

Top of the Administration's Agenda: Stem the Rising Cost of Healthcare

By John Rother

A pragmatic, step-by-step approach to lower existing and future healthcare costs.

The rising cost of healthcare is one of the greatest economic, fiscal, and moral challenges facing the United States, not just for the next four years, but also for coming generations. Successful efforts to simultaneously improve quality and outcomes while “bending the curve” of healthcare spending must be a top national priority.

Where We Stand Today

Despite substantial progress reforming the health insurance market and reshaping healthcare delivery in the past six years, current trends are not promising for America's older adults, or the population as a whole.

Undoubtedly, the United States has benefited from an unexpected slowdown in health spending growth and the fact that more than 90 percent of the population is currently insured. But that fortuitous slowdown has largely ended, with spending climbing again at a rate well above inflation and wage growth, albeit not as high as historical norms. The reality is that the cost of Medicare and Medicaid will consume increasing shares of our economy and our fed-

eral budget in the years and decades ahead. Any resurgence of healthcare spending growth will only accelerate the impact of an aging population on health spending. And as Medicare costs grow, so will the premiums paid by beneficiaries, a development which will negatively affect their ability to afford care—with the greatest immediate impact on the 5 percent of beneficiaries, who generate 50 percent of healthcare spending.

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In the non-Medicare population, the situation is no better. Recent analyses of the employer market and the non-group market show rising premiums and rapidly climbing deductibles.

On this trajectory, future generations of Americans will find it increasingly difficult to afford the care they need. Faced with these affordability barriers, Americans will experience higher rates of illness, disability, and early

→**ABSTRACT** Rising healthcare costs are one of the largest financial threats facing American families, businesses, and public finance. Current trends are squeezing out other vital investments and do not reflect increases in value. Federal health policy changes are needed in three areas to keep health expenditures sustainable in the face of an aging population: better care for those with multiple chronic conditions through delivery reforms; prescription drug transparency, competition, and value-based pricing measures; and population health initiatives designed to counter harmful behaviors. | **key words:** *healthcare costs, chronic conditions, prescription drugs, transparency, value-based pricing, population health*

mortality than they otherwise might. Unless we act, this combination of poor health and the increasing cost of care will gradually erode our standard of living—until the security provided today by programs like Medicare, and the American dream of generational progress, both vanish under the growing burden of healthcare costs.

The Path Forward

Difficult as it will be, our health system requires major additional reforms to change its cost trajectory. There are three broad strategies with the power to accomplish this goal without sacrificing quality or access, but only if they are pursued aggressively: reform healthcare delivery and benefits to better care for the chronically ill; make prescription drugs more affordable; and reduce demand for healthcare through public health initiatives.

This article outlines a series of targeted policies that would implement these strategies.

The root causes of our healthcare spending problem have been known for years, if not decades: poor quality often is due to failures of care coordination, inefficient and uncompetitive markets for prescription drugs, and high rates of preventable chronic disease. The United States can no longer afford to leave these root causes unaddressed. And with strong leadership from the new Administration, they need not be.

Efficient, Effective Care for the Chronically Ill

The U.S. Agency for Healthcare Research and Quality estimates that people with multiple chronic conditions (representing 5 percent of the population) account for 66 percent of total healthcare spending (Agency for Healthcare Research & Quality, 2016). Yet our healthcare system too often furnishes these patients with inefficient, ineffective, and uncoordinated care. While there is no silver bullet, several steps, if taken together, can meaningfully improve

Americans' experience of care and outcomes, while also saving money.

Restore primary care's central role

Historically, primary care clinicians have been trained to see the needs of the whole person and design a care plan accordingly. Nowhere is this more important than among older adults and disabled Americans.

A broader embrace of medical homes and other advanced primary care models, particularly for high-cost populations, could help bring our healthcare system back to this holistic model. The concept of a medical home conveys both the assurance to the patient that their full range of needs are recognized, and also conveys the responsibility of the physician to coordinate with a range of specialists, when appropriate, to provide more efficient care.

The evidence is clear that local markets, states, or even nations with stronger primary care sectors have lower healthcare spending (Starfield, Shi, and Macinko, 2005). For lower costs in Medicare and the United States as whole, primary care must be a top priority.

