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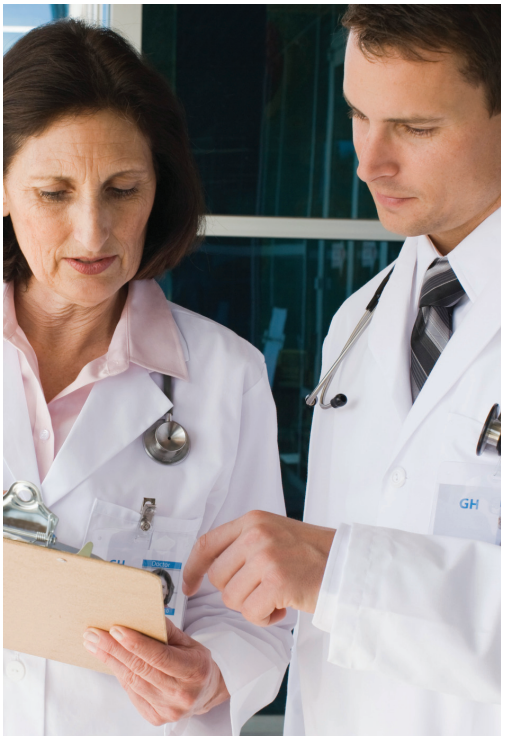

A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment

April 2013

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ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

ACKNOWLEDGEMENTS

BPC would like to thank the Peter G. Peterson Foundation and the Robert Wood Johnson Foundation for their generous support of the Health Care Cost Containment Initiative.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

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Health Care Cost Containment Initiative

With this Initiative, BPC embarked on an effort to address unsustainable health care cost growth in the United States. Under the leadership of former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN), former Senator Pete Domenici (R-NM), and former White House and Congressional Budget Office Director Dr. Alice Rivlin, BPC's Health Care Cost Containment Initiative explored and evaluated strategies to contain health care cost growth on a system-wide basis, while enhancing health care quality and value. This report is the culmination of that work, and a joint product of BPC's Economic Policy Project, directed by Steve Bell, and Health Project, directed by Katherine Hayes.

Report

This report was produced by BPC staff, in collaboration with a distinguished group of senior advisors and experts, for the Health Care Cost Containment Initiative. BPC would like to thank Sheila Burke, Chris Jennings, Paul Ginsburg, Steve Lieberman, and Joe Minarik, who shaped and strengthened the content of this paper by providing substantial feedback, support, and direction. BPC would also like to thank Julie Barnes for her leadership in conceptualizing and launching this initiative. Special thanks to Shai Akabas with the Economic Policy Project, and Janet Marchibroda and Katie Golden with BPC's Health Innovation Initiative for their support and contributions. Additionally, BPC thanks the many experts and stakeholders we engaged throughout this process for their guidance and feedback, with particular appreciation to Dr. Jonathan Gruber, Dr. Thomas MaCurdy and the staff of Acumen LLC, Dr. Ron Goetzel, and American Institutes of Research for their thoughtful analysis.

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Letter from the Co-Leaders

Our nation's health care system and our federal debt trajectory are on unsustainable paths. For too long, health and budget experts and policymakers have worked in silos rather than in collaboration. Such disjointed efforts have led to missed opportunities and falsely suggested that, in a time of limited resources, we must choose between investments in health care and fiscal health. We, the four leaders of the Bipartisan Policy Center (BPC) Health Care Cost Containment Initiative, came together to change the conversation around health and budget reform. A strong health care system, a stable federal budget, and a productive economy are complementary, not competing, priorities.

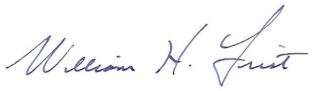
We can achieve a higher-value health care system—meaning both greater efficiency and higher quality. The enclosed report outlines our recommendations to achieve the critical goal of containing high and rising health care spending while improving the quality and affordability of care for all Americans. This report is the culmination of nearly a year of work, including stakeholder outreach, thorough research, and substantive analytics to quantify the impact of our proposed policies.

Our efforts embody the BPC approach—driving principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. As such, this report and its recommendations represent our broad consensus on comprehensive, system-wide health care and budget reforms. This comprehensive, systemic approach is key, and we as individuals do not necessarily endorse each piece in isolation.

This report is not the end of the story, but the beginning. By presenting this approach to federal, state, and private-sector leaders, we hope to promote a collaborative dialogue and a shared understanding of strategies to put our nation's health system, as well as our economic outlook, on a sounder and more sustainable path. No single set of recommendations can fix the health care system or the nation's debt and deficit crisis overnight, but we hope this report can start a constructive, pragmatic dialogue among policymakers and political leaders. We look forward to further refining and developing these ideas in collaboration with leaders, experts, and stakeholders across the health care system.

Sincerely,

Former Senate Majority Leader
Tom Daschle



Former Senate Majority Leader
Bill Frist, M.D.

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Former Senate Budget
Committee Chairman Pete Domenici

Former Congressional Budget Office Director
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Executive Summary

Background

In the United States, nearly a fifth of all spending is currently devoted to health care. High and rising health care costs consume a large and rapidly growing portion of the federal budget, crowding out investments in other crucial priorities such as education, defense and infrastructure and putting pressure on other priorities of households, businesses and governments. This trend will only accelerate with the aging of the population and its increased dependence on federal and state financing of health care. Yet despite our high national spending, health care in the United States is uneven in quality and often wasteful, uncoordinated and inefficient. Leaders on both sides of the political aisle, and in the health and economic policy communities, recognize the urgency of improving the quality and effectiveness of care, while slowing the growth of spending. However, far too often, attempts to address our nation's health and budget issues have been fragmented and unproductive, frequently due to partisan disagreements over how to approach these highly sensitive issues.

We, the four leaders of the Bipartisan Policy Center (BPC) Health Care Cost Containment Initiative, came together to bridge this divide—to start a constructive dialogue on strengthening the U.S. health care system. We focused our efforts on what is necessary to improve quality and eliminate waste. We feel that budget-driven efforts to achieve health care savings alone will fail; public and private health care savings must be an outgrowth of health reform, not the underlying reason for it. We believe our policy analysis and recommendations reflect this principle.

Our Vision

After decades of very rapid increase, health care spending growth has slowed somewhat in the last few years. Experts attribute this slowdown to the economic downturn, recent structural health system changes, a slower pace of technological innovation, and other factors. This cost slowdown is welcome, but we believe temporary. Longer-term, affordable care will require meaningful reform, which will take substantial time to enact and implement. If policymakers wait until the economy recovers, and unsustainable health spending growth resumes, the lead time required for real reform will be gone—forcing rushed, less-effective health-spending cuts, or severe revenue increases and spending cuts elsewhere in the budget. Moreover, to ensure greater value and affordability from our health care investment, we believe our nation should always be working to improve quality and eliminate waste and overpayments. The United States must act now to begin the transformation to a higher quality, more sustainable health care system.

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In the long term, we envision health care that is value-driven and coordinated through organized systems, rather than volume-driven and fragmented. These systems will be developed and evolve through a process of innovation and improvement, based on collaborative structures of care delivery and payment with accountability, coordination, competition, and patient choice. The tools and incentives built into these systems will ensure that patients receive high-quality, coordinated care across multiple settings. They will avoid unnecessary or redundant treatments and services, engage patients in decisions about their care, and pay physicians for the services that patients want—including more time talking with their doctors. The recommendations in this report seek to align today's good work in the public and private sectors. Our Medicare reforms include steps toward greater coordination in care delivery and payment, such as shared savings, bundled payments, and competitively-bid, capitated health plans.

We are convinced that reforming our nation's health care system to prioritize quality and value over volume will not only improve health outcomes and the patient experience, but also constrain cost and produce system-wide savings. Such an outcome would be a real cost benefit to consumers, businesses and taxpayers, while helping to reduce our federal deficit. Our policy recommendations for Medicare and federal health-related tax policy were scored by nationally-respected, independent experts. Although we do not have estimates of the private sector savings that would be certain to evolve from our recommendations, we do estimate that our policies would achieve approximately $560 billion in federal deficit reduction over the next 10 years, growing significantly in the years beyond. Our quality and efficiency improvements will make a major contribution toward addressing our nation's indisputable demographic as well as federal debt and deficit challenges; we acknowledge, however, that additional revenue will be needed to meet these challenges from a policy-sound and politically viable perspective. However, comprehensive tax reform is beyond the scope of this report.

Why Our Initiative is Different

Our effort breaks with approaches that prioritize or even focus solely on federal health-costs and deficit reduction. Although health spending is growing rapidly, we cannot simply shift costs to generate public budgetary savings. Our nation needs a comprehensive, sustainable policy that addresses system-wide health care cost growth. Thus, we focus on improving the entire system of care. Our primary motivation is to improve the health system for patients and families. A higher quality health care system for all would reduce the current system's substantial inefficiency and waste, effectively constraining cost growth.

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We have also brought bipartisanship to the table, dedicating nearly a year to reasoned negotiations to break through the partisan rhetoric surrounding health care. We sought policy options around which both sides of the political aisle could realistically coalesce, and we prioritized political and economic realities over discrete options that achieve budget savings in the near term.

Key Recommendations

Our policies would engage both beneficiaries and providers with incentives to pursue a more coordinated, accountable, and sustainable health care system. These recommendations span four broad categories:

1. Improve and Enhance Medicare to Incent Quality and Care Coordination;
2. Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition;
3. Prioritize Quality, Prevention, and Wellness; and
4. Incent and Empower States to Improve Care and Constrain Costs Through Delivery, Payment, Workforce, and Liability Reform.

Our recommendations would improve how health care is delivered and financed in both the public and private sectors. Focusing only on federal health programs runs the risk of shifting costs to the private sector or state and local governments without achieving higher-quality care. Each policy recommendation requires trade-offs to improve care as we constrain cost growth. Though all four policy pillars are essential, the two with the most-immediate delivery and cost impact are our recommendations on Medicare policy and the federal tax exclusion for employer-sponsored health insurance (ESI).

Improve and Enhance Medicare to Incent Quality and Care Coordination

Medicare has been and can continue to be a leader in demonstrating and promoting system-wide health reform. Therefore, we carefully constructed policies to strengthen and improve Medicare – to preserve traditional Medicare's promise of beneficiary choice, basic guaranteed benefits, and financial security from potentially catastrophic health care costs. We also add new choices and new protections for beneficiaries, while strengthening and modernizing the traditional Medicare benefit.

A NEW OPTION IN TRADITIONAL MEDICARE: "MEDICARE NETWORKS"

Our policies would encourage beneficiaries to engage more actively in choosing the coverage that best suits their needs. In addition to fee-for-service Medicare and Medicare Advantage, we would offer a new option within traditional Medicare called "Medicare Networks," wherein providers could share the savings from higher quality, more cost effective care. Beneficiaries could choose to enroll in a Medicare Network and would receive a premium discount if they do so. They and their providers also could share in savings that result from greater quality and efficiency of care. To encourage physicians, hospitals, and other health care providers to participate, we would provide financial rewards for joining these Medicare Networks and disincentives for staying in the less efficient fee-for-service system.

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MEDICARE ADVANTAGE

We also propose to bring market forces to bear on Medicare Advantage by implementing a competitive-bidding structure, while providing transitional protections for beneficiaries as we do so. Competitively-bid payments to plans would only take effect in regions where it costs less than current law, therefore guaranteeing savings for the Medicare Trust Funds. Initially, a portion of the savings would be allocated to finance reduced beneficiary premiums and cost-sharing. To help beneficiaries navigate plan selection, we propose a user-friendly, up-to-date Medicare Open Enrollment website.

FEE-FOR-SERVICE MEDICARE

Beneficiaries would also be free to remain in an improved fee-for-service Medicare. Our report identifies inefficiencies, misaligned incentives, and fragmented care delivery in the current fee-for-service reimbursement system that have both undermined quality and increased costs.[i] We would modernize the program through a greater commitment to competitive bidding, bundling, and other reforms that make health systems more accountable and affordable. We also offer "carrot-and-stick" incentives to encourage both beneficiaries and providers to move toward organized systems of care, such as our Medicare Networks. We believe that these organized systems would give patients and families better, more coordinated care, while reducing overall spending growth. For those geographic areas of the nation that could not set up alternative delivery systems, the Department of Health and Human Services (HHS) Secretary would be authorized to ensure adequate reimbursement levels to fee-for-service providers.

BENEFIT MODERNIZATION

As we propose to improve the Medicare benefit by providing long-overdue catastrophic protections, we also would offer a modernized cost-sharing design. Our proposal would ensure that beneficiaries could visit their doctors without facing high out-of-pocket costs; however, we also would prohibit first-dollar supplemental coverage because it can lead to greater use of services without necessarily producing better outcomes. We pursue further balance by providing additional cost-sharing support to low-income beneficiaries while reducing federal subsidies for higher-income individuals.

Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition

We propose to target our nation's limited financial resources on health care coverage and services that are valuable. The nation cannot achieve affordable care with an open-ended, overly generous subsidy for the purchase of private health insurance. The tax exclusion for ESI makes providing health benefits cheaper than paying cash wages, and thereby encourages high-cost benefit designs and blunts incentives to deliver care more efficiently. We therefore propose to reform and rationalize the current ESI tax exclusion and make it

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[i] For more information, see *What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth,* Bipartisan Policy Center, September 2012.

less regressive. We recommend replacing the flawed "Cadillac tax" on high-cost health insurance plans with a limit on the income-tax exclusion for employer-sponsored health benefits. We also support replacing the current excise tax on fully insured plans with a paid-claims tax, to avoid creating additional distortions in the health insurance market.

Another strategy for aligning incentives to support high-quality, coordinated care delivery and payment is to ensure that private-sector payers and providers who want to form integrated delivery systems have clear guidance on how to do so without violating antitrust or fraud and abuse laws. We believe that guidance should be provided in this area just as we believe that there should be strong enforcement against consolidation that leads to anti-competitive behavior and increases costs.

