THIRD WAY

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A Health Policy Failsafe for the Super Committee

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Health care policy often seems like the Cold War of domestic politics, with both sides vying for control of the debate. But there is one issue that threatens mutually assured destruction: high costs. For Republicans, spiraling health care costs have placed them in the increasingly untenable position of proposing steep Medicare cuts in order to avoid tax increases in their budget proposals. Democrats are looking at a long-term budget where health care spending crowds out other progressive priorities such as education, housing, and public investments.

In the face of an unsustainable fiscal outlook, both parties have an opportunity to use the "Super Committee" to work together on controlling health care costs. Despite the rancor that has clouded the overall health care debate, some goals are mutually acceptable: improved patient care, fiscal sustainability, and broad-based cost restraint. Third Way has included several such ideas in a $1.65 trillion failsafe plan for "Super Committee" success. [1] This memo explains three policy areas over which the two sides could come together.

Improve care for chronic diseases

Diabetes, heart disease, stroke, cancer and other chronic diseases cause seven of every ten deaths in the U.S. [2] They cause more disability than anything else in American life. They also consume three out of every four health care dollars. [3]

Better patient care can save lives and money by stopping a chronic disease from becoming an expensive crisis. Unlike traditional acute care for accidents where doctors take charge of the care, treating chronic disease requires patients to be an active partner in their care. For example, diabetes requires patients to do everything from checking their blood sugar to monitoring their diets. Chronic disease treatment works best

with a team approach to medicine involving medical specialists, primary care doctors, nurses and other staff who help coordinate the care. Outside of large clinics like Mayo and the Cleveland Clinic, such care systems are scarce.

Patients with the most chronic conditions are the so-called dual eligible patients who use the federal Medicare program for their regular care and also qualify for the state-based Medicaid program because they are disabled or poor. With two separate sources of financing, care coordination falls through the cracks. For example, states have no way to ensure that patients in state-paid nursing homes are getting all they can out of federally-paid health care that, if fully utilized, would let patients return home.

Nine million Americans fall into the dual eligible category. They make up 16% of the Medicare population but account for one-quarter of its spending. [4] In 2005, Medicare and Medicaid spent an average of $26,185 on their care. [5] For those patients with five or more chronic conditions, the costs averaged $50,278. [6]

The way to build health care networks that work the same way as large clinics is by changing the financing of care. Chronic care requires services that are not traditionally covered such as care coordination and patient education. Emory University health economist Ken Thorpe has recently estimated federal savings of $125 billion over ten years if all states adopted best practices for all patients who are dual eligible. [7] Best practices have proven to significantly reduce hospitalizations and improve patients' management of their chronic conditions. They include the use of health coaches for patients, pharmacists assisting patients with following doctors' instructions for medications, and follow-up care after hospitalizations.

A mechanism for improving patient care and lowering costs is already in the works. As part of implementing the *Affordable Care Act*, the Centers for Medicare and Medicaid Services (CMS) has authorized 15 states to be part of an integrated care program for dual eligibles. CMS has since extended a

similar opportunity to additional states, and a total of 37 states and the District of Columbia intend to participate. [8] CMS has already developed patient protections such as requirements for physician networks that are large enough to handle all of a patient's needs, and key services such as prescription drug coverage could continue to be managed through Medicare Part D.

Private health plans have been at the forefront of arranging such services. Some states would likely turn to them for their expertise. Other states without an infrastructure of organized networks may build upon their existing fee-for-service reimbursement system. Both approaches can work; plans and fee for service approaches can be aligned with the rest of Medicare to achieve savings. Over time, if savings are not achieved, the federal government should reduce federal Medicaid funding to the states by at least 33 percent of the projected savings. CMS would have the authority to increase the penalty based on the results of the state demonstration programs now underway. That would guarantee federal savings of at least $41 billion over 10 years. [9]

Another way to lower the health problems and costs from chronic disease is to prevent it in the first place. The Centers for Disease Control has developed a proven, cost-effective weight loss program that can prevent diabetes, heart disease and their associated costs. [10] Congress should expand this program nationwide. Studies show that expanding it to just 60-64 year-olds would achieve an estimated savings of at least $7 billion over the next ten years in Medicare. [11] Expanding it regardless of age would save Medicare and Medicaid $142.9 billion over ten years. [12]

Because these initiatives don't require a choice between public and private health plans, they thread the ideological needle that often stymies progress on health policy.