Within Medicare, advanced primary care models like Independence at Home and Geriatric Resources for Assessment and Care of Elders (GRACE) have been shown to improve care quality, outcomes, and curb costs for the most challenging Medicare beneficiaries (Centers for Medicare & Medicaid Services [CMS], 2015). In both cases, the models applied long-standing principles of geriatric care, emphasizing functional assessment, care for multiple chronic conditions, non-clinical needs, provision of services in the home, and care driven by patient and caregiver preferences and values.

Two immediate steps for fostering such models would be to enact legislation converting Independence at Home to a permanent part of the Medicare program, available nationwide, and to integrate geriatric care principles into ongoing multi-payer medical home initiatives like the Comprehensive Primary Care Plus

model as well as Accountable Care Organization (ACO) programs.

Training and educating for team-based care

Physicians are not the only trained professionals who can deliver top-quality care. Other professionals—physician assistants, nurses, home health aides, social workers, and community health workers—often can provide more responsive and more efficient care and services to those with multiple chronic conditions. That is why smart providers and plans, including physician practices, are increasingly relying on teams that embrace a wide range of healthcare and social service professionals.

The new Administration should work with Congress to support broader embrace of team-based care in three ways.

'The market for prescription drugs is clearly broken.'

First, all federally supported education and training programs must train every health profession to work collaboratively in multidisciplinary teams to care for the chronically ill, particularly the highest-cost, highest-need patients.

Second, because traditional fee-for-service payment is ill-suited to support interdisciplinary teams, the Administration should press forward with the transition away from fee-for-service toward alternative payment models sparked by the Affordable Care Act's payment reform provisions and the Medicare Access and CHIP Reauthorization Act (MACRA; goo.gl/2eqXa4).

Finally, current funding levels lapse in 2017 for Federally Qualified Health Centers, the Teaching Health Center program, and the National Health Service Corps, threatening the healthcare sector with a primary care funding cliff. Beyond their important role in improving access for underserved communities, these programs will be crucial if we are to effectively

train the next generation of team-focused, primary care clinicians. The new Administration should work with Congress to substantially expand federal funding for each of these programs and make that funding permanent.

Social service interventions to reduce medical costs

Studies have demonstrated the value of social services such as nutrition, in-home support services (Holland, Evered, and Center, 2012), and supportive housing services (Dohler et al., 2016) in reducing downstream medical costs for older adults and disabled beneficiaries. Capitated and integrated health plans that serve Medicaid enrollees and beneficiaries dually eligible for Medicare and Medicaid are using their flexibility to provide some of these services today (Philip, Kruse, and Soper, 2016).

However, current law and regulations generally prohibit spending Medicaid dollars on housing. And if a beneficiary is not enrolled in Medicaid, neither Medicare providers nor plans are permitted to deploy in-home support or nutritional interventions—even when these interventions could forestall disability or institutionalization. The new Administration should insist that federal healthcare programs allow providers and plans the flexibility to better serve high-cost, high-need beneficiaries. It is time to work with Congress to update the existing Stark (goo.gl/9haJkx) and anti-kickback statutes, overhaul rules governing supplemental benefits in Medicare Advantage (MA) and ensure that Medicare-Medicaid Plans, MA plans, and advanced Alternative Payment Models (APM) like the Next Generation ACO Model (goo.gl/wBFvRb) have the flexibility to provide services and supports not covered by either program whenever they would help lower overall costs and improve outcomes.

Paying for value: next steps

Transitioning healthcare reimbursement away from paying for the volume of services and toward paying for the value of care is now a

consensus-backed, bipartisan strategy. We can see it in the enthusiastic embrace of Health and Human Services Secretary Burwell's payment goals by stakeholders, and the enormous show of bipartisan support for recently enacted legislation overhauling physician payment (MACRA) and Medicare post-acute care (the IMPACT Act; goo.gl/mb4EtP).

However, if this transition is going to succeed, there is much work left to do: improving the accuracy of value metrics, risk-adjusting for patient populations, and calibrating incentives to reward the highest quality care are just three of the challenges ahead. Additionally, despite the spread of alternative payment models like ACOs and episodic bundling, fee-for-service remains the predominant payment approach. Even most APMs continue to rely on fee-for-service billing or payment to some degree.

Federal policy should begin supporting payment models that de-couple provider reimbursement from the fee-for-service chasis. On the regulatory front, the Center for Medicare and Medicaid Innovation (CMMI) can encourage Next Generation ACOs in fee-for-service Medicare to move toward capitation (also known as global payment) and ensure that MACRA's 5 percent Advanced APM participation incentive is available to clinicians participating in the capitated models now used by some MA plans. But the new Administration should also capitalize on bipartisan congressional interest in legislation to establish global payment options within traditional Medicare for well-qualified provider organizations.

