

CURBING COSTS IMPROVING CARE

THE PATH TO AN
AFFORDABLE
HEALTH CARE
FUTURE



The National Coalition on Health Care, (NCHC) the oldest and most diverse group working to achieve comprehensive health system reform, is a 501(c)(3) organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers and groups representing consumers, patients, women, minorities and persons with disabilities. Member organizations collectively represent—as employees, members, or congregants—over 100 million Americans.

Some members of the National Coalition Health Care do not, or cannot, take positions either on specific legislation, strategies or on any policies outside their respective mission areas. However, all that can, do endorse broad policy positions in support of comprehensive health system change.



Dear Fellow Citizens,

Since its founding in 1991, the National Coalition on Health Care has brought together a diverse array of stakeholders and advocates around the goal of building a high-quality, affordable health system. By 2011, the consumer groups, religious communities, disability advocates, providers, employers, labor organizations, and health plans that make up the Coalition collectively recognized that the policy choices confronting the country in late 2012 and 2013 could be decisive for the attainment of the Coalition's mission.

Over the past year, NCHC held intensive discussions with its member groups and health care experts in order to craft a path forward on national health and fiscal policy. It was quickly apparent from our discussions that simply shifting costs among stakeholders in our health system, whether they are providers, payers, consumers, or taxpayers, is not acceptable. Instead, the United States must dramatically accelerate and expand efforts to reduce costs by promoting well-coordinated, high-quality care and improved health.

In support of that effort, we are proud to present *Curbing Costs, Improving Care: The Path to an Affordable Health Care Future*. NCHC's plan, set forth in this document, offers an alternative to cutting provider reimbursement or reducing the benefits on which the most vulnerable citizens depend. To help meet America's fiscal challenges, our plan identifies nearly \$500 billion in real budgetary savings, achieved through both lower spending and enhanced revenue. More importantly, it couples those budget recommendations with game-changing proposals that will transform the incentives for all actors in our health system.

We hope that you find this plan informative. We invite you to join with the National Coalition on Health Care as we continue to work toward an American health system we all can afford.

Sincerely,

A handwritten signature in black ink, reading "George Diehr".

George Diehr
Vice President, CalPERS Board of Administration
Chair, NCHC Board

A handwritten signature in black ink, reading "John Rother".

John Rother
President and CEO



HEALTH SYSTEM GAME-CHANGERS

- Permanent repeal of the Sustainable Growth Rate formula and a transition from Medicare's fee-for-service payment system toward pay-for-value approaches;
- Value-based insurance design and quality-based tiering of providers;
- Investment in training the full range of health professionals needed for team-based primary care; and
- Innovative medical liability reforms, such as disclose and offer, evidence-based safe harbors and health courts, that improve patient safety, more effectively compensate injured patients AND reduce defensive medicine.

Executive Summary

Over the next several months, Congress and the President will face two major fiscal and health policy challenges: closing the immediate gap between federal spending and revenues and addressing the longer-term challenge of rising health costs.

The budget proposals advanced to date by leaders in both political parties have relied heavily on blunt, across-the-board cuts to beneficiaries, providers, and states. Taking this path simply shifts the costs now borne by the federal government onto the private sector and the states. It does not seriously address the challenge of reducing health care costs over the long term and ultimately makes the task of sustaining federal health programs more difficult and expensive.

America needs a new path forward. To ensure the affordability of health care in Medicare, Medicaid, and the private sector, we must pursue a comprehensive set of policies that together improve performance, reduce waste, and increase value.

This document presents a seven-point strategy, accompanied by 50 specific, actionable policy recommendations. The elements of that strategy are as follows:

1. Change provider incentives to reward value, not volume;
2. Encourage patient and consumer engagement;
3. Use market competition to increase value;
4. Ensure that the highest-cost patients receive high-value, coordinated care;
5. Bolster the primary care workforce;
6. Reduce errors, fraud, and administrative overhead; and
7. Invest in prevention and population health.

This strategy and the accompanying recommendations are designed to achieve two related, but distinct objectives: (1) reduce the impact of health care costs on the federal government's short-term (ten-year) fiscal balance and (2) simultaneously build a health system that is sustainable and affordable over the long term. This document includes two categories of policy recommendations: health system game-changers and supporting recommendations.

The four health system game-changers have tremendous potential to reduce both federal and private sector health spending. They may not all produce significant scoreable spending reductions in the short term, but each of these game-changers could have a transformative impact on our health system over the long term.

The remaining supporting recommendations discussed in this report lack the transformative impact of the game-changers, but can contribute to better functioning health care markets or federal programs in the short and long term. Some will curb federal spending by changing incentives to produce higher value care. A few of these recommendations will require modest federal investments in areas like workforce, health care information technology, quality measurement or prevention, but will amplify the impact of other cost-saving measures. Still others will generate increased health-related revenues.