Require Higher Payments from Wealthy Seniors

Over the next 40 years, the cost of Medicare will roughly double in real terms and the number of beneficiaries will double while the number of taxpayers will grow by only one-third. One way to create a more sustainable fiscal future for Medicare is to ask more of those who can afford to pay more. Unlike Social Security, workers' Medicare taxes pay only for hospital coverage under Medicare. Income taxes and beneficiary premiums pay for physician services (Part B) and prescription drug coverage (Part D).

The financing from income taxes should be phased out for upper income seniors making more than $150,000 annually ($300,000 for couples). [13] They would pay the full cost of Part B and Part D coverage. In addition, for beneficiaries with incomes above $85,000 per year ($170,000 for couples), the income brackets that determines the portion of the Part B premiums that they pay (e.g., an individual with a modified adjusted gross income from $160,000 to $214,000 pays 50% of the Part B premium) would not receive inflation updates in 2020 and 2021 (the freeze is already in effect through 2019). Lastly, this proposal would increase the premium share by 10% for each category of high-income beneficiaries (e.g., a 50% share of premium becomes 55% for an individual with a modified adjusted gross income from $160,000 to $214,000 beginning in 2015. [14]

These changes total about $30 billion in savings over the next ten years. They are a way to make Medicare more progressive and sustainable without threatening the basic benefits for middle-class Americans.

Reward States for Cost Control

For every cost control idea whose time has clearly come, there are many more promising ideas that need time to mature. Since the states are responsible for much of the economic, legal and regulatory structure of health care, they are a logical testing ground for cost-saving innovations. To encourage more leadership on the part of governors and state legislators, the federal government should share a portion of

the savings with states that it would accrue from their leadership.

For example, states should share savings that will accrue to the federal government when defensive medicine declines due to tort system reform. That will require giving doctors confidence that the court will consistently apply accepted medical standards, so that they are clear about how to prevent injuries. Such change will require testing new models of justice, such as health courts, over time to see what works best for compensating and preventing patient injuries.

Additional state level problems include scope of practice laws that limit what trained health professionals like advanced practice nurses can do without a doctor's approval. States are also at the center of efforts to digitize medical records—a necessary precursor to enabling doctors to do a better job taking care of their patients. This is especially true for those with chronic conditions who need significant amounts of routine care.

It is difficult to predict how much savings would be achieved if states shared federal savings from reforms. But one to illustrateive possible savings, analysis shows that reducing projected federal health care costs by just 0.5% below the projected trend line in costs would produce an aggregate savings of $61220 billion over ten years. [15] That 0.5% amount is from the low end of the estimates of waste from the medical malpractice system alone. [16]

States could help reduce underlying costs by streamlining the regulatory and legal climates for health care. The shared savings would give them more rewards for taking on entrenched problems.

Avoid False Savings

The first line of defense against runaway health care cost should be measures aimed at the root causes of runaway costs. That's what the three items above aim at. Simply clamping down on prices without addressing underlying causes can be far less effective because it can create

undesirable side effects and false savings in the following ways:

1. **Limits on patients' access to care.** If prices do not cover the costs, then providers and suppliers will stop offering care. That's what happened to many Medicaid beneficiaries who cannot get basic services such as dental care because provider payments are too low.

2. **Cost-shifting to the private sector.** If a provider such as a hospital cannot stop offering services, then it will try hard to charge others more. It couldn't do that in tightly competitive marketplace, but health care is often anything but that.

3. **More inappropriate care.** Another response to lower prices is for providers to increase the volume of services. That has happened as a matter of course in response to price controls in Medicare, and the result is wasted care that sometimes puts patients at risk due to the inherent risks of medical tests and procedures.

4. **Curbs on innovation.** Tight controls on prices limit the amount of money that providers and suppliers have to plow back into innovation. Drugs and devices in particular cannot afford the expensive and uncertain process of bringing new products to market unless they have a significant rate of return. With looming costs from major diseases like Alzheimer's emerging in the nation's demographic bulge, now is not the time to curb investments in promising development.

Conclusion

With looming debates over broad entitlement reform and the ongoing implementation of the Affordable Care Act ahead, the end to Washington's health care Cold War isn't likely just over the horizon. However, the "Super Committee" offers the chance for a summit issues that are meaningful to both sides. By arriving at some common ground on cost controls as part

of a deficit reduction deal, D.C.'s health care Cold Warriors can engage in some much needed détente and improve the odds for future compromises.

TOPICS

BUDGET 89

END NOTES

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