Although most pundits expected the 2012 presidential campaign to focus on the economy, the central theme that has emerged has been the candidates’ profoundly different views on the role of government in our lives. For health care, this dispute centers on whether the federal government should finance access to health insurance coverage and on how much to rely on market forces—or government—to restrain growth in health spending. Yet, politics has a way of softening sharp, ideological differences. Our federal government system, with its multiple layers of often arcane checks and balances, limits decisive policy departures and tends to reinforce the status quo even when the status quo is highly imperfect. Politics can trump policy and usually does. For example, it was politics and not policy that lead Romney to repudiate running mate Ryan’s House budget, which adopted the same $718 billion Medicare payment reductions that were in Obama’s Patient Protection and Affordable Care Act (ACA).

The ACA is now the law of the land, reaffirmed—sort of—by the Supreme Court. Despite the vows of many Republican state governors and legislatures not to set up health insurance exchanges or administer major Medicaid coverage expansions, it will be difficult for Republicans to prevent implementation short of a decisive Republican sweep in the November elections. Once past the election’s glare, governors who now stridently oppose Medicaid expansions will almost surely moderate their views under pressure from providers and businesses who want their states to take advantage of the federal largess found in the ACA to reduce uncompensated care.

Under Obama’s plan, currently uninsured patients will have greater access to regular and continuous care from their selected clinicians, rather than having to rely on urgent, episodic care in emergency rooms. Expanded insurance is the ACA’s great achievement. However, left mostly unaddressed by the ACA are the reluctance of many physicians to serve Medicaid patients (1) and the shortage of the primary care workforce, both of which will make it difficult to meet demands for care when 30 million more Americans become insured (2).

Republicans ideologically favor major restructuring of Medicare for future generations and Congressman Ryan initially proposed to give beneficiaries a voucher to shop for health insurance only from competing, private health plans. Yet, in the face of Democratic attacks arguing that this proposal would provide an insufficient voucher in a poorly regulated insurance market, Ryan backed off and instead now promotes a more moderate “premium support” approach. While this plan still raises concerns about moving Medicare from a defined benefit to a defined contribution program, it is much less ambitious than Ryan’s initial proposal (3, 4). Even so, Democratic opposition to “vouchercare” makes it less likely that this modified approach will gain bipartisan support after the election.

To alter the status quo, the Obama Administration, in developing the ACA, fought hard for formation of the Independent Payment Advisory Board (IPAB) to address the inordinate influence of stakeholder interests in Congressional decisions over Medicare. This group of 15 nonpartisan experts is responsible for developing payment and related Medicare policy changes to assure that Medicare spending does not exceed budget targets tied to economic growth (5). A merit of this approach is that the trigger would not produce automatic, across-the-board payment cuts but rather would require discrete decisions on where cutting might best be accomplished with the least harm. The IPAB recommendations would take effect unless they were overturned by Congress with a super-majority vote. Yet, affected stakeholders have demonized this Board, causing Republicans and some Democrats to vow to oppose this approach to Medicare spending control. Although now in law, the IPAB may never form because the Senate is unlikely to find 60 votes required to confirm IPAB members. Again, politics is at work to reinforce the status quo.

On practical policy issues that directly affect physicians, there is more agreement among elected officials and the health policy intelligentsia in Washington. For example, there is consensus that payment approaches need to evolve from “volume” to “value,” although precisely how one goes about paying for value remains vexing. Current measures do not permit an accurate global assessment of quality, while overspending arguably is better attacked by putting providers at financial risk through forms of bundled or global payment than expecting marginal bonuses or penalties (pay-for-performance) to have enough impact to change clinician behavior (6).

The ACA set up the new Center for Medicare & Medicaid Innovation to test a raft of new payment and organizational delivery models, including enhanced primary care practices, “shared savings” for accountable care organizations, and home visits for the frail elderly and disabled. By Congressional intent, these approaches should be designed not only to work for Medicare but also for Medicaid and commercial payers. Although conservatives believe that innovation evolves from the “bottom-up” through market forces, most Republicans are interested in the results of the Innovation Center’s “top-down” demonstrations. The budget stakes are too high to simply hope that unplanned innovation will eventually bend Medicare’s and Medicaid’s spending curve.
There is growing bipartisan appreciation that the primary care workforce is insufficient to handle increasing demand for primary care services and to serve as a core component of integrated delivery systems. Although Republicans are more skeptical than Democrats that one can titrate administered prices to correct payment anomalies that promote procedures and tests at the expense of evaluation and management services, there is growing bipartisan concern that the distortions in the resource-based relative value scale, the basis of the Medicare Fee Schedule, adversely affect patient care and generate unneeded health spending (7).

Yet, with tight budgets, made worse by the $300-plus billion budget hole created by repeated “doc fixes” to override the cuts mandated by the sustainable growth rate formula, increasing payments for primary care services will be difficult to achieve without redistribution. The Medicare Payment Advisory Commission recommended a sustainable growth rate fix that would involve a 17% reduction in fees over 3 years for physician services other than primary care services while also proposing payment reductions for a variety of other providers in Medicare (8). Not surprisingly, this proposal was met with deafening silence by Congress, responding to the opposition from those who would be adversely affected.

It is important to note one issue that has not yet received needed attention from either party’s policy agenda. Although some laud the promise of Big Medicine built on mega-hospital systems that absorb physician practices to provide missing consistency and reliability in the provision of health care services (9), others are less sanguine about this prospect—in part because monopoly behavior raises prices (10) but also because of uncertainty about how professionalism would fare in an overtly commercially oriented health system. Yet, given the current trends of hospital consolidations and acquisitions of physician practices, it is likely that Big Medicine will come to dominate U.S. health care, like it or not. So far, the developing, divergent views on Big Medicine have not divided into polarized, red and blue positions. That provides some hope that policymakers will actually explore the merits of Big Medicine in a bipartisan manner to help shape its evolution to serve the public interest, as its advocates wish.

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