Former Obama advisers float proposals for cutting health care costs

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Speakers at this week's Democratic Convention in Charlotte, North Carolina will undoubtedly point to the overhaul of the US health care system as one of the finest achievements of the first term of the Obama administration. The Democrats will seek to perpetuate the lie that the Affordable Care Act (ACA) signed into law by Barack Obama in 2010 will provide near-universal access to quality health care for ordinary Americans.

An article published in the August 30 online edition of the *New England Journal of Medicine* (NEJM) provides some telling insight into what is actually being prepared behind the scenes in the realm of health care should Obama win the election.

Authors of "A Systematic Approach to Containing Health Care Spending" include former administration officials who were key in shaping the health care legislation. Among them are Peter Orszag, former White House budget director; Donald Berwick, former Medicare chief; Neera Tanden, a senior member of the White House team that helped pass the health law; and former Senate Majority Leader Tom Daschle, Democrat of South Dakota, Obama's first choice to lead the Department of Health and Human Services.

Of particular note is the inclusion of Ezekiel Emanuel, former special adviser to Orszag on health care policy, who has informed much of the Obama health care agenda. The author of *Healthcare Guaranteed: A Simple, Secure Solution for America*, Emanuel has advocated rationing care for the elderly, infants and the disabled in an effort to ensure access to finite health care resources to more "participating" productive segments of society. (See "Obama advisor champions rationed health care")

Although the White House has not formally endorsed the proposals contained in the NEJM article, it is clear that they build on the health care law's schemes for cutting spending for government and big business, while reducing and limiting care for ordinary Americans. The authors take as a given that health care—especially Medicare, the government-run health care program for the elderly—must be cut in order to "save" it, and that there is "no money" to finance the improvement and expansion of medical services for the vast majority of Americans.

The approach presented broadly resembles legislation signed this summer by Massachusetts Governor Deval Patrick, which aims to cut health care costs in the state by $200 billion by 2028. (See "Massachusetts health care bill aims to cut $200 billion over 15 years") The new law builds on the reform of the Massachusetts health care system under Governor Mitt Romney, now the Republican presidential nominee, which required almost all state residents to obtain insurance or pay a penalty. The 2006 state overhaul has been widely seen as the model for the Obama-backed federal legislation.

As in the recent Massachusetts legislation, one of the key targets for cost-cutting is fee-for-service payments to providers. With the assertion that "Fee-for-service payment encourages wasteful use of high-cost tests and procedures," the article advocates that a fixed amount be paid to doctors and hospitals for a bundle of services—"bundled payments"—or that this fixed payment cover all the care that a patient receives—"global payments."

It is proposed that within 10 years, 75 percent of payments to Medicare and Medicaid (the program for the poor jointly administered by the state and federal governments) be based on alternatives to the fee-for-service model. According to either of these proposals, the finite amount of money allocated to either bundled or global payments serves as an incentive for health

care providers to ration care. The very real probability is that when the fixed payment is exhausted, services will cease.

Another proposal by the authors is the suggestion that the insurance exchanges set up under the health care law—where individuals and families without insurance are required to purchase coverage or face a penalty—be required to offer "tiered products." This approach has already been initiated in Massachusetts in the private health insurance market.

Under this system, hospitals and doctors are ranked by cost and quality measures, giving those providers that supposedly offer the best service at the lowest cost a "high-value" tier designation. Providers are ranked by the insurance companies themselves according to complicated formulas of quality and cost that vary from insurer to insurer.

In one Massachusetts insurance plan, co-payments are lowered by as much as $1,000 if patients choose from 53 high-value providers. How this works out in reality is that patients selecting these plans can be denied the specialized care more expensive hospitals provide, and may end up being treated at lower-cost providers with less experience in critical areas, such as pediatrics and oncology.

"It really is dividing the system into the haves and have-nots" Amy Whitcomb Slemmer, executive director of the Boston patient advocacy group Health Care for All, told the *Boston Globe*. "People who can pay for the higher tier, can pay more for office visits, will be able to maintain the choice and access."

The NEJM piece also targets the Federal Employees Health Benefits Program (FEHBP), which provides private health insurance to 8 million federal employees and their families. It recommends that, along with Medicare, FEHBP be required to transition to alternative payment methods, i.e., bundled and/or global payments, and that FEHBR require insurance carriers to offer tiered products.

The article also calls on doctors to police themselves and cut back on providing tests and procedures that may be "overused or unnecessary." The authors cite favorably an initiative announced earlier this year by the American Board of Internal Medicine Foundation in partnership with Consumer Reports called "Choosing Wisely." A group of nine medical specialty boards have recommended that doctors perform 45 common medical tests and procedures less often, while urging patients to question these services if they are offered.

"A Systematic Approach to Containing Health Care Spending" is the latest volley in the Obama administration's effort to reduce health care spending for corporations and the government by shunting workers and their families into "tiered" and other substandard health care plans, rationing care through "bundled" and "global" payments to health providers, and rating doctors and hospitals by their ability to cut costs.

These are some of the Democrats' alternatives to the Republicans' proposals to privatize Medicare through "premium support" vouchers. In the end, the differences between the two big-business parties on health care policy are of a tactical, not a principled character. Both reject any policies that would impinge on the earnings of the private insurers, giant health care chains and drug companies, who all stand to increase their profits whichever policies are pursued following the November elections.