Improving end-of-life care

Today, 32 percent of Medicare expenditures go to care and services for beneficiaries who are in their last two years of life, according to the Dartmouth Atlas of Healthcare (2016). But much of this money is spent on overuse of procedures, often subjecting patients to pain and discomfort, with little chance of improving their quality of life. We know palliative care is associated with

improved experience for the patient and their caregivers (Smith et al., 2014)—as well as lower costs (Morrison et al., 2011).

The movement to respect patients' care choices and broaden the availability of palliative care has made great progress—most notably with Medicare's recent decision to reimburse for advanced-care-planning discussions with patients. But more could be done to integrate support for caregivers into all federal healthcare programs, and expand additional training and continuing education in palliative care for health professionals. The new Administration should also work with Congress and the states to pursue the regulatory and statutory changes necessary to ensure all Americans' advanced care plans are properly documented, accessible, and transferable across time and care setting.

The Need for More Affordable Prescription Drugs

The rising cost of prescription drugs represents an immediate threat to efforts to constrain healthcare costs. Prescription drugs have the power to dramatically improve outcomes, even cure deadly and disabling disease. This is particularly true for the nation's Medicare beneficiaries, who use more prescription drugs than does the overall population. But today's rapid rate of increase in drug spending means that fewer and fewer patients can afford the drugs they need and prescription drug costs are now the single largest driver of increases in the overall cost of care.

The failures of our prescription drug market are numerous. New medications often are priced very high, without regard to their clinical value. Existing medications have their prices increased frequently, again without regard to value. And even some generic drugs have experienced very high price increases when the manufacturer finds itself the sole remaining producer. The market for prescription drugs is clearly broken, and needs a series of steps to repair it. Restoring a balance between affordability and rewards for

innovation will be critical to the sustainability of federal healthcare programs and the Administration's overall efforts on healthcare policy.

Transparency

For a market to function, information relevant to value must be transparent. Currently, there is little relevant information available about the value of a new medication. FDA approval is based on demonstration that a medication is safe and effective compared only to a placebo. Information on comparative effectiveness between medications is lacking, and purchasers have no basis for a negotiation based on value.

The new Administration should insist that both price and effectiveness information is broadly available so consumers and payers can fully evaluate the value of the drugs for which they are paying. Requiring manufacturers to disclose pricing information in conjunction with a product launch, or in conjunction with price increases above general inflation, is a necessary first step toward a functioning market. Also the new Administration should work with Congress to require manufacturers to submit studies comparing new treatments to existing therapies as part of the approval process—similar to requirements in the European Union and other nations.

Competition

The FDA today does not take competition into account when considering new drug applications for either brand or generic compounds. But its actions have a great deal of impact on whether competition can exist. The substantial backlog in approving generics, long waits for approval of competitors to expensive drugs, and the FDA's failure to provide even draft guidance on interchangeable biologic medicines all are factors that limit effective competition. If we are going to be able to rely on competition to keep drugs affordable, the FDA must act to address these limitations. Also the new Administration should work with Congress to bring down sta-

tutory barriers to competition, including the excessively long, twelve-year period in which new brand-name biologic drugs are entirely protected from generic competition and the Risk Evaluation and Mitigation Strategies loopholes that allow brand-name manufacturers to deny competitors access to samples needed to develop lower-cost, generic versions.

Pay for value

Ultimately, a functioning market should be able to reward value in a way that encourages innovation but keeps overall cost increases sustainable. To achieve this, there needs to be transparency, competition, and comparative effectiveness information. Paying for results is one way to reward value—by tracking patients who take certain drugs and rewarding the manufacturer for good outcomes. The industry is beginning to explore such tactics, but more aggressive policies are needed. Payers, including government programs, could base reimbursements on agreed upon measures that assess how well the medication works in practice.

One approach would be to base initial pricing with reference to the existing standard of care prior to launch, with incentive payments post-launch based on clinical and economic results. Reimbursements also could be based on the findings of the independent and highly respected work of the Institute for Clinical and Economic Review (ICER). In addition, manufacturers of drugs priced in conformity with ICER standards of affordability could receive incentive awards designed to support additional investments in research and development.

