



# Why Health Reform is the Right Prescription for Health Professionals and Their Patients

Ellen-Marie Whelan and Mandy Krauthamer | October 5, 2009

The health care community will play an important role in the eventual implementation of health care reform legislation, but will also have a unique ability to explain to patients how health reform will impact their lives, the health of their communities, and the delivery of their health care. The public has very high confidence in health professionals to recommend the right thing. One recent survey found that 79 percent of responders had at least a fair amount of confidence in nurses' groups, and 70 percent in doctors' groups.<sup>1</sup>

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## The health care system is broken and health professionals agree we need reform

Health professionals see the shortcomings of our health care system firsthand every day: insurance companies denying coverage for the care they prescribe, families losing access to their doctors, and a system that forces them to spend more time with paperwork and less time with patients. They see a health care system that is uncoordinated, payment incentives that are misaligned, and inadequate investments in prevention and wellness.

The broad health care community has shown unprecedented support for health reform in recent months. Many health professionals have been supportive of health care reform efforts in the past, but medical professional organizations have been traditionally resistant to reform. Yet even these groups are now publicly advocating on its behalf. In the physician community, organizations representing over half a million physicians have publically endorsed the health reform legislation moving through Congress.<sup>2</sup> It is clear that clinicians' interest to best serve their patients is aligned with the American public's desire for a health care system that works. Both groups no longer accept the unacceptable status quo. Today's evolving consensus on health reform targets precisely the issues that have frustrated clinicians and hampered their ability to do their jobs.

Creating a health care system—a true system—that works well for all Americans is the most important goal. Health care providers have long attempted to “work around” the myriad of barriers they encounter when trying to provide a single standard of high-quality

patient care.<sup>3</sup> They volunteer in free clinics, alter plans of care for patients with inadequate health care, provide important services that are not reimbursed, and trudge through seemingly arbitrary health insurance regulations.

There are six core elements of the emerging health reform package that meet the provider community's shared goals and will begin to fix this dysfunctional system:

1. Expanded insurance coverage for all Americans
2. Delivery system reform and payment innovation
3. A focus on prevention and wellness
4. Enhanced primary care and chronic care management
5. Robust comparative effectiveness research
6. Attention to the health workforce

Each of these elements will help ensure that providers are better able to serve their patients in critical ways.

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## 1. Expanded insurance coverage for all Americans

A system in which all Americans have adequate health insurance coverage would allow health professionals to provide needed care to all Americans without cutting corners. The health care reform proposals that Congress is developing contain many common measures to improve health care coverage for all Americans. The most important aspect of health care reform is making coverage more affordable for the 46 million uninsured and the 25 million underinsured Americans.<sup>4</sup>

**Health insurance exchange:** Legislation in both the House and Senate contain a health insurance exchange. The exchange would create a marketplace where individuals not covered by an employer's health plan could comparison shop and purchase coverage with benefits and rates similar to those negotiated by large employers.

**Subsidies for low-income Americans:** The legislative proposals would provide subsidies on a sliding scale to enable more low-income and middle-class Americans to purchase health insurance within the exchange.

**Caps on out-of-pocket spending:** The bills place a limit on the maximum amount an individual spends on health care in a single year or over a lifetime, which would greatly reduce the incidence of medical bankruptcy.

**Expansion of Medicaid:** The legislation expands the Medicaid program so that it can provide insurance to many more low-income individuals. It is estimated that this provision will cover an additional 11 million people.

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## 2. Delivery system reform and payment innovation

Integrated delivery systems can promote collaborative team-based care to better serve patients' complex care needs, especially in primary care and chronic care management. The currently fee-for-service payment system rewards the volume of services provided rather than ultimately paying for making patients better. This has exacerbated the fragmentation that characterizes health delivery today and drives up the cost of health care. New payment systems will reward the value over volume, and quality over quantity. Changing the incentives away from high-tech, procedure-driven medicine to a better integrated system that practices a team-based approach will likely create better patient outcomes in a more efficient, cost-effective way.

**Rewards for primary care:** All bills currently being considered by Congress address the underpayment of primary care clinicians by proposing increased fee-for-service payments for primary care providers by 5 to 15 percent depending on where the service is provided. The higher rate will be applied in health professional shortage areas. The Finance bill would extend the bonus payments for general surgeons. Both bills include nurse practitioners and physician assistants as primary care providers.

