System Reform Will Require a Much More Comprehensive Scheme:
Response to Rabkin and Cook's proposal for "Balanced Incentives for Health Care"

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Rabkin and Cook seek to move from fee-for-service physician services to a capitated scheme for primary care physicians (PCPs) with incentives to moderate total health care expenditures. Their proposal is a very gentle effort to "bend the curve" of unsustainable cost increases in health care while enhancing quality of care and patient satisfaction. I support their intent to move from inflationary fee-for-service incentives to better-coordinated, patient-centric, budget-bound health care. Since they have been writing on this theme for many years, one must ask why such experiments have not already emerged in significant numbers.

Rabkin and Cook expect small teams of 5–15 primary care physicians to choose this scheme even though they will not control all critical cost expenditures, as their patients are to be permitted in Stage One and in Stage Two/Option One to continue to go to specialists of their choice. The PCPs, in short supply, will be expected to spend more time per patient, but their schedules are already full. The PCPs will have to figure out how to manage their practices to very different financial parameters. The team will need to hire sophisticated staff to manage the financial plan, document potential savings, and negotiate variables in formulas in the annual adjudication.

The authors hope that some specialists will join the Team on a salaried basis. They do not address the style of practice that already has physicians and patients in Miami, Boston, and elsewhere accustomed to spending much more per Medicare beneficiary than the median in the rest of the country, let alone Minneapolis or Seattle. They do not specify objectives for cost control or cost reduction, and they require upfront expenditures from Medicare and other payers without putting the PCPs at financial risk. They do not estimate how many teams will be needed to have any chance of making a dent on the overall expenditures, or what size of Team would be necessary to have sufficient patients to create credible budget and risk parameters — surely much larger. Moreover, even these small groups may be hard to find in rural America. Nor is there a plan to generate and deploy much larger numbers of primary care physicians — a gap now recognized in implementing the current Massachusetts health care plan. They invest no responsibility in nurse practitioners, physician assistants, or community/public health.

For the past 100 years, there has been a serious effort at comprehensive health care reform every 20 years, as if on a metronome, led by Theodore Roosevelt, The American Medical Association, Harry Truman, Richard Nixon, Ted Kennedy, Jimmy Carter, the Clintons, and now President Obama. Despite a noisy public confrontation over the role of government and the scale of long-term deficits and debt, the stars may yet align for major action this calendar year. If the action is blocked or is incremental, there could be ample time for several years of pilot experiments and demonstrations of the kind proposed by Rabkin and Cook, preferably enhanced by addressing the deficiencies noted above. Accountable Care Organizations, which are under consideration in Massachusetts, would have greater scale and leverage. If Congressional action is bold, there may still be provisions for states, insurance-exchanges, or cooperatives to try alternatives to

achieve the trifecta of affordable health care (for families, employers, and the country), higher quality health care, and universal insured access. After the contentious process of creating and passing legislation, there will be an extended period of implementation. Strong public-private, provider-consumer partnerships will be critical to set clear goals, adopt credible metrics, and show that incentives can make a big difference. If a federal Commission is established, the members will need demonstrations, evidence of comparative effectiveness of practice alternatives, and analyses of agreed-upon goals, metrics, and incentives.

Current Congressional proposals address the following key elements:

1. *For the insured.* For those with insurance, prohibit exclusions for pre-existing conditions, mandate portability, assure reasonable choice of providers, and provide no-deductible health promotion and disease prevention services and counseling. These more generous coverage terms will surely lead to higher premiums. Standardization of insurance policies, benefits, billing forms, and other sources of wasteful spending and frustration for patients and providers remains to be addressed — probably in the private sector.
2. *For the uninsured.* Create insurance pools through private insurance exchanges, a public or non-profit option, or other means so that uninsured employed individuals and unemployed individuals without government insurance are no longer forced to rely on highest premiums and poorest coverage in the individual insurance market. Individual insurance is not a good deal for most insurers either. Large numbers of newly insured will bring major revenue to insurers, providers, and drug and device manufacturers; constraining their rate of increase in premiums, fees, and prices will be difficult in the

high-demand setting without a governmental regulatory role. Apparently jawboning will be tried first.