Prioritize Quality, Prevention and Wellness

Our other recommendations would complement our strategies for strengthening Medicare and rationalizing health-related taxes, and remain consistent with our core vision. Many proposed policies would lower barriers to implementing more integrated systems of care or would provide resources and supports for these systems. Additionally, we recommend exploring the potential of prevention to improve health and contain costs, as well as eliminating barriers to wider implementation of prevention approaches, such as workplace wellness programs, that are found to be effective.

QUALITY

Effective quality metrics are essential to accountability in organized systems of care. Quality-performance metrics must be precise and clinically relevant to incent better delivery, to show providers how their performance relates to their peers', and to facilitate the real-time design and implementation of strategies to improve quality and safety. Quality metrics must also provide the meaningful data needed for patients and families to make informed choices. Attempting to achieve these goals, providers have pursued quality metric design, evaluation, and reporting, as well as the identification of new and different quality metrics. However, the quality-reporting roles and responsibilities of organizations such as health plans and accrediting bodies are ill-defined, leading to confusion and inefficiencies. We would strengthen the quality-reporting system and the validity of available metrics by identifying barriers to better alignment of current metrics and promulgating minimum requirements that are clinically relevant and useful to providers, and understandable and accessible to consumers.

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Encourage and Empower States to Pursue Needed Reforms to Improve Care and Value

The nation must transform the entire health system, and in doing so must engage leaders at all levels of government and in all sectors of the health care industry, as well as patients, consumers, and families. States should actively promote health-system innovation and transformation. We support resources and incentives, rather than top-down mandates, to engage state leaders in supporting coordinated and accountable models of health care delivery and payment. To this end, we recommend policies to strengthen the primary care workforce and make greater use of non-physician practitioners; to create safe harbors for physicians to improve our nation's medical liability system and reduce the practice of defensive medicine; to address consolidation in the financing and delivery systems; and to promote price and quality transparency for consumers, families, and businesses.

A more detailed list of recommendations follows this executive summary. We believe that the vision and recommendations articulated in this report, if enacted together, would help to put our nation's health system, as well as our economic outlook, on a more sustainable, healthy path for the future.

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List of Recommendations

Chapter 1: Improve and Enhance Medicare to Incent Quality and Care Coordination

A. PRESERVE AND IMPROVE MEDICARE CARE DELIVERY AND PAYMENT SYSTEMS

1. **MEDICARE NETWORKS**: Promote quality and value through an improved version of Accountable Care Organizations (ACOs) that encourages providers to meet the full spectrum of their patients' needs. In doing so, replace the Sustainable Growth Rate (SGR) formula for physician reimbursement, and offer all Medicare providers strong financial incentives to participate in new payment models.

2. **MEDICARE ADVANTAGE**: Establish a standardized minimum benefit for Medicare Advantage Plans—including all services covered by traditional Medicare, a cost-sharing limit to protect against catastrophic expenses, and slightly lower cost-sharing—and pay plans using a competitive-pricing system.

    a. Incorporate a measure of functional status in Medicare's risk adjustment.

    b. Implement a reinsurance system for Medicare Advantage by 2016.

    c. Require all Medicare Advantage Plans to include prescription drug coverage.

    d. Allow Medicare Advantage Plans to adopt tiered network designs.

    e. Replace the Medicare Plan Finder with a user-friendly, up-to-date Medicare Open Enrollment website that beneficiaries could use to make coverage selections upon enrollment and during the annual open-enrollment period.

3. **BUNDLED PAYMENTS**: Expand the voluntary payment bundling demonstration into a standard Medicare payment method. Bundles—including inpatient, physician, and post-acute care, and any readmissions within 90 days—should be established nationwide no later than 2018 for certain diagnosis-related groups (DRGs).

4. **FALLBACK SPENDING LIMIT**: No earlier than 2020, implement a fallback spending limit that would restrain annual standardized (age-adjusted) per-beneficiary spending growth to a target of GDP per-capita growth + 0.5 percentage points (over a five-year moving average), and apply separately to fee-for-service, Medicare Networks, and Medicare Advantage.

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B. STRENGTHEN AND MODERNIZE THE MEDICARE BENEFIT

1. **BENEFIT DESIGN**: In 2016, implement a new traditional Medicare benefit structure for Parts A and B that would:

    a. Maintain the same aggregate cost-sharing for beneficiaries as today;

    b. Provide beneficiaries with protection from catastrophic medical costs by establishing an annual, beneficiary cost-sharing limit of $5,315 for Medicare-covered services (all additional covered services would be at no-charge to the beneficiary);

    c. Replace the two existing deductibles with a single, combined (Parts A and B) annual deductible of $500;

    d. Replace coinsurance on most covered services with copayments similar to those proffered by Medicare Payment Advisory Commission (MedPAC);

    e. Maintain preventive care and the annual wellness visit with no beneficiary cost-sharing; and

    f. Exempt physician office visits from the combined deductible. (Beneficiaries would only pay the copayment for an office visit, even if the deductible has not yet been met.)

2. **SUPPLEMENTAL COVERAGE**: To lower costs for Medicare beneficiaries and encourage more appropriate utilization of care, beginning in 2016, all supplemental coverage from medigap plans and employer-provided plans (including Tricare-for-Life and the Federal Employees Health Benefits Program) should:

    a. Include a deductible of at least $250;

    b. Include an out-of-pocket maximum no lower than $2,500 (out of the beneficiary's pocket); and

    c. Cover no more than half of beneficiary copayments and coinsurance.

3. **LOW-INCOME SUPPORT**: Beginning in 2016, expand cost-sharing assistance to Medicare beneficiaries with incomes up to 150 percent of the federal poverty level.

4. **HIGH INCOME REFORMS**: Establish lower thresholds beginning in 2016 so that approximately 17 percent of beneficiaries would pay income-related premiums.

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C. MAKE MEDICARE AND RELATED SYSTEM REFORMS THAT IMPROVE CARE AND LOWER COST GROWTH

1. **DURABLE MEDICAL EQUIPMENT**: Implementation of the durable medical equipment (DME) competitive-bidding program should continue apace for all urban markets nationwide, but for some equipment types, benchmarks should be set lower.

2. **SITE OF CARE DIFFERENTIALS**: Equalize payment rates for evaluation and management services (known to most patients as office visits) to the rate in the lowest-cost setting, including facility payments. Equalize payments at the level of the lowest-cost site for procedures that are conducted in both the outpatient department and in the physician's office when:

    a. the procedure is performed more than half of the time in the office setting;

    b. the procedure is performed less than 10 percent of the time in the emergency department; and

    c. there is not a significant difference in patient severity between settings.

3. **MEDICARE ADVANTAGE STAR RATINGS:**

    d. End the CMS demonstration and revert to the smaller bonus payments under current law, which are restricted to four- and five-star plans.

    e. When regional markets convert to competitively bid payments, discontinue bonus payments entirely.

4. **HIGH-QUALITY, LOW-COST DRUG UTILIZATION**: Encourage use of high-quality, low-cost drugs in Medicare and system-wide:

    a. Adjust the Part D LIS cost-sharing to encourage the use of high-value drugs;

    b. Change Part B reimbursement for provider-administered medications;

    c. Convert from average wholesale price to average sales price for remaining Part B drug and vaccine reimbursements;

    d. Address anti-competitive settlements between brand and generic drug manufacturers; and

    e. Close the REMS loophole that inhibits development of generic drugs.

5. **PHYSICIAN SELF-REFERRAL LAW**: Limit the in-office exception to the Stark Law to providers who meet accountability standards.

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6. **GRADUATE MEDICAL EDUCATION**: To better align Medicare's investment with our overarching vision for reform and to achieve a workforce that can efficiently and appropriately deliver care:

a. Reduce the indirect medical education (IME) percentage add-on to inpatient hospital admissions from 5.5 percent to 3.5 percent. All savings should be repurposed for performance-based incentive payments and additional residency slots.

b. Repurpose 50 percent of the proposed reduction in IME funds for performance-based incentive payments. Restructure Medicare's investment to require that all recipients of IME funding be held accountable for reaching specified educational goals and outcomes. Only institutions that meet these standards should be eligible for the performance-based payments.

c. Repurpose the remaining 50 percent of savings from IME payment reduction to additional residency slots, one-third of which should be made available to teaching hospitals that are training above their cap. Half of the additional slots should be allocated to programs that train primary care physicians and other providers for which there are identified specialty shortages.

d. Limit the PRA to 120 percent of the locality-adjusted national average PRA when calculating direct graduate medical education payments.

7. **HEALTH INFORMATION TECHNOLOGY**: Prioritize electronic sharing of information among providers in the next stage of the Medicare and Medicaid EHR Incentive Programs. HHS should provide implementation support for such information sharing, with a particular focus on the needs of small physician practices and community hospitals.

Chapter 2: Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition

1. **EMPLOYER-SPONSORED HEALTH INSURANCE TAX EXCLUSION**. Replace the Cadillac tax on high-cost health insurance plans with a limit on the income-tax exclusion for employer-sponsored health benefits at the dollar amount equivalent to the 80th percentile of single and family ESI premiums in 2015 (age- and gender-adjusted).

2. **PAID-CLAIMS TAX**: Replace the ACA tax on fully insured plans with a paid-claims tax.

3. **COMPETITION AND CONSOLIDATION**: Streamline and clarify the application of existing federal legal and regulatory guidance for private-sector entities seeking to form integrated, coordinated systems of care delivery.

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a. Review effectiveness of current fraud and abuse laws in today's changing care delivery and payment environment.

b. Authorize the Federal Trade Commission (FTC) to gather market data on a routine basis.

Chapter 3: Address Other Federal Policies that Block Efforts to Enhance Care and Constrain Costs

1. **QUALITY**: Prioritize, consolidate, and improve the use of quality measures by consumers and practitioners:

    a. The National Quality Forum (NQF) should refocus efforts to convene accrediting and certifying bodies—including the National Committee for Quality Assurance (NCQA), the Joint Commission, and the American Board of Medical Specialties (ABMS)—to identify common measures used for value purchasing by public and private purchasers, to identify barriers to alignment of current metrics, and to deliver a minimum set of requirements for providers that are clinically relevant, understandable to consumers, and useful for improvement.

    b. NQF should develop pathways that allow physician-created and clinically relevant quality measures to be accelerated in the process towards an endorsement for use.

    c. The Measures Application Partnership (MAP) should place a greater emphasis on public-private collaboration.

    d. NQF should convene a group to create consensus metrics for commercial ACOs and other integrated delivery systems.

    e. In endorsing specific quality measures, NQF should assure that they are accessible to consumers as they make decisions regarding providers or treatment options.

    f. Support the electronic capture of data for measurement through the use of common standards.

2. **PREVENTION:**

    a. Invest the Prevention and Public Health Fund in demonstration programs to help identify the most cost-effective prevention strategies.

    b. Support collection, analysis, and dissemination of data from prevention programs, both governmental and nongovernmental.

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c. Provide financial incentives to help spur investment and innovation among small businesses in comprehensive worksite health promotion.

d. Support health promotion strategies for the federal workforce to accelerate the generation of additional data on effective interventions.

Chapter 4: Encourage and Empower States to Pursue Needed Reforms to Improve Care and Value

1. **DUAL ELIGIBLES**: Adopt a broad strategy to deliver Medicare and Medicaid services to dual eligible individuals through a single program.

2. **FEDERALLY QUALIFIED HEALTH CENTERS**: The HHS Secretary, using authority provided to the Center for Medicare and Medicaid Innovation, should test alternative models of reimbursement to assure quality and value in the Medicaid program. Changes to federally qualified health center (FQHC) payment methodology should carefully evaluate the impact on access to care in medically underserved areas for both Medicaid and uninsured patients and should ensure that reductions in Medicaid payments do not shift cost-shift to public and private grant dollars intended to finance the cost of uninsured patients.

3. **MEDICAID FRAUD AND ABUSE**: Implement the Medicaid and Children's Health Insurance Program Payment and Access Commission's recommendations to strengthen Medicaid program integrity.

4. **TRANSPARENCY:**

    a. Encourage pro-competitive rules for insurer-provider contracting:

        i. Prohibit providers from requiring placement in the preferred tier as condition of contracting;

        ii. Restrict "all-or-nothing contracting" for providers that have multiple distinct units; and

        iii. Ban "most-favored nation contracting" between providers and insurers.

    b. Promote price transparency that will help consumers better understand and anticipate health care costs. Insurers should share pricing data that will help individuals in consumer-directed plans to better understand out-of-pocket costs before accessing care and should provide estimates for the average cost of out-of-network care for various types of providers, locations, and services.

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5. **MEDICAL LIABILITY**:

    a. The Institute of Medicine (IOM) should convene a panel of providers, consumers, and quality-measurement groups to determine whether evidence-based quality measures could be used as a basis for provider defense in medical liability cases and, if so, to provide guidance on a process for the adoption of appropriate measures through a quality-certification organization. Adoption of measures should be consistent with efforts to create a uniform set of quality measures used for provider reimbursement and quality improvement.

    b. Provide continued opportunities for states to test alternative models designed to reduce insurance and utilization costs associated with medical liability litigation by appropriating the $50 million in state demonstration grants authorized in the ACA for the development, implementation, and evaluation of promising alternatives to current tort litigation.

6. **HEALTH PROFESSIONAL WORKFORCE**: Eliminate outdated statutory or regulatory requirements in Medicare and Medicaid that interfere with states' abilities to regulate and determine scopes of practice.

7. **INCENTIVES FOR STATE REFORM**: The federal government should consider offering a financial incentive to states that enact the following reforms:

    a. Adoption of evidence-based quality measures that could be used as a provider defense in medical liability cases;

    b. Pro-competitive insurance contracting rules; and

    c. National Council of State Boards of Nursing Advanced Practice Registered Nurse Consensus Model Act.

