2001: A Health Odyssey?

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Two and one-half years ago, the *Journal* began this Health Policy series. I had just returned from Washington, DC, where I had worked in the US Senate on the failed national health care reform proposed by President Clinton. In the initial article, entitled "Health Policy and the Future of Health Care Reform,"[1] I outlined what I thought would take place in the near future. Now, with Congress having recently passed its first major legislation related to health care since 1993, I will review these recent changes and look at what the next few years will likely bring in the area of health policy.

At the beginning of 1996, I anticipated the following:

1. Major changes in federal health care policy would take place—but mainly in the form of budget cuts. Downsizing would remain the focus of future health care debates, and the government would not protect providers from these pressures.
2. Health care reform was not dead—it was just going to take place in the marketplace, with little government involvement.
3. States would be severely hampered in undertaking major health care reforms because of ERISA (the Employment Retirement Income Security Act).[2]
4. It was critical for coalitions of primary care physicians, all physicians, and all health care providers to work together.

What has happened in the past 2 years? In 1996 the Kassebaum-Kennedy bill was passed, which provided many important insurance reforms (eg, preexisting conditions), but without the financial regulations that would have made them most helpful to those who need them most. In addition, a small pilot test of medical savings accounts (MSAs)[3] was approved.

Downsizing the Federal Health Care Programs

This past year of even greater importance was the Balanced Budget Act of 1997 (BBA), which substantially decreased federal spending on health care for the next 5 years. Most of these savings were taken from the Medicare program, and most were aimed at providers (predominately hospitals, but also physicians). Despite the rhetoric to pass this bill to eliminate the federal deficit, current estimates at the time indicated that the deficit was already less than $40 billion and would likely be in balance within a year if there were no legislation. In fact, the BBA actually increased spending and delayed the time estimated to eliminate the federal deficit.

The BBA decreased Medicare spending by approximately $116 billion, and Medicaid spending by $17 billion. Of interest, the level of these Medicare cuts was similar to those proposed in the Clinton Health Security Act ($124 billion).[4] A major difference between the BBA and the 1994 Health Security Act, however, is that the Clinton plan proposed using these Medicare savings to finance from one third to one half of the cost of providing universal health care, while the 1997 BBA coupled these savings with more than $100 billion in tax cuts, predominately for persons who already had health insurance. Former Senate Majority Leader George Mitchell had been correct in his prediction that if the Clinton health plan was not enacted, it would provide future Congresses with the blueprint of where to make future cuts in the Medicare program.[5]

Graduate medical education (GME) also received decreases in funding of more than $5 billion for 5 years, although $4 billion of GME funding was carved out of managed care rates to return this educational money back to teaching hospitals. Small but important workforce changes were enacted in the BBA, including a cap on the total

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number of residents who would be paid GME funds, counting the time residents spend in outpatient settings for indirect medical education reimbursement, and a program similar to the New York State waiver, whereby hospitals that voluntarily decreased the number of their residents—but maintain or increase primary care residents—would receive special transition payments for 5 years. In addition, the BBA cut $10 billion from disproportionate share payments to hospitals that care for the poor.

The one major expansion of health care passed in 1997 was the State Children's Health Insurance Program (SCHIP).[6] This $24 billion program, financed in part by an increase in cigarette taxes, is the largest new health care program in decades. It provides states with new block grants to provide health care for low-income children (defined as residing in a family with income below 200 percent of the poverty line) who are not currently eligible for Medicaid and do not have health insurance. States can either expand their current Medicaid program or develop a new state health insurance program that must be similar to current coverage in their state. It is estimated that this program will provide coverage for between one quarter and one half of the current 10 million uninsured children.

Health Care Reform—The Marketplace

Having rejected a governmental approach, it now appears clear that the United States has chosen the marketplace as the mechanism by which it will attempt to organize and deliver health care while trying to control health care costs. For the public programs, including Medicare and Medicaid (which make up almost one half of the total national health care costs), the BBA encourages further market reforms. It allows Medicare beneficiaries a wider range of choices, including obtaining care from preferred provider organizations (PPOs) or provider-sponsored organizations (PSOs, a new hospital-physician entity that can function as a health plan) and participating in MSAs. It changes the capitation reimbursement rates for the rapidly growing Medicare managed care programs—increasing payments for those areas that currently have the lowest rates (eg, many rural areas) while guaranteeing a 2 percent increase in those areas that already receive the highest reimbursement—and moves toward providing all areas with rates that are closer to the national average. For family physicians, establishing a single Medicare conversion factor for 1998, a more accurate mechanism to update this factor, and a down payment on changing the resource-based practice expenses for office-based services, all provide some positive, albeit modest, financial gains. The BBA also allows state Medicaid programs to require recipients to enroll in managed care plans without obtaining a federal waiver.

While there was less in the BBA directly relating to the private sector of health care, managed care appears to have held down health care costs for the first time in many years. Despite predictions that they will soon rise again, payers (predominately business and government) appear to be comfortable with managed care's ability to provide some level of predictability in their health care costs. Although there have been some new legislative regulations related to managed care at the federal level (eg, 48-hour newborn discharge),[7] the overwhelming and rapid national changes in health care reform continue to be taking place in the marketplace. And the federal government appears to have decided to try to minimize its regulation of the marketplace, at least for the time being.

