

REFORMING AMERICA'S HEALTH CARE SYSTEM



A look at the Trump administration's approach.

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In December, the Trump administration released a 119-page report entitled "Reforming America's Healthcare System Through Choice and Competition."¹ This report was signed by the secretaries of the US Department of Health and Human Services, Alex M. Azar II; the Department of the Treasury, Steven T. Mnuchin; and the Department of Labor, Alexander Acosta. Its avowed purpose was to identify "actions that states or the Federal Government could take to develop a better functioning health care market."

The report was wide-ranging in its scope, dealing with topics that have implications for our profession, including health care workforce and labor markets, scope of practice legislation, provider and facility consolidation, telehealth, changes in the health care insurance market, implications of consumer-driven health care, Federal Trade Commission issues, certificates of need (CON), the Patient Protection and Affordable Care Act (ACA), and health care information technology. The treatment of some topics was superficial; other topics (those reflecting the interests of the administration) were dealt with in greater detail.

The report's premise was stated succinctly: "As health care spending continues to rise, Americans are not receiving the commensurate benefit of living longer, healthier lives." Secretaries Azar, Mnuchin, and Acosta cited statistics and literature to support the claim that quality of care is not rising as quickly as costs, and that, because

value equals quality divided by cost, the value of health care services in the United States is going down. Much of the report focuses on ways to reduce costs—increasing market competition, implementing price transparency, and reducing regulatory burdens that add to cost—and highlights negative economic consequences of provider, particularly physician and facility, consolidation.

ADMINISTRATION INITIATIVES

The Trump administration outlined several specific initiatives:

- **Encouraging the purchase of short-term limited-duration insurance.** The authors advanced this as an alternative to coverage under the ACA. By definition, these plans are less than 365 days in duration (sometimes much less), are medically underwritten, generally do not provide all of the ACA's essential benefits, and generally have high deductibles and narrow networks. They present a particular burden for physicians in

determining coverage.

- **Launching *American Patients First*.** The administration previously released a plan called American Patients First to reduce high list prices for drugs, to introduce negotiation into Medicare Part D drug purchasing, to promote competition for biologics, to promote the use of biosimilars, to encourage generic drug development and approval, and to require site neutrality in payment. The report said the administration hopes to implement some of the plans outlined in that blueprint.
- **Promoting Medicare Advantage plans.**
- **Simplifying documentation and payment in the use of evaluation and management coding.**

MEASURES OF CONCENTRATION

Of particular interest to ophthalmologists and reflecting the influence of the Federal Trade Commission and the Departments of Treasury and Labor

AT A GLANCE

- ▶ The Trump administration's 119-page report on health care in the United States dealt with topics such as scope of practice legislation, health care workforce and labor markets, provider and facility consolidation, and telemedicine.
- ▶ The report's findings generally favor less government intervention and suggest a departure from fee-for-service payment models.

were comments relating to *measures of concentration* (consolidation and geographic concentration) in the physician workforce, scope of practice regulations and legislation, and the relationship between CON and facility construction and marketplace competition. The document emphasized that “scope of practice laws and regulations, like other health and safety regulations, may be justified when there are substantial risks of consumer harm. ... These regulations may be especially important with respect to certain health care professions, where consumers might be at risk of serious harm if they were treated by unqualified individuals, and where patients might find it difficult (if not impossible) to assess quality of care at the time of delivery.” The report goes on to note that, specifically, optometrists “can safely and effectively provide some of the same health care services as physicians, in addition to providing complementary services.” Philosophically, this is entirely consistent with the collaborative, team-based model of care articulated by the AAO. The AAO has also gone on record to support “the Secretaries’ stated standard of a justified safety regulation to prevent risk of serious harm.”

The AAO also supports repeal of state-based CON laws in the 36 states where such laws exist. In some locations, these laws have placed limitations on the creation and construction of ambulatory surgery centers, forcing some ophthalmologists to perform surgery in more expensive and less efficient hospital settings and restricting access to care. The report endorses site-neutral payment policies that would eliminate differentials between hospital outpatient departments and independent sites of practice.

OTHER ISSUES

Telemedicine. The administration’s report touches on telehealth and telemedicine. Calling out the potential application in ophthalmology, it notes the technology’s potential to “enhance price and nonprice competition, reduce

transportation expenditures, and improve access to quality care.” Noting the complications posed by state-based licensure, the report supports interstate medical licensure compacts as an effective mechanism to increase physician workforce mobility.

Cost-conscious consumer behavior.

A substantial portion of the report is devoted to mechanisms to foster “cost-conscious consumer behavior.” In general, it supports alternatives such as high-deductible health plans, health savings accounts, and health reimbursement arrangements as payment mechanisms that more directly connect people to the real cost of their health care. It does not, however, address the many problems experienced by physicians regarding coverage determination, out-of-pocket costs, and medically undesirable and financially driven avoidance of tests and unfilled medication prescriptions.

Moving away from a fee-for-service system. Consistent with the underlying theme of less government intervention, the report touts the benefits of Medicare Advantage as moving away from a fee-for-service system and “better empowering consumers—letting them determine what constitutes value, as opposed to deferring the judgement to Washington.” The percentage of Medicare-eligible beneficiaries enrolled in Medicare Advantage programs has risen in some areas to greater than 60%.

The report unequivocally supports a departure from fee-for-service medicine: “The Administration should pursue policies and programs that ... move away from a fee-for-service model.” It endorses alternative payment models that are currently thoroughly replete with a complex regulatory environment and which are not friendly to smaller practices. Yet, at the same time, the report notes that “it is important that delivery system reform efforts do not harm smaller practices that lack economies of scale to satisfy new rules and requirements accompanying delivery system reform more easily.” It will be

difficult to have it both ways.

In an interesting twist, the report’s authors state that they believe that narrow networks generally foster competition and should be encouraged to the point that states “should consider loosening network adequacy standards and avoid stringent requirements.”

Quality reporting. The report addresses quality reporting and notes that it poses an administrative burden for a number of specialties. (The AAO’s IRIS Registry clinical data reporting system clearly gives ophthalmology a strong advantage as a no-cost, low-burden, highly successful alternative.) It endorses (as does the AAO) the implementation of provisions of the 21st Century Cures Act to prevent information blocking, promote interoperability, and make electronic health records “clinically usable and informative.” In a surprising and disappointing twist, however, the report states that the “administration should seek to develop [quality] measures,” a position that the AAO strongly opposes. The AAO believes that physicians, not the government, are best positioned to develop clinically relevant quality measures.

SUMMARY

The 119-page report covers many aspects of health care reform. In general, the report’s authors endorse a competitive approach, but some of the solutions could be argued to favor new or greater government intervention on issues ranging from graduate medical education funding to alternative payment models. Overall, it provides a valuable glimpse into this administration’s legislative and regulatory priorities for the next several years. ■

1. Azar II AM, Acosta A, Mnuchin ST. Reforming America’s Healthcare System Through Choice and Competition. Washington, DC. US Department of Health and Human Services. December 3, 2018.

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