EDITORIAL | Kenneth E. Thorpe and Thomas P. Trimarco

The health reform we still need

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Now that the Supreme Court has upheld the Affordable Care Act, the law’s ultimate success or failure may be judged on whether we can afford it.

A look at the Massachusetts experience with health care reform illustrates the point. The law, which was used as a template for federal reforms, shows us that expanding coverage can be achieved through a government mandate (98 percent of the state’s citizens are insured), but controlling costs is far more difficult. The typical regulatory solution is to reduce payments for services, cut benefits, or both. Facing an epidemic in chronic disease, a struggling economy, and physicians who won’t take another Medicare cut, these ideas have clearly reached their workable end.

We think the answer lies in two policy changes. First, we must control runaway spending on preventable chronic diseases with delivery and payment reforms that emphasize prevention and primary care. Second, we must allow any exchanges created by new state laws to form a true marketplace where consumers can purchase health care coverage that most effectively suits their own individual needs regardless of insurance status and who is paying for the care.

National health expenditures totaled $2.6 trillion in 2010, or 17.9 percent of the gross domestic product. The Centers for Disease Control says that 75 percent of health care costs are due to preventable chronic illnesses like diabetes, heart disease, cancers, and stroke. That figure is up to 96 percent for largely fee-for-service government programs like Medicare and Medicaid, which spend up to 20 percent on duplicative tests and uncoordinated care.

The good news is that these costly conditions are largely preventable and very treatable when caught early. The bad news is that with all the reforms, we still pay our best providers handsomely by the visit but not at all for preventing chronic disease in the first place. Payment reform pilots like Accountable Care Organizations are a part of the Affordable Care Act, but the time for pilots is over. A statewide patient-centered medical home program in North Carolina has paid doctors to reduce chronic illness in the Medicaid program. The state has saved $700 million in Medicaid since 2006.

It’s time to take these reforms to Medicare and Medicaid and the exchanges for individuals and small business. We must stop paying a premium for procedures for the sick and transition to system that pays health providers to keep their patients well. Models like the medical home, ACOs, and bundled payments can show the way for a transition in these costly government programs.
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In Massachusetts, the Health Insurance Connector Authority administers all aspects of the subsidized Commonwealth Care program and is a market clearinghouse for the purchase of private insurance in the individual and small group market. It gets high marks for expanding health coverage to over 98 percent of the state. But the grades for reducing cost, establishing a marketplace, and improving actual health care aren’t as good. The rich benefit mandated by their “minimum creditable coverage” is a one-size fee for service benefit that does not fit all and is proving to be too burdensome for the state, individuals, and small business. Furthermore, the Connector has not lived up to its full promise to be a market-based clearinghouse for private insurance. In a potential non-group market of almost 800,000, only 36,000 — less than 5 percent of that market — uses the Connector. The exchanges need to allow the principles of consumerism to work in this market or they won’t work. If exchanges are allowed to create a workable marketplace for health benefits, they can help move employers away from designing health benefit plans for their employees and allow choice and flexibility where little or none exists today.

If we offered US consumers a fairly regulated and transparent marketplace where benefit plans with the best evidence-based practices, services, and programs would have to compete for their business, people would flood the Massachusetts Connector and other exchanges around the country — mandate or not. To make this happen, we must ensure that plans offered in the exchanges can offer what the market needs, and that plans covered by our tax dollars must emphasize prevention and primary care. We can’t afford to pay for sick care anymore. Incentivizing value, quality, and coordinated care is the health care reform we can’t afford to live without.

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