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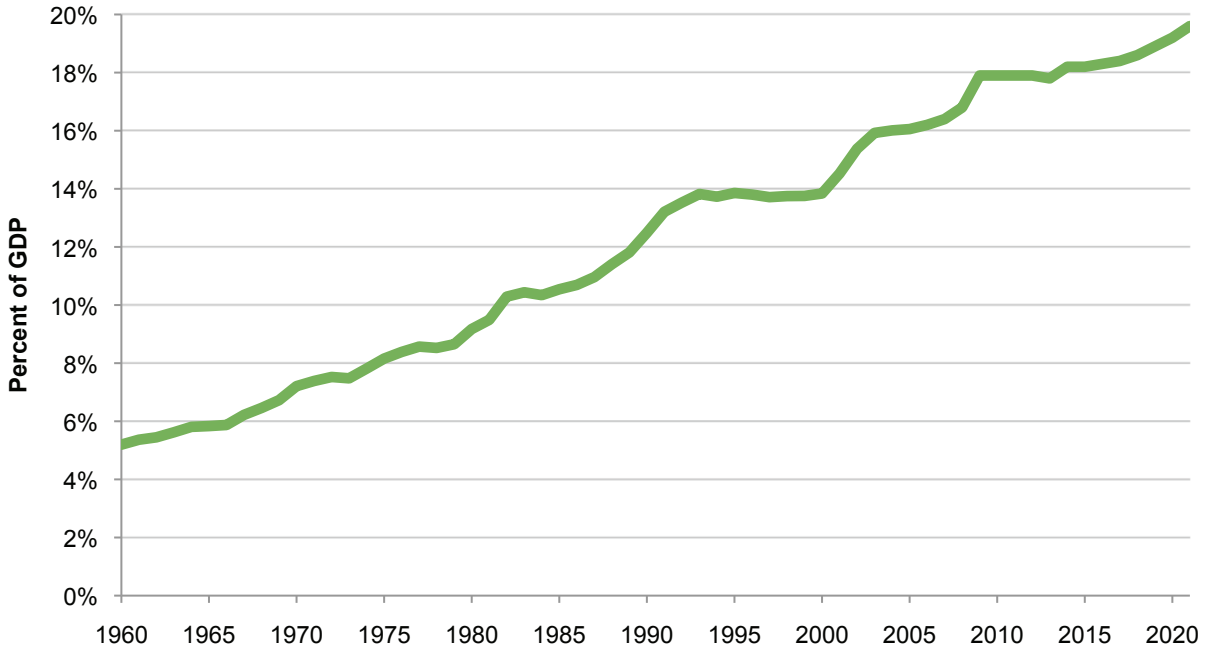
Introduction

Government policymakers and experts have long recognized that health care costs and spending—at 18 percent of U.S. GDP and rising—burden both the economy and the federal and state governments that pay nearly half of the bill.[1] As the nation struggles to control an unsustainable federal debt, and as rising health care costs erode wage growth and the global competitiveness of American business, tackling health care costs is both essential and unavoidable.

Chart 1. National Health Expenditures as a Share of the Economy



Source: CMS

Despite the highest per-capita spending in the world, the U.S. health care system fails to deliver commensurate value. In return for approximately $2.8 trillion annually, millions of Americans receive care that is uncoordinated, unnecessary, or overpriced, while others receive little or no care at all. We must act now to ensure that the health care system is effective and sustainable.

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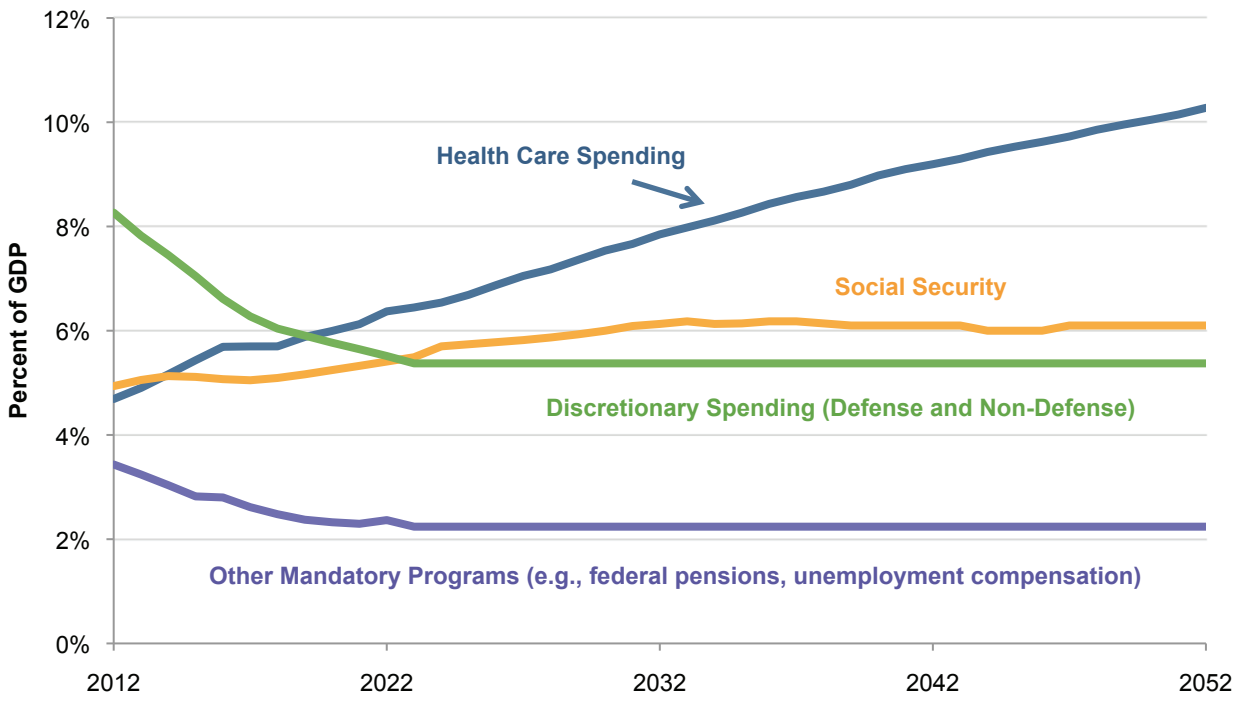
A comprehensive approach to the nation's fiscal challenges requires policies to address rising health care costs in general and the cost of federal programs such as Medicare in particular. However, even if we improve health care and reduce the growth of health costs, demographic trends will drive government health and retirement spending toward a larger

share of the economy. Elected policymakers must make difficult judgments and choices to slow cost growth and meet our health care commitments without undermining obligations for education, research, infrastructure, and defense. The quality and efficiency improvements that we propose would make a major contribution toward addressing our nation's indisputable demographic as well as federal debt and deficit challenges; we acknowledge, however, that additional revenue will be needed to meet these challenges from a policy-sound and politically viable perspective. However, comprehensive tax reform is beyond the scope of this report.

Chart 2. Health Care Costs are the Primary Driver of the Debt



Source: Congressional Budget Office's Alternative Fiscal Scenario (February 2013), additionally assuming that combat troops overseas decline to 45,000 by 2015 and that Hurricane Sandy funding is not allocated in future years; Bipartisan Policy Center extrapolations

Health- and budget-policy leaders strive to develop and support a more cost-efficient, higher-value, higher-quality health care system. Still, they often fail to work effectively together to achieve these shared goals. Success will require a truly collaborative effort that will both strengthen the health care system and embrace fiscal responsibility and restraint.

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Our recommendations are not aimed solely at federal health care spending. Though the federal government must play a lead role in any effective health system transformation, and the rate of growth in federal health care spending must be slowed, reform is needed at all levels, including in the states and in the private sector. For that reason, this report focuses on strategies that will bring about system-wide cost containment and transformation.

By presenting this report to federal, state, and private-sector leaders, we hope to promote a collaborative dialogue and a shared understanding of feasible strategies to achieve more-affordable, higher-quality care. No one set of recommendations can fix the health care system and meet the nation's debt and deficit challenges overnight, but we believe that this report can begin and direct a productive conversation.

We forthrightly acknowledge that curbing the underlying drivers of expensive, inefficient, and low-value care requires a long-term commitment and continuing action. Even if the reform process begins immediately—and it should—the real payoff is likely to take decades. That is because responsible reform must allow time for careful implementation and give patients, providers, and other health care actors the notice that they need to adjust. Eagerness must not undermine the ultimate achievement of a sustainable, affordable health care system.

System-wide health care cost containment would ultimately benefit consumers, purchasers, and providers. The current structure is unsustainable. Policymakers have often responded to short-term budget challenges by cutting provider payment rates; continued pressure on reimbursements could reduce beneficiary access without addressing underlying cost drivers. Similarly, the broken SGR Medicare physician payment formula perpetuates continued political brinksmanship and threatens doctors with sudden, steep cuts to payment rates. Health care cost containment that fosters an efficient system would increase stability and reduce uncertainty for providers, and it would reward them for the delivery of high-quality care. Consumers and patients would also benefit. Health insurance premiums for family coverage rose 97 percent between 2002 and 2012, far outpacing earnings growth (33 percent for nonsupervisory workers) during the same period.[2] Cost containment would slow the growth of premiums and employee contributions, thereby allowing employers to further increase cash wages.

Health Care Cost Drivers

The U.S. health care system is a complex, multitrillion-dollar industry. In September 2012, we issued a report, *What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth*, illustrating that the drivers of health care costs are complex and interwoven, and that no single step will reverse high and rising health care spending.[3] Our earlier report identifies these cost drivers, ranging from demographic changes to advances in medical technology to the current health care delivery and payment systems.

The recommendations in this document address the drivers of spending that are most amenable to reform through direct policy intervention, including:

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Table 1. Cost Drivers

COST DRIVER	STRATEGY TO ADDRESS
Inefficiencies and misaligned incentives in the current fee-for-service reimbursement system	Realign health care delivery and payment incentives and systems to encourage greater accountability and coordination.
Fragmentation in care delivery	Promote systems that coordinate care delivery for all patients across different settings and effectively meet the needs of individuals with chronic and comorbid conditions.
Tax favored treatment of health care insurance	Reform health-related tax provisions to limit the tax incentive toward overly expensive insurance products.
Limited information and incentives for consumers to make cost-effective choices	Improve consumer cost-sharing incentives in public and private programs, and increase transparency of both cost and quality of care to promote patient engagement and informed choice in provider and other health care decisions
Legal barriers to more cost efficient care delivery, including medical liability laws and medical licensing and supervisory requirements	Reform laws and regulations that impede care coordination and cost-effective care delivery.
Increasing prevalence of chronic disease and comorbidities	Reduce the growing burden of chronic disease by promoting prevention and healthful lifestyles and wellness programs in the workplace.

THE RECENT HEALTH CARE SPENDING SLOWDOWN DOES NOT JUSTIFY INACTION

After a long stretch of rapid cost growth—including 11 percent average annual growth between 1980 and 1990, and 7.6 percent between 2000 and 2007—the growth of national health expenditures has slowed over the past few years.[4] Indeed, between 2009 and 2011, growth held steady at 3.9 percent.[5] This slowdown is likely due in large part to the recent recession with its very high, prolonged unemployment—worse than other U.S. recessions since 1945—stagnant wages, and sluggish economic growth. Research has shown that health care spending is sensitive to overall economic growth.[6] The loss of ESI for the unemployed and lower income growth (partially attributable to the earlier rapid growth in health care costs) for those with jobs may be important factors in this health care spending slowdown.[7]

However, some experts believe that a significant portion of it arises from lasting structural changes in the health care system. Those experts point out that the current cost slowdown actually started before the recession, which is especially notable because in other recessions, lower health spending growth has been a lagging indicator.[8] While the evidence does not show clearly which structural factors are important, possibilities include movement toward new models of care and payment (which have been adopted by some private-sector payers); the shift toward high-deductible, consumer-directed health plans; and slower technological innovation.

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Other analysts doubt the pervasiveness and importance of these structural changes. A plausible alternative explanation is that health spending endured a one-time rapid increase following the consumer and employer pullback from managed care at the turn of the millennium. Thus, the slower health spending growth just before the recession may have been merely the end of this transition.

While the spending growth slowdown has provided some relief for government and personal budgets in this difficult economy, and structural changes may have played a role, relying on this trend's permanence would be unwise. If policymakers wait until the economy recovers, with GDP and unemployment returning to more-typical levels for an extended period, and high health care spending growth then resumes, it will be too late to take necessary action to bend the cost curve in the 2020s without draconian policies that would harm both beneficiaries and providers.

Alternatively, if policymakers act earlier to improve both the efficiency and quality of the U.S. health care system, Americans would benefit even if health care spending is already on a lower growth trajectory. The United States has the highest health care costs in the world, so we have substantial room for improvement. Also, the lower Congressional Budget Office (CBO) baseline for Medicare spending provides a legislative opportunity to make broader changes to strengthen the program, such as replacing the flawed SGR physician payment formula, at a lower cost than before.

A New Vision: Delivery and Payment Reform to Secure Patient-Centered Care

Imagine a health system in which multidisciplinary teams of doctors, nurses, pharmacists, hospitals, nursing facilities, and many others work together to ensure that patients receive high-quality care that is responsive to their values and preferences. Care is organized around what the patient needs, not around what is expedient for an individual provider. Information, such as lab test results, referrals, notes, and updated medication lists, is shared seamlessly among health care professionals, without the need for patients to intervene. Practitioners are informed about their patients, they proactively move to the next step in the care process (such as a referral from a primary care provider to a specialist or a referral from a hospital to a post-acute care facility), and they intervene quickly and appropriately to avoid or address any emerging problems. Health information technology facilitates the necessary electronic information sharing across care settings for both clinical decision-making and coordination of care.

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In this aspirational system, physicians, nurse practitioners, physician assistants, and other health professionals all work to the top of their training, in a coordinated manner, and are assigned responsibility for improving patients' experiences. For instance, an obesity screening during an annual wellness visit might lead to a referral to a nutritionist—maybe even on the same day. Care for a patient newly diagnosed with diabetes might extend

beyond the physician's office with in-home visits from a diabetes educator, who would help the patient learn the intricacies of managing this very complex condition.

A patient's needs and preferences influence the setting in which he or she receives care—in essence, this is a patient-centered system. Patients with simple questions can communicate securely with their providers by e-mail, resolving straightforward issues without a time-consuming face-to-face visit. This saves providers' time for patients whose health needs are more complex. Patients use information about quality and cost to choose plans or providers and share in decision-making that incorporates their personal preferences and needs. Local communities of providers are empowered to innovate—to find and adopt the changes that lead to better care for patients—and then are held accountable for quality outcomes, value, and the patient experience.

