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Health Policy

Obama Health Care for All Americans: Practical Implications

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Rapidly rising health care costs over the decades have prompted the application of business practices to medicine with goals of improving the efficiency, restraining expenses, and increasing quality. Average health insurance premiums and individual contributions for family coverage have increased approximately 120% from 1999 to 2008. Health care spending in the United States is stated to exceed 4 times the national defense, despite the wars in Iraq and Afghanistan. The U.S. health care system has been blamed for inefficiencies, excessive administrative expenses, inflated prices, inappropriate waste, and fraud and abuse. While many people lack health insurance, others who do have health insurance allegedly receive care ranging from superb to inexcusable.

In criticism of health care in the United States and the focus on savings, methodologists, policy makers, and the public in general seem to ignore the major disadvantages of other global health care systems and the previous experiences of the United States to reform health care. Health care reform is back with the Obama administration with great expectations. It is also believed that for the first time since 1993, momentum is building for policies that would move the United States towards universal health insurance. President Obama has made health care a central part of his domestic agenda, with spending and investments in Children's Health Insurance Program (CHIP), American Recovery and Reinvestment Act of 2009, and proposed 2010 budget. It is the consensus now that since we have a fiscal emergency, Washington is willing to deal with the health care crisis. Many of the groups long opposed to reform, appear to be coming together to accept a major health care reform.

Reducing costs is always at the center of any health care debate in the United States. These have been focused on waste, fraud, and abuse; administrative costs; improving the quality with health technology information dissemination; and excessive regulations on the health care industry in the United States. Down payment on health care reform, American Recovery and Reinvestment Act, and CHIP include many provisions to reach towards universal health care.

Key words: Health care reform, universal health care, national health expenditures, gross domestic product, sustained growth rate formula, physician payments, American Recovery and Reinvestment Act of 2009, Children's Health Insurance Program, health information technology

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Health care spending in the United States grew 6.1% to $2.2 trillion, or $7,421 per person, in 2007. Consequently, the health spending share of the gross domestic product (GDP) reached 16.2% — an increase of over the 16% share in 2006. The news looks bad for everyone involved in health care — patients, providers, employers, and the government, however, there is a silver lining. The 2007 rate of growth in national health expenditures (NHE) was the slowest since 1998, and 0.6 of a percentage point lower than the 6.7% growth in 2006. The deceleration in 2007 was attributed mostly to slower

growth in both retail prescription drug spending and Medicare spending associated with administering the Medicare benefit (1).

In contrast to overall spending growth of 6.1%, Medicare spending increased 7.2% in 2007, to $431.2 billion. However, the silver lining is that spending growth for fee-for-service Medicare, which accounted for about 80% of total Medicare spending in 2007, slowed significantly to 3.6% in 2007. Consequently, increase in Medicare Advantage spending accounted for almost 60% of the total change in Medicare spending in 2007, largely because of the shift in enrollment (1).

Health spending projections through 2018 (2) show substantial increases along with uncertain effects of the recession. It is expected that national health spending is projected to reach $2.4 trillion in 2008 (2). Over the projection period from 2008 to 2018, this spending is expected to increase 6.2% per year, on average, reaching $4.4 trillion by 2018. Growth in GDP over the projection period is expected to average 4.1% per year — 2.1 percentage points slower than average annual health spending growth. As a result, the health share of GDP is expected to rise from 16.2% in 2007 to 20.3% in 2018. Table 1 illustrates national health expenditures, whereas Fig. 1 illustrates increasing health care costs with either proportion of GDP, private funds and public funds being spent on health care (3).

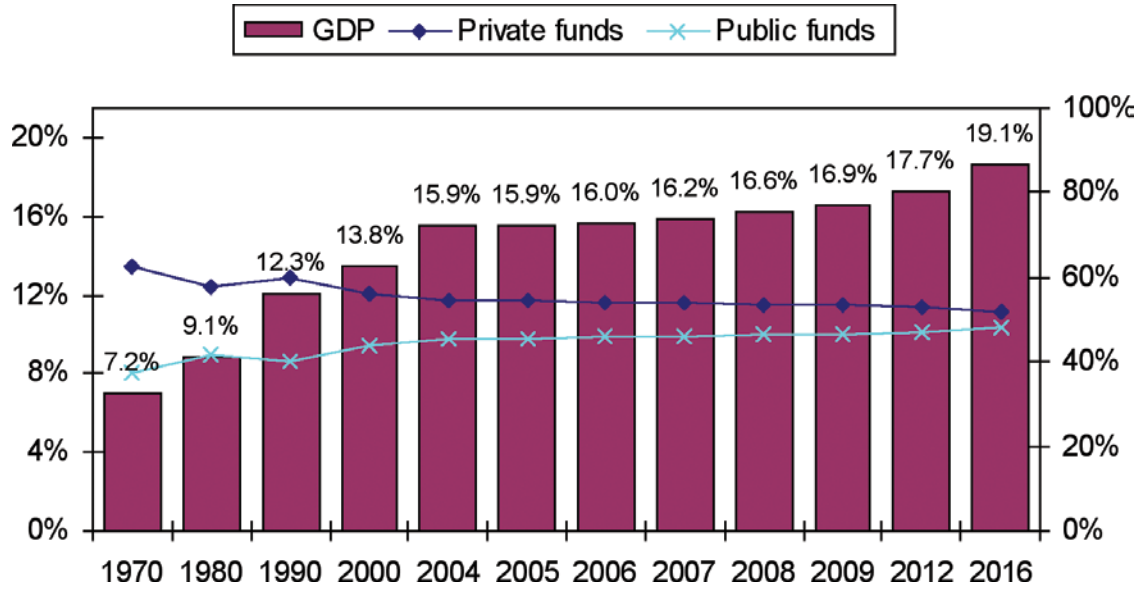
It is also expected that, due to recession, the differences in growth rates between national health spending and GDP are expected to be the greatest in 2008 and 2009, during which time national health care spending is expected to increase steadily in 2008 at

