Ask the Experts

In this and future issues of *MPM*, we ask a panel of experts to comment on a pressing issue of the day. Let us know if you have suggestions regarding experts you would like to hear from or questions you would like to see addressed.

The Climate for Change

Incoming White House Chief of Staff Rahm Emanuel says universal health coverage will be an early and top priority of the new administration.

In his new book, *Critical: What We Can Do About the Health-Care Crisis,* Tom Daschle, President-elect Barack Obama's nominee for Secretary of Health and Human Services (HHS), calls for the creation of a Federal Health Board modeled on the Federal Reserve Board that would oversee and set the rules for government-funded, government-subsidized health programs, including Medicare, Medicaid, and the expanded Federal Employees Health Benefits Program (FEHBP). Daschle also supports the patient-centered medical home concept in which primary care providers (PCPs) would receive capitation payments for care coordination services currently not covered by Medicare or private payers.

What do you consider to be the greatest opportunity ahead? What is your single greatest concern?

C. Gresham Bayne, MD
Past President, American Academy of Home Care Physicians (AAHCP)

My biggest concern is that organized medicine continues to make the same mistake of the past, which helped to create the problem: lack of patient selection criteria. Tom Daschle's book shows his support for the patient-centered medical home (PCMH), which I support, but it will fail for the same reasons 15 out of 15 chronic care initiative demonstrations did: lack of targeting the high-cost patient for the intended benefit. Patients able to reach our offices are, by definition, better off than those too frail, demented, or acutely ill to come in. In fact, the top 5% of most costly patients consume 43% of the entire Medicare budget, but these are patients with five comorbid conditions, significant problems with activities of daily living, and a history of ambulance/skilled nursing facility/rehab or home health benefit in the past 6 months. They are NOT the ones coming into our offices because they cannot get there; we don't want them there (wheelchair patients with advanced dementia are difficult to handle); and they are currently calling 911 as the only viable alternative in their mind. So my concern is that we will continue to think bringing the high-cost patient to the office is more cost-effective than taking office services to the homebound patient…ie, making house calls.

Nathan Kaufman
Managing Director
Kaufman Strategic Advisors, LLC

The primary focus of the politicians' health care reform plan is mandated universal coverage. Experience in Massachusetts shows that mandated universal coverage may improve access to care, but other systemic problems may get worse. The newly insured beneficiaries in Massachusetts are reported to be using emergency department (ED) services at almost twice the rate of the nation. One possible reason for this is the shortage of PCPs in the state, which is a function of poor reimbursement rates, and these are not getting better, even under the much touted medical home model. Thus far, universal coverage has not addressed the critical shortage of providers nor has it addressed the deteriorating financial condition of physicians and hospitals. Since the implementation of universal coverage in 2006, the operating margin for Massachusetts hospitals has trended downward.

Universal coverage appears to have accelerated the exponential growth in health care expenditures. In his March 24, 2008, Op-Ed article in the *Boston Globe,* Christopher Anderson (president of the Massachusetts High Technology Council) states: "With its massive cost overruns and missed

deadlines, the health care reform law is quickly becoming the Big Dig of the next generation, an ambitious and beneficial but deeply flawed public initiative with back-breaking costs to the taxpayers. Unlike the Big Dig, Massachusetts taxpayers, not Congress, will pay most of the healthcare tab."

The old adage clearly applies to the Massachusetts Healthcare Reform Plan: *If you think health care is expensive now, wait until it's free*. Implementing a universal coverage plan nationwide could cost the nation an additional $124 billion per year.

Under universal coverage, costs will increase exponentially. Most state and federal payment plans provide unrestricted access to the most expensive care available regardless of the patient's prognosis. It has been reported that as much as 30% of Medicare dollars is spent on beneficiaries during their last year of life. A recent federal court decision prevented Medicare from limiting its coverage to the least expensive appropriate care. Thus elderly and low-income beneficiaries, who represent some of the highest-risk patients, are given a blank check and unrestricted access. Thus far, the government's response to cost escalation is to reduce provider reimbursement. Ultimately, this will make the problem worse as hospitals and physicians are forced out of business. In addition, the current malpractice environment contributes significantly to escalating costs. In the recent study by the Massachusetts Medical Society, physicians reported that as much as 13% to 30% of expensive imaging tests, hospital admissions, and specialty referrals were not clinically indicated but resulted from the need to practice defensive medicine because of malpractice risk.

Any plan for universal coverage must be accompanied by the development of standards of care. That is, coverage for beneficiaries will be limited to that specified in the standards of care. Also providers will be protected from malpractice litigation if they practice within the standards of care. Patients who wish to deviate from these standards should be allowed to purchase discretionary care insurance, much like they can purchase supplemental plans today.

Marvin E. Herring, MD
Clinical Professor, Family Medicine
University of Medicine and Dentistry of New Jersey

As a practicing physician/educator for the past 50 years, I have never been more personally rewarded in all my areas of interest—family health, psychosocial medicine, cultural medicine, pain management, teaching—than from my involvement in palliative care, and its ability to "let me be a doctor," see positive outcomes from my ministrations, profit from the effective implementation of interdisciplinary team care, see better and more economical care both enhance and extend quality of life for people and loved ones dealing with life-limiting illness, and actually be thanked for my efforts. This is a great opportunity to extend the Medicare-supported role of current hospice-level care teams, already established and functioning clinically and fiscally successful entities, adapting their knowledge, skills, and soul-enhancing expertise to the team management of advanced, disabling chronic illnesses well before patients attain a "terminal" label.

There is an old Yiddish proverb—"An egg today is better than the promise of a chicken tomorrow." My single greatest concern is that while Medicare reform seeks, for instance, to address system-based issues, fraud, and deceit; and enhance preventive care, pharmaceutical costs, electronic record-keeping, and prescribing; it will lose PCPs because of its failure to reimburse more than what it costs PCPs to care for their patients, and perhaps to repay at least what it costs for the vaccines they administer. If that doesn't occur, Medicare will run out of doctors who accept Medicare patients and future family physicians as well. MPM

We welcome your input.
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