

# Healthcare Reform

## Key Players and Terms

### Key Players in the Senate

Chairman Max Baucus (D-MT) & Ranking Member Charles Grassley (R-IA) head up the Senate Finance Committee – one of the two major committees on the Senate side that will tackle healthcare reform this year. The jurisdiction of this committee includes health programs under the Social Security Act and health programs financed by a specific tax or trust fund as well as tax code changes. The Finance Committee traditionally acts in a bipartisan fashion and often produces legislation that has the best chance of passing the Senate.

Chairman Edward Kennedy (D-MA) & Ranking Member Michael Enzi (R-WY) head up the Senate Health, Education, Labor and Pensions Committee. The HELP Committee, as it's often referred to, has jurisdiction over public health and welfare programs as well as biomedical research.

### Key Players in the House

Chairman Pete Stark (D-CA) & Ranking Member Wally Herger (R-CA) head up the House Ways & Means Health Subcommittee – one of the three major committees on the House side that are working on healthcare reform. The Ways & Means Committee has jurisdiction over providing payments (from any source) for healthcare, health delivery systems, or health research as well as tax credit and tax deduction provisions of the Internal Revenue Code dealing with health insurance premiums and healthcare costs.

Chairman Frank Pallone (D-NJ) & Ranking Member Nathan Deal (R-GA) are the leaders of the House Energy & Commerce Health Subcommittee, which has jurisdiction over health facilities (except healthcare supported by payroll deductions), biomedical research and public health.

## Key Players in the Obama Administration

HHS Secretary Kathleen Sebelius of the **United States Department of Health and Human Services (HHS)** – the government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Secretary Sebelius oversees Medicare, Medicaid, the National Institutes of Health, Food and Drug Administration and many other agencies under HHS.

Nancy Ann DeParle heads up the **White House Office of Health Reform**, which provides leadership to the executive branch in establishing policies, priorities and objectives for the Federal Government's comprehensive effort to improve access to healthcare, the quality of such care, and the sustainability of the healthcare system.

## Key Terms

**Accountable Care Organizations (ACO):** A group of providers held responsible for the quality and cost of healthcare for a population of Medicare beneficiaries. An ACO would be a combination of one or more hospitals, primary care physicians and possibly specialists, and would be accountable for total Medicare spending and quality of care for the Medicare patients served. Bonuses and penalties could be tied to overall Medicare spending and quality measures.

**AHRQ:** Agency for Healthcare Research and Quality, Department of Health and Human Services. Charged with major areas of healthcare research such as quality improvement and patient safety, outcomes and effectiveness of care.

**Bundling:** A single charge for a group of related health services. For example, a bundled charge for diabetes services might cover blood tests, diagnosis and treatment. In recognition of the complexity associated with bundling payment, the Medicare Payment Advisory Commission (MedPAC) has laid out an incremental approach to a bundling policy, starting first with confidential disclosure of information and moving to "virtual" bundling for all providers.

MedPAC described virtual bundling as a process in which payment to hospitals and inpatient physicians would be adjusted based on aggregate use of resources over a single episode of care. High and low benchmark spending levels for select conditions

would first be determined. CMS would then take a withhold from all hospital and physician inpatient services for the select conditions, and would refund the withholds to the providers except those with high spending across the episode of care. Providers with low spending that also delivered high-quality care would have their withholds refunded in addition to a bonus.

**Chronic Care Management:** The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as obesity and diabetes. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

**Comparative Effectiveness:** Comparative Effectiveness: Research comparing the relative merits of two drugs or methods of treating an illness. Of particular concern is the distinction between clinical effectiveness—which examines the merits of various treatment options without respect to their cost—and cost-effectiveness research.

**Crowd-Out:** A phenomenon whereby public programs or expansions of public programs designed to extend coverage to the uninsured encourage some employers to drop health coverage, urging their employees instead to take advantage of the expanded public subsidy.

**Employer Mandate:** A requirement that all employers, or at least those of a certain size, offer health benefits that meet a specific standard and pay a set portion of the cost of those benefits on behalf of their employees.

**Evidence-Based Medicine:** The use of current best clinical evidence in making decisions about the care of individual patients, often with the assistance of information technology. Patient preferences are considered along with clinical expertise.

**Federal Employees Health Benefits Program:** A program that allows federal employees to annually choose among a number of approved private health insurance plans. The federal government pays a major portion of the coverage.

**Fee for Service:** Method of paying for healthcare services based on the actual care delivered.

**Health Insurance Exchange (also referred to as Connectors):** Marketplace created to give individuals, small businesses and others access to affordable private health insurance.

**HHS:** The United States Department of Health and Human Services is the government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS oversees Medicare, Medicaid, the National Institutes of Health, Food and Drug Administration and many more.

**Individual Mandate:** A requirement that all individuals obtain health insurance. A mandate could apply to the whole population, just to children and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

**Markup:** Refers to the meeting of a Committee held to review the text of a bill before reporting it out. Committee members offer and vote on proposed changes to the bill's language, known as amendments. Most mark-ups end with a vote to send the new version of the bill to the floor for final approval.

**Medical Home:** An approach in which patients, especially those with chronic illnesses, are cared for by a primary care physician heading a team that might include behavioral experts and dieticians.

**MedPAC (Medicare Payment Advisory Commission):** MedPAC is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

**Pay for Performance:** System under which providers are rewarded for high-quality services.

**Pay or Play:** A requirement that employers that decline to offer health benefits pay a specified dollar amount or percentage of payroll into a designated public fund that would provide a source of financing for uninsured workers.

**Prospective Payment System (PPS):** System used by Medicare to pay for several types of services including inpatient, outpatient and skilled nursing services. Rates are linked to diagnoses rather than the actual costs of the care given.

**Public Plan Option:** Insurance program organized by the Federal Government to compete with private health insurers.

**Resource-Based Relative Value Scale (RBRVS):** Method used by Medicare to reimburse physicians, where the cost of providing a service is divided into three categories—physician work, practice expense and medical liability insurance. The payment is determined by multiplying the costs by a dollar conversion factor set by the CMS.

**Self Insured Plan:** A group plan in which employers assume the financial risk (although many buy reinsurance) for covering employees, rather than buying insurance from a commercial carrier. A third-party administrator or insurer typically provides administrative services.

**Single Payer System:** A system under which a single entity, usually the government, collects healthcare fees and pays the bills, but isn't involved in the delivery of care.

**Shared Responsibility:** Most often used in referring to the premise that all would be required to have healthcare coverage.

**Sustainable Growth Rate (SGR):** Formula that's intended to control Medicare spending by restraining doctors' fees. But numerous problems have led the formula to require repeated fee cuts—a requirement that Congress has overridden.