



Perspective

Implementation and the Legacy of Health Care Reform

Christopher C. Jennings

Now that President Barack Obama has signed into law the Patient Protection and Affordable Care Act, pundits and politicians are debating whether the landmark legislation will be a political

asset or an albatross. The truth is that the legacy of this new law will be determined by the underlying policy and the competence with which it is implemented.

The stakeholders in Washington, D.C., know all too well that the players who will wield the most influence over how the law's reforms are integrated into the nation's health care system do not reside in the Capitol Building. The new power brokers will be housed in the White House, the Office of Management and Budget, and myriad federal departments and agencies — particularly the Department of Health and Human Services, which will administer the bulk of the new act's phased-in provisions.

Recognizing this fact, virtually all the interested parties, including representatives of health insurers, medical product manufacturers, health care providers, consumers, most businesses, and organized labor, are quickly positioning themselves as supporters of successful implementation. It matters not whether they opposed the health care reform legislation. Suddenly, virtually all parties in Washington say (or will say) they want to be helpful friends of the administration at this stage of the process, for they know this law will not be “repealed and replaced” — certainly as long as Obama is in office, and probably ever. More important, they know that the new law provides unprecedented

discretion to the implementing agencies and that close-call decisions can make a huge positive or negative difference to their interests.

In return, the administration, will probably (wisely) tone down its criticism of past opponents of reform, recognizing that effective governing requires constructive input and investment from all affected parties. They will begin to call all the players in health care reform “stakeholders,” rather than “special interests and well-heeled lobbyists.” That does not mean that the stakeholders will agree with all the administration's calls on final interpretations and implementation of the law; it simply means that they — particularly those who have prepared most substantively — will be heard and their ideas seriously considered.

But this is Washington, not Mr. Rogers' Neighborhood. To cover their bases (in case they

Key Health Care Reform Provisions That Are Effective Immediately (2010).^{*}

Insurance and small-business market reforms

- Prohibits rescissions and removes lifetime caps on insurance payouts
- Allows for coverage of young adults <26 yr of age on parent's policy
- Eliminates exclusions for preexisting conditions for children
- Establishes a high-risk pool
- Creates a reinsurance program for early retirees
- Requires coverage of preventive service with no cost sharing
- Requires health plans to report medical loss ratios
- Offers tax credits to small employers that offer health coverage to employees

Health care workforce

- Establishes new workforce commission to assess needs of national health care workforce
- Increases availability of student loans for medical students entering primary care
- Increases funding for National Health Service Corps
- Establishes and increases grants for nurse education and training
- Increases funding for training in cultural competency and diversity

Medicare coverage and quality

- Begins to phase out the prescription-drug "doughnut hole" under Medicare Part D
- Provides immediate Secretarial authority to ensure evidence-based preventive-benefit-coverage designs in Medicare
- Establishes a grant program for recruitment and training of rural physicians
- Establishes the CMS Center for Medicare and Medicaid Innovation to develop new payment models to reward quality over quantity
- Establishes a new CMS Federal Coordinated Health Care Office to design better models of care for patients with chronic diseases

Fraud and abuse

- Increases funding and penalties for antifraud activities
- Allows data sharing across federal agencies to track fraud and abuse
- Strengthens anti-kickback laws

* CMS denotes Centers for Medicare and Medicaid Services.

disagree with the administration's implementation decisions or in case the Republicans regain power), many of these stakeholders (health care providers, health plans, medical product manufacturers, and businesses, in particular) will give notably more generous financial support to the party that is out of power, the Republicans, than they have been recently. When they don't like the direction of implementation, they will quietly encourage Republicans to publicize problems and undermine implementation decisions. They will also

seek out sympathetic Democrats, particularly those who serve on the committees with oversight jurisdiction over the relevant agencies, urging them to intervene. Some observers outside Washington might call this double-dealing; inside the Beltway, it is called good business practice.

Both political parties are well aware that first impressions of this law now that it has been enacted will be incredibly important. Despite all the competing rhetoric about what is in this legislation and whether it is good or bad, people in the political

middle of the electorate — where elections are won and lost — have not made a final call on what they think. The degree of success (or lack thereof) the administration will have in securing the support of the so-called sensible center will largely depend on its ability to competently implement the numerous policies that go into effect within the first few years — and its ability to do so within a political environment whose hostility will continue to be inflamed by many Republicans and their "Tea Party" base.

Notwithstanding the perception that few important provisions will be put into place before 2014, there are actually more than 150 policies (see box for examples) that become effective this year. It will therefore be incumbent on the administration to effectively implement them in ways that garner stakeholders' support and investment and engender a positive public reception. Although some of these policies (particularly those that build on existing programs) can be implemented fairly easily, others require the federal government to administer and enforce policies in realms where it has little experience. Policy that is related to insurance reform particularly comes to mind.

And though all eyes will be on the administration — which will rightly get the lion's share of the credit or blame for implementation — many other parties will play major roles. They include Congress and its oversight bodies, stakeholder groups (physicians, nurses, other health care professionals, and hospitals, as well as drug and device manufacturers, health plans, state and local governments, and the broad array of purchasers), the media, and perhaps most important, the public and patients (who should always be part of the core audience of this effort).

But the administration's work on implementation will be front and center. The President's implementation effort will not work well — or at all — without the involvement of highly qualified, motivated, coordinated, and empowered personnel, some of whom must be physicians. Although it has strong people in some rele-

vant posts, the administration remains understaffed. Moreover, a number of its nominees have yet to be confirmed, some of them because Republican senators have placed "holds" on their confirmation votes. In the current polarized atmosphere, it seems highly likely that this sour mood will continue to pervade Congress for the rest of this year. If it does, the lack of leadership within the key agencies could well have a devastating impact on effective implementation of health care reform.

Just as important as well-regarded and confirmed personnel is skilled management. "Skilled" means that the administration must provide for a clearly delineated line of authority; interagency and interdepartmental coordination; a process for prioritizing the review, interpretation, and implementation of myriad provisions; the competent completion and timely resolution of work; the effective and adequate allocation of responsibility and resources for conducting implementation work; a serious effort at outreach to and integration of stakeholders; and a cooperative relationship with the relevant congressional committees, the Government Accountability Office, and other similar oversight entities. Perhaps most important, the administration needs professionally run communications shops in the White House and throughout the relevant departments and agencies to communicate in user-friendly ways with a wide range of audiences (the press, opinion leaders, stakeholders, and the public) about timing, process, and substance.

Good management structure and managers are not easy to find, in either government or the private sector. Moreover, little more than a year into its existence, this administration has not had the time to build the experience or form all the trusting relationships it will need within and among the departments and the White House to be running on all cylinders. Although this situation will improve, there will inevitably be growing pains and mistakes that all parties must expect and be prepared to address. The handling of these problems may end up being the biggest test of all for both stakeholders and the government. And this implementation effort is as high-stakes as they come, since its failure or success will mean the difference between giving ammunition to the repeal advocates and protecting the legacy of the Patient Protection and Affordable Care Act.

As always in the political world, the prescription for successful implementation involves acknowledging problems, accepting responsibility for their resolution, working with stakeholders and opinion leaders to find workable solutions, and then delivering on that promise. But as every doctor knows, prescribing interventions is far easier than achieving adherence among patients.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

Mr. Jennings is president of Jennings Policy Strategies, Washington DC, and was senior health care advisor to President Bill Clinton from 1994 to 2001.

This article (10.1056/NEJMp1003709) was published on March 31, 2010, at NEJM.org.

Copyright © 2010 Massachusetts Medical Society.