IMPLEMENTING HEALTH REFORM

The Prevention Fund

One of the controversial elements of the Affordable Care Act is creation of the Prevention and Public Health Fund, which sets aside about $15 billion to finance public health programs over the next decade. Under the program, the Health and Human Services department awards grants for projects that prevent illness or promote health.

Supporters of the program say that it will ultimately save money by detecting diseases early and better managing costly chronic conditions. Opponents have deemed it a "slush fund" and are seeking to eliminate it.

Dr. Georges C. Benjamin, executive director of the American Public Health Association (APHA), offers his views on the Prevention Fund.

RHEUMATOLOGY NEWS: Why has the Prevention Fund been caught up in politics?

Dr. Benjamin: I think the fund has been grossly misunderstood. For years, public health has been the most underinvested part of our health system. The goal of the Prevention Fund was to build on existing funding sources and, for the first time, create a stable, reliable funding stream, which would allow the system to mature and reach its full potential. People who want to demonize the fund have said things that don't represent its intent.

RHEUMATOLOGY NEWS: The APHA supported the creation of the Prevention Fund. Why is this type of investment important?

Dr. Benjamin: From a pure fiscal perspective, this is our best chance to address some of our health care costs. If we don't do this now, it's going to be years before we can actually begin to get our hands around it. To have a major national restructuring of the way we deliver health care services and not put in a prevention component would be foolhardy.

RHEUMATOLOGY NEWS: Can prevention efforts like this really save money?

Dr. Benjamin: We know that screening for high blood pressure is cheap. We know every patient with diabetes that does not progress to diabetic retinopathy represents a huge savings for the health system. But what often doesn't get captured in our economic analyses are the savings outside of health care. If a child doesn't get exposed to lead because of a good public health program and doesn't suffer complications, there are savings to the health system but also savings to other sectors. In that case, we don't count the savings from special-education programs. We don't count the potential savings to the juvenile justice system. When folks say prevention doesn't save money, they are usually looking only in the health bucket.

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DR. BENJAMIN

RHEUMATOLOGY NEWS: Is the Prevention Fund likely to survive in the long run?

Dr. Benjamin: The fund will survive. If we are going to continue to throw $2.5 trillion into health care, to only spend about 3% of that on prevention is poor public policy. I hope that we'll be able to make the case that not only is this fund needed, but that the amount of money dedicated to this area must grow. ■

DR. BENJAMIN is currently serving as a distinguished fellow in public health at Hunter College, part of the City University of New York system. He will return to his role at the APHA in 2012.

CMS Eases E-Prescribing Rules

BY FRANCES CORREA

Based on feedback from physicians and health care providers, the final federal e-prescribing regulations are more flexible and contain more exemptions, the Centers for Medicare and Medicaid Services announced.

The changes come after concern that the program criteria should be more aligned with the Medicaid incentive program for electronic health records, according to CMS officials.

"[The changes] will encourage more doctors and other health care professionals to adopt this technology and give them the added flexibility to help them succeed," Dr. Patrick Conway, chief medical officer at CMS and director of the agency's Office of Clinical Standards and Quality, wrote in a blog post announcing the change. "With electronic prescribing, providers can better manage patient prescriptions, reducing drug interactions or other preventable prescription errors." Under the Medicare Electronic Prescribing Incentive Program, eligible prescribers who meet the e-prescribing criteria will get a 1% bonus payment for 2011 and 2012 and a 0.5% bonus in 2013. Those who do not meet the criteria in 2012 will be penalized 1% of Medicare payments; the penalty will escalate in 2013 and 2014.

Under the final rule, prescribers who use certified electronic health records can claim this as a "qualified" e-prescribing system. This move was designed to more closely align the e-prescribing program with the program that offers incentives for meaningful use of electronic health records, CMS officials said.

The final rule, which goes into effect 30 days after its official publication in the Federal Register, contains hardship exemptions for those who live in a rural area without high-speed Internet access and those who work where there are not enough pharmacies that can take electronic prescriptions. The deadline to apply for a hardship exemption has been extended until Nov. 1, 2011.