The vision described above is difficult—if not impossible—to achieve in today's fragmented and poorly coordinated U.S. health care system. Because no one actor in the fee-for-service health care system is directly and consistently responsible for coordinating care, patients are often left to do the job on their own. This can be frustrating and inconvenient—such as when patients themselves need to ensure that routine test results are sent to their physicians—or even dangerous, if necessary care is missed due to lack of communication or poor transition planning.

Fee-for-service payment is not the only barrier to this vision. The 20th-century Medicare benefit design—a regressive, inflationary tax-exclusion policy—and the lack of valid, actionable, and timely quality information for patients and practitioners all contribute. Additional barriers include inadequate incentives at the state level to provide coordinated care for low-income seniors and people with disabilities, to institute medical liability reforms, and to build and strengthen the workforce required to meet care needs.

Our Approach to Cost Containment and Improved Care

Several governing policy principles emerged as we worked toward consensus on cost containment. These principles ultimately served as key criteria for policies that advance our comprehensive vision of health system reform:

- Promote high-value, coordinated care by holding providers accountable for quality and cost, and by encouraging greater patient engagement in health care decisions.
- Address the drivers of high cost and poor quality system-wide for the benefit of patients, providers, and taxpayers, including excessive reliance on and use of fee-for-service payments that drive volume and not value.
- Implement reforms that achieve substantial savings and better care over time, rather than large, short-term federal cuts to payment rates, which might undermine care and retain inefficiencies of the current system.

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- Avoid cost-shifting from the federal government where possible; if unavoidable, it should generally be limited to policies that promote efficiency and accountability without excessively burdening consumers, providers, businesses, and states.
- Improve transparency to empower consumers and businesses to make choices based on cost and quality of care.
- Prioritize the protection of patient choice, privacy, and safety in all care delivery and payment system reforms.

Policy Levers to Achieve Objective of Better and More Affordable Care

Many of the recommendations that follow are intended to facilitate a transition to new payment models that reward quality and efficiency while giving providers flexibility to improve care delivery. Some of these initial efforts to move away from classic fee-for-service reimbursement have already demonstrated savings.[9-10] For example, private insurers were the first to implement shared-savings arrangements, which establish spending targets for providers who are otherwise compensated through fee-for-service payment; if they meet quality metrics and contain costs, providers get to keep a portion of the savings. This and other advanced payment models, such as payment bundles and partial capitation, also have the benefit of encouraging providers to work together, coordinate care, and improve quality. Spurred by this private-sector leadership, Medicare is implementing shared-savings arrangements as well, already including participation from over 250 ACOs, in which various providers agree to work together to deliver care for beneficiaries. These changes, however, are at an early stage, as almost 90 percent of private health care payments remain unrelated to quality or value.[11]

Despite the myriad of factors driving health care cost growth, many innovative organizations are successfully slowing or reversing their cost trends. The following recommendations seek to support and accelerate these high-performing, private-sector innovations and to align the progress in the public and private sectors. To do so, while we focus on four federal policy areas that impact our ability to improve care and constrain cost growth, we place particular emphasis on the two policy levers that are most responsible for driving change across the entire health care system:

- Medicare, the payer for 21 percent ($554 billion) of national health care expenditures; and
- Federal health care tax policy, which provides enormous subsidies to the purchasers of private health insurance (approximately $250 billion annually).[12]

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Federal programs, including Medicare and the federal tax code, have been used successfully to drive change in our health care system in the past. For example, the Internal Revenue Code's exclusion for ESI has promoted employer provision of health benefits and changes to

Medicare reimbursement approaches, such as paying hospitals fixed payments per admission based on the diagnosis, have spurred efficiency in the health care system. At times, however, longstanding federal policies have become barriers to change; these need to be adjusted to facilitate improvements in health care delivery and to eliminate counterproductive incentives.

Beyond Medicare and the tax code, many other policy areas need attention in order to facilitate an improved national health care system that yields better and higher-quality outcomes at a lower cost. With that in mind, we present two additional sections of federal policy interventions that are critical to achieving these goals. The first focuses on policies designed to be driven at the federal level (though certainly implemented locally), and the second set is focused on federal incentives and interventions needed to influence action at the state level. These policies address numerous areas, including: development and use of meaningful quality measures, better application of preventive services, a greater focus on transparency, the need to advance medical liability reform, the imperative to maximize the capability of the health care workforce, and the importance of better integrating acute and long-term care services for beneficiaries enrolled in both Medicare and Medicaid. Truly system-wide reform must be a collaborative effort that engages federal, state, community, and private-sector leaders across all sectors of the health care system.

ESTIMATES OF FEDERAL BUDGET SAVINGS

Many of our recommendations to address the drivers of health care cost growth have implications for the federal budget. Some have publicly available budget estimates from respected organizations, including CBO and MedPAC. BPC commissioned Acumen, LLC, to model and develop federal budget estimates for our proposed Medicare policies and commissioned MIT economist Jon Gruber to model and estimate the revenue impacts of our proposal to reform the tax exclusion for employer-provided insurance. As of the initial release of this report, not all of our policy proposals have been modeled. Taken together, our proposals with completed estimates are projected to result in approximately **$560 billion** in deficit reduction over ten years, including the cost of a fix to the SGR physician payment formula. Of this, our Medicare proposals are estimated to save roughly $298 billion over ten years and $1.25 trillion over 20 years.

Medicare's Role in System-Wide Payment Reform and Delivery System Improvement

The dominant fee-for-service payment system, and its impact on how care is organized and delivered, is the most significant barrier to achieving this vision of improved, coordinated care, greater value, and better outcomes. Medicare, historically a forerunner in establishing payment policies for the entire sector, provides both the best opportunity and a critical mass to change the current payment system. And many payers are looking to Medicare for leadership in developing promising new payment methodologies requiring extensive data analysis, such as bundles that incorporate a variety of inpatient and post-acute care

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services into one payment for an episode of care, which would encourage coordination and high-value care.

Medicare can—and we believe should—lead the development of a stronger health care delivery system with better quality, higher value, and an improved patient experience for all Americans. Private payers who wish to move away from fee-for-service payment find such a shift to be challenging without Medicare, the largest and most-respected payer, leading the way—or at least heading in the same direction. Similarly, providers are reluctant to invest the resources necessary to transition to quality- and value-based payment structures unless a critical mass of their practices' revenue is derived from these structures. Medicare's participation is therefore becoming increasingly critical for progress on this front, especially as the program's enrollment swells over the next two decades with 78 million baby boomers gaining eligibility.[13]

ACA and Fee-For-Service

The Patient Protection and Affordable Care Act (ACA) includes a variety of demonstrations and voluntary programs to test alternative provider payment systems. While these are important and necessary efforts, the ACA by itself is not sufficient to put Medicare and the health care system on a sustained course away from fee-for-service reimbursement. To contain costs and improve the quality of care across the entire health care system, further action is necessary.

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Chapter 1: Improve and Enhance Medicare to Incent Quality and Care Coordination

Overview: Preserve Traditional Medicare, Make Improvements, and Accelerate Payment Reform

Since Medicare began serving beneficiaries more than 40 years ago, it has kept its promise of providing access to health care for millions of seniors and people with disabilities. The Medicare guarantee—of a health care benefit designed to mitigate the risk of loss of financial security due to health care costs—must be preserved for future generations. The hallmarks of traditional Medicare—beneficiary choice and access to a wide spectrum of providers—also can and should be maintained.

While preserving these critical elements, Medicare must make some fundamental changes to improve quality of care and address excessive cost trends. For traditional Medicare, we propose to accelerate the shift away from fee-for-service payment toward new, value-based payment models. The significant regional variation in per-beneficiary Medicare spending is well-established, and only a portion of this variation is explained by the health status of beneficiaries. A recent report from the IOM showed that, even within regions, there is substantial disparity in spending among sub-regions, all the way down to physician group practices.[14] To address variation in cost and quality, IOM stated that "payment reforms need to create incentives to encourage behavioral change at the locus of care (provider and patient), and thus payment should target decision-making units."[15]

OUR APPROACH TO PAYMENT REFORM IN MEDICARE

The ACOs created as part of the Medicare Shared Savings Program (MSSP) represent a helpful start toward meaningful payment reform, as they align with previous efforts in the private sector and have already attracted substantial interest from providers. However, we believe that they need critical improvements to be successful and sustainable, including much stronger incentives for providers to participate and better tools to engage patients in their care. Other payment reforms, such as bundles that include inpatient and post-acute care, should be accelerated as well.

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At the same time, the 1960s-era traditional Medicare benefit design should be modernized to provide beneficiaries with new protections, reduce the need for supplemental insurance as well as its impact on program costs, and strengthen support for low-income seniors and people with disabilities. These proposals would complement payment reform by encouraging beneficiaries to have greater involvement in health care decisions.

Medicare Advantage has achieved some of the goals of payment reform by creating entities that are accountable, at least at the payer level, for cost and quality. However, in most cases, Medicare Advantage has not generated savings for taxpayers. We propose to phase in a new payment system for Medicare Advantage Plans, replacing the administratively set payments to plans with a payment set through competitive bidding, modeled after Medicare Part D prescription drug coverage. Additionally, we offer proposals to improve risk adjustment and promote integration between Medicare Advantage and Part D drug coverage.

With our proposed reforms combined, we envision three Medicare options for beneficiaries and providers: two within traditional Medicare—the existing fee-for-service system and a significantly reformed version of ACOs that we call "Medicare Networks," as well as a more competitively designed Medicare Advantage. To encourage organized systems of care that are accountable for quality and cost, there would be incentives for providers and beneficiaries to transition away from fee-for-service and toward Medicare Networks or Medicare Advantage.

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Figure 1. Our Approach: Three Medicare Choices for Beneficiaries and Providers

Beneficiaries: Each year, beneficiaries may select one of three Medicare options with a strengthened benefit and increased low-income assistance

TRADITIONAL MEDICARE		MEDICARE ADVANTAGE
Fee-For-Service	**Medicare Networks**	**Medicare Advantage Plans**
Guaranteed and strengthened benefit Constrained updates for providers Protections for rural areas	Guaranteed and strengthened benefit Provider-led Better care coordination Providers accountable for cost and quality Savings shared with beneficiaries, providers, and taxpayers	Guaranteed and strengthened benefit Plan-led Competitively priced Improved risk adjustment Savings for taxpayers and beneficiaries

Providers: Could participate with any or all Medicare options

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SUMMARY OF MEDICARE RECOMMENDATIONS

A. Preserve and Improve Medicare Care Delivery and Payment Systems:

1. Promote quality and value through an improved version of ACOs that encourages providers to meet the full spectrum of their patients' needs. In doing so, replace the SGR formula for physician reimbursement and offer all Medicare providers strong financial incentives to participate in new payment models.

2. Improve Medicare Advantage with competitive pricing as well as better risk adjustment.

Budget savings: **$315.6 billion (FY2014–2023) Gross savings**
-$138.0 billion (FY2014–2023) Cost of SGR fix
$177.6 billion (FY2014–2023) Net savings

3. Expand payment bundles to increase coordination of care and facilitate the adoption of broader payment and delivery system reform.

Budget savings: **$8.2 billion (FY2014-2023)**

4. Introduce a new, carefully designed fallback spending limit that would promote accountability for cost, quality, and patient satisfaction.

B. Strengthen and Modernize the Medicare Benefit:

Strengthen and modernize the Medicare benefit, protecting beneficiaries against catastrophic costs, increasing support for low-income seniors, and reducing subsidies to high-income beneficiaries.

Budget savings: **$53.1 billion (FY2014–2023)**

C. Make Medicare and Related System Reforms that Improve Care and Lower Cost Growth

1. Expand competitive Medicare pricing for certain goods and services.
2. Ensure that payment differences across sites of care reflect actual differences in cost.
3. Reform the quality bonus payments to Medicare Advantage Plans.
4. Encourage the use of high-quality, low-cost drugs in Medicare and system-wide.
5. Limit the in-office exception to the physician self-referral law.
6. Enhance graduate medical education.
7. Assure health IT investments support electronic information sharing to meet the needs of new delivery and payment models.

A. Preserve and Improve Medicare Care Delivery and Payment Systems

1. PROMOTE QUALITY AND VALUE THROUGH AN IMPROVED VERSION OF ACCOUNTABLE CARE ORGANIZATIONS: "MEDICARE NETWORKS"

The Challenge: The prevalent fee-for-service reimbursement model in traditional Medicare is a major barrier to improvements in cost and quality and is increasingly an impediment to private-sector efforts at payment reform. Initial payment reform endeavors are promising but lack important tools and need broader adoption to bend the cost curve.

Our Approach: Accelerate the transition to value-based payment models by creating an enhanced version of ACOs, called "Medicare Networks," which would feature an enrollment model and stronger incentives for beneficiaries and providers to participate.

To facilitate payment for high-value, coordinated care, we propose the creation of Medicare Networks, a new approach within traditional Medicare that reforms the current payment model and encourages patient-centric, accountable care. Medicare Networks would be a substantially reformed version of the existing ACOs. These networks would help providers work together to improve care for patients while taking responsibility for cost and quality. This section will explain Medicare Networks, how they would be different from the existing MSSP ACOs, how the networks would compare with Medicare Advantage, how they would be formed, and how they would affect beneficiaries.

How Medicare Networks Would Work

Medicare Networks would be formed by a group of providers who want to work together to deliver care. A network could include, for instance, small physician practices, large multispecialty physician groups, and hospitals. It might also include other providers, such as post-acute care facilities or mental/behavioral health providers. Each Medicare Network would have an internal governance process, such as a board of directors elected by the member providers. Each network would also agree on how to work together, how to share any savings, and how to distribute any losses.