**Accountable Care Organization pilot projects:** Both the House and Senate bills include proposals that would increase efficiencies in the health system by encouraging different providers to work together to provide wide sets of services to patients. ACOs are a new concept that is being explored as a pilot project in current health care reform legislation. New payment incentives would help providers who are organized either as an established or virtual entity to achieve both better outcomes and save money. These new ACOs could be based around an integrated delivery system, a physician-hospital association, small groups of providers coming together, or an academic medical center. ACO members share responsibility for the quality and cost of care patients receive. If the ACO achieves quality and cost targets, it could receive a bonus; if it fails, its members could face lower Medicare payments. The incentive is to deliver coordinated, efficient care.

**A revised Sustainable Growth Rate:** The Sustainable Growth Rate is the formula that the federal government uses to calculate the growth of reimbursement rates for physicians' services under Medicare. Physician payments are scheduled to be cut again next year, due to this flawed formula, and they will likely be cut in subsequent years as well. The Senate bill proposes ensuring that Medicare beneficiaries continue to have access to care by replacing the impending cut with a 5 percent increase for 2010—but only for one year. The House bill establishes a new payment policy that completely reforms the SGR

formula. The revised formula would recognize the importance of primary care by allowing these services to grow at a higher rate than other services and updating current payment rates as these reforms are implemented.

**Options to address medical liability:** Both the House and Senate legislation explore potential state-level solutions would allow physicians to focus on their patients rather than practicing defensive medicine. The Senate bill includes a provision to encourage the development and testing of alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, and encouraging the efficient resolution of disputes. Still under consideration is the establishment of state demonstration programs to evaluate alternatives to the current civil litigation system. The House includes a provision for state pilot programs to address medical liability reforms.

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### 3. A focus on prevention and wellness

Health professionals know better than anyone that we must change the focus of health care activities from reactive care for sick patients to preventive approaches that forestall the development of many conditions in the first place. Health reform will enhance community-based care capacity by improving public health services and enabling health professionals to provide quality wellness and prevention care for individual patients. Both the House and the Senate have proposed some strong provisions to merge public health with traditional clinical medicine by introducing a mixture of community and medically based prevention.

**A Prevention (or Wellness) Trust:** Both bills before Congress establish a new fund—either the Prevention Trust or the Wellness Trust—to provide expanded and sustained national investment in prevention and public health programs that would improve health. This fund is modeled off of the Wellness Trust concept, developed at the Center for American Progress, which prioritizes prevention in the U.S. health care system.

**Prevention task forces:** Both bills also create task forces on preventive (clinical) services and community preventive services. These would work together to set prevention priorities and communicate with state and local entities to optimize the environment in which individuals can pursue a healthy lifestyle.

**Reduced co-pays on preventive services:** Both the House and Senate proposals have provisions that would require Medicare and private health insurers to fully cover preventive services including well visits and patient screenings without additional co-payments or deductibles.

**Annual wellness visit:** The Senate Finance Mark also requires Medicare to cover a personalized prevention plan and an annual wellness visit for all Medicare beneficiaries with a primary doctor. Designing a personalized plan will help patients better understand how to

address and minimize the possibility of health risks and chronic diseases. The House bill also includes an initial physical exam without a co-pay as part of preventive services.

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#### 4. Enhanced primary care and chronic care management

The 20 percent of Medicare beneficiaries with five or more chronic conditions each year account for two-thirds of Medicare spending, see about 14 different physicians, visit an office 40 times, and fill 50 prescriptions.<sup>5</sup> Care remains fragmented across all of the conscientious and hard-working professionals and providers—with no one really in charge of coordinating the care. As a result, the total care is often less than the sum of the parts. Patients hear conflicting diagnoses and treatment recommendations, receive duplicative or incompatible medications, and suffer avoidable medical errors due to lack of coordination. Coordinated care management will reduce confusion within the system and help health professionals manage patients' chronic conditions.

**The Medical Home:** The Medical Home is used to describe an approach to providing comprehensive primary care. It involves, in most cases, a bonus payment to primary care clinicians who agree to provide full primary care services for a patient. The House put forth an extensive Medical Home Pilot Program based on two models that are very flexible in their design: the Independent Patient-Centered Medical Home led by a primary care clinician or appropriate specialist for beneficiaries with chronic conditions, and the Community-Based Medical Home, which uses non-physicians to assist primary care physicians to deliver medical home services. Both models focus on the chronically ill and provide bonus payments to the medical home providers. The Senate bills provide less defined descriptions of the Medical Home models, but include language to encourage and reimburse providers who choose to participate in such a program.

