

COMMENTS

Healthcare reform in the USA, 2010: the rocky road ahead?

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Abstract

Historic legislation for healthcare reform in the United States was enacted in March 2010. Reforms in medical practice, payment for services, and access to care and insurance will be introduced by complex processes over time through 2019. The overriding goals of healthcare reform are cost containment and guaranteeing access to all Americans. The contentious political struggle that preceded the legislation is emblematic of the continuous struggle in American society to define who is worthy of services. Understanding the value framework for social and welfare provisions in American society is crucial to making sense of the piecemeal policymaking characteristic of the development of healthcare over the past 50 years. Here some highlights of the reform and the complex organisation of American healthcare are discussed.

Where to begin? This question faced and continues to face patients, doctors, healthcare insurers, and hospitals - in short, all providers and consumers of healthcare in the United States on March 23, 2010. Prior to the passage of the 2,400 page Patient Protection and Affordable Care Act bill, the call of "Kill the Bill" came from Tea Party* adherents, who advocate a limited role for government, from Republican politicians, and from others opposed to comprehensive healthcare reform. On March 24, the day after passage, many of the law's supporters, stung by the acrimonious debate, pointedly remarked, "It is the law."

The reform bill, identified as "...one of the most profound changes in social policy in generations" (1), endorses the right to health insurance for all Americans. (Illegal immigrants will not be covered.) In recent years, the number of adults for whom costs were a barrier to care have increased steadily. They were estimated to be about 39 million in 2006 (2). In a population of 310 million, the uninsured typically include low wage earners; the unemployed; young people in first jobs waiting to be eligible for insurance; people refused insurance or ousted from policies because of pre-existing health conditions; and individuals who choose not to purchase insurance even if they can afford to do so. A precipitating factor in the push for healthcare reform was the prediction that Medicare, a key component of American retiree life, would be insolvent by 2019 (3). Continued growth of healthcare costs, reaching 16% of the gross domestic product in 2007 (4), had to be contained. One corporation, the carmaker General Motors, burdened by the cost of retiree healthcare, was the object of a joke describing it as a health insurance company that happened to make

cars. States (like California, New Jersey among others) who have been generous in union contracts with state workers for pensions and healthcare find themselves faced with enormous state deficits. Therefore, combined forces in the public and private sectors pushed the healthcare debate to a critical point, giving impetus to Obama's goal of achieving healthcare reform early in his term of office.

The path to this bill has been a convoluted one. Some cite a failed effort after World War II to pass universal healthcare, as well as thwarted efforts by various political leaders over the years after that, most notably, the late Senator Edward Kennedy. In a course on health policy in the late 1960s, my teacher had a poster board identifying numerous healthcare bills, named after various legislators, then at some stage of development or review. In classes I taught in 1993-1994, I held up a small card to show students what their universal health card would look like. At that time, a complex healthcare reform plan guided by President Bill Clinton's wife, Hillary, seemed likely to become law. It, too, landed in the graveyard of failed efforts at universal healthcare coverage.

The 2010 law has critics who decry that the "one payer" model was not passed, and denounce the bill as one favouring insurance and pharmaceutical companies.

However, the history of past failed attempts to realise this universal model tempered even many progressives to opt for a bill that could pass in Congress (even though, in the end, no Republicans voted for the final bill). The realistic assumption was that this would be the last opportunity for many years to pass any healthcare reform law. One alternative, suggested by those pessimistic that the bill would pass, was that individual states would proceed with reforms. This may have been a valid assessment, as the example of Massachusetts' introduction of universal health insurance in 2006 shows. There has also been progressive reform in the state of Vermont which has its own health insurance programme for residents, based on their income levels. However, the bill has passed; new territory lies ahead. Spelling out this new terrain will be policy guidelines developed in federal government agencies, like the department of health and human services. Every day news media proclaim a new guideline or a new action taken by insurance companies to comply with regulations. And, among local physicians here in New Jersey, patients are often told that we are now under "Obamacare," with the office staff in doctors' practices attending training on how to effect changes in services and

billing practices, as penalties will be applied if these are not carried out by established timelines.

Before discussing the new bill, it should be noted that federally sponsored healthcare programmes, some with state level inputs, have long been in place: Medicare covering 45 million in 2008 (5); Medicaid covering 59 million in 2006 (6); Children's Health Insurance Program covering 4.9 million in June 2009 (7); Veterans Administration Health Affairs serving 5.5 million in 2008, with 3 million more, who did not use the system in that year, eligible for care (8); Tricare covering 9.4 million active and retired military and their families (9), and Indian (native Americans) Health Services covering 2 million (10). Thus, approximately 127 million Americans are covered by government health programmes.

I will highlight key features of the bill's provisions. Some of these will be implemented in 2010 and others will be introduced up to 2019. Then I will discuss the historic, cultural and social underpinnings in American society that help to explain what appears to others as an incomprehensible approach to achieving universal health coverage.