Public Health: Curbing Demand for Healthcare Services Through Behavior

The United States has the highest healthcare costs in the world, in part because of the demands placed on the health system by individuals' unhealthy behaviors. If we are to keep healthcare affordable in the United States, the new Administration's strategy must priori-

tize not just delivering healthcare more efficiently, but also keeping Americans healthier, thus lowering demand. We must fight against the epidemics of tobacco use, alcohol abuse, obesity, and opioid abuse, which are taking lives and driving up health costs for Americans in all age cohorts.

Tobacco

Tobacco use today is the single biggest cause of preventable death and costs the healthcare system an estimated \$170 billion a year (Xu et al., 2015). About one in every five deaths (almost 500,000 every year) is associated with tobacco use, including 42,000 from exposure to secondhand smoke. Measures that effectively deter tobacco use include social media cam-

'One measure to curb the obesity and diabetes rate is a sugar-sweetened beverage tax.'

paigns directed at teens, raising tobacco taxes (Campaign for Tobacco-Free Kids, 2016), and raising the age for purchase to 21 (Institute of Medicine, 2015). The new Administration should work with Congress to bolster funding for effective federal tobacco prevention programs, while pursuing incentives for states that increase the tobacco age of purchase to 21 and an improved, strengthened federal excise tax on all tobacco products.

Alcohol

Alcohol abuse contributes to an estimated \$27.5 billion in healthcare costs annually, in addition to substantial costs due to lost productivity, car insurance claims, and criminal justice expenses (Stahre et al., 2014). The Centers for Disease Control and Prevention (CDC) estimates that excessive drinking accounts for one in ten deaths among working age adults, and is the fourth leading preventable cause of death (CDC, 2015). Enhanced enforcement of retailer compliance regarding the sale of alcohol to minors and

higher taxes on alcohol have each been shown to be effective (Community Preventative Services Task Force, 2007). Both should be on the new Administration's policy agenda.


Sugar-sweetened beverages and obesity

Medical costs for obesity-related health conditions are estimated to be \$190 billion, with roughly half these costs paid for publicly through the Medicare and Medicaid programs (Harvard University, T.H. Chan School of Public Health, 2016b). Rising consumption of sugary beverages has been a major contributor to the obesity epidemic (Harvard University, T.H. Chan School of Public Health, 2016a). Thus, one measure to curb the obesity and diabetes rate is a sugar-sweetened beverage tax. Taxing sugar-sweetened beverages would reduce the adverse health and cost burdens of obesity, diabetes, and cardiovascular diseases (Wang et al., 2012), and the resulting increase in revenues could provide resources to support broad implementation of the most cost-effective obesity prevention interventions available.

Opioid abuse

The U.S. Department of Health and Human Services estimates that the abuse of opioids generates an estimated \$72 billion in medical costs each year, which is comparable to the costs of major chronic conditions, such as asthma and HIV. Opioid overdoses killed more than 28,000 people in 2014—more than any year on record, and an alarming 14 percent increase from the previous year (CDC, 2016). To effectively address this epidemic, the new Administration should challenge Congress to back up its talk with meaningful action. The Administration can begin by insisting on robust appropriations for substance abuse prevention and treatment, along with stronger standards and funding for the community behavioral health centers that serve patients facing both addiction and other mental health disorders.

These initiatives, taken together, would have a very substantial impact on the cost of healthcare, benefitting both families and the economy by lowering premiums and burdensome cost-sharing. They would also save lives. Given the imminent threat that rising health costs represent, we should not delay acting. While no single magic bullet can fix healthcare, the combination of reforms focused on high-cost, high-need patients, measures to keep pre-

scription drugs affordable, and successful public health initiatives would constitute the single most important set of actions that the incoming Administration could take to put Medicare, as well as our broader health system, on a more sustainable course and to benefit all Americans. 

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The Summer of Love

W. Andrew Achenbaum, Erlene Rosowsky, and Mercedes Bern-Klug, **Guest Editors**

The Summer of Love in 1967 stands as a seminal moment in U.S. history, when the counter-culture entered the mainstream and the rest of America saw firsthand the power of anti-war activism, free love, feminism, and drug- and music-fueled optimism. The Summer 2017 issue of *Generations* will explore how this group of current baby boomers are experiencing later life. How is this cohort, which broke traditions in the 1960s, faring now as they are long past the age they said was not to be trusted? The issue will address generational dichotomies, women’s roles, global violence and the impact of military conflicts, love in older age, retirement, pressures to remain “young,” friendship, caregiving, and general post-1968 expectations, illusions, and disillusion.

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Generations

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