Table 1. *National health expenditures (NHE), aggregate and per capita amounts, and share of gross domestic product, selected calendar years 1993 – 2018.*

Spending category	1993	2006	2007	2008*	2009*	2013*	2018*
NHE (billions)	$912.5	$2,112.7	$2,241.2	$2,378.6	$2,509.5	$3,110.9	$4,353.2
Health services and supplies	853.1	1,976.1	2,098.1	2,226.6	2,350.1	2,915.8	4,086.2
Personal health care	773.6	1,765.5	1,878.3	1,992.6	2,099.0	2,598.3	3,639.2
Hospital care	317.1	649.3	696.5	746.5	789.4	992.6	1,374.1
Professional services	280.8	661.4	702.1	744.7	785.8	953.7	1,338.1
Nursing home and home health	87.3	178.4	190.4	201.8	213.6	269.8	375.8
Retail outlet sales of medical products	88.4	276.4	289.3	299.6	310.2	382.1	551.3
Program admin. and net cost of private health insurance	52.8	150.4	155.7	165.6	178.8	225.2	315.0
Government public health activities	26.8	60.2	64.1	68.3	72.3	92.3	132.0
Investment	59.3	136.6	143.1	152.0	159.4	195.2	267.0
NHE per capita	$3,468.3	$7,062.3	$7,420.8	$7,804.3	$8,160.3	$9,767.3	$13,100.3
Population (millions)	263.1	299.1	302.0	304.8	307.5	318.5	332.3
GDP, billions of dollars	$6,657.4	$13,178.4	$13,807.5	$14,290.8	$14,262.2	$17,072.6	$21,479.9
Real NHE#	$1,032.3	$1,810.7	$1,870.5	$1,938.6	$2,019.1	$2,296.6	$2,854.4
Chain-weighted GDP index	0.88	1.17	1.20	1.23	1.24	1.35	1.53
PHC deflator~	0.81	1.25	1.29	1.33	1.36	1.55	1.86
NHE as percent of GDP	13.7%	16.0%	16.2%	16.6%	17.6%	18.2%	20.3%

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.
NOTES: Numbers might not add to totals because of rounding. 1993 marks the beginning of the shift to managed care.

***** Projected.
# Deflated using GDP chain-type price index (2000 = 100.0).
~ Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input, price index for nursing home care, and consumer price indices specific to each remaining PHC component (2000 = 100.0).



Projected values (2008 – 2016) from CMS website. Private funds includes out-pocket payments (3)

Fig. 1. *Illustration of increasing health care costs from 1970 – 2016.*

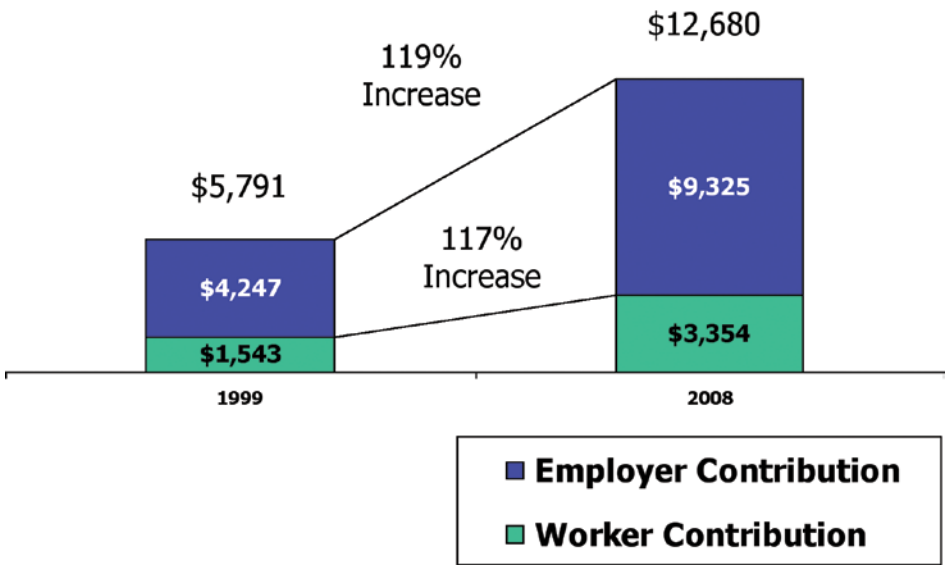
6.1% followed by a reduction in 2009 to 5.5%. However, during this same period GDP growth is projected to be 3.5% in 2008 and -0.2% in 2009. In a report of the Congressional Budget Office (CBO) (4), without changes in policy, it was estimated that a substantial and growing number of people under the age of 65 will lack health insurance. Further, the CBO estimates that the average number of non-elderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019 (4). That projection is consistent with long-standing trends in coverage and largely reflects the expectation that health care costs and health insurance premiums will continue to rise faster than people's income — making health insurance more difficult to afford.

Health Care Crisis

Rapidly rising health care costs over the decades have prompted the application of business practices to medicine with goals of improving efficiency, restraining expenses, and increasing quality (5). Further, concern about escalating costs and the quality of health care delivered in the United States has led to an increase in focus on pay-for-performance, value-driven health care, and public reporting of quality and cost information. At the same time, employers fear cost of health insurance and individuals are also worried about soaring health care costs (6). Figure 2 illustrates average health insurance premiums and worker contributions for family coverage. The employer contribution has soared from $4,247 in 1999 to $9,325 in 2008 with a 119% increase. During the same period employee contributions have increased from $1,543 to $3,354 in 2008 at 117% increase. Total expenses increased from $5,791 to $12,680 a 119% increase.

It has been quoted that health care spending is 4.3 times that for national defense, despite the wars in Iraq and Afghanistan. Further, our system has been blamed for inefficiencies, excessive administrative expenses, inflated prices, inappropriate waste, and fraud and abuse. While many people lack health insurance, others who do have health insurance allegedly receive care ranging from superb to inexcusable.

It was shown that per capita spending in the United States is the highest among Organisation for Economic Co-operation and Development (OECD) countries (7,8). The expenditures per capita in the United States were $5,635 on health care in 2003, whereas



Note: The average worker contribution and the average employer contribution do not add to the average total premium due to rounding.
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008 (6).