Summary of Identified Savings (Spending):¹

Implement Centers of Excellence Program for select surgical services	\$0.45 billion
Equalize payment for outpatient and physician office services in Medicare	\$19 billion
Reform Medicare post-acute and home health payment	\$37 billion
Strengthen penalties for potentially avoidable acute care complications	\$23 billion
Strengthen penalties for potentially avoidable acute care readmissions	\$29 billion
Create trigger imposing a value-based withhold on Medicare providers if savings are not realized from specified delivery and payment reforms	\$64 billion
Use competitive bidding to lower Medicare and Medicaid DME costs	\$9.8 billion
Remove barriers to competition for affordable generic drugs	\$24.3 billion
Double proposed increase for Health Care Fraud and Abuse Control funding	\$3.7 billion
Miscellaneous budgetary savings	\$10.72 billion
Total	\$220.97 billion

Summary of Identified Savings (Revenue):

Equalize and increase federal taxation of tobacco	\$88 billion
Impose penny-per-ounce federal excise tax on sweetened beverages	\$130 billion
Equalize federal alcohol taxes and update for inflation	\$58 billion
Total	\$276 billion

¹ This list summarizes the budgetary impact of the specific policy options identified in this document as producing credible budgetary savings. Whenever possible, we have relied on existing estimates produced by the Congressional Budget Office or MedPAC. In other instances, we have relied on credible estimates from other sources or extrapolated our own savings estimates from existing CBO estimates of similar policy options. Please note that this list does not reflect the impact of those recommendations in this document that lack a specific estimate of savings.



SUCCESS STORY

CalPERS and Safeway

Market Competition/ Consumer and Patient Engagement

Both public and private sector workers in California have experienced remarkable increases in health insurance premiums, and it has become increasingly apparent that excessive prices of medical procedures and diagnostic tests are key drivers of those costs. Analysis from the California Public Employee Retirement System (CalPERS) has found that the price CalPERS paid for comparable hip and knee replacement surgeries ranged from \$15,000 to \$110,000—a seven-fold difference with little observable impact on quality. The grocery chain, Safeway, observed that the price of colonoscopies in the San Francisco area ranged from \$900 to \$7,200.²

In response to similar trends, employers in California and across the country have turned to a new approach to foster competition in the market for medical care. Through this approach known as reference pricing, an employer's health plan identifies a limited number of providers of common services at high quality and low cost. The plan then caps the allowable reimbursement amount for certain procedures at the level charged by those high quality providers. Enrollees are free to seek higher-cost treatment elsewhere, but they must cover the additional cost out of pocket.³

CalPERS found that reference pricing reduced the cost of joint replacement procedures by 26 percent. Safeway has also implemented reference pricing, limiting reimbursement for colonoscopies to \$1250 per procedure.⁴

With the growing use of reference pricing, California consumers and providers face a transformed set of incentives. Providers, who may have encountered little pressure to reduce the prices of tests and procedures, now have strong incentives to streamline their operations. Consumers, who often lacked awareness of the real cost of their health care, now have a strong financial reason to seek out providers who deliver the best value.

2 Catalyst for Payment Reform. (2011, Dec 7). *Action Brief: From Reference Pricing to Value Pricing*. Retrieved from http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf.

3 Catalyst for Payment Reform. (2011, Dec 7). *Action Brief: From Reference Pricing to Value Pricing*. Retrieved from http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf.

4 Catalyst for Payment Reform. (2011, Dec 7). *Action Brief: From Reference Pricing to Value Pricing*. Retrieved from http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf.



SUCCESS STORY

Horizon Blue Cross Blue Shield, Duke University School of Nursing and Rutgers College of Nursing

Bolstering the Primary Care Workforce/Reforming Provider Payment

In early 2011, the New Jersey health plan, Horizon Blue Cross Blue Shield, and the New Jersey Academy of Family Physicians launched a patient-centered medical home pilot that successfully reduced per patient costs by 10 percent while improving rates of diabetes management and preventive screening.⁵ The pilot's success depended not only on a value-based approach to physician payment, but also on highly-skilled, multi-disciplinary care teams.

As this medical home initiative expands across New Jersey, Horizon is investing in those care teams. In partnership with the Duke University School of Nursing and the Rutgers College of Nursing, Horizon is providing an online program that trains Registered Nurses to serve as Population Health Coordinators.⁶ The program is designed to equip these RNs to provide patient education, case management, and care coordination as part of an integrated medical home team.

With this program, New Jersey families will be able to count on another highly trained professional as part of their care team.

⁵ Horizon Blue Cross Blue Shield. (2012, Apr). Early Results Show Patient-Centered Medical Homes Drive Quality and Cost Improvements. Press Release. Retrieved from http://www.horizon-bcbnsj.com/eprise/main/SiteGen/horizon_bcbnsj/Content/old_news_room/news_releases/article.html?id=33878.

⁶ Patel, U.B., Rathjen, C., & Rubin, E. (2012, Sep). Horizon's Patient-Centered Medical Home Program Shows Practices Need Much More Than Payment Changes To Transform. *Health Affairs*. Retrieved from <http://content.healthaffairs.org/content/31/9/2018.full>.