Finally, every network would enter into a contract with the CMS. As part of this contract, each network would have a unique spending target. Networks could be paid entirely through the Medicare Fee Schedules or accept partial capitation, in which networks would receive a combination of a fixed per-beneficiary payment plus some payment through the fee schedules. For any given year, if actual spending is below the target and quality goals are met, the network would share in some of the savings.[ii] Networks that spend more than the

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[ii] Medicare Networks would share in 60 percent of savings once they meet the minimum savings rate (achieving a spending reduction of at least 2 percent compared to the target). Maximum shared savings is capped at 15 percent of the target.

target would be required to absorb some of the overage.[iii] Medicare Networks would have substantial flexibility to design processes to improve care.

We anticipate that providers would have one of two kinds of relationships to a Medicare Network. Some providers would be members who would be involved in the governance of the Medicare Network, such as contracting with CMS, determining how to use any shared savings, and other business decisions related to the network. Other providers might choose to contract with one or more Medicare Networks to provide services for their enrollees, but would not be a member involved in the network governance. While we assume that Medicare networks must be governed by providers, nothing in our policy would preclude providers from contracting with health plans to perform administrative services.

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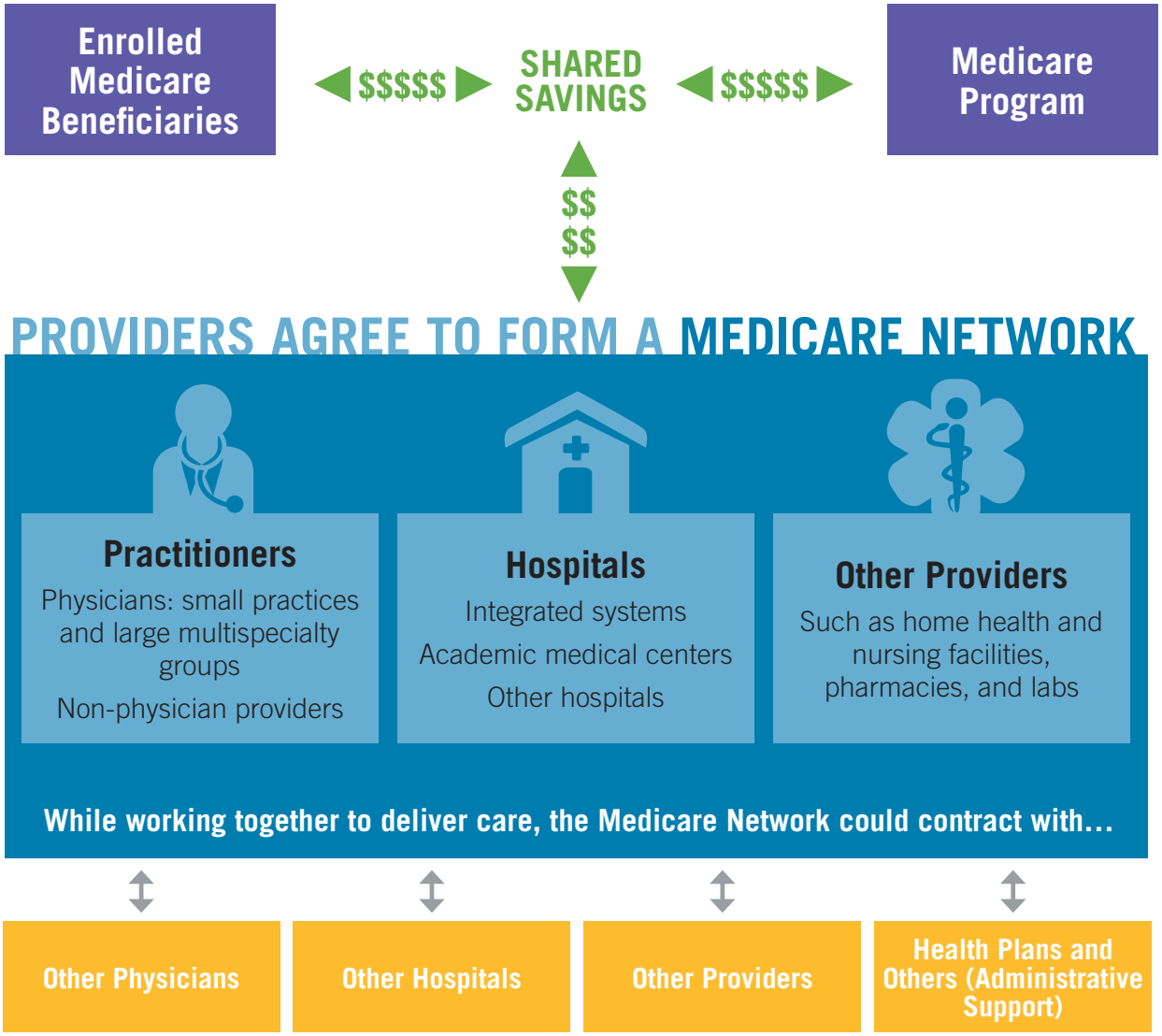
[iii] Medicare Networks would pay shared losses if their average per-beneficiary Medicare spending rises 2 percent above the target during the performance year. Shared losses cannot exceed a rate of 60 percent and are capped at 10 percent of the target.

Figure 2. An Illustrative Example of a Medicare Network



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Beneficiaries and providers could choose to participate in this new option or remain with the original, fee-for-service component of traditional Medicare. As part of traditional Medicare, Medicare Networks would have its hallmarks, including a defined benefit that beneficiaries can count on and access to all Medicare providers, but the networks would also contain the following improvements:

- Provider compensation would be based, in part, on quality, value, and patient satisfaction;
- Providers would have more freedom to adopt innovative care models, which could include services not previously reimbursed by Medicare, such as enhanced primary care, patient education, and broader care coordination;
- Strong collaborative relationships among providers would be facilitated in a variety of arrangements—providers need not merge with or be employed by larger organizations; and
- Member providers who meet quality and financial goals would share in savings from improved efficiency.

Medicare Networks and Providers

- Medicare Networks would be formed by providers who want to work together to deliver care for patients.
- Beginning in 2017, full payment updates would be reserved for providers who participate in Medicare Networks.
- Initially, each Medicare Network would have a unique spending target based on the historical spending of enrolled beneficiaries; over time, spending targets would transition to become regional and risk-adjusted.
- Networks that meet quality goals may share in any savings, while networks that overspend their target would be required to absorb a portion of the overage.

Spending Target

Initially, each Medicare Network would have a spending target based on the historical costs of the network's enrolled beneficiaries, plus a nationwide update to reflect rising program-wide costs since the previous year. At the end of each year, the actual spending of each Medicare Network would be compared with this target. If the network generated savings compared with the target and met goals for quality outcomes and patient satisfaction, providers in the network would share in a portion of the savings. If actual costs exceed the target, providers would share in a portion of the losses.

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Higher Payments for Providers within Medicare Networks

Beginning in 2017, all providers who belong to or contract with Medicare Networks would continue to receive normal updates as set by current law, whereas providers who choose to participate only in the fee-for-service portion of traditional Medicare would have payment rates frozen through 2023, at which point normal current law updates would continue. Any Medicare-covered services delivered in the context of a Medicare Network, whether by a member provider or a contracted provider, would be reimbursed by CMS at the higher (non-frozen) rate.

Providers may choose to form Medicare Networks prior to 2017, but we believe that payment changes for providers who do not participate in these networks should be delayed until that time. This would allow adequate time for the significant transformation in the delivery system that would be inherent in this reform. Also, we recommend that the HHS secretary be given authority to intervene with a purpose of ensuring that providers, especially in underserved, rural, and frontier areas, have the time and tools necessary (including Medicare data), to form Medicare Networks. For example, the HHS secretary could temporarily provide full payment updates after 2017 for rural providers if Medicare Networks are slow to form. Further, we recognize the challenges associated with the delivery of health services to Native American populations, and recommend that the HHS secretary give special attention to the health systems serving them.

Replacement of the SGR Physician Payment Formula

The SGR formula would be repealed. Beginning in 2017, physicians and other Part B providers delivering services to those enrolled in Medicare Networks would receive updates based on the Medicare Economic Index (MEI), a measure of the annual increase in the cost to operate a practice. Other physicians would be protected from payment reductions, but would not receive updates.

Before 2017, physicians who participate in the MSSP or in an organization accepting two-sided risk (sharing in savings and losses) would also receive updates based on the MEI; those in organizations accepting only one-sided risk (only sharing in gains) would receive annual updates equal to one-half of the MEI. All other physicians would be paid at 2013 rates.

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Medicare Networks and Beneficiaries

- Beginning in 2017, traditional Medicare beneficiaries would have the opportunity to enroll in a Medicare Network.[iv]
- Beneficiaries who enroll in a Medicare Network would benefit from greater care coordination, lower premiums, and lower cost-sharing for in-network providers.
- Enrolled beneficiaries could always see out-of-network Medicare providers at a higher cost-sharing rate.
- Beneficiaries could switch to any Medicare option once a year during an open-enrollment period.

Improved Care Coordination for Older Americans and People with Disabilities

Enrollees would experience greater coordination of care, reducing a burden for many patients (and their families), especially those living with complex, chronic conditions. Because providers in Medicare Networks would not be constrained by the barriers that fee-for-service poses to new care models, enrollees would benefit from new services, such as care coordination and patient education, that Medicare Networks could offer in order to improve quality outcomes and efficiency. Additionally, when Medicare Networks exceed quality and patient-satisfaction targets and generate savings, enrolled beneficiaries would share in the savings through lower premiums.

Shared Savings with Beneficiaries

Beneficiaries who enroll in a network would be guaranteed at least a $60 annual discount on their Medicare premium for the first three years, after which point the discount would depend on network performance, as described below. Cost-sharing would be based on the traditional Medicare benefit design (as revised by our proposal described below), with one important difference. Enrollees would benefit from reduced cost-sharing (in the form of lower copayments) for services from providers that are part of their network, but would pay higher cost-sharing to receive service from providers outside of the network. Medicare Networks would be required to meet standards for network adequacy and consumer protection. If a network meets quality goals and generates savings, a portion of the government's share of the savings would be redirected to reduce the monthly premium for enrollees of that network.

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[iv] Before 2017, providers would have the ability to form Medicare Networks, but beneficiaries would be automatically attributed. The enrollment process would begin in 2017, along with the associated benefits for beneficiaries.

Patient Engagement

The option for beneficiaries to choose to enroll in a Medicare Network and take advantage of the coordinated nature of in-network care is a key improvement over the existing MSSP ACOs. In the current MSSP, beneficiaries are attributed, meaning that they are automatically assigned to ACOs based on claims data, and many beneficiaries have no idea that they are part of the program. The current approach expects providers to be held accountable for beneficiary outcomes, but it does not provide beneficiaries with the opportunity to directly engage with a coordinated system of care.

Comparing MSSP ACOs and Medicare Networks

Medicare Networks would replace the current MSSP ACOs, which have been an important start toward the goals of higher-quality and better-coordinated care, but which require strengthening to meet these goals. Similarities between MSSP ACOs and Medicare Networks include:

- Both are formed and led by providers, not health plans.
- Both are part of traditional Medicare with the federal government bearing insurance risk, unlike the fully capitated Medicare Advantage program.
- Both create an environment for providers to collaborate and coordinate care for beneficiaries.
- Both ensure that providers are accountable for the care of a defined group of beneficiaries.
- Both enable providers to share in savings if they meet quality and efficiency targets.
- Both support many different organization types, from an integrated health system to an alliance of independent providers working together under contractual agreements.

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Table 2. Key Differences between MSSP ACOs and Medicare Networks

MSSP ACCOUNTABLE CARE ORGANIZATIONS	MEDICARE NETWORKS
Weak incentives for providers to participate.	Stronger incentives for providers to participate—full payment updates reserved for care delivered within Medicare Networks.
Paid through the Medicare payment schedules, with opportunities for different payment methods limited to demonstrations.	Could be paid entirely through the Medicare payment schedules or could accept partial capitation.
Providers can share in savings without taking any risk (one-sided risk).	Providers would share in both savings and excess cost growth (two-sided risk).
No patient engagement—beneficiaries are automatically "attributed" and have no incentive to access care delivered within the ACO.	Patients would be engaged from the beginning – patients in traditional Medicare could choose to enroll in a Medicare Network and enrollees would pay lower cost-sharing for in-network care, higher cost-sharing for out-of-network care.
Beneficiaries do not share in savings.	For consistently high-performing networks, a portion of the savings would be devoted to a premium rebate for enrollees.

Comparing Medicare Advantage and Medicare Networks

Medicare Advantage is the system of private plans that beneficiaries can choose instead of traditional Medicare. Medicare Advantage Plans are paid on a capitated basis—a fixed payment per member, per month. These plans may use the tools associated with managed care, such as closed networks of providers and prior-approval processes for access to specialists and certain procedures or tests.

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Table 3. Key differences between Medicare Advantage and Medicare Networks

MEDICARE ADVANTAGE PLANS	MEDICARE NETWORKS
Run by health plans or a provider-sponsored organization with an insurance component.	Provider-led (must be governed by a majority of providers).
Fully-capitated payments to plans – not paid through Medicare payment schedules. Maximum flexibility to adopt different payment and delivery approaches, although many plans pay providers on a fee-for-service basis.	Paid through the Medicare payment schedules (as modified by our proposals), but could share in savings and losses, with an opportunity for partial capitation. More flexibility in provider payment and service delivery than fee-for-service outside of a Medicare Network.
Insurance risk – plans take financial risk for services performed by others. Requires sufficient financial reserves and compliance with other insurance regulations.	Performance risk – providers take financial risk for services that they themselves perform.
The standard Medicare benefit is guaranteed. For an additional premium, plans may offer extra benefits, such as dental and vision, in addition to the standard Medicare benefit.	The standard Medicare benefit would be guaranteed. Medicare Networks could offer additional services, such as care coordination and patient education, as part of their efforts to improve quality and efficiency.
Beneficiaries may be restricted to receiving service from plan providers.	Beneficiaries could access any Medicare provider, but would pay higher cost-sharing out-of-network.