Fig. 2. *Average health insurance premiums and worker contributions for family coverage, 1999 – 2008.*

based on the analysis it should be $3,990 per capita. Consequently, the United States spent $1,645 per capita more than would have been expected. In absolute terms, the highest discrepancy was noted in hospital care of $224 billion, followed by outpatient care of $178 billion. However, the largest discrepancy was the category of administration of health care system, on which the United States spends 6 times more per capita than its peer countries ($412 versus $72) almost a quarter of excess spending in the United States.

In contrast, in 2006 the United States spent nearly $650 billion more on health care than peer OECD countries, even after adjusting for health. Of this amount, outpatient care, which includes same-day hospital visits and is by far the largest and fastest growing part of the U.S. health system. Four other cost categories – drugs; health administration and insurance; investment in health; and inpatient care – are responsible for $279 billion in spending above expected. In the remaining 2 categories of long-term and home care and durable medical equipment U.S. spending is $72 billion less than expected. Consequently, U.S. health spending totalled $2.1 trillion in 2006, an increase of $363 billion since 2003, and total nearly $6,800 per capita.

Outpatient care accounts for more than 40% of the overall health care spending and 68% of spending, expanding at 7.5% per annum from 2003 to 2006 – a faster pace of growth than observed in any other cost category – adding more than $166 billion in costs during this period. Same-day hospital care accounts for $245 billion, physician office visits account for $392 billion, and ambulatory surgery centers and diagnostic imaging centers contributed to $28 billion. However, same-day hospital care is the fastest growing of all outpatient cost categories at 9.3% per year.

Drugs account for 12% of overall health care costs and 15% of total spending above expected ($98 billion), growing 6.9% annually from 2003 to 2006, resulting in a $45 billion increase in costs. These increases are due to 3.5% a year prescription growth and 4.5% net price growth and a more expensive drug mix. However, it appears that the United States on average uses 10% fewer drugs per capita than other OECD countries, whereas prices are 50% higher than those in other countries for equivalent drugs (8).

Provider groups believe that outlandish administrative costs represent one of the biggest problems with our health care system (9). These costs accrue from insurers, both public and private, from medical

groups and hospitals. Administrative expenses account for about 30% of the total costs of the health care in the United States (10). That translates to approximately $680 billion of $2.3 trillion spent in 2007 or $7,421 spent per person.

In fact, the study by McKinsey Global Institute (8) shows that health administration and insurance expense category accounts for 7% of overall health care costs and 14% of total spending above expected ($91 billion), spending growing by 6.3% annually over the 3-year period, resulting in a $25 billion increase in costs. However, it appears that this report grossly underestimates administrative costs. Further, this report (8) also shows that the administrative costs for Medicare enrollee grew by nearly 30% per year, which largely reflected payouts to private administrators or Medicare advantage plans and the Part D drug benefit. From 2005 to 2006 alone, administration for all Medicare programs increased by nearly $8 billion.

McKinsey Global Institute report (8) shows that long-term and home care accounts for 9% of overall health care costs, but is $53 billion less than expected, reducing total spending by 8%. Even then, the report shows that from 2002 to 2006, this category grew by 6.2% annually, resulting in a $30 billion increase in costs. In contrast, a recent Government Accountability Office (GAO – 09 – 185) report shows that fraud and abuse helped boost Medicare spending on home health services 44% over 5 years as some providers exaggerated patients medical conditions and others billed for unnecessary services or care they did not provide. The GAO reviewed home care payments from 2002 to 2006, when spending reached $13 billion. Continuing with the increasing trend, during the past year, Medicare spent about $16.5 billion on home care for the services reviewed by the GAO out of the total budget of $455 billion.

Great Expectations

"Change is in the air," we have heard this on many, many occasions. There is always too much talk and very little action (9,11). Starting with Harry Truman in the 1940s, Richard Nixon in the 1970s, and Bill Clinton in the 1990s, all of them attempted change in the health care system and enacted some kind of national health insurance (11). Other health care mavericks such as Representative Stark bill with his calling for greater reliance on the government than the Clinton plan also failed. In addition, Representative Cooper's plan with a bipartisan group of 80 representatives in support of a more market-friendly plan, and Senators Breaux and Durenberger similar plan in the Senate also failed (12).

Health care reform is back with the Obama administration with great expectations (13). It is believed that for the first time since 1993, momentum is building for policies that would move the United States towards universal health insurance. President Obama has made health care a central part of his domestic agenda, coupled with promises from key members of Congress to introduce ambitious health care reform legislation in 2009 and nomination of Governor Kathleen Sebelius as secretary-designate of the United States Department of Health and Human Services (DHHS).

In May 2006, former Senate majority leader, Tom Daschle (the first nominee for secretary designate for DHHS — nomination withdrawn 2/3/2009), prophetically said that it may take a major fiscal emergency to make Washington deal with the health care crisis (14,15). Further, there is growing sentiment that the prospects for meaningful health care reform have never looked better (16). As many of the groups long opposed to reform, including the insurance industry and physician groups, are reportedly prepared to make a deal — willing to accept radical surgery (7,17-19). In fact, a budget for change has been proposed with down payment in health care reform (20-23).

However, Obama's ambitious plan is not without criticism and negativity. The Obama plan has been described as more regulation with unsustainable spending (24-26). Further, Obama's health plan is considered ambitious in any economy, but more so in present economy (10). The majority of the physicians have a negative view on Obama's health plan (25).

Differences from the Past

The difference is the economic climate appears to be more in favor of health care reform. Further, in 1993, numerous individuals and organizations preferred the status quo, and the political system gave them many opportunities to block change (12). It has been stated that most critics of U.S. health care incorrectly focused on greedy drug companies and overpaid physicians rather than systematic problems in funding, organization, and delivery of care (12).