State Health Reform

Regarding state health care reform, a few states have made important progress during the past few years. Although many states have passed so-called "anti-managed care" legislation, however, these regulations apply to fewer than one half of state residents because of ERISA (Employment Retirement Income Security Act). Although there are some indications that the all-encompassing scope of ERISA might be becoming somewhat more limited through judicial rulings, Congress appears unlikely to make wide-scale changes in this area. Even if it did, leaving each state to reform its own health care system is likely to put extraordinary pressure and greater cost on those poorest states that already have the highest uninsured population rates.[8] In response to the BBA, most states are in the process of developing their own new children's health plans.

The Critical Need for Coalitions

My final point in 1996 came from an increasing awareness of how critically important are the im-

pact of coalitions on health policy and, therefore, the need to work cooperatively. There has not, however, been enough progress in this area. Within medical schools and in the practice community, the three primary care specialties continue to spend valuable energy competing with each other. The relations between generalists and specialists, between physicians and nonphysician providers, and between physicians and hospitals appear to be equally competitive. To be most effective, however, providers will need to focus collaboratively on those major issues related to the provision of high-quality and affordable medical care for patients and the role of providers in the medical decisions of health care systems. Although collaboration and consolidation will result in some loss of autonomy, it will also result in greater influence—whether in the marketplace or in government.

What About the Future?

In a general sense the four points listed at the beginning of this paper will continue to drive health policy during the next several years. In fact, now that Congress has made a very large number of changes in health-related issues (albeit most of them of relatively small scope), it might be difficult to make many more changes until legislators have a chance to assess the impact of what has already been passed. The two major health legislative priorities in the President's 1999 budget proposal—expanding Medicare to early retirees and the consumer protection measures from the President's Consumer Bill of Rights—both face major opposition. Of more importance, however, is the realization that the only major health care legislation Congress has adopted in the past decade has been within the context of a budget—not a health—bill. Because this trend is likely to continue in the future, it is questionable whether there will be any major new changes in federal health care legislation until the next budget bill is required—in 2001.

What will likely happen during the next 5 years? Additional legislation setting health plan standards might pass but will not stop the growth in managed care. Only a public that is more concerned about the negative aspects of managed care than it is in paying more for a different type of health insurance will slow these marketplace forces. So far, there is little to indicate that this shift has occurred. While the form of managed care will likely change, the underlying principle of providing high-quality health care at a competitive cost will remain. These continued cost pressures will force future health policy to remain budget driven, especially for publicly funded programs. States will make further progress, but their impact is only likely to offset the continuing decline in the rate of employer-purchased insurance. Calls for universal coverage will continue but are not likely to be acted upon unless they become in the individual interest of the majority of Americans. The private sector will see even more aggressive competition, attempting to take advantage of the considerable overcapacity that exists in the health care system in most areas.

A bipartisan commission on the future of Medicare, created as part of the BBA, is required to report to Congress by 1 March 1999 with recommendations on actions to ensure the solvency of the Medicare program through 2030 (including recommendations concerning funding of GME). This report will be released during the next presidential primary election season and right before the next major budget (and therefore health care) legislation is to be enacted in 2001. A number of the items that were included in the 1997 Senate Finance Committee proposal, including increasing the eligibility age of Medicare to 67 years and increasing Medicare premiums for higher income persons, will likely be back on the table for discussion. Enormous pressure will also continue for further decreases in payment to providers, for additional reductions in GME funding from the Medicare program, and for moving Medicare from a defined benefits program toward a more defined contribution program (ie, providing beneficiaries with a specific dollar amount toward their insurance coverage, rather than a specific set of benefits). Likewise, increasing the choice of options available to Medicare beneficiaries—using the Federal Employee Health Benefits Program (FEHBP) as a model—will be seriously debated.

What will happen to the physician workforce? It appears that market forces might have already started to decrease the total number of residents, predominately because of a decrease in the number of international medical graduates.[9] Likewise, the generalist-specialty balance of residents is changing, with fewer US graduates entering the specialties,[10] more residents in family practice,

and fewer residents in the medical subspecialties and hospital-based specialties.[9] Despite these changes, however, the total number of physicians being trained is so large that analysis of the practicing physician workforce indicates the oversupply of specialists will continue to worsen in the future, and the US might soon no longer have an overall need for more generalists except in underserved areas.

How will family practice adapt and prepare for these changes during the next 5 years? If the nation is approaching a time when the aggregate supply of primary care physicians is in line with the needs of the country, it will represent the first time in the history of the specialty of family practice that our major value to society will be no longer in our growth but in our role in the health care system. That is not to say that improvements in health care quality and a better distribution of physicians are not critically important. These changes will force the specialty of family practice to reexamine its own role and its relation with other health care providers. These changes, which will take place during the next 5 years, are likely to raise a number of critically important health policy questions for family practice. Family physicians will need to be prepared to address them, when the next chapter in health policy—the next health odyssey—arrives in 2001.

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