers said, and Sen. Kennedy is urging fellow Democrats to unite behind the proposal from President-elect Obama.

No legislation has been drafted yet, but whatever comes out of the Congress will need to address both the cost and quality of health care and expanding coverage to the uninsured, Mr. Myers said.

In the weeks leading up to the election, aides to Senate Democrats have been trying to lay the groundwork for this legislation by meeting with stakeholders from across the spectrum. Now that the election is over, Mr. Myers said there will be more discussions with Republicans in Congress.

The interest in achieving comprehensive health reform and the cooperation among stakeholders is higher now than at any point in the last 25 years, said Ron Pollack, executive director of Families USA. "There's a very significant likelihood that meaningful health reform will be a top and early priority for action in the 111th Congress," Mr. Pollack said. ■

Mary Ellen Schneider, New York Bureau, contributed to this report.

Long-Term Care Is Overlooked In Health Reform Discussions

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — The topic of long-term care isn't making the cut as part of otherwise excited discussions of potential health care reform in the next administration, according to political observers, advocates, and insurance representatives.

Sen. Ron Wyden (D-Ore.) said that although he's certain there will be movement toward overhauling the health system, long-term care (LTC) is not on the radar screen. "All of us have to make sure that long-term care is not the afterthought, the forgotten stepchild in the debate."

Rep. Jim McCrery (R-La.) agreed that LTC is in danger of being overlooked. He called for leadership to avoid that policy mistake. The lawmakers and other health care leaders spoke at a meeting sponsored by the Brookings Institution.

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Currently, the debate over how to finance long-term care is being silenced, yet nursing home and home-care spending shows no sign of slowing down. Medicaid is the primary payer for these services—and states are grappling with how to manage Medicaid budgets in an environment of declining tax revenues.

According to several recent studies, about half of nursing home and home-care costs are covered by Medicaid, with Medicare covering another 20%-30% of the bills. The Government Accountability Office estimated in a recent report that LTC cost $193 billion in 2004. Only about 10% was covered by private insurance, the GAO said.

There's also a huge burden borne by Americans out of their own pockets. Larry Minnix, president and CEO of the American Association of Homes and Services for the Aging, said that caregivers spend an average of $5,500 annually out of pocket on assistance for elderly and disabled family members. "It's an expensive national pastime," he said at the forum.

Long-term care is an insurable event, he said, and yet it has not been treated as such, which has made Medicaid a "$100 billion problem and growing," he said. "It's time to solve the problem and look at the downstream effects on Medicaid," Mr. Minnix said.

Very few Americans have purchased private LTC insurance. Buck Stinson, president of the LTC division at Genworth Financial, told attendees that an estimated 7 million people hold private LTC policies. Genworth is the largest LTC insurer in the United States. Mr. Stinson noted that policies were attracting younger buyers—currently, the average age of a purchaser is 57—which should help spread the industry's risk and bring premium prices down. The average claimant is 80, and the claim is generally open for 2 years, Mr. Stinson said. The company is paying out $2.5 million a day, with 40% of claims made for Alzheimer's disease.

Policy makers and others often approach LTC financing as a problem facing all 300 million Americans, which "paralyzes the discussion," Mr. Stinson said. But about one-third of Americans can cover the costs of LTC through prudent financial planning, he said. Another third will be strictly Medicaid eligible due to their incomes.

The target market for LTC policies is only about 13 million people—those who are in an income bracket where they might tip into Medicaid, but could stay out of the program if they had an alternative, Mr. Stinson said.

Mr. Minnix suggested a pay-as-you-go system with all workers, starting at age 21, paying premiums to a quasi-governmental LTC program. "People are willing to pay their fair share—they already are," he said.

Sen. Wyden said that a voluntary contribution system would make LTC financing more palatable to the American public and to Congress, which is required to fund only budget-neutral programs. A voluntary system would generate "huge waves of support from both sides of the aisle," Sen. Wyden said. ■

Physician-Rating Program Used by Aetna Meets NCQA Standards

BY MARY ELLEN SCHNEIDER
New York Bureau

Aetna Inc.'s physician-rating program recently received a passing grade from the National Committee for Quality Assurance.

The evaluation was conducted under a 2007 agreement between Aetna and New York Attorney General Andrew Cuomo, and was aimed at addressing allegations that health plans were using physician-rating programs to steer members to less-expensive providers.

To date, seven state, regional, and national insurers have signed on to the agreement and pledged not to base their physician rankings entirely on cost. The health plans have also agreed to involve physicians in measure development and to allow physicians to review their performance data and request changes.

In the most recent evaluation, the NCQA reviewed the compliance efforts of Aetna Health Inc., an HMO–point of service plan, and Aetna Life Insurance Co., a preferred-provider organization, both operating in New York. The plans were found to be in full compliance with the eight requirements reviewed by the NCQA.

Aetna officials said they were pleased with the results and committed to continuing to offer physician-rating information to members. "We will continue to base our programs on available evidence-based and externally validated measures to help ensure our programs are credible and useful to consumers," Dr. James Coates, senior medical director for Aetna Informatics, said in a statement.

The National Committee for Quality Assurance published reviews of CIGNA Healthcare of New York, an HMO, and Connecticut General Life Insurance Company, a PPO, in July.

The organization is currently reviewing United Healthcare's physician-rating program. ■

The full report on Aetna's compliance is available at http://nyrxreport.ncqa.org.