Timeline for healthcare reforms

The provisions for healthcare reform will be implemented according to a multi-year timeline (11). The multi-year calendar targets several areas: in 2010, these are insurance reform, Medicare**, Medicaid***, prescription drugs, quality improvement in healthcare practices, the workforce, and tax changes. Among the first objectives, scheduled for 2010, are to correct some of the most widely identified, egregious problems of healthcare coverage. There will be formation of high risk pools in the states to cover those without insurance through loss or denial of insurance because of pre-existing conditions (first to be offered to children, then adults); coverage of young adults up to age 26 (a category often without insurance because they are in jobs not offering insurance, or in the current recessionary economy, unemployed) under their parents' insurance. In addition, there will be coverage of gaps in prescription drug payments for those on Medicare; expansion of Medicaid coverage to adults without children and assistance to states to expand CHIP (Children's Health Insurance Program)****; establishment of effectiveness of treatments; and review of health workforce needs.

2012 will see the introduction of voluntary health insurance pools to provide long-term community-based coverage; state competition to provide models for healthcare litigation reform; implementation of models for wellness, health risk assessments and proven prevention screenings for Medicare recipients; prohibition of payments to states for Medicaid recipients who have healthcare-acquired conditions; foci on development of wellness and prevention programmes; and quality improvement in healthcare programmes and practices. In succeeding years, models will be set up to establish best practices. For example, one model will bundle payments for physicians for hospital services and for post-hospital care in order to achieve a single payment for an acute care episode.

Since Medicare and Medicaid are federal programmes, they will serve as the laboratory for such experimental programmes.

Beginning in 2013, rationalisation of healthcare administration, now managed through numerous insurance companies, will be achieved by requiring universal eligibility rules, applications, claim forms and payments, and referral methods. Also in 2013, under the rubric of quality improvement, disclosure of financial relationships among health entities - including hospitals, physicians, pharmacists and providers of pharmaceuticals, devices, medical supplies - will be required.

By 2014, one of the most controversial requirements will be in place - all American citizens and legal residents will be required to have health coverage, or face penalties. Demands on employers to provide insurance will depend on the size of the workplace, with the expectation that smaller workplaces without a company plan will be assessed several thousand dollars for each employee so that they may obtain their coverage in a health insurance pool; companies with over 200 workers will be obliged to have an employee health plan. Employers will realise tax benefits for providing insurance.

As these examples illustrate, the healthcare reform law, in order to achieve the goal of coverage for all, calls for changes in healthcare delivery, programmes, administration, provider behaviours, and patient behaviours. The rationale is that costs must be contained to realise universal coverage, and to prevent the failure of respected programmes, like Medicare, to be able to meet the needs of the growing aged population.

Why choose complexity?

A defining feature of American healthcare is its complexity. Incremental change has contributed to the multi-faceted nature of this system, which leads many to call it a non-system. As one examines the complex, multi-year agenda of change, it becomes clear that using federal health programmes as models for change, and stipulating regulatory changes and controls for non-government health insurance programmes, may prove to be the pragmatic approach. Rather than dismantling the entire non-governmental system as it currently exists, the attempt will be to rationalise government and non-government programmes in order to include all Americans under a comprehensive umbrella.

An explanation of this baffling labyrinth may have its roots in a phenomenon identified by Rosemary Stevens, a historian of American healthcare. Stevens argues, using the veterans' health system as a primary example, that Americans have opted to provide state protections, especially for health needs, to those groups identified as worthy of care (12, 13). Hence, in the 1960s, once a high percentage of poor elderly Americans were identified as unable to pay medical bills, Medicare was established; Medicaid, for the poor, another group made visible during activist movements of the era, followed. In the 1990s, as the pool of uninsured persisted, children in families unable to afford insurance and above income limits of Medicaid, were singled out as beneficiaries of the CHIP.

Various states have created programmes to increase health coverage deemed suitable to their populations.

Now, the exceptionalism principle seems about to sweep in the 35-45 million uninsured, and to finally address an unacceptable failure of compassion, at least in the eyes of the 45% of Americans who support health reform. Illegal immigrants will not be covered; immigration reform now seems to be the next pressing social and economic agenda for the Obama administration. A final key point of contention, the cost of health reform, was temporarily laid to rest by the Congressional Budget Office and the Joint Committee on Taxation providing an estimate that enacting the healthcare reform law would reduce federal deficits by \$143 billion during the 2010-2019 period (14).

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Notes

- * The Tea Party Movement was started in 2009 in protest against perceived excessive government spending and taxation, first by President George Bush, then by President Barack Obama. It takes its name from The Boston Tea Party (1773), a key event in the American War of Independence. Colonists dumped tea from England, taxed by the British Parliament, into Boston Harbor, with the declaration, "Taxation without representation is tyranny."
- ** Medicare, a federal government program established in 1965, covers those above 65, disabled, kidney dialysis patients.
- *** Medicaid, a federal programme established in 1965, calls for states to contribute to its costs, and covers low income individuals, based on income eligibility.
- **** CHIP or Children's Health Insurance Program, a federal programme for children's health coverage, established in 1997, is implemented at the state level