There are differing opinions on how the economic crisis will help or hurt health care reform. While proponents state that declines in employment and employment-based insurance strengthens the pressure

for a bold new approach to coverage, opponents will argue that because the federal government already faces a large and increasing budget deficit, this is not an opportune time to increase government spending on health care and focus on a large system change. However, these conflicting views may be reconciled if reform addresses coverage and cost issues simultaneously (12).

Keys to Health Care Reform

Key essentials for health care reform are different for physicians, providers, employers, insurers, politicians, government officials, and finally methodologists and advocacy groups. It is inevitable that when pushing boundaries, obstacles such asvested interests, politics, structures, and finance will be in the path (27). Yet, it is stated that large system changes in health care is achievable. It has been mentioned that the UK National Health Care Service over 44 months engaged 5,500 primary care office practices covering 32 million individuals in England and gained measured improvement in access and secondary prevention of coronary artery disease (28). Another example frequently quoted is that of the Australian Primary Care Collaborative (29). However, it is all not positive, in 2006, a UK health board decreed that elderly patients with macular degeneration had to wait until they went blind in one eye before they could get a costly new drug to save the other eye. However, the decision was reversed after 3 years of public protests (26). Further, Americans cannot forget the demise of AHCPR in 1995 following the development of acute low back pain guidelines (30), which issued 19 guidelines between 1992 and 1996 at a cost of $750 million for 15 guidelines, at a cost of $50 million per guidelines (31). The Agency for Healthcare Research and Quality (AHRQ) which replaced AHCPR continues to function (32) with DHHS and its Medicare Coverage Advisory Committee (MCAC) (33) which can make sweeping decisions in health care coverage (34-36). Further, numerous deficiencies related to health care experiences across the globe have been downplayed (7).

Reducing costs is always at the center of any health care debate in the United States (12). It has always been stated that there is a great deal of waste, fraud, and abuse in the present health care system, but there also was a great deal of waste, fraud, and abuse in the system 40 years ago (12). Further, there is evidence that the U.S. population is becoming unhealthy with numerous diseases and disorders (37-40). Even then, excessive usage, potential abuse, and increasing care seeking have been well described (41-49), there is no evidence that waste, fraud, and abuse account for a larger share of spending today than they did then, or that they will be any easier to eliminate (12). Some state that every dollar of waste, fraud, and abuse, is a dollar of income to someone in the system.

So what are the factors accounting for the cost. Per capita spending in the United States is highest among OECD countries (8,50,51). Measured in terms of the share of GDP, the United States spent 15% on health care in 2003 compared with the OECD median of 8.5%. There are multitude of issues in comparison of these figures (7). Some have stated that the cost of regulations of U.S. health care themselves exceed $339 billion (52). Others have proposed that an alternative view of savings of 20% from health care spending may also solve the problems. Above all, the best chance for a sizeable one-time reduction in the level of costs is through a reduction in administrative expenses which attributes to almost 30% of health care expenses in the United States. The differences among other countries and the United States is that employment-based insurance and Medicaid both require costly administration. In contrast, universal coverage, funded in a straightforward manner, would result in administrative savings large enough to pay for most of the additional utilization by those previously uninsured (53).

Jessee (9) proposed 4 keys to health care reform as follows: 1) provide health care as a basic human right; 2) total reform is needed the way health care services are paid; 3) reduce administrative wastage; and 4) better aligned financial incentives for insurers, health care providers, and patients.

In a different perspective, Fuchs (54) describes 4 Cs as essentials which include: 1) coverage for 100% of Americans; 2) cost control; 3) coordinated care; and 4) choice.

The foundation of President Obama's health care plan is to provide affordable, accessible health care for all Americans. Instead of a complete overhaul, this builds on the existing health care system's providers, doctors, and plans. President Obama plans to lower health care costs by $2,500 for a typical family by investing in health information technology (IT), prevention, and care coordination. Further savings are also expected to come from investing in and extending coverage of preventive services, including cancer screening, and from increasing state and local preparedness for terroristic attacks and natural disasters.

Tom Daschle, former nominee for Secretary of DHHS, provides insights into United States health care reform and the administration's priorities (17). This book proposes creating a Federal Health Board, similar to the Federal Reserve System, whose structure, functions, and enforcement capability would be largely insulated from politics. Daschle also proposes merging employers plans, Medicaid, and Medicare with an expanded federal employee health benefits program that would cover everyone.

Stefanacci (55) writes that the foundation for the Obama plan is rooted in several Rs:

1. Regulation
2. Reimbursement
3. Reporting
4. Resource investment.

Pitfalls of the Reform

Any reform either fundamental or simple will have daunting obstacles and there are multiple reasons for likely failure (56). Reasons for likely failure of sweeping reform include sheer size of the system with expenses of $2.2 trillion in 2007, which is larger than the entire economy of France. Disorganization of the current system which could be fuel for the reform, but at the same time could be a damper with "big-bang" changes, unanticipated consequences of sweeping reform and no one can fully anticipate the consequences or ultimate desirability and political acceptability of the reform options. Thus, some advocate narrower reforms for now with strengthening IT and cost-effectiveness of health care, establishing a national health insurance clearinghouse, and by providing federal financial support for universal coverage.

Down Payment on Health Care Reform

President Obama outlined a far-reaching set of initiatives that would increase the role of government well beyond the boundaries sketched out by the $787 billion economic stimulus package (22). He proposed a 2010 budget supporting his commitment to expanding a range of domestic programs, redistributing wealth to middle- and lower-income families, and reforming the health care system. Iglehart (22) describes that the spending plan is breathtaking in scope and is designed to replace conservative policies that have been embraced by Republican administrations going back to Ronald Reagan.