Even with the changes, however, some physicians still have concerns. The American Medical Association said it is worried about the amount of time physicians will have to apply for the exemptions. ■

Slimming Boomers Could Save Medicare $15 Billion

BY JEFFREY S. EISENBERG

FROM HEALTH AFFAIRS

ATLANTA – Medicare could be in the position to save between $7 billion and $15 billion over the remaining lifetimes of one cohort of baby boomers if community-based weight loss programs for individuals ages 60 years or older who are at risk for diabetes or heart disease were to be instituted, according to a recent study.

Obesity, defined as body mass index (BMI) of 30 kg/m^2, more than doubled from 18% to 37% of adults ages 65 years and older between 1980 and 2008, according to data from the Centers for Disease Control and Prevention. At the same time, obese adults spent about 40% more on health care than normal-weight adults, because of higher rates of diabetes and other chronic illnesses.

"It seems to me that Medicare has an incentive to reach out earlier and improve the health of people who will be coming into the program," study author, Kenneth E. Thorpe, Ph.D., of Emory University, Atlanta, said in a statement.

Dr. Thorpe and his colleague, Zhou Yang, Ph.D., proposed an evidence-based weight loss program for individuals aged 60-64 who are not yet eligible for Medicare but who are overweight (BMI higher than 24) or obese and at risk for diabetes, cardiovascular disease, or both (Health Affairs 2011 [doi:10.1377/hlthaff.2010.0944]).

Specifically, they suggested expanding an existing community-based weight loss program developed by the CDC, the YMCA of the USA, and UnitedHealth Group, in which trained lifestyle coaches help overweight individuals select healthier foods and increase physical activity. The program is provided by 50 YMCAs and is available at more than 116 sites in 24 states. Studies of this and similar programs show that participants aged 60 years and older lose weight and reduce their risk of developing diabetes by up to 71%.

For the current study, the investigators used 2009 census data to estimate net savings to Medicare over a 10-year period over the lifetime of a single cohort of eligible individuals. Their findings were based on the assumption of participation rates of 70% and 55% of eligible individuals using two enrollment scenarios.

The first scenario would limit enrollment to individuals ages 60-64 who have prediabetes and whose BMI is higher than 24. The cost to enroll 70% of that target group would be about $590 million ($240 per person for 2.6 million participants) but would result in a net savings of $2.3 billion over 10 years and $9.3 billion in net lifetime savings. If 55% of those eligible participated, estimated savings would exceed $1.8 billion over 10 years and $7.3 billion in net lifetime savings.

VITALS

Major Finding: Community-based weight loss programs for individuals aged 60 years or older who are at risk for diabetes or heart disease could save Medicare between $7 billion and $15 billion over the lifetimes of one cohort of baby boomers.

Data Source: Estimates of net savings to Medicare over 10 years and participants' lifetimes.

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The second scenario would broaden eligibility to individuals with the same BMI who were at risk for cardiovascular complications (high blood pressure or elevated cholesterol) regardless of whether they had prediabetes. If 70% of eligible patients participate, Medicare would achieve an estimated net savings of $1.4 billion over 10 years and $5.8 billion in net lifetime savings. If 55% of eligible patients participate, the estimated additional net savings to Medicare would be $1.2 billion over 10 years and $4.6 billion over participants' lifetimes.

By extending eligibility to both at-risk groups, the authors estimate that Medicare would save $3 billion to $3.7 billion over the next 10 years and $11.9 to $15.1 billion over participants' lifetimes, depending on the participation rate.

"Our results show the potential savings to Medicare if a proven community-based approach to reducing obesity and related chronic disease were to be made available, nationwide, to high-risk individuals soon to become Medicare beneficiaries," the researchers said. "In doing so, they also present a potential business case for the federal government to partner with the private sector in order to encourage broad enrollment in effective weight loss programs."Estimated lifetime savings of $7 billion to $15 billion depend on several factors, such eligibility and participation, they said. ■