Additional Considerations as Medicare Networks are Formed

If coordinated care succeeds in improving the patient experience and quality outcomes—thereby lowering patient costs and saving money for Medicare, while benefiting providers—we expect that, in time, most providers and most beneficiaries in traditional Medicare would choose to participate in a Medicare Network. However, the fee-for-service component of traditional Medicare would remain an option for those who would prefer it. As Medicare Networks form and evolve, special considerations and assistance in certain areas may be necessary, including:

- Assistance for the formation of Medicare Networks in rural areas;
- Ensuring Medicare Networks have access to capital;
- Providing appropriate implementation resources for CMS;
- Allowing Medicare Networks to coordinate and share savings with Part D Prescription Drug Plans; and
- Establishing opportunities for Medicare Networks to adopt progressively advanced payment models.

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Additional recommendations covering these areas, along with detailed specifications, are included in the appendix.

2. IMPROVE MEDICARE ADVANTAGE WITH COMPETITIVE PRICING AND BETTER RISK ADJUSTMENT

The Challenge: Medicare Advantage Plans offer an integrated benefit package that many beneficiaries prefer, but in many cases, these plans have not generated savings for taxpayers.

Our Approach: Transition to competitively bid payments to Medicare Advantage Plans in regions where the new, competitive price would generate savings compared with the old, administratively set price. Continue to improve risk adjustment and address remaining risk-selection through a budget-neutral reinsurance program.

Medicare Advantage, the system of competing, fully capitated, private plans that serve as an alternative to traditional Medicare, is now selected by over a quarter of beneficiaries and is growing in popularity, especially among new Medicare beneficiaries. Medicare Advantage usually offers seniors and people with disabilities comprehensive plans with additional benefits compared with traditional Medicare, including catastrophic coverage (all plans must include an out-of-pocket maximum) and/or lower premiums, often in return for more limited provider networks and greater controls on utilization.

While Medicare Advantage has achieved considerable success, the program has not fulfilled one of its initial purposes, which was to generate federal budget savings that would reduce Medicare's reliance on general tax revenue and improve the health of the Medicare Hospital Insurance Trust Fund. While the ACA reduces payments to Medicare Advantage Plans, these changes leave in place a flawed plan-payment system that fails to guarantee the best prices for beneficiaries and Medicare.

The current Medicare Advantage system sets plan payment levels administratively (at between 95 percent and 115 percent of the cost of traditional Medicare in a county) and encourages plans to compete on extra benefits, such as reduced cost-sharing or lower premiums for Part D drug benefits. Moreover, if a plan can deliver the basic Medicare benefit for a lower cost, that plan keeps 75 percent of the savings—most of which are shared with beneficiaries through extra benefits, reduced cost-sharing, and/or reduced Part B and D premiums—and taxpayers get 25 percent of the savings. Today, plans predominantly compete on the basis of extra benefits, not lowering costs for beneficiaries or taxpayers. Requiring plans, instead, to offer a standardized benefit package for a price that is competitively bid would introduce price competition into the Medicare Advantage system, which would yield lower costs for taxpayers, lower Part B premiums for beneficiaries, and improve the solvency of the Part A trust fund.

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RECOMMENDATION:

Establish a standardized minimum benefit for Medicare Advantage Plans—including all services covered by traditional Medicare, a cost-sharing limit to protect against catastrophic expenses, and slightly lower cost-sharing—and pay plans using a competitive pricing system.

- Medicare Advantage Plans would be required to submit two bids: one under the current, non-competitive system and a second bid for the standardized benefit package under the competitive system.
- The new competitive price would only take effect in regions where there are at least two plans, and where that price is lower than the current law, administratively set payment rate, ensuring that the government would realize savings from this reform.
- In the initial years of the competitive system, plans would bid on a standardized benefit package with a slightly higher actuarial value than traditional Medicare, resulting in lower beneficiary cost-sharing. This method would ensure that enrollees benefit from some of the savings derived from competitive bidding, while minimizing disruption, as many Medicare Advantage Plans currently have far more generous benefits than traditional Medicare. Over time, the actuarial value of the standardized package would phase down until it is equivalent to traditional Medicare.
- Under the competitive system, plans would be paid a benchmark of either the enrollment-weighted average of all plan bids or, if Medicare Advantage enrollment exceeds 40 percent in a particular region, the 35th percentile of bids.
- Medicare Advantage issuers would be required to offer beneficiaries the option of enrolling in a basic plan that only includes the standardized benefit package, which serves as the basis for plan bids.
- If a particular plan bid is below the benchmark, the enrollee would receive a rebate dollar-for-dollar equal to the difference; alternatively, if the plan bid is above the benchmark, the enrollee would pay the difference.
- For an increased premium, Medicare Advantage issuers could continue to offer plan options with additional benefits, such as dental and vision, and/or reduced cost-sharing.

Under this new system, beneficiaries and the government would be sure that they are getting the best price possible, and efficient, high-quality plans would be the most competitive options. An illustrative comparison of bidding under the existing administrative system and our proposed competitive system is included in the Appendix.

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Table 4. Comparing Payments to Medicare Advantage Plans and Medicare Networks

	CURRENT PAYMENTS TO MEDICARE ADVANTAGE PLANS	COMPETITIVELY-BID PAYMENTS TO MEDICARE ADVANTAGE PLANS	PAYMENTS TO MEDICARE NETWORKS
Region	Payments to plans differ based on the county of service.	Payments to plans would differ based on region (metropolitan area or grouping of rural counties).	Spending targets based on historical Medicare spending in a region.
Benchmark payment to plans	Counties are divided into four categories: in highest quartile of FFS spending counties, plans are paid up to 95% of the per-capita Part A and B spending in each county; in lowest quartile of FFS spending regions, plans are paid up to 115% of traditional Medicare.	Plans would enter bids. The benchmark would be either the enrollment weighted-average of plan bids or the 35th percentile of plan bids (if MA enrollment exceeds 40% of beneficiaries in a region). The new benchmark would take effect *only* if it saves money compared with the old benchmark.	Payments to Medicare Networks would not be affected by competitive bidding. Networks would be paid through the Medicare payment schedules, but could share in savings/losses if spending is below/above the target.
Plan design	Not standardized. Price is fixed and plans compete on richness of benefits and cost-sharing.	Standardized. Base level plans with the standard Medicare benefits (including catastrophic protection) would have to be offered. Plans with additional benefits could be offered, but beneficiaries would pay the difference.	Guaranteed traditional Medicare benefit.
Savings for government	Overall, program is more expensive than traditional Medicare.	Substantial savings compared with current law.	Government would share in savings if spending is below target.
Benefits for beneficiaries	Because plans compete on benefits, part of the extra government subsidy (over the cost of traditional Medicare) funds extra benefits and lower cost-sharing.	Some savings resulting from the new competitive bidding system would be directed to beneficiaries to reduce cost-sharing or premiums.	25% of the government's share of savings would be redirected to lower beneficiary premiums.
Risk adjustment and reinsurance	Payments to plans are risk-adjusted. No reinsurance.	Risk adjustment methodology would continue to be improved and a budget-neutral reinsurance system (described below) would be added.	Regional spending target would be risk-adjusted.

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Additional Improvements to Medicare Advantage: Risk Adjustment, Reinsurance, Drug Coverage, and Tiered Networks

Risk adjustment plays an essential role in Medicare Advantage, modifying payments to each plan based on the health status of enrollees. Risk adjustment would also play an essential role in the proposed Medicare Networks, because spending targets would need to be risk-adjusted. The goals of risk adjustment are to provide fair treatment to plans that enroll beneficiaries who are likely to have higher- or lower-than-average costs and to curtail the incentives for plans to attempt to cherry-pick low-cost enrollees through benefit design or marketing.

RECOMMENDATIONS:

1. Incorporate a measure of functional status in Medicare's risk adjustment.

Risk-adjustment methodologies are continuously improving, and Medicare should keep refining its system. In particular, we believe that risk adjustment could be made more accurate by incorporating a measure of functional status, the degree to which a beneficiary has difficulty performing day-to-day living activities. Functional status, which is usually not reflected in the diagnosis and claims data upon which the current risk-adjustment system is based, is an important predictor of health care spending and would significantly improve the CMS risk-adjustment system.[16] The challenge will be to develop a valid measure of functional status that could be reported to CMS.

2. Implement a reinsurance system for Medicare Advantage by 2016.

We believe that Medicare Advantage risk adjustment could be effectively augmented through the implementation of a budget-neutral reinsurance arrangement, in which a portion of payments to plans would originally be withheld, and then distributed to plans when costs for particular enrollees exceed certain thresholds. A similar reinsurance arrangement is used successfully for Medicare Part D Prescription Drug Plans.

3. Require all Medicare Advantage Plans to include prescription drug coverage.

To encourage the development of systems of care that are accountable for all of a beneficiary's health care needs, we recommend that, beginning in 2015, all Medicare Advantage Plans include Part D prescription drug coverage as a required benefit. In particular, this would ensure that plans have appropriate incentives to manage medication therapy and encourage drug adherence, which can lead to better outcomes and lower overall costs.[17] (For more information, see the appendix.)

4. Allow Medicare Advantage Plans to adopt tiered network designs.

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Tiered network health plans include two or more tiers of in-network providers, who are sorted based on quality and cost. Beneficiaries pay lower cost-sharing when receiving services from providers in the preferred tier. This relatively new plan design has become popular in commercial insurance in some areas, such as Massachusetts, and is a promising approach to engage patients in selecting health care providers based on quality and

efficiency. A Medicare Advantage Plan should be able to offer a tiered network design, as long as the plan features an adequate network within the preferred tier and the overall value of the plan's benefit is not reduced.

Improve Open Enrollment

As Medicare has become more complex with more options for beneficiaries—such as Medicare Advantage and Part D Prescription Drug Plans—access to information about options in a clear, understandable, and user-friendly format is increasingly important. Unfortunately, the current Medicare Plan Finder website for comparing plan options is poorly designed, uses confusing terminology, and does not automatically display some of the most important information that beneficiaries seek and need to make coverage decisions. For each coverage option, this tool should prominently display the pricing and benefit information that is most important to beneficiaries, including the cost to visit a doctor. A helpful resource would avoid confusing jargon, such as "out-of-pocket maximum," in favor of plain-language descriptions, such as "the most you would have to pay."

RECOMMENDATION:

Replace the Medicare Plan Finder with a user-friendly, up-to-date Medicare Open Enrollment website that beneficiaries could use to make coverage selections upon enrollment and during the annual open-enrollment period.

This redesigned website should allow users to quickly and easily compare and enroll in all traditional Medicare options (including existing fee-for-service and proposed Medicare Networks), as well as Medicare Advantage and Part D Prescription Drug Plans. The tool should easily display all coverage options in which a beneficiary's primary care provider participates, including Medicare Advantage Plans and Medicare Networks. It should compare premium costs apples-to-apples, including the cost of supplemental insurance (medigap) and Part D Prescription Drug Plans for traditional Medicare beneficiaries. Investment in an improved Medicare Open Enrollment process would help to ensure that beneficiaries have the information they need to make educated enrollment choices.

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Figure 3. Our Approach: Key Elements of Three Medicare Options

	TRADITIONAL MEDICARE		MEDICARE ADVANTAGE
	Fee-For-Service	**Medicare Networks**	**Medicare Advantage**
Organized by	Not organized	Providers	Health plans
Medicare Beneficiaries	Remains an option	May choose to enroll Lower premiums Lower in-network cost-sharing	May choose to enroll May offer extra benefits, lower premiums Some savings from competitive bidding dedicated to lower cost-sharing
Quality	Limited incentives for quality (e.g. value based payment, readmission penalties)	Quality goals must be met in order to share in savings Quality information is shared with beneficiaries before enrollment	Temporary quality bonus payments Quality information is shared with beneficiaries before enrollment
Participating Providers	Remains an option Constrained updates (including SGR fix)	Higher updates (including SGR fix) Ability to share in savings Flexibility to adopt new care models	Negotiated between provider and plan May include higher payments, different payment methods, network exclusivity
Payment	Claims paid by the Medicare program	Claims paid by the Medicare program, but with shared savings and shared risk. Replaces MSSP Accountable Care Organizations Opportunity for partial capitation Transition from historical spending target to regional target Risk-adjusted	Full capitation for covered benefits Payments set by regional competitive bidding Risk-adjusted
Integration with Part D Prescription Drug Coverage	Not integrated, same as current law	May designate preferred Part D plans	All plans required to include drug coverage
Budget Limitation	Enforced through cuts to provider rates and increases to beneficiary premiums	Enforced by limiting growth of the spending target	Enforced by limiting growth of the benchmark payment

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3. INTRODUCE PAYMENT BUNDLES: A STEP TOWARD BETTER COORDINATION

The Challenge: For episodes of care that include inpatient, physician, and rehabilitation services, the fee-for-service payment system discourages coordination and promotes inefficiency. Post-acute care is the largest source of variation in Medicare spending across regions, in part because no party is accountable for spending and outcomes for an overall episode.

Our Approach: Expand the current, voluntary payment bundling demonstration into a standard Medicare payment method.

Payment bundles, which group together in one payment all health services related to an episode of care, are an important first step toward payment models that reward coordinated, high-value care. Bundles around an acute inpatient admission are currently the subject of a Center for Medicare and Medicaid Innovation (CMMI) demonstration. We believe that further refinement and expansion of this payment approach would lead to improved quality of care and lower costs, because bundles would establish provider accountability in areas where there is unacceptable variation in cost and quality.

Post-acute care is an area that has great potential for improved coordination and value. Traditionally, hospitals and post-acute care providers (i.e., skilled nursing facilities, home health, long-term acute care hospitals, and inpatient rehabilitation facilities) have existed as independent silos with very little or no coordination. Hospitals often have no information about what happens to their patients post-discharge. The wide variation in cost and quality outcomes from post-acute care is not acceptable, and substantial improvement in this area should be a priority for Medicare and the health care system as a whole.[18] Placing responsibility for the later stages of care at the inpatient level has the potential to yield substantial improvements in post-acute care quality and value.[v]

Implementation

Payment bundles are a natural evolution of Medicare payment approaches; the payment systems that Medicare currently uses to reimburse hospitals are actually narrower versions of bundling that cover services exclusive to the inpatient setting. Implementation of a successful payment bundling expansion would require an initial investment of resources in CMS to develop systems to monitor bundles and give providers the information that they need to coordinate care for patients. This investment would pay dividends beyond Medicare; many private payers would like to adopt payment bundles more broadly, but lack the data resources and technical capacity to develop the bundles and the information systems necessary for their success.

