

Economists Offer Dollars and ‘Sense’ Behind Reform

The economics of health care reform were the subject of both the Simon Dack and Louis F. Bishop lectures at ACC.09.

Uwe Reinhardt, Ph.D., the James Madison professor of political economy and professor of economics and political affairs at Princeton University in Princeton, N.J., offered a cautionary perspective on the trends in American health care during the annual Simon Dack Lecture. Reinhardt warned health care spending reform will likely be a long process and that now is not the time to cut off health care spending. “The struggle to get spending down is a 10- to 20-year struggle. If Washington is thinking they can do this in one year, I wish them luck. They can’t and they shouldn’t.”

However, Reinhardt emphasized that the U.S. must do something to help Americans who can’t afford the skyrocketing individual cost of care. It costs \$15,600 out of pocket for a family of four to pay for health care. “We are pricing the bottom half of the American income distribution out of health care,” he said. Although the poorest Americans benefit from Medicaid and other programs, cab drivers, sales clerks and others who make modest incomes of \$40,000 to \$50,000 a year can’t sustain these costs.

Of the current debate on Capitol Hill about a public health insurance plan, Reinhardt said he believes the plan will either die or be converted to something like Medicare or Medicaid. He expressed concerns about how the government would finance a public plan. While the administration has said it would use \$318 billion from increased tax revenues from citizens who earn more than \$250,000, as well as \$316 billion saved from cuts in health care spending,

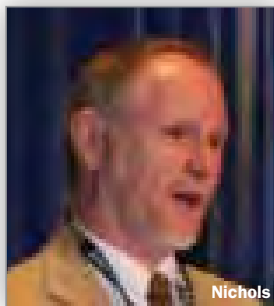
Reinhardt likened the plan to “634 billion sparrows in a tree: Climb up and try to catch them.”

He finished on a note of optimism, however, saying the economic crisis is an opportunity. Reinhardt said he “wholeheartedly endorses” the ACC approach to health care reform and is “most impressed with the patriotic, progressive way of thinking about health care at this organization.”

Len Nichols, Ph.D., health care economist and director of the Health Policy Program at the New America Foundation in Washington, D.C., also lauded the ACC’s health care reform efforts during the 40th Annual Louis F. Bishop Lecture. Nichols focused on the costs of current status quo trajectories, the costs associated with reform and what it will take for true health care reform to succeed.

According to Nichols, the U.S. health care system is primed for reform. Not only is health care becoming increasingly unaffordable to average Americans, but employer health care costs are exceeding revenue growth. In addition, 30 percent of what the U.S. spends on health care has no clinical value, and wide variations exist across the country in terms of outcomes and quality of care. Even more important, Nichols said, the incentive structure is deeply flawed and behavioral choices are affecting health and health costs “big time.”

Like Reinhardt, Nichols noted that the current economic meltdown, while also an impediment, has created an opportunity to focus on priorities. He said that many policymakers and other stakeholders are willing to say the status quo is not sustainable and that delivery system reform must accompany coverage expansion and insurance market reform. He estimated coverage expansion will cost \$150 to \$175 billion per year (1 percent of GDP), while



delivery system investments will also be needed for health information technology, comparative effectiveness research and payment reform.

Importance of Payment Reform

“Payment reform is the Big Kahuna,” he said. “It is critical that we align incentives among providers, payers and patients.” In moving away from the current “fee-for-service” structure, Nichols advocated for sharing risks and rewards in sustainable ways; bundling payments across time and space; malpractice reform; legal and negotiation strategy changes; and verification of quality care and responsibility for that care. “Shared responsibility includes patients,” he added.

Among the dangers associated with reform, Nichols listed inappropriate use of technologies and procedures, “brute-force

price controls,” a strong consensus that evaluation and management is undervalued; and the medical home “sounding like apple pie.” “Market outcomes will need to be monitored and government programs will need to be evaluated,” he said.

Nichols urged the College and all medical professionals to work with other like-minded societies and develop new voices. He said it is critical to teach policymakers how to think about, measure and encourage appropriate technical change. He suggested that the ACC could play a role in identifying physicians or practices providing high quality and efficient care and use them as examples for policymakers and other medical professionals. Outside of the medical community, Nichols said bipartisan cooperation and compromise will be key to successful reform — as will the president alienating some allies.

Nichols closed by illustrating the key components of reform: coverage expansion, payment reform, incentive alignments, cost/growth reduction and fiscal and economic sustainability. All of these elements feed into each other in a continuous circle. “We can’t afford business as usual,” Nichols said. “Change is impossible, but absolutely necessary.”

ACC Approves Blueprint for Health Care Reform

The ACC Board of Trustees (BOT) in March re-affirmed the College’s commitment to leading health care reform by approving a “blueprint” for reform, including six guiding principles and a series of action plans to implement those principles.

The ACC is engaging patients, lawmakers, payers and others in the medical community around a new standard of health care delivery focused on increasing the quality of care and ensuring greater patient value.

Under the organizing principle of “Quality First,” the BOT approved the following six principles: universal coverage; expansion of coverage through public/private programs; a focus on patient value (transparent, high-quality, cost-effective, continuous care); professionalism and partnership with empowered patients; coordination across sources and sites of care; and payment reforms that reward quality and ensure value.

“While coverage and financing are extremely important, cardiovascular professionals can have the most impact on the last four principles, which focus on reforming delivery and payment systems to improve quality of care,” says **ACC CEO Jack Lewin, M.D.**

In addition to the six principles, the BOT also approved a series of action plans in areas in which it believes the College can make major contributions in both cardiovascular care and overall system reform. The plans focus on reducing cardiovascular-related hospital re-admission rates; limiting inappropriate imaging; reducing geographic variations in care; encouraging adherence to guidelines; partnering on patient-centered medical home models; ensuring transparency and professionalism; testing payment models that reward quality; and increasing primary and secondary prevention through medication adherence and lifestyle choices.

According to Lewin, ACC leaders believe that carefully crafted partnerships among patients, the Centers for Medicare and Medicaid Services (CMS), the Congress, the Obama administration and willing professional societies will achieve these results and expedite the progress needed. Each of these pilots will move us even closer to providing the right care, to the right patient, at the right time, he said.

For more on the ACC’s health care reform efforts, go to qualityfirst.acc.org.