**Transition care:** Many have identified potentially avoidable readmissions to hospitals as both an enormous financial drain on the health care system and an indication of poor quality care. Transition care is the term used to describe the care delivered to patients as they transition out of the hospital. Proper care delivered during this time has been shown to improve patient outcomes while preventing costly preventable rehospitalizations. The Senate Finance Bill includes a proposal to reimburse care management activities performed by clinicians—often nurse-care managers—for patients with chronic diseases as they are discharged from the hospital. The House provision takes a different approach to address transitional care. The legislation directs the Health and Human Services secretary to study how physicians can be included in a preventable hospital readmission policy since access to a physician (or lack thereof) is also important to avoiding readmission.

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## 5. Robust comparative effectiveness research

Comparative effectiveness initiatives are designed to support clinician-patient decision making, not interfere with it as some assert. An increased investment in comparative effectiveness research will, by improving the quality and quantity of research studies, permit patients and their health providers to make better decisions about care based on evidence.<sup>6</sup>

**A new home for comparative effectiveness research:** Both the House and Senate make a single entity responsible for developing, compiling, and disseminating comparative research on various treatments for the same conditions. The House and Senate HELP committee proposals would establish a center for comparative effectiveness research as a government entity—likely in the Agency for Healthcare Research and Quality. The Senate bill proposes establishing a private, non-profit corporation. In both cases the entity would promote health outcomes research and evaluation that enables patients and providers to identify which therapies work best for most people and to effectively identify where more personalized approaches to care are necessary for others. Nothing in any of the developing pieces of legislation would mandate coverage or recommend any reimbursement requirements.

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## 6. Attention to the health workforce

Both the House and Senate legislation have important investments in enhancing the health workforce to ensure that there are enough health care professionals in every community to care for all Americans. The legislation also recognizes the importance of access to primary care in rural and underserved communities.<sup>7</sup>

**National Health Service Corp:** The National Health Service Corp was established in 1972 to provide scholarships and loan repayment to health professionals who agree to work in Health Professional Shortage Areas in the United States. More than 30,000 clinicians have served in the corps since its inception, expanding access to health services and improving the health of people who live in urban and rural areas where health care is scarce. Both the House and Senate have acknowledged the importance of this long-standing program and include provisions to expand the program. The House specifies increased appropriation amounts and would allow for part-time service repayment.

**National Workforce Advisory Planning:** The majority of the nation's financial investment in developing the health workforce is in hospital-based residency programs, and there is no single entity to look at the entirety of the nation's health workforce capacity and future needs. Both the House and Senate establish a new Workforce Advisory Committee or Commission to establish a national workforce strategy and report to Congress on plans to improve the nation's workforce capacity. Both chambers also have provisions to establish a Center for Workforce Analysis to collect data to assess and plan for the nation's workforce needs on the local and national level.

**Primary care residency programs:** There is a cap on expanding the number of residency slots in hospitals, but every year there are a number of slots that go unfilled. Both the House and the Senate would allow and encourage these unused slots to be targeted toward primary care and general surgery residency programs. The redistribution would focus on areas with low resident-to-population ratios, health profession shortages, and rural areas.

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## Endnotes

- 1 Kaiser Family Foundation, NPR, and the Harvard School of Public Health, "Survey on the Role of Health Care Interest Groups" (2009) available at <http://www.kff.org/kaiserpolls/7992.cfm>.
- 2 Survey of doctors that support reform, see: <http://www.doctors-support-reform.org/>.
- 3 Robert A. Berenson and Ellen-Marie Whelan, "Health Reform: Delivering for Those Who Deliver Health Care?" (Washington: Center for American Progress Action Fund, 2009) available at [http://www.americanprogressaction.org/issues/2009/04/health\\_reform\\_providers.html](http://www.americanprogressaction.org/issues/2009/04/health_reform_providers.html).
- 4 Peter Harbage and Hilary Haycock, "Achieving a Culture of Health Coverage: Creating Seamless Insurance Coverage." (Washington: Center for American Progress, 2009) available at <http://www.americanprogress.org/issues/2009/08/autoenrollment.html>.
- 5 Gerard F. Anderson, "Medicare and Chronic Conditions." *New England Journal of Medicine* 353 (3) (2005): 305-09, available at <http://content.nejm.org/cgi/content/short/353/3/305>.
- 6 Ellen-Marie Whelan and Sonia Sekhar, "Better Health through Better Information: Issue Brief on Comparative Effectiveness Research," (Washington: Center for American Progress, 2009) available at [http://www.americanprogress.org/issues/2009/09/ce\\_r\\_brief.html](http://www.americanprogress.org/issues/2009/09/ce_r_brief.html).
- 7 David C. Goodman, "Twenty-Year Trends in Regional Variations in the U.S. Physician Workforce." *Health Affairs* Web Exclusive, VAR90-7 (2004), available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.var.90/DC2>.