Health Reform: The Role of Chronic Care and Primary Prevention

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PARTNERSHIP TO FIGHT CHRONIC DISEASE

Medicare and Health Care Reform

- Need both!
- Political debate over health care financing reform for at least 60 years largely unresolved
- This time need:
  - New message
  - New strategy
  - Bipartisan approach for both Medicare and health care reform

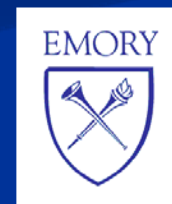
Solutions to Date

- Largely focus on cost-shifting to other payers
- Increasing age of eligibility
- Increasing cost sharing
- Income-related premiums
- Cut provider payments

- These "solutions" do not address the core issues accounting for the rise in Medicare spending

Overview

- Crafting effective policy interventions requires a clear understanding of the factors driving the rise in spending
- Previous work has focused on several demographic (aging) and demand side explanations (insurance, income, etc.) that account for a small share of the rise in spending
- Residual (more than 60-70%) assumed to be "technology" largely due to the lack of alternative explanations



Bottom Lines

- Over 95% of health care spending in the Medicare program is associated with patients w/1 or more chronic health care conditions and overall 75% of spending linked to chronically ill patients
- Medicare beneficiaries receive only about 60% of the clinically recommended preventive care for these conditions
- Most of the rise in spending (over three quarters) is linked to a rise in prevalence of treated disease:
  - Linked to rising rates of obesity
  - Linked to more aggressive detection and treatment of asymptomatic patients (particularly for CVD risk)

Implications

- While disability rates have declined, obesity has increased and with it the prevalence of (largely preventable) chronic disease
- Big financial implications. Normal weight Medicare beneficiaries spend 15-40% LESS over their lifetime compared to obese beneficiaries with one or more chronic illnesses.

Rising Treated Disease Prevalence among Medicare Beneficiaries, 1997-2004

Medical Condition	1987 %	2004 %
Hyperlipidemia	11.0%	28.7%
Mental Disorders	13.0%	20.7%
Hypertension	37.9%	48.4%
Osteoarthritis	3.1%	6.8%
Pulmonary Disorders	20.2%	20.8%
Arthritis	21.2%	28.2%
Diabetes	13.5%	18.5%
Cancer	12.4%	13.9%
Heart Disease	25.8%	28.0%

Medicare and Health Reform Policy Agenda

- Bipartisan opportunity to focus not only on health care financing reforms but HEALTH reform
- Means finding proven approaches for reducing the prevalence of obesity and smoking and with it chronic disease prevalence
- Need fundamental reforms of the traditional FFS Medicare program

Medicare and Health Reform

- These are not the traditional politically divisive issues that have framed the health financing debate for past 60 years
- Either a McCain or Obama administration could build a bipartisan coalition around the issues of affordability and quality with a modest federal investment

Medicare and Health Reform

- Ideas
  - **Universal wellness and lifestyle benefit for all targeting adults 50 and above. Includes HRA, physical, disease detection screens with no cost sharing. Followed by appropriate care plan**
  - **Build integrated health care homes around PCP in traditional Medicare**
    - Public utility model (Vermont)
    - PMPM supplemental payments by tier
    - Allow for contracting with HHA, DM vendors, hospitals, health plans others

Medicare and Health Reform

- These models need to build on the proven cost-effective models from the PGP, MHS results by identifying the key factors generating improved outcomes
- Federal government could provide (voluntary) incentives for FEHB plans to work within this approach as well—potential to leverage impacts further
- Major infrastructure project focusing on HIT, payment reforms and creating integrated teams within traditional Medicare

Can Primary Prevention and Chronic Care Management Work? (Yes)

- Wellness
  - Community based interventions (Trust for America's Health shows a ROI of 5.6-1 for well designed interventions—could save $16 Billion for just a $10 per person intervention)
  - Workplace interventions. Several examples of well designed programs that reduce costs and increase productivity—with ROI up to 5-1.

Chronic Care Management

- **RCT evidence provides valuable lessons**
  - **Targeting**: CHF, multiple chronic conditions, recently discharged hospital patients, homebound patients
  - **Structure**: HIT, payment reform, linking PCP to nurses, NP others, payment reforms
  - **Savings?** Well designed programs save $$ and improve outcomes. Poorly targeted and designed ones do not.

Medicare and Health Reform

- We will never address level and growth in spending unless policy addresses:
  - High and rising rates of chronic illness (primary prevention—which when well designed does work)
  - The embedded chronic care spending in health care
  - Accelerating the key tools to drive change– HIT, payment reforms and providing incentives for PCP physicians to migrate toward healthcare home
  - Increase compliance among patients with clinical precention protocols

How to Proceed?

- State health reforms
  - Vermont and on-going in West Virginia
  - Payor-specific initiatives (North Carolina)

- Medicare Reform
  - Restructuring the traditional Medicare program