

REFORM—HENDRICKSON
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have coverage to make ends meet.

■ A “medical home” model of practice will reduce costs and improve quality through greater coordination of care.

Maybe they will. Maybe they won't. Even the Congressional Budget Office (COB) admitted at the July 8th hearing in from of the Senate Health Education Labor and Pensions (HELP) Committee that it was impossible to quantify many of the elements, both in terms of cost and in terms of savings, on such speculative and imprecise program proposals.

These hopes are accompanied by statements from the President to the effect that healthcare reform must be budget neutral. This simply is impossible. Here is what President Obama told Senator Kennedy and Senator Baucus in his

June 2nd letter on this issue:

Health care reform must not add to our deficits over the next 10 years — it must be at least deficit neutral and put America on a path to reducing its deficit over time. To fulfill this promise, I have set aside \$635 billion in a health reserve fund as a down payment on reform. This reserve fund includes a number of proposals to cut spending by \$309 billion over 10 years — reducing overpayments to Medicare Advantage private insurers; strengthening Medicare and Medicaid payment accuracy by cutting waste, fraud and abuse; improving care for Medicare patients after hospitalizations; and encouraging physicians to form “accountable care organizations” to improve the quality of care for Medicare patients. The reserve fund also includes a proposal to limit the tax rate at which high-income taxpayers

can take itemized deductions to 28 percent, which, together with other steps to close loopholes, would raise \$326 billion over 10 years.

I am particularly amazed by the statement in this letter, “I have set aside \$635 billion in a health reserve fund” referring to hoped-for savings in the coming years from Medicare and Medicaid cuts as well as prospective revenues from additional taxes on the wealthy made possible by limiting itemized deductions. None of these funds have been realized yet, and may never be. How sound a basis does this really appear to be for a national policy revision of the scale and scope being debated in Congress?

It's not just the money, however, its what the limits of the money available will mean to individuals concerned about whether their needs will be truly taken care of when they or a family member faces a real health care crisis. On the

front page of the July 8, 2009 edition of *The Washington Post*, perhaps the most daunting question facing policy makers on health reform was asked. Here it is:

The question came from a Colorado neurologist. “Mr. President,” he said at a recent forum, “what can you do to convince the American public that there actually are limits to what we can pay for with our American health-care system? And if there are going to be limits, who . . . is going to enforce the rules for a system like that?”

In other words, who decides what care is paid for, and on the basis of economic enablement, makes the de facto decision of what care is given?

The President did not directly answer the question, nor does any Congressional legislative language yet unveiled. In fact, the debate has yet to get to a straightforward acknowledgement that there are very stringent limits on the funds available, regardless of how any reform plan is configured.

There is a fundamental disconnect between policy goals that seem to be completely obscured by the political haze that is accompanying the current health care reform debate. This disconnect comes in the lack of comprehension as to just what is being reformed through the various and competing national health care reform proposals. There does not seem to be any grasp, either on the part of any group in Congress or The White House of the difference between a payment system anchored in and governed by the limits of public funds on the government side, and the profit demands on the private insurance side, and a clinical care program which should be governed by the unique needs of each patient, the health care choices of that consumer and the best clinical judgment of the attending professionals guided by appropriate best practices data. Instead of understanding the difference and providing accordingly, there seems to be a belief that these competing dimensions of the national health care system can be addressed without reconciling the limits of our national resources with the unlimited demands for care. This simply will not work.

We see in Medicare today a system where instead of being forthright with beneficiaries and saying that the program has limits — this is all Medicare can afford to pay, and you are responsible for the rest — there is a policy of bending clinical necessity arguments to try and fit the program's limited economic capacity that now borders on the absurd. Providers of all types are being bombarded with audits, repayment demands and worse by Medicare, with the program using claims that services were not demonstrated to be “medically necessary” when the real situation is that they just do not have the resources to pay for them. Private insurance is even worse.

The multi-billion dollar question is whether it is simply too late to slow this rush to a poor solution and try and inject some new element of candor and practical problem solving into this debate? The alarming state of the nation's finances makes any health reform effort inherently much more complicated and difficult, requiring painful choices and limitations. I think it best serves the Administration and those who are trying so hard to provide the President with genuine, enthusiastic support in the urgently

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