EMBARGOED

[v] An administration proposal to reform payment for post-acute care using payment bundles is estimated to save $8.2 billion over 10 years.

RECOMMENDATION:

Expand the voluntary payment bundling demonstration into a standard Medicare payment method. Bundles—including inpatient, physician, post-acute care, and any readmissions within 90 days—should be established nationwide no later than 2018 for certain diagnosis-related groups (DRGs).

- Implement expanded bundles through a withholding approach: a portion of all provider payments related to the covered diagnoses would be held back.
- Providers could earn back the withheld amount (and possibly a bonus) by keeping spending below the bundle payment rate and meeting quality standards. (See the appendix of this report for full specifications, including a transition to nationwide payment rates.)
- The HHS Secretary should select suitable DRGs for which bundled payment will be implemented nationally. These should have large Medicare spending, be relatively homogeneous in patients' medical needs, and have substantial variation from hospital to hospital in rates of readmission and spending for physician services and post-acute care.

4. INTRODUCE FALLBACK SPENDING LIMIT

The Challenge: A spending limit for Medicare should not be the main driver of cost containment, but may be necessary to protect against unforeseen circumstances, such as imperfect competition in certain areas or extraordinary volume growth in fee-for-service.

Our Approach: Establish a fallback spending limit that is enforced separately on fee-for-service Medicare, Medicare Networks, and Medicare Advantage, ensuring that providers and plans are held accountable for spending that is within their control.

We expect that the traditional Medicare and Medicare Advantage reforms that we propose would accelerate Medicare—and indeed health insurance more broadly—toward a system with the incentives and capabilities necessary to slow the rate of cost growth. These reforms should be allowed time to play out without immediate expectations for a certain level of savings. However, we also believe that as a backstop to our proposed reforms, a new, carefully designed spending limit would establish a clear, minimum goal for reducing federal health care cost growth. This new limit would be triggered by per-beneficiary spending growth (adjusted for age) that exceeds GDP per-capita growth + 0.5 percentage points, and would apply separately to all three program options. For example, if Medicare Advantage payments for a region were growing faster than the limit, but fee-for-service and Medicare Network spending was not, only Medicare Advantage Plans in the region would be impacted by the spending limit.

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RECOMMENDATION:

No earlier than 2020, implement a fallback spending limit that would restrain annual standardized (age-adjusted) per-beneficiary spending growth to a target of nominal GDP per-capita growth + 0.5 percentage points (over a five-year moving average), and apply separately to fee-for-service, Medicare Networks, and Medicare Advantage.

Importantly, the proposed spending growth limit is per *standardized* beneficiary, meaning that it is age-adjusted to limit the influence of Medicare's changing demographics as the baby boom generation ages into the program.

Table 5. Proposed Spending Limit Formulas

FEE-FOR-SERVICE MEDICARE	MEDICARE NETWORKS	MEDICARE ADVANTAGE
75% of spending over target would be recovered through uniform reductions in FFS payment rates, and 25% would be recovered through Part B premium increases for traditional Medicare beneficiaries who remain in FFS and are not enrolled in a Medicare Network.	Each Medicare Network's spending target could not increase annually by more than the spending limit, before risk adjustment.	The benchmark federal contribution to fully-capitated plans could not increase annually by more than the spending limit.

B. Strengthen and Modernize the Medicare Benefit

The Challenge: The Medicare benefit package is out-of-date and fails to provide adequate protections for enrolled seniors and people with disabilities. Largely for this reason, roughly 90 percent of Medicare beneficiaries have some source of supplemental insurance to fill in coverage gaps. At the same time, assistance for low-income beneficiaries is inadequate.

Our Approach:

1. Improve, simplify, and modernize the basic traditional Medicare benefit package, providing predictable cost-sharing for beneficiaries;
2. Reform supplemental coverage to minimize cost-shifting from private plans to Medicare and to reduce beneficiary premiums;
3. Increase and improve support for low-income Medicare beneficiaries; and
4. Reduce subsidies to higher-income Medicare beneficiaries.

EMBARGOED

Addressing these issues will require providing beneficiaries with important additional benefits that they do not currently have, including protection from catastrophic medical expenses, the ability to see a doctor for a copayment before meeting a deductible, and replacement of a confusing, multiple-deductible system with a single, annual deductible. These improvements would reduce the need that many perceive for supplemental coverage. Greater protection and assistance must also be provided for low-income beneficiaries. Additional goals that these changes would fulfill include reducing overall costs for beneficiaries, producing budget savings for the federal government, adopting a modern insurance design that gives beneficiaries as well as providers a stake in appropriate utilization, and reducing cost-shifting from supplemental insurance plans to taxpayers and those beneficiaries who do not have such coverage.

1. IMPROVE, SIMPLIFY, AND MODERNIZE THE BASIC MEDICARE BENEFIT

Medicare's benefit structure reflects the cutting edge of private health insurance from 50 years ago and has not kept up with modern benefit design. In many areas, the design has become obsolete. For example, a large hospital deductible ($1,184 in 2013) is assessed for each spell of illness—meaning that beneficiaries risk having to pay the full deductible multiple times per year. In addition, a separate, non-hospital deductible ($147 in 2013) applies to Part B services, which must be met before Medicare starts paying for covered services. Without supplemental coverage, seniors and people with disabilities are exposed to the full cost of a physician visit until they meet the separate Part B deductible.

Most importantly, unlike almost all private insurance, Medicare fails to provide protection against the costs of catastrophic illness. Patient cost-sharing is also uneven, with very high deductibles for inpatient care and no cost-sharing at all for home health and laboratory services. One positive aspect of the current benefit design, which we would retain, is the availability of preventive services, including an annual wellness visit, cancer screenings, flu shots, and more, all with no beneficiary cost-sharing.

A simpler and more up-to-date benefit structure would:

- Provide financial protection from the costs of a catastrophic illness. The current Medicare benefit provides *no limit* on the amount that a beneficiary can be liable for in a given year.
- Allow beneficiaries to see a doctor for a copayment only, even before the deductible is met. This is in line with most private insurance benefit designs.
- Reduce the need for supplemental coverage. With a modernized Medicare benefit design that caps a beneficiary's annual out-of-pocket expenses and does not require patients to pay the full cost of physician visits, some beneficiaries would be able to save money by forgoing the purchase of a supplemental insurance policy.

EMBARGOED

Importantly, this reform would not change beneficiary cost-sharing in the aggregate. In order to provide the essential protections described above and a more rational benefit,

some beneficiaries would pay more in cost-sharing while others would pay less in any given year.

RECOMMENDATION:

In 2016, implement a new traditional Medicare benefit structure for Parts A and B that would:

- Maintain the same aggregate cost-sharing for beneficiaries as today;
- Provide beneficiaries with protection from catastrophic medical costs by establishing an annual, beneficiary cost-sharing limit of $5,315 for Medicare-covered services (all additional covered services would be at no-charge to the beneficiary);
- Replace the two existing deductibles with a single, combined (Parts A and B) annual deductible of $500;
- Replace coinsurance on most covered services with copayments similar to those proffered by MedPAC (as shown in Table 6, below):[19]

Table 6. MedPAC illustrative copay/coinsurance rates

MEDICARE SERVICE	COPAY/COINSURANCE
Hospital (per stay)	$750
Physician—Primary Care / Specialist (per visit)	$20 / $40
Part B drugs	20%
Advanced imaging (per study)	$100
Skilled nursing facility (per day)	$80
Durable medical equipment	20%
Hospice	0%
Home health (per episode)	$150

- Maintain preventive care and the annual wellness visit with no beneficiary cost-sharing; and
- Exempt physician office visits from the combined deductible.[vi] (Beneficiaries would only pay the copayment for an office visit, even if the deductible has not yet been met.)

EMBARGOED

[vi] The MedPAC benefit redesign specifications included a $5,000 annual beneficiary cost-sharing limit, but did not allow physician visits for a copayment before meeting the deductible. According to a BPC-commissioned analysis by Acumen, if physician office visits are allowed for a copayment before the deductible is met, the actuarial value of the benefit design would remain the same if the annual beneficiary cost-sharing limit were increased to $5,315.

Figure 4. Examples of Beneficiary Cost-Sharing: Today vs. Proposed Reform

Scenario	A beneficiary visits her doctor about headaches. She has not met her deductible.	A beneficiary develops a condition that requires long stays in a hospital and a skilled nursing facility.	A beneficiary sees a doctor and receives an MRI for lower back pain. He has not met his deductible.
Cost today	**$73**	**$17,464**	**$210**
Explanation of today's cost	Beneficiaries currently pay the entire cost of an office visit before meeting the Part B deductible.	Medicare currently has very high cost-sharing for long hospital and skilled nursing stays. There is also has no out-of-pocket maximum.	After meeting the Part B deductible, beneficiaries currently pay coinsurance for advanced imaging.
Cost after Reform	**$20**	**$4,750**	**$407**
Explanation of post-BPC reform cost	Office visits would be a flat $20 copay, even if the deductible is not yet met.	Per-day hospital copayments for long stays would be replaced with one copay per admission. Additionally, the skilled nursing copay would be lower.	Because the new combined deductible would be higher than the old Part B deductible, a beneficiary who has not met the deductible would pay more of the cost for advanced imaging.

Note: The post-reform amounts would be lower for a beneficiary who qualifies for expanded low-income cost-sharing assistance, described in the next section of this report.

Source: Medicare fee-schedule payments from Codemap.com for CPT Codes 99213 and 72148, BPC calculations.

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2. REFORM SUPPLEMENTAL COVERAGE TO MINIMIZE COST-SHIFTING FROM PRIVATE PLANS TO MEDICARE AND TO REDUCE BENEFICIARY PREMIUMS

(FY2014–2023 Budget Savings: $61.6 Billion)

Most Medicare beneficiaries (90 percent) have some form of supplemental coverage to help cover their cost-sharing and protect them from the costs of catastrophic illness.[20] However, many studies have found that supplemental coverage leads to increased use of services without necessarily producing better outcomes, thereby shifting costs to taxpayers and other Medicare beneficiaries.[21] The market for individually purchased supplemental coverage (medigap) plans is highly concentrated—two issuers control three-quarters of it—raising concerns about adequacy of competition.[22] Additionally, the minimum medical loss ratio (MLR), the percentage of premiums that must be used for health care claims, for medigap is 65 percent, compared with an 80 percent MLR for individual health insurance coverage.

Supplementing Medicare is very expensive. Modernizing and strengthening the Medicare benefit package, as we recommend—including a new beneficiary out-of-pocket limit, lower costs for early year physician visits, and other improvements—would make such supplemental policies less necessary and enable beneficiaries to forgo an expensive product.

First-Dollar Coverage and Health Care Spending

Supplemental insurance serves an important purpose, but has a harmful side effect. Just like fee-for-service provider incentives, policies that cover all of a beneficiary's cost-sharing have been shown to encourage unnecessary, redundant, and even harmful care. According to a study commissioned by MedPAC in 2009, "total Medicare spending was 33 percent higher for beneficiaries with medigap policies than for those with no supplemental coverage after controlling for demographics, income, education, and health status. Beneficiaries with employer-sponsored [supplemental] coverage had 17 percent higher Medicare spending, and those with both types of secondary coverage had 25 percent higher spending."[23] As a consequence, the government, taxpayers, and other Medicare beneficiaries are effectively subsidizing the private insurers who offer medigap plans, those individuals who buy medigap plans, and employers who offer supplemental policies to retirees even above the already-favorable tax treatment of employer-sponsored retiree coverage. Because first-dollar supplemental coverage, whether individually purchased or employer-provided, results in higher Medicare costs, policies to address this cost-shift should apply equally to all sources of supplemental coverage.

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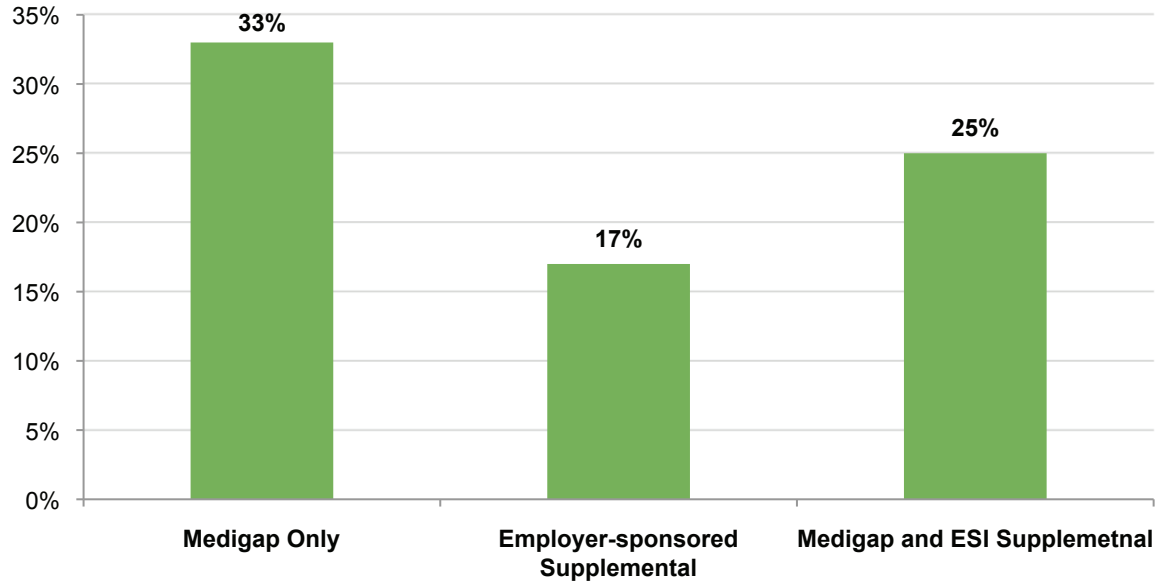
Chart 3. Percentage Increased Medicare Spending Compared with Beneficiaries Without Supplemental Coverage



Source: MedPAC

Medigap Plans Unnecessarily Increase Part B Premiums

Increased spending associated with medigap plans and overuse of unnecessary and even harmful care raises everyone's Medicare premiums (because premiums are calculated as a percentage of total Part B costs) and increases federal outlays. Restricting first-dollar coverage, combined with a modernized Medicare benefit package, would reduce costs for the large majority of medigap enrollees, as their lower premiums would outstrip any increased cost-sharing. The Kaiser Family Foundation estimates that approximately 80 percent of medigap enrollees would see a cost reduction under reforms similar to our recommendation, even without our increased cost-sharing assistance for low-income beneficiaries (proposed below).[24]

RECOMMENDATION:

To lower costs for Medicare beneficiaries and encourage more appropriate utilization of care, beginning in 2016, all supplemental coverage from medigap plans and employer-provided plans (including Tricare-for-Life and the Federal Employees Health Benefits Program) should:

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- Include a deductible of at least $250;
- Include an out-of-pocket maximum no lower than $2,500 (out of the beneficiary's pocket); and
- Cover no more than half of beneficiary copayments and coinsurance.

