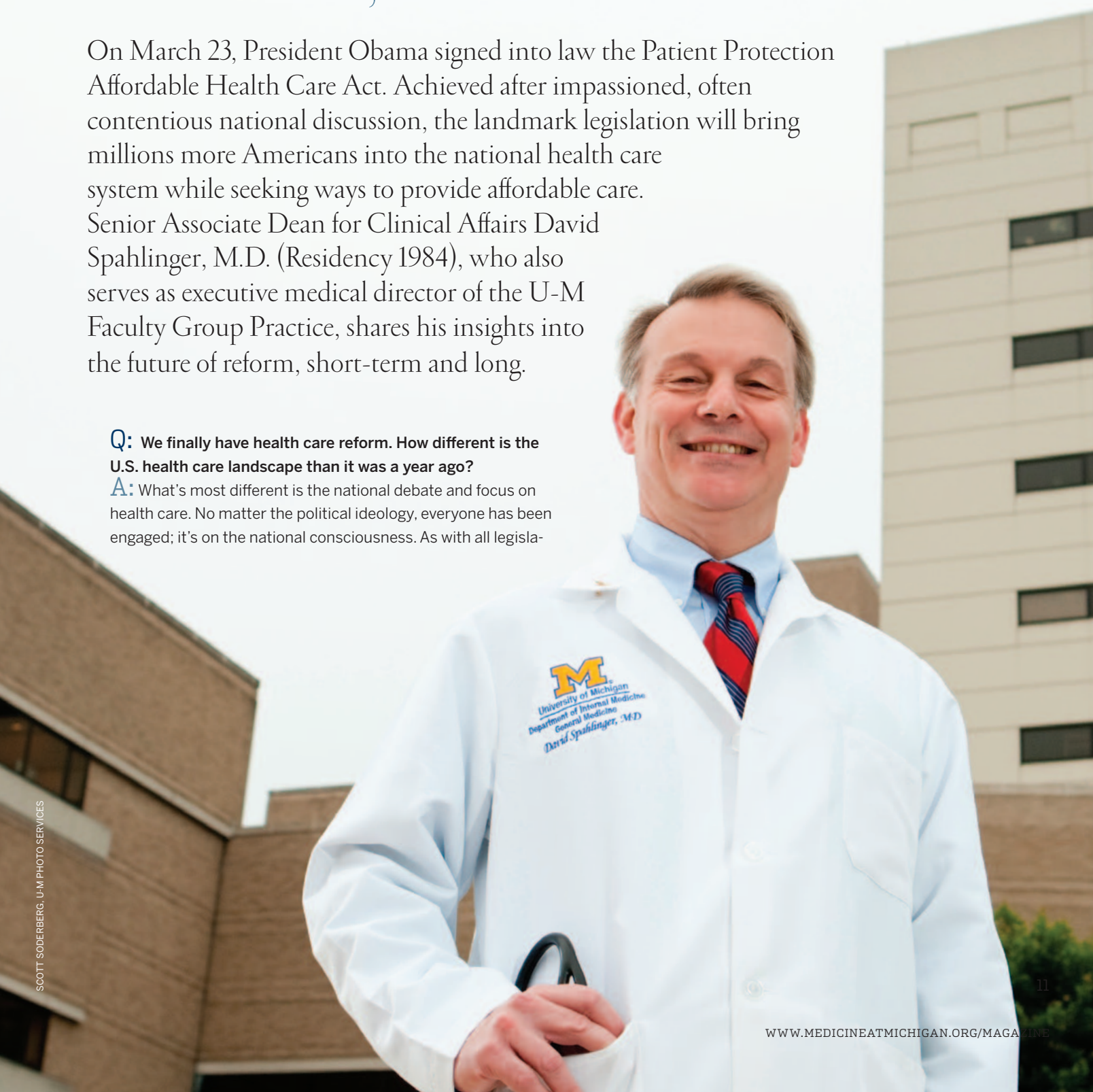
Health Care, Reformed

On March 23, President Obama signed into law the Patient Protection Affordable Health Care Act. Achieved after impassioned, often contentious national discussion, the landmark legislation will bring millions more Americans into the national health care system while seeking ways to provide affordable care. Senior Associate Dean for Clinical Affairs David Spahlinger, M.D. (Residency 1984), who also serves as executive medical director of the U-M Faculty Group Practice, shares his insights into the future of reform, short-term and long.

Q: We finally have health care reform. How different is the U.S. health care landscape than it was a year ago?

A: What's most different is the national debate and focus on health care. No matter the political ideology, everyone has been engaged; it's on the national consciousness. As with all legisla-



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tion, there will be intended and unintended consequences over time. I hope there will be continued engagement to make our overall health care system better. I think everyone acknowledges that the challenge is to provide both expanded coverage and affordable costs.

Q: What was the U-M's involvement in reform?