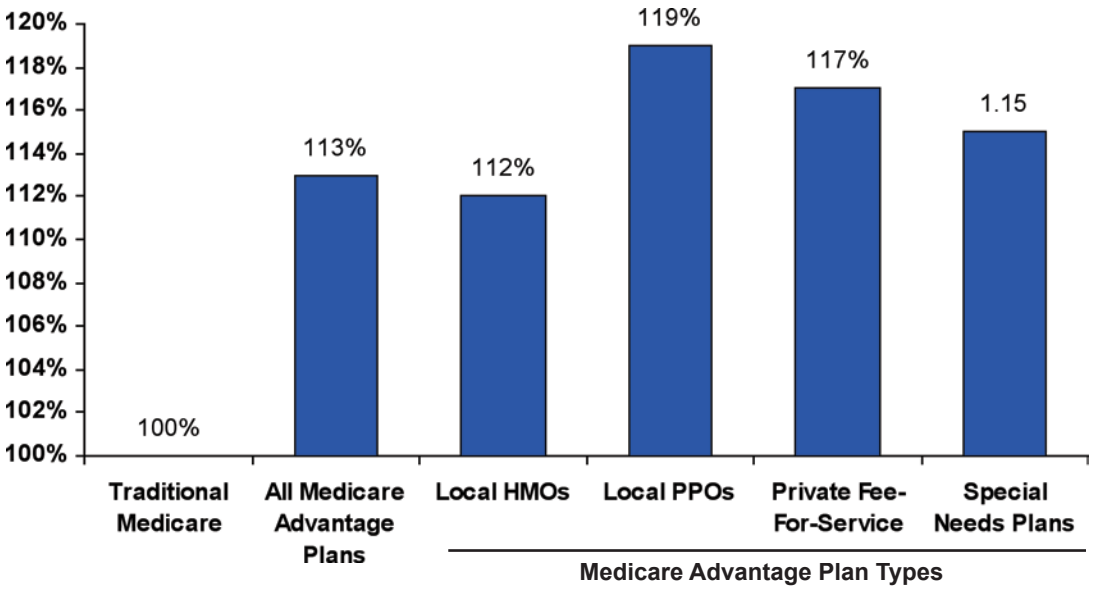
The budget proposal indicates that a reform package will be paid for in part by reductions, totally $318 billion over 10 years, in Medicare and Medicaid payments to health plans, pharmaceutical companies, hospitals, and home health care providers. The other half of the down payment would be secured by increasing taxes for Americans in high tax brackets. The budget also incorporates proposals for accelerating efforts to root out fraud and abuse, working to reduce hospital readmission rates, and setting the stage for reforming the way Medicare pays physicians. However, it is not indicated how this will be accomplished.

The major part of the $634 billion budget ($318 billion) will be from savings from reductions of approximately $175 billion over 10 years in Medicare's payments to health plans. Under the current law, it appears that Medicare Advantage plans are overpaid approximately 14% more ($103 per member per month) than traditional fee-for-service providers for the care of comparable beneficiaries. About 9.9 million Medicare beneficiaries (22%) are enrolled in Medicare Advantage plans, which are required to use most of the overpayments to provide enhanced benefits, most of which come in the form of reduced cost sharing for patients (22,57). Further, the patient co-payments have been increasing rapidly (Fig. 3). The Obama administration believes that it will be beneficial and reduce costs if the current mechanism to establish payments with a competitive system in which payments would be based upon an average plans' bids submitted rather than Medicare setting the reimbursement rate.

Table 2 illustrates the details of down payment on health care reform.

Children's Health Insurance Program

The Children's Health Insurance Program or CHIP was also signed into law on February 4, 2009, which has been hailed as the first step towards universal health coverage (58). This reauthorization expands the program by $32.8 billion over 4½ years and is expected to cover about 4 million more children than the 7 million enrolled in the existing program. Further, this bill also rescinded restrictions on CHIP eligibility that were issued by the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007. These restrictions barred a state from using federal matching CHIP funds to cover children and families at or above 250% of the federal poverty level unless the state had covered 95% of kids and families at or below 200% of poverty. The CHIP reauthorization allows states to receive enhanced federal matching funds to cover children and families earning up to 300% of poverty.



Note: HMO is health maintenance organization; PPO is preferred provider organization.
SOURCE: Medicare Payment Advisory Commission Report to Congress, March 2008.

Fig. 3. *Average payments to Medicare Advantage plans relative to traditional fee for service Medicare, 2007.*

Table 2. *Details of down payment on health care reform.*

- ♦ $634 billion to help pay for health care reform over the next 10 years.
- $318 billion of that—about half—will come from tax increases that include reducing the mortgage and charity deduction for high income Americans.
  - Charging wealthier seniors more for the Medicare Part D drug benefit—as is done for Medicare Part B now.
  - Cutting Medicare HMO payments by $175 billion over 10 years.
  - Reducing Medicare hospital payments by $17 billion over 10 years by bundling inpatient and outpatient reimbursement to include the 30-days after discharge.
  - Cutting Medicare hospital payments by $8.4 billion over 10 years for re-admissions resulting from substandard care.
  - Requiring drug makers to increase the rebates on drugs sold to Medicare patients from 15% to 21% saving $19.5 billion over 10 years.
- $316 billion from increase in taxes for Americans in high tax brackets.

American Recovery and Reinvestment Act

The American Recovery and Reinvestment Act, also known as the economic stimulus bill with a package of $787 billion also promotes health care spending and coverage (59,60). The major aspects of the stimulus package are health care IT and comparative effectiveness research. President Obama described health care IT the "low hanging fruit" on health care reform (61).

Table 3 illustrates health care spending provisions of the American Recovery and Reinvestment Act of 2009. This package directs to health care about $170 billion in new funds, most of which will be spent within 2 years (60). The spending includes $87 billion for Medicaid, $24.7 billion to subsidize private health insurance for those who have lost their jobs, $19.2 billion for health IT, and $10 billion for National Institutes of Health (NIH) (a third of its budget).

