Obamacare' explained at SBU symposium

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A symposium on the new federal health care law at Stony Brook University's Wang Center has shed some light on a dimly understood law. "Communicating Health Care Reform: Why Don't People Get It?" was held Nov. 1.

The principal speaker was Karen Davis of the Commonwealth Fund, a charitable organization that promotes quality health care. Davis explained the main elements of the complex new law.

First, Davis reviewed the main features of what its detractors call Obamacare. The law, she explained, is designed to accomplish three things: extend adequate health care coverage to the vast majority of the population; significantly improve the quality of care; and accomplish both while holding down ever-increasing health care costs. Davis said the currently 50 million uninsured would have reached 60 million by 2019 without the new law. It is anticipated that only 20 million will remain without insurance once all elements of the law are in place later this decade. Further, she explained many of those currently counted as having insurance are really underinsured and the new law provides minimum coverage that is adequate.

Next, Davis explained some of the major dictates the new law imposes. These include a mandate that everyone purchase insurance or be subject to a fine. This requirement is justified by the premise that insurance doesn't work if the healthiest in the population are allowed to opt out. Second, employers with 50 or more employees must either provide health insurance or pay any subsidy for which their employees qualify. Next, Davis continued, insurance companies must offer open enrollment and can only vary premiums based on age or cigarette smoking, not on gender or health status. Finally, insurance companies must dispense at least 85 percent of premiums for health care claims.

The main vehicle for quality improvement will be the Accountable Care Organization. Initially for Medicare only, the ACO will expand to cover the national health care system. Davis said the ACO has three basic models. The "patient home" is a primary care model where a group of primary care doctors join together and agree to take responsibility for providing high-quality care to a group of patients while controlling costs. The minimum number of patients necessary to qualify as an ACO is 5,000.

The second ACO model is a "multi-specialty" group, which would accept more responsibility for overall care of the patient than the primary care group can by itself. The third model is an "integrated inpatient, outpatient group," a partnership between hospitals and doctors that would, according to the intent of the law, be accountable for patients in their group getting top-notch care.

These organizations differ in important ways from the HMO or managed care organizations, Davis said. First, they are not insurance companies but instead partnerships among providers. Second, they are supposed to be transparent to the patient. The patient doesn't join anything and the patient can see any doctor or go to any hospital they choose. Exactly how the ACO is responsible for care and costs in this environment still isn't clear since the working rules for these organizations haven't been published.

A third difference between the ACO and the HMO is that doctors and hospitals aren't supposed to be put at risk by being in the ACO. Davis said there is no penalty if they don't meet guidelines, only bonuses paid if they do meet quality guidelines and keep costs below averages Medicare would have expected to pay.

A panel discussion followed Davis's presentation. Moderator Howard Schneider, dean of SBU's School of Journalism, asked each panelist how their particular constituency felt about the law. Dr. Charles Rothberg, president of the Suffolk County Medical Society, explained that doctors were afraid they would lose their autonomy and would not be able to advocate for their patients. Kevin Dahill, president of the Nassau-Suffolk Hospital Association, reported that hospitals, through their national organization, have already agreed to $158 billion in cuts. Their hope is these cuts will be compensated by the increased number of insureds and resulting decrease in bad debt incurred by hospitals. Nonetheless Dahill

fears these cuts, considering the current economy, may cause many hospitals to face

bankruptcy.

The panel then addressed why "people don't get it," said Schneider. The consensus was political sound bites had drowned out the message. The best example, several agreed, was the commotion over so-called death panels. Ruth Finkelstein of the New York Academy of Medicine was representing the health care consumers.

"The wonderful people of the Health Care Advocacy Group, whose only concern was dignity, respect and services at the end of life, made a modest proposal," Finkelstein said. The panel suggested as people neared the end of life, their physicians should talk about what options were available. This, she said, got shot through a "distortion prism" that turned the proposal into death panels designed to feed people's fears.

More information about the Patient Protection and Affordable Care Act can be found at the Commonwealth Fund's website: www.commonwealthfund.org.