

What the Deficit Reduction Plan Means to You

Dr. Joseph Boffa

Director - HealthLink Wellness of New England

We now have a deficit reduction process in place as worked out by the President and Congress. But as director of a wellness program for retirees I do have concerns as to how events will ultimately unfold. Part of the agreement was that a “super committee” will be charged with reform of entitlements. As President Obama proclaimed in his comments about deficit reduction, “that means making some adjustments to protect healthcare programs like Medicare so they’re there for future generations”. However the committee was not able to make the changes as expressed by President Obama so there are real concerns in my mind as to how the process of deficit reduction will be implemented.

Since the Committee is now over and if there is no further action spending is to be cut by \$1.2 trillion automatically including a 2% across the board cut to all Medicare providers. If such an unfocused cut in expenditures comes to pass then the long term progress we made to date will be hampered. Our primary goal should be to transform our healthcare system from a disease focused model of coverage to a true health oriented system. As director of a wellness program that serves retirees of southeastern Massachusetts and northern Rhode Island, I have seen our retirees’ health steadily improve from our health education and chronic disease monitoring programs, and improved access to physicians and therapies through the Medicare program. It would be detrimental to our members if there is a scramble in cutting expenses that is on automatic pilot without regard to setting much needed new goals and priorities for the Medicare program.

A recent Center for Disease Control and Prevention study pointed out that providing health care for an older American costs 3 to 5 times more than for an individual under age 65. As the population ages, the nation's health care spending is projected to increase 25% by 2030. Currently, about 80% of older Americans are living with at least one chronic condition. This latter statistic coincides directly with surveys of our members. In a review of the data from our wellness and screening program held last May, 81% reported being diagnosed with either diabetes, hypertension or elevated cholesterol. Of those, 27% reported having one condition, 39% with two conditions and 15% having all three conditions. Also of those who participated in our program, 76% reported taking medication for the three conditions. This broke down into 28% taking medication for one condition, 38% for two of the three conditions and 10% taking medication for all three conditions. This level of disease morbidity points to the need to keep our seniors involved in the community and ambulatory as the only viable long term strategy to keep them home and out of the hospital and nursing home.

There are two interrelated strategies needed to achieve healthcare reform. One is to assure our members keep up with their prescribed medications that not only keep them alive but also help them maintain an active lifestyle. Passage of Medicare Part D has reduced economic barriers to medications and has significantly helped our members maintain adherence with recommended drug therapy regimens. The elimination of the “doughnut hole” in Part D coverage that is part of the Affordable Care Act also helps maintain access to important therapies for our retired citizens.

Researchers at Harvard Medical School found that Medicare Part D was associated with lower non-drug medical costs for seniors compared with what would have been expected had Part D not been created. Most of the drop was the result of reductions in high-cost inpatient and nursing home care. Though we have not done a complete survey of our member’s Medicare costs, it is not unreasonable to assume that our members have, or will experience similar cost savings.

Maintenance of adequate adherence to drug therapies is only effective if there is also a primary care physician who leads the wellness team. Drastic cuts in Medicare physician fees would hamper our attempts to build a wellness team with the physician as the leader. A May online survey of more than 9,000 physicians conducted by the American Medical Association found that practices already are making changes based on underpayments from Medicare. About 17% of all physicians who accept Medicare patients are restricting the number of beneficiaries they see. And more than 30% of respondents who were identified as primary care physicians said they limit their Medicare patient load. For both sets of physicians, the top two reasons they cited were that Medicare rates were too low to cover the cost of caring for patients and that the constant threat of cuts made Medicare an unreliable payer. More cuts to Medicare is sure to continue tipping the balance away from patients, putting care further out of reach for many striking a serious blow to our ongoing wellness efforts.

From our wellness program’s inception, we have solicited opinions from our members regarding how we can better serve their health needs. One clear message is that physicians need to be part of the overall wellness process and that we must integrate our community based services with the care they regularly receive through the medical office. Our program has evolved whereby we are now testing the recruiting of new wellness program members through the primary care physician’s office. It is a model of wellness patterned after the Patient Centered Medical Home as endorsed by the Academy of Family Practice. Health care delivery should be team based and occur at home, the community and in medical offices. Only in that environment will real progress be made in combatting the high cost of treating chronic diseases by replacing treatment with prevention. Effective and efficiency models of care such as these, not cuts, should be the future of Medicare.

The exodus of the primary care physician would be a serious blow to the progress we have made to date. Inefficiencies in the Medicare program need to be identified and eliminated along with a concerted effort to root out fraud. Improved information systems that provide up to date evidenced based therapy information to the physician is also critical. However, when confronting

the issue of chronic disease prevention or its management once it occurs, much depends on changing patient health related behaviors. These are behaviors that are difficult to change and it all starts with access to a physician-led team that can follow up with community based resources. Let's not impede the progress we made with short term cost savings that will eventually limit our options for true long term reform.