3. *For employers.* Mandate employers to sustain current coverage, offer coverage, or contribute to a federal or health insurance-exchange fund for employees not offered insurance. Provide transparency to employees on full costs and charges, quality measures, and patient satisfaction surveys, with variable co-pays for the alternative health plans from which they can choose. Stimulate practice reforms that might moderate insurance costs for employers, along with others.
4. *For providers.* Provide data and financial incentives for safer, higher quality, more coordinated care through case management for chronic disease, higher payments for primary care and coordinated care, clinical guidelines, electronic health records and order-entry systems, comparative effectiveness research, and community-based disease prevention/health promotion. Like the Rabkin-Cook scheme, each of these components has substantial upfront costs before any savings might be generated. Major changes in practice will be essential to achieve any cost savings from these quality improvement programs, especially health information technology, as emphasized by the CBO under Peter Orzsag's leadership. Physician leadership will be critical.

There are several big issues not yet addressed:

1. Rapidly increased health care insurance coverage does not equate to access. There must be appropriate providers in sufficient numbers with time slots on their office calendars to welcome the demand of large numbers of newly insured and empowered individuals and families. There must be coverage for evenings and weekends, rather than a phone

message directing patients to emergency rooms. Recruiting new PCPs takes years, and retaining them is uncharted territory.

2. Large and growing geographic variation in expenditures. For more than 30 years Jack Wennberg and his protégés have documented the huge differences in per beneficiary expenditures by Medicare for the 65-and-over and disabled SSI populations. Examples from their work are "practice styles" with twice as high spending in Boston compared with New Haven, three times higher in Miami compared with Minneapolis or Seattle. Elliott S. Fisher et al. further demonstrated that acute and compelling medical problems were treated at similar cost in these regions; the high cost emerged from discretionary or marginally indicated use of services and technologies. These excess expenditures go far beyond local wage rate differences and poorer health among people in poverty. They represent a hidden tax on the people in lower-expenditure geographic areas of our country. And expenditures are rising more rapidly in regions with higher spending. Thus, this issue is a matter of equity for the public and the providers. It is core to the President's stated desire to make health care affordable and to generate savings that will offset costs of dramatically increased coverage and not increase the deficit.

3. Malpractice, defensive medicine, and tort reform. Health care reform will put many new pressures on practicing physicians to enhance quality, invest and utilize electronic medical records and order-entry systems, see more patients, and accept constraints on fee increases. No issue is more frustrating to practicing physicians and more emotional among them than very expensive malpractice insurance premiums regardless of one's good record and fear of litigation and the burdens of defending oneself. To many physicians otherwise inclined to support or even campaign for health care reform, the

lack of attention to this issue is viewed as a kowtow to the plaintiff bar as a political constituency.

4. Controlling costs. Total health spending is projected to reach $2.8 trillion in 2010, or 17.9 percent of GDP, according to the Centers for Medicare and Medicaid Services. This amount represents a doubling of spending as a percentage of GDP over the past three decades, from 8.1 percent in 1975. Premiums for health insurance offered through employers have doubled since 1999, as has the cost paid directly by workers. Under present law, the CBO projects health care spending to grow five percentage points faster than GNP over the coming decade. Arm-waving about cost-savings and efficiencies, on one extreme, or tossing the public to the wolves with a modest voucher or tax credit to buy individual insurance on the open market, on the other, does not equate to a credible proposal for "affordable" health care or federal cost control. "Affordable" means providing good, even better, quality care to the full population while keeping growth in national and federal health care expenditures at or near the rate of growth we can achieve in gross national product of the economy to pay for these services and our desired advances in the capability of the health care system. Scenarios for the fiscal future of the nation are the subject of a forthcoming report from the National Academies.

Attending to these four large challenges would come closer to justifying the "system reform" phrase applied by Rabkin & Cook.