SUCCESS STORY

MassHealth

Investing in Prevention and Public Health

Prior to 2006, nearly four in ten adults under the age of 65 in Massachusetts' Medicaid program were smokers. These enrollees, many of whom were poor or disabled, lacked the means and support they needed to drop the habit. Consequently, taxpayers were forced to cover increased medical costs related to tobacco use.

In 2006, however, Massachusetts enacted a new requirement that its Medicaid program, MassHealth, cover the full range of comprehensive tobacco cessation services. In two short years, nearly 40 percent of the enrolled smokers took advantage of these new services and the rate of smoking among MassHealth enrollees fell to 28.3%.⁷ Every dollar that taxpayers invested in this program yielded \$2.12 in savings from reduced costs related to heart disease.⁸

Massachusetts' decision to cover comprehensive tobacco cessation services has produced healthier enrollees and lower program costs. A MassHealth enrollee who is ready to take responsibility for his or her own health has a far better chance of successfully quitting smoking. Meanwhile, Massachusetts taxpayers are paying millions of dollars less because of this new change.

7 Land, T. et.al. (2010, Dec). A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease *PLOS Medicine*. Retrieved from <http://www.plos-medicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000375>.

8 Ku, L. et. al. (2012, Jan). The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. *PLOS One*. Retrieved from <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0029665>.



SUCCESS STORY

Missouri HealthNet

New models of care for high-cost,
high-need patients

Patients facing both serious mental illness and multiple chronic physical conditions, such as diabetes and heart disease, represent one of the most challenging populations to treat. When these patients' physical illnesses flare up, it can disrupt the treatment of their behavioral health conditions. Likewise, when a patient undergoes a serious episode related to their mental health, they can find it difficult to adhere to the treatment regimens needed to keep their physical ailments at bay. In most parts of the country, this continues to be a recipe for poor outcomes and higher costs.

Missouri's Medicaid program, MO HealthNet, has pioneered a highly effective solution. Over the past two years, MO HealthNet has been implementing a behavioral health home model that provides primary care, care coordination, and behavioral health services in one location—the community mental health center. An initial pilot program yielded better care outcomes and approximately \$300 in reduced per member per month costs. Early in 2012, this program was expanded statewide.

Today, 18,000 Missourians coping with serious mental illnesses are receiving the services they need, and the state Medicaid program is on stronger financial footing as a result.

Member Organizations

AARP
Actors' Equity Association
Adrian Dominican Sisters
AFL-CIO
Altarum Institute
American Academy of Family Physicians
American Academy of Pediatrics
American Association of Birth Centers
American Cancer Society
American College of Cardiology
American College of Emergency Physicians
American College of Nurse-Midwives
American College of Surgeons
American Dental Education Association
American Federation of State, County,
and Municipal Employees (AFSCME)
American Federation of Teachers
American Federation of Television and Radio Artists
American Heart Association
American Legacy Foundation
American Library Association
American Lung Association
Asian Pacific Islander American Health Forum
Association of American Medical Colleges and Teaching
Hospitals
Association of American Universities
Best Doctors, Inc.
Blue Cross Blue Shield Association
Blue Shield of California
C-Change
California Public Employees' Retirement Systems (CalPERS)
California State Teachers' Retirement System (CalSTRS)
Childbirth Connection
Children's Defense Fund
CodeBlueNow!
Colorado Public Employee Retirement Association
Committee for Economic Development
Common Cause
Communication Workers of America
Consortium for Citizens with Disabilities
Consumers Union
CVS Caremark
Duke Energy Corporation
Duke University Medical Center
Easter Seals
Evangelical Lutheran Church in America

Georgetown University Center for Children and Families
Giant Food, Inc.
Gross Electric, Inc.
Illinois Municipal Retirement Fund
International Brotherhood of Electrical Workers (IBEW)
International Brotherhood of Teamsters
International Federation of Professional and Technical
Engineers (IFPTE)
International Foundation for Employee Benefit Plans
Japanese American Citizens League
League of Women Voters
Michigan Health & Hospital Association
Midwest Business Group on Health
Motion Picture Association of America
National Association for the Advancement
of Colored People (NAACP)
National Association of Childbearing Centers
National Association of Community Health Centers
National Community Action Foundation
National Conference on Public Employee Retirement Systems
National Consumers League
National Coordinating Committee for Multiemployer Plans
National Council of Churches of Christ in the U.S.A.
National Council of La Raza
National Council on Teacher Retirement
National Multiple Sclerosis Society
National Quality Forum
National Rural Health Association
New York State Teachers' Retirement Systems
Pacific Business Group on Health
Presbyterian Church, U.S.A.
Religious Action Center of Reform Judaism
SCAN Health Plan
Sheet Metal Workers' International Association
Small Business Majority
Stop and Shop, Inc.
Teva Pharmaceuticals, Ltd
The Episcopal Church
The Salvation Army
U.S. PIRG
Union for Reform Judaism
United Food & Commercial Workers
United Methodist Church
Verizon

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