A: The U-M, with 10 other groups across the country, has been part of the Medicare Physician Group Practice Demonstration Project for the last five years, which is the prototype for accountable care organizations in the legislation. It was a successful project. Quality of care improved and Medicare saved millions of dollars. (Professor of Internal Medicine) Mark Fendrick and Dean Smith (professor of health management and policy, School of Public Health) have been proponents of value-based insurance design, which encourages reduction of barriers for treatments of proven benefit, and that concept was included in the legislation. You want to reduce utilization of discretionary services and not services that are absolutely needed. These are just two examples of U-M involvement.

Q: Is the national health care delivery network prepared for the 32 million currently uninsured Americans who will be covered under reform? Is the U-M Health System prepared for its share of uninsured Michiganians?

A: Most of the change occurs in 2014, with Medicaid expansion and insurance exchanges for individuals and small businesses. Between now and then, there is a national high-risk pool for people with pre-existing conditions who haven't been able to get insurance, and for people over 55 who are retired but not yet Medicare-eligible. Certainly the experience in Massachusetts has been that dramatic expansion of access to insurance dramatically increases demand. I think it was wise to increase access a few years out to allow delivery systems to plan for the additional demand.

Currently Medicaid covers many people with illness. We'll be adding people who are low-income — not necessarily those with illness. Medicaid expansion continues until 2019, which is when they expect to reach the level of 32 million additional insured individuals. Will we be prepared? Yes, I think we will be.

Q: Will health care reform change the U-M Health System?

A: Absolutely — but we're changing even now. We're not the same organization we were 10 years ago, or even five. What reform does is increase the pace of change. I believe we'll be in two clinical businesses. One will result from the creation of accountable care organizations. We'll be responsible for meeting the health needs of a population of patients for a fixed price. The other business, which we've traditionally been in, will be as a referral center. Referral centers will need to perform a high volume of services such as renal transplants or bone marrow transplants. These services require huge investments, and it's going to be much less expensive for smaller health systems to buy those services from a large-volume center. So we'll take care of a certain number of patients, from primary care to quaternary care, but then we'll also provide tertiary and quaternary care to patients from other health systems. The referral business will have more national competition. Patients will travel to high-volume centers anywhere.

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Q: Do you see that as a good thing?
A: It's a good thing from a societal perspective because it'll drive down costs and improve quality. It'll be a challenge for us since we'll have more competitors, not just within Michigan.

Q: Some changes go into effect now or soon, such as bans or restrictions on annual and lifetime limits of coverage, and free preventive care under new private plans. What effect will those changes have?
A: The limit on lifetime coverage seems to me to play a role in some of the medical bankruptcies in this country. In fact, medical care is the top reason for personal bankruptcies. Getting people covered by insurance is important, but also it's important that there are no lifetime limits so that patients who need care don't end up bankrupted because of it.

The U.S. Preventive Services Task Force and others have stipulated preventive care that needs to be part of new health insurance plans, and it gets back to benefit design — why would you put a barrier to these services if you determine that the services are really critical to diagnosing disease early and preventing disease down the road? What we see now is that these services aren't being used because there are out-of-pocket costs. So I hope we have better compliance in the future with preventive services that don't carry out-of-pocket costs.

Q: What would you like to have seen included in the bill that wasn't?
A: I really liked the original House bill, which called for a defined benefit, and then other benefits being added on and separately priced in the health insurance exchange. Whether or not the exchanges will end up this way isn't clear. The defined benefit is important from my perspective as a practicing physician because I can treat my patients without having to tailor that treatment according to varying insurance coverage. We spend a lot of time now trying to figure out people's coverage in order to come up with a plan to get them home from the hospital. People have different co-insurance, they have different co-pays, they have differences in what's covered and not covered. That complexity creates cost for everybody.

I would have liked to see a national person index or number — though I know that creates fears that you're *just* a number and the federal government is watching over your shoulder. I have a national provider number as a physician, and if I want to get information on the patient I'm caring for, it would be so much more efficient if that patient had a number that's the same in every hospital that patient has touched so that we could get the information we need to treat people more effectively. We now have to use a complex matching system to identify a patient, and trying to get information across organizations is problematic. It's an identity problem, and you then have to do identity management across these systems. The lack of unique patient identities makes information exchange much more difficult, much more expensive.

Q: What's left to do to make health care reform work for everyone?
A: If we want to make it affordable, we have to reduce administrative costs. Some of the things I identified earlier — defined benefits, standard medical policy, understanding what works and what doesn't work — simplification in those areas would be helpful. I think we need to evaluate the progress of the bill. Anyone who believes that passing the bill suddenly fixes the problem is naïve. We're going to have to make mid-course corrections. (Former Dean) Allen Lichter said to me once that 'Perfect is the enemy of progress.' I know this isn't a perfect bill. I have a lot of reservations about it, but I think we've put into place some things that can make a difference, and modify them as we go along. [M]

Interview by Rick Krupinski