More importantly, on the medical research front, comparative effectiveness studies that directly compare the risks and benefits of different treatments for a particular condition receive $1.1 billion. While these are essential for improving practice and slow-

ing cost escalation, such studies, however, have been controversial. The federal government has already funded many important comparative studies. Further, the federal government also had the Agency for Healthcare Policy and Research (AHCPR) which over the years issued 19 guidelines at a cost of $750 million (31). It is expected that with $1.1 billion allocated in the stimulus bill, the government will be able to fund many more trials, as well as clinical registries, clinical data networks, and systematic reviews. It is considered that $1.1 billion in new funding for comparative effectiveness research dwarfs the current $334 million annual budget of the AHRQ, which will administer $300 million of the funds; the NIH and DHHS will administer the rest. In addition, the act also includes funds for a contract under which the Institute of Medicine will make recommendations (by June 30, 2009) for national priorities for comparative effectiveness research. It establishes a Federal Coordinating Council for Comparative Effectiveness Research, which will be composed of up to 15 federal officials (at least half of whom are physicians or others with clinical expertise) and chaired by the secretary of DHHS. Fortunately, the council will be tasked with recommending and coordinating research, but will not be able to establish clinical guidelines or to mandate coverage, reimbursement, or other policies for any public or other payor (59,60). Further, the legislation points to the importance of including women and minorities in this research, since different groups may have different responses to treatments.

The comparative effectiveness research is based on the principles recommended by Daschle in his book which includes 2 major recommendations, a Federal Health Board similar to the Federal Research Board (with its numerous deficiencies in recent months) and a National Institute for Health and Clinical Excellence (NICE) from the British National Health Services (62).

Table 3. *Health care spending provisions of the American Recovery and Reinvestment Act of 2009.*

Program or Investment Area	Amount and Purpose of Funding
Comparative effectiveness research	$1.1 billion, of which $300 million will be administered by the Agency for Healthcare Research and Quality, $400 million by the NIH, and $400 million by the secretary of health and human services.
Continuation of health insurance coverage for unemployed workers	$24.7 billion to provide a 65% federal subsidy for up to 9 months of premiums under the Consolidated Omnibus Budget Reconciliation Act. The subsidy will help workers who lose their jobs to continue coverage for themselves and their families.
Departments of Defense and Veterans Affairs	More than $1.4 billion for the construction and renovation of health care facilities.
Health information technology	$19.2 billion, including $17.2 billion for financial incentives to physicians and hospitals through Medicare and Medicaid to promote the use of electronic health records and other health information technology and $2 billion for affiliated grants and loans to be administered by the Office of the National Coordinator for Health Information Technology. Physicians may be eligible for grants of $40,000 to $65,000 over multiple years, and hospitals for up to $11 million.
Health Resources and Services Administration	$2.5 billion, including $1.5 billion for construction, equipment, and health information technology at community health centers; $500 million for services at these centers; $300 million for the National Health Services Corps (NHSC); and $200 million for other health professions training programs.
Medicare	$338 million for payments to teaching hospitals, hospice programs, and long-term care hospitals.
Medicaid and other state health programs	$87 billion for additional federal matching payments for state Medicaid programs for a 27-month period that began October 1, 2008, and $3.2 billion for additional state fiscal relief related to Medicaid and other health programs.
National Institutes of Health	$10 billion, including $8.2 billion for new grants and related activities and $1.8 billion for construction and renovation of NIH buildings and facilities, extramural research facilities, and research equipment.
Prevention and wellness	$1 billion, including $650 million for clinical and community-based prevention activities that will address rates of chronic diseases, as determined by the secretary of health and human services; $300 million to the Centers for Disease Control and Prevention for immunizations for low-income children and adults; and $50 million to states to reduce health care–associated infections.
Public Health and Social Services Emergency Fund	$50 million to the DHHS to improve the security of information technology.

Adapted from: Steinbrook R. Health Care and the American Recovery and Reinvestment Act. *N Engl J Med* 2009; 36.; 1057-1606 (60).

According to Daschle, doctors have to give up autonomy and "learn to operate less like solo practitioners" (26). However, keeping doctors informed of the newest medical findings is important, but enforcing uniformity goes too far. In a recent interview, American Medical Association President Nancy Nielson, MD, stated that government control of the doctor-patient relationship is a no deal. She added, "although there is no question that we need to be sure that the best science and evidence is used when we deal with a patient, it isn't that easy. People who think that 'we just put out a guideline and if you don't follow it' is not appropriate" (63). Further, hospitals and doctors that are not meaningful users of the new system will face minorities. "Meaningful user" is not defined in the bill and it will be left to the secretary of DHHS, who will be empowered to impose more stringent measures of meaningful use over time (26).

Federal Coordinating Council for Comparative Effectiveness Research, as Daschle's book explained, is to slow the development and use of new medications and technologies because they are driving up costs (26). Daschle praised Europeans for being more willing to accept a "hopeless diagnosis" and forego experimental treatments, and he claimed that Americans expect too much from the health care system. Consequently, the changes may hit the elderly more than anyone else as Medicare will be changing its rules from paying for treatments which are deemed safe and effective by applying a cost effectiveness formula.

The federal council is modeled after the U.K.'s NICE. Essentially this board approves or rejects treatments using a formula that divides the cost of treatment by the number of years the patient is likely to benefit — cost effective analysis.

Critics (26) claim that the stimulus bill will affect every part of health care, from medical and nursing eduction to how patients are treated and how much hospitals get paid. The bill allocates more funding for this bureaucracy than for the army, navy, marines, and air force combined (26). Further, in promotion of universal health coverage and national health systems, many aspects are ignored, including the deficiencies of numerous global systems on which principles U.S. health care reform is based (7), the failure of AHCPR (30,31), and the deficiencies in the NICE system itself. It is also interesting to note that, even with strict regulations, in many European countries a double standard exists for the national health care and private insurance and even the experimental treatments not provided in the United States are provided in the other countries. In addition, the mismanagement of evidence-based medicine (64-67), and flawed evidence synthesis and its impact on many aspects of medicine, specifically interventional pain management has been described extensively (68-85).

The second part of the Recovery and Reinvestment Act of 2009 crucial to physicians is electronic medical records and the investment proposed. Even though the federal government has long spent billions on health care, there is no precedent for the act's massive investment in escalating the adoption of health IT or for the expanded leadership role that government will assume in this arena (60). At present approximately 17% of U.S. physicians and 8% to 10% of U.S. hospitals have at least a basic electronic health record system (60,86). It is expected that such technology will lead to improvements in the quality of care and savings on other health care costs, however, only if the implementation is done appropriately. The federal government's involvement in health care IT is not new. In 2004, the Bush administration, by executive order, created the Office of National Coordinator for Health Information Technology as part of the DHHS. However, Congress has never established the office in law and its funding has been limited to $60 million a year. The stimulus legislation codifies the national coordinator position and office, provides $2 billion for discretionary spending, primarily for grants and loans, and sets a goal of "utilization of a certified electronic health record for each person in the United States by 2014." It also establishes 2 federal advisory committees on health IT. One is on policy and the second one on standards, through which the government will work with the private sector and consumer groups to develop the specifics of a nationwide health information network. These include the design of "interoperable" electronic health records that permit the seamless exchange of data among physicians, hospitals, laboratories, pharmacies, and other health care organizations, as well as methods for ensuring the privacy and security of patient data (33). The DHHS will certify specific products with standards being developed in 2009 and tested and certified in 2010.

Medicare and Medicaid will provide financial incentives over multiple years of up to $40,000 to $65,000 per eligible physician and up to $11 million per hospital for "meaningful" use of health IT beginning 2011. Health IT includes the electronic exchange of data and reporting of clinical quality measures.

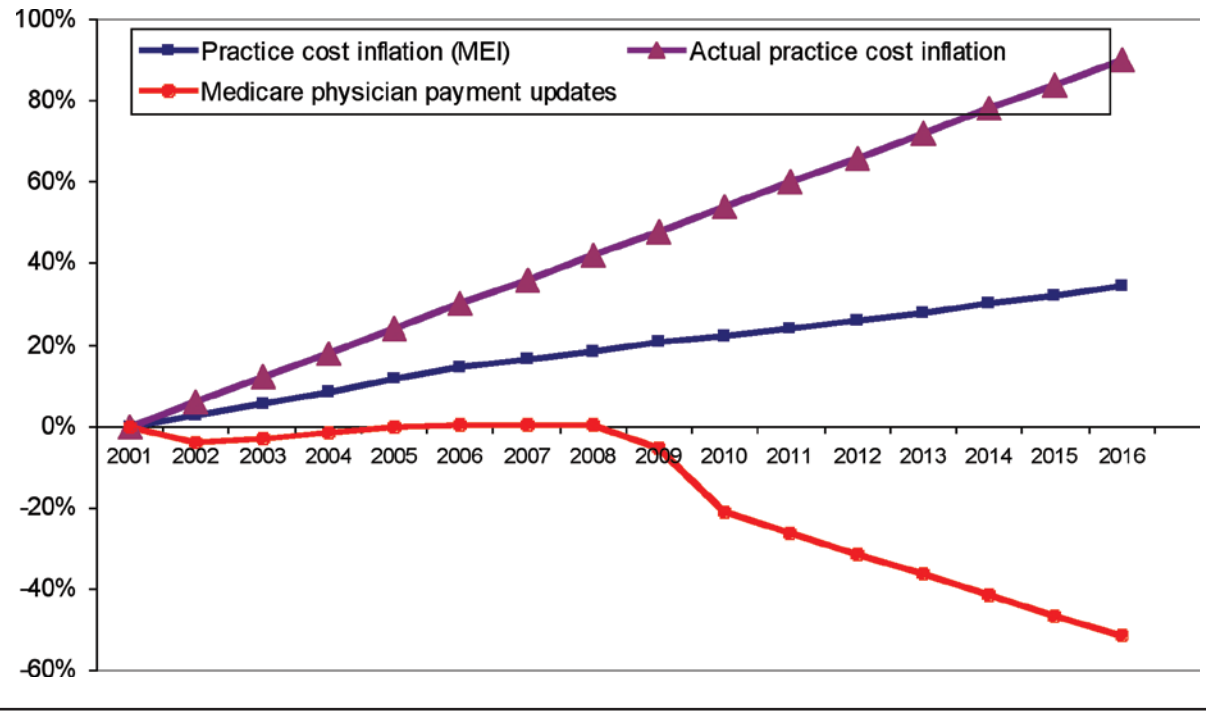


Fig. 4. *Comparison of increase in practice costs and proposed Medicare cuts*

In addition, physicians and hospitals that do not use certified products in a meaningful way will be penalized after 2015. The CBO projects that the incentives will boost the proportions of physicians and hospitals adopting comprehensive electronic health records by 2019 to 90% and 70%, respectively from the 65% and 45% that would be expected to do so anyway (87).

Apart from the bureaucracy created by Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 also incorporates other rule changes that privacy advocates and some lawmakers have been seeking for years. Such examples include patients who request an audit trail showing all electronic disclosures of their health information and mandates that they be notified about any unauthorized disclosure or use. It also extends protections to personally controlled electronic health data, as well as to companies that do work on behalf of health care providers, health plans, and health care clearinghouses — all the entities covered under HIPAA. In addition, when individually identifiable health information is transmitted or physically transported, such as on a laptop computer, outside a health care entity, it must be encrypted or otherwise rendered indecipherable to unauthorized individuals (60). The additional limitations include the penalties for violations on the sale of an individual patient's health information or its unauthorized use in marketing or fund-raising. Finally, it strengthens enforcement and oversight.

Effect on Medicare

So how does health care reform affect Medicare? Will that fix Medicare, fix physician payments, eliminate Medicare Advantage Plans, expand Medicare Part D coverage, or define it in such a way that everyone will be affected with cost-cutting measures, or will just the physicians be affected (Fig. 4).

Whatever the expectations are, what is true is that Medicare is underway for radical surgery. Based on the President, Secretary, and chairman of the Senate Finance Committee proposals, specific changes will be made. Apart from the general Medicare crisis with an increase in enrollment, reducing payroll taxes, the new economic crisis with rising unemployment, Medicare's finances are worsening faster than expected. Even then, Medicare is a bell weather agency and the largest insurer in the United States or the world,

which may lead the reform field if it reigns in escalating health care costs as policies of Medicare are often adapted by private payors.

With an increased budget for general accounting office, increased focus on fraud and abuse, and comparativeness effectiveness research, Medicare leads the way. The President's budget, CHIP regulation, and the American Recovery and Reinvestment Act reflect the reality of changing Medicare. It is touted that the President's efforts focus on increasing efficiency and quality in the Medicare and Medicaid programs using Medicare to engender increased quality and efficiency in our health system which is considered as central to bending the health care cost curve (88). Some believe that over time, it is possible to deliver savings within our health system. Highly respected analysts estimate that more than 30% of what we spend on health care does not add clinical value. Consequently, if health care costs are projected to be over $4 trillion by 2015, if 50% of unnecessary spending or spending without clinical value is reduced along with a 50% reduction in overhead costs, the health care budget will be trimmed to approximately $120 billion a year and $12 trillion over a period of 10 years.

Among the changes in the Medicare, physician payments are crucial. All physicians, especially interventional pain physicians, are all too familiar with what has become nearly an annual ritual and government relations effort or Medicare pay with escalating cuts each year. What is little understood, is that despite a hailed 1.1% boost in 2009 rates which temporarily averted a devastating 10.6% cut, physicians ended up with a 5.3% cut due to adjustment of evidence-based relative value system neutrality adjustment over a 5-year period in 2008 (Fig.4).

Now, the most unprecedented payment cut is expected in 2010 — 21%, and no one can predict the extent of the damage that such a disastrous reduction would bring. Even worse than that is the impact of cuts for interventional pain physicians.

Congress has little less than a year to stop the double-digit cut in pay or risk having many physicians simply become unable to take care of the seniors and disabled who need them the most.

Congress for several years stepped in to prevent physicians from seeing yearly cuts in their fees. While this may buy lawmakers a little more time to address the need for a new system of implementation, it also makes the eventual solution even more expensive, since Congress has been providing funding only for the costs of the current year's fix, not for its ongoing costs. Consequently, when the latest adjustment takes effect in January 2010, physicians payments are supposed to revert to the lowest level they would have reached had it not been for the temporary patches. This would amount to a 21% reduction in fees. While it is hard to imagine such a draconian cut actually occurring, it is even harder to envision what Congress is prepared to do in response to this latest threat. Most recent discussion of reforming physician payment has focused on the sustained growth rate (SGR) formula, which has caused the pressure to lower physician's fees. Because of the use of an SGR mechanism only for physicians forces just one part of the Medicare to maintain a rigid relationship to the economy, one option proposed by the Medicare Payment Advisory Commission (MedPAC) is to expand the use of such expenditure targets throughout Medicare (89,90). However, this would not address the question of the appropriateness of any given distribution of Medicare spending among the various components of the program. Further, expenditure targets in and of themselves do nothing to improve quality, ensure clinical appropriateness, or accomplish other Medicare goals. Numerous short-term fixes have been established, most of them focusing on how the SGR is calculated. Multiple measures suggested to correct this problem include the use of multiple SGRs reflecting the differences among specialties in the rate of spending growth, and the use of separate SGRs for multispecialty group practices which encourages the development of more such groups, which have been associated with high clinical quality and appropriate financial incentives (90,91). Another way to reduce physicians' spending, and thus some of the downward pressure on physicians' fees is to have CMS more aggressively review billing by physicians who are clear outliers in terms of their use of medical procedures and ancillary services, a strategy that appears to be permitted under the Medicare bill that Congress passed in July 2008. Such a strategy has been recommended by physician groups (44) and the Office of Inspector General (OIG) (92). In addition, the services must be restricted to physicians who are well qualified and well trained including performance of them in an appropriate location (for certain procedures either only a facility setting or an accredited office setting).

However, Wilensky (89) believes that the key to reforming physician payment is to develop a more aggressive payment strategy. These changes include payments that cover all the services that a single physician

provides to a patient for the treatment of one or more chronic diseases in the near term. This approach is consistent with, and could be related to, the work that CMS and others are doing on medical homes. Mainly, it is suggested that bundled payments should be developed for high-cost, high-volume diagnosis-related groups (DRGs), to include, at a minimum, the reimbursement for all physician services associated with the DRG and perhaps the hospital payment as well.

In fact, during the confirmation hearings, Daschle pledged to replace Medicare's SGR formula with a system that bundles payments in an attempt to reward good patient outcomes. Daschle commented that Medicare's SGR formula just is not working right. The latest in a series of temporary payment patches expires at the end of 2009. If Congress doesn't act before January 1, 2010, physicians will undergo an estimated 21% Medicare pay cut. Daschle does not support the so-called performance-based approach, but believes that there are episodic ways with which to look at reimbursement that gives a lot more latitude to reward better outcomes. Consequently, it is expected to lower costs and lessen hassles for physicians, though he did not elaborate further, and no ones knows what the impact would be.

At present, Congress is considering a permanent fix; however, there is no solution in the near future. Over the years the democratic Congress has focused on savings from Medicare Advantage plans; however, these savings have been taken for down payment on health care fix. It is not quite certain if Congress will be able to make any additional savings from Medicare Advantage plans. Another option was the cigarette tax in the CHIP bill proposed in 2007; however, the CHIP bill which was signed into law by President Obama in 2009 has no such provisions to fix physician payment.

Conclusion

While health care reform is not only essential but also mandatory, creation of a huge bureaucracy may not achieve the goals of increasing efficiency, improving the quality, and reducing the costs resulting in universal coverage. It would be ideal to study the effectiveness or lack thereof of the UK's health care system, NICE, the demise of AHCPR, and the effectiveness of AHRQ.

Apart from the economic crisis, we will be watching, with great interest, the health care reform. It has been stated that (60) the Obama administration's chief of staff prior to taking office, remarked, "you never want a serious crisis to go to waste," implying that the economic crisis has allowed the Obama administration to undertake far-reaching health care initiatives that it could not otherwise have launched quickly, if at all (60). However, now the government, public, and providers will have to determine how the reform will effect the health care system of the United States — is it radicular surgery, cosmetic surgery, or surgery gone bad.

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