As in the past, the National Association of Insurance Commissioners should be asked to develop standardized designs for medigap plans that would meet the new requirements. A medigap policyholder would be allowed to switch into any of the new plan designs offered by their insurer for 2016.

Impact on and Protections for Beneficiaries

Importantly, as part of our proposed benefit modernization, beneficiaries would also receive an improved standard Medicare benefit package that includes, for the first time ever, a cap on total annual out-of-pocket expenses and access to physicians for a copayment only, even before reaching the deductible. We also recognize that it would not be appropriate to expect low-income beneficiaries to pay the same cost-sharing as middle-income seniors. Lower-income seniors and people with disabilities, as described below, would therefore receive substantially greater assistance with premiums and cost-sharing, leaving those individuals as well or better off than they are today.

Supplemental Coverage and Medicare Networks

Limitations on supplemental coverage are essential to the goals of our proposed Medicare Networks—namely, provider accountability and patient engagement. First-dollar supplemental coverage eliminates incentives for beneficiaries to use more efficient providers, making it nearly impossible to hold a network of providers responsible for the care of a group of beneficiaries.

3. INCREASE AND IMPROVE SUPPORT FOR LOW-INCOME MEDICARE BENEFICIARIES
(FY2014–2023 Cost: $74.8 Billion)

Currently, certain low-income Medicare beneficiaries are eligible to receive assistance with premiums and cost-sharing for hospital and physician services through the Medicaid program, administered by the states and jointly financed by states and the federal government. Extra help is not only provided for beneficiaries who are eligible for full Medicaid benefits (which include dental and long-term care), who generally have incomes well below the federal poverty level (FPL), but is also available for those enrolled in the Medicare Savings Programs (MSPs), which assist beneficiaries earning up to 135 percent of the FPL.[25] This additional coverage helps approximately nine million people with Medicare premiums and, for those with incomes below the poverty level, physician and hospital cost-sharing, including deductibles, copayments, and coinsurance.

With the introduction of Medicare Part D in 2006, the federal government (with a financial contribution from states) also began providing assistance to help low-income beneficiaries with their premiums and cost-sharing for prescription drug coverage. This new Part D Low-Income Subsidy (LIS) is available to all full Medicaid and MSP beneficiaries and also to additional seniors and people with disabilities, as eligibility extends to those with incomes up to 150 percent of the FPL, depending on assets.

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Eligibility for different levels of support is predominantly based on a beneficiary's income and assets; thresholds vary across the nation because states are allowed to ease (but not tighten) eligibility requirements.

Table 7. Current Assistance with Premiums and Cost-Sharing available for Low-Income Medicare Beneficiaries through Medicaid, the Medicare Savings Programs, and the Part D Low-Income Subsidy

INCOME LEVEL	ASSISTANCE FOR PARTS A AND B	ASSISTANCE FOR PART D
<100% of FPL	100% of premiums and cost-sharing.	100% of premium and standard deductible; reduced copayments.
100-135% of FPL	100% of Part B premium. No assistance with cost-sharing.	100% of premium and standard deductible; reduced copayments
135-150% of FPL	No assistance with premiums or cost-sharing.	Sliding scale: 75% to 25% of premium, reduced deductible and coinsurance.

Note: Assistance may be subject to various asset tests. Additionally, enrollment in the Qualified Individual (QI) program, which assists beneficiaries between 120 percent and 135 percent of the FPL with Part B premiums, is limited by annual federal appropriations, and applications are only accepted on a first-come, first-serve basis.

Limited Help for Beneficiaries with Incomes Just Above Poverty

Cost-sharing is a substantial expense, averaging $1,679 per beneficiary per year for Parts A and B in 2010.[26] While most seniors and people with disabilities with incomes below the poverty level qualify for assistance that covers 100 percent of their non-drug cost-sharing liability—including deductibles, copayments, and coinsurance—there is no physician or hospital cost-sharing help available for beneficiaries with incomes that are near-poverty. Unless these low-income seniors and people with disabilities have access to supplemental coverage, they are left to pay (what is often substantial) cost-sharing on their own modest incomes. This is a significant gap in the safety-net—one that also complicates efforts to reform Medicare's benefit design and limit first-dollar supplemental coverage due to legitimate concerns about the potential impact on beneficiaries with incomes just above the poverty level who do not currently qualify for any cost-sharing assistance.

RECOMMENDATION:

Expand cost-sharing assistance to Medicare beneficiaries with incomes up to 150 percent of the federal poverty level beginning in 2016.

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This proposal would help more than seven million low-income beneficiaries with Medicare's cost-sharing for physician and hospital services. Under this new, federally funded assistance:

- 50 percent of cost-sharing (including deductibles, copayments, and coinsurance) would be covered for Medicare beneficiaries with incomes between 100 percent and 135 percent of the FPL; and
- 25 percent of cost-sharing would be covered for beneficiaries with incomes between 135 percent and 150 percent of the FPL.

Eligibility would be automatically determined by the Social Security Administration based on an individual's modified adjusted gross income (MAGI). There would be no asset tests for this new assistance, enabling automatic enrollment.

Improve Access to Existing Programs for Low-Income Beneficiaries

Despite their promise, the existing low-income support programs for those who are not poor enough to qualify for full Medicaid—the Medicare Savings Programs and the Part D LIS—are not used by many who would qualify. Enrollment in the MSPs for beneficiaries above the poverty level is particularly low. Many eligible seniors are not aware that they qualify for these programs, and a complex application process may serve as a barrier, especially in states that continue to require applicants to demonstrate that they do not have assets over a certain amount. State and federal policymakers should work to ease or eliminate such asset tests for the existing Medicare Savings Programs and Part D LIS, while promoting the availability of these programs to low-income seniors and people with disabilities through new avenues, such as an improved Medicare Open Enrollment website.

4. REDUCE SUBSIDIES TO HIGHER-INCOME MEDICARE BENEFICIARIES (FY2014–2023 Budget Savings: $66.3 Billion)

Since the launch of Medicare in 1966, Part B coverage of physician services has been financed by a combination of beneficiary premiums and general tax revenue. Initially, all beneficiaries paid premiums equal to half of the Part B program costs. Today, most seniors and people with disabilities who are enrolled in Part B pay a premium equal to 25 percent of the program's cost ($104.90 per month in 2013).[27] Higher-income beneficiaries have paid higher Part B premiums since 2007, when a provision that was included in the 2003 legislation creating the Part D Prescription Drug Benefit took effect. The ACA applies the income-related premium system to the prescription drug benefit; higher-income beneficiaries started paying increased Part D premiums in 2011.

Under current law, Medicare beneficiaries with incomes starting at $85,000 (or $170,000 for joint filers) must pay higher Part B and D premiums, which start at 35 percent of program costs and peak at 80 percent of program costs for beneficiaries with incomes over $214,000 (or $428,000 for joint filers). Only about 5 percent of Medicare beneficiaries currently pay higher, income-related premiums. Originally, the thresholds for these higher premiums were adjusted annually for inflation, but an ACA provision freezes the income thresholds through 2019, at which point, almost 10 percent of beneficiaries are projected to pay income-related premiums. Beginning in 2020, the thresholds are scheduled to bounce back upward as if

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they had never been frozen, thereby reducing the proportion of beneficiaries (to roughly 7 percent) who would then be subject to higher premiums.[28]

Because Parts B and D of Medicare are not pre-funded like Part A or Social Security, the federal government contribution through general tax revenue amounts to a subsidy for medical and prescription drug coverage. We believe that a generous government contribution is appropriate for low- and middle-income seniors and for people with disabilities, but providing generous subsidies to high-income beneficiaries who do not need the assistance is unjustified.

RECOMMENDATION:

Establish lower thresholds beginning in 2016 so that approximately 17 percent of beneficiaries would pay income-related premiums.

The proposed thresholds, indicated in the table below, would reduce the ratio between single and couple income-related premium brackets from 1:2 to 1:1.5. The thresholds would be in effect through 2018, and thereafter updated annually for inflation.

Table 8. Reduce Subsidies to Higher-Income Medicare Beneficiaries

CURRENT LAW THRESHOLDS			PROPOSED THRESHOLDS		
Single	**Couple**	**Premium**	**Single**	**Couple**	**Premium**
<$85,000	<$170,000	25%	<$60,000	<$90,000	25%
$85,001-$107,000	$170,001-$214,000	35%	$60,001-$82,000	$90,001-$123,000	35%
$107,001-$160,000	$214,001-$320,000	50%	$82,001-$135,000	$123,001-$202,500	50%
$160,001-$214,000	$320,001-$428,000	65%	$135,001-$189,000	$202,501-$283,500	65%
>$214,000	>$428,000	80%	>$189,000	>$283,500	80%

Note: New thresholds take effect in 2016 and would be updated for inflation beginning in 2019.

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C. Make Medicare and Related System Reforms that Improve Care and Lower Cost Growth

The Challenge: Most of the potential reform-related quality improvement and cost-containment benefits for beneficiaries and taxpayers would be realized over many years as longer-term improvements to Medicare are implemented.

Our Approach:

1. Continue to expand competitive Medicare pricing for certain goods and services;
2. Ensure that payment differences across sites of care reflect actual differences in cost;
3. Reform the bonus payments to Medicare Advantage plans based on quality ratings;
4. Encourage the use of high-quality, low-cost drugs in Medicare and system-wide;
5. Limit the in-office exception to the physician self-referral law;
6. Enhance graduate medical education; and
7. Ensure that Health IT investments meet the information sharing needs of new delivery and payment models.

Some policies could be implemented in the near term to correct distortions in Medicare payments and generate savings for beneficiaries and taxpayers by promoting high-value care. We recommend a limited number of these policies that are consistent with our long-term strategy for improving the health care payment and delivery systems.

1. CONTINUE TO EXPAND COMPETITIVE MEDICARE PRICING FOR CERTAIN GOODS AND SERVICES

The CMS program to establish competitively bid prices for durable medical equipment (DME), such as walkers, hospital beds, and home oxygen equipment, has successfully lowered spending by 42 percent in the first nine regions of implementation with no apparent negative impact on beneficiary access or patient satisfaction.[29] These savings benefit all beneficiaries through lower Part B premiums and benefit those who use DME through lower cost-sharing, in addition to generating savings for the federal budget. The program should continue to be expanded nationwide, as scheduled.

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We believe that the DME competitive-bidding program sets a positive example for future efforts to establish competitive pricing and other payment reforms, which require significant up-front investments in implementation and monitoring in order to be successful. This DME approach also demonstrates the importance of providing CMS with the authority and

resources to design and implement such programs and to allow them to evolve and be expanded over time, thereby maximizing savings for beneficiaries and taxpayers.

RECOMMENDATION:

Implementation of the DME competitive bidding program should continue apace for all urban markets nationwide, but for some equipment types, benchmarks should be set lower.

Under the DME program, suppliers submit bids and the benchmark payment is set at the median bid. While this was a reasonable approach for the initial implementation of the program—as CMS was attempting to ensure that patient access was not affected—over the long term, we believe the median-bid level is unnecessarily generous to DME suppliers.

As competitive bidding expands to other types of equipment, we recommend that the benchmark payment rate be set as follows:

1. For commodity-type goods that are standardized and do not require supplier support, we recommend the adoption of competitive bidding processes that would obtain the lowest bid possible for the quantity required, plus sufficient reserve capacity.
2. For goods that are standardized, but require some supplier support, we recommend establishing a benchmark payment rate that would balance the goals of obtaining the lowest possible price for the necessary capacity and maintaining an adequate base of suppliers to assure beneficiary access.
3. To introduce competitive pricing to other goods and services that require more complex handling, we recommend the use of competitive bidding processes similar to the DME program that include:
    a. Restricting the program to markets where there are sufficient providers to participate in a bidding system;
    b. A benchmark payment rate that would be set at the median bid in a given market; and
    c. Active surveillance programs and quality-monitoring systems to ensure that patient access and quality outcomes are not negatively affected.

2. ENSURE THAT PAYMENT DIFFERENCES ACROSS SITES OF CARE REFLECT ACTUAL DIFFERENCES IN COST

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Currently, Medicare pays different amounts for the same service depending on the setting of care. For instance, a procedure conducted in a hospital outpatient department may result in a different (generally higher) level of reimbursement than would the same procedure performed in a physician's office or in a freestanding surgical center. In some cases, these differences may be justified, such as when procedures done in an outpatient department

primarily serve patients with more complex needs. In other cases, there is no compelling justification for the difference.

Hospitals do provide important community services, such as standby capacity (e.g., burn units), but the cost of these services is more-appropriately reflected in rates for inpatient services than in outpatient rates for services that are often provided in other settings. We recommend that Medicare adopt changes to payment rates to minimize or eliminate reimbursement differentials across settings, retaining only those variations that reflect true differences in the characteristics of patients and the associated cost of serving them. This proposal to equalize payments across sites for some services would provide immediate benefits to beneficiaries (through reduced cost-sharing and premiums) and taxpayers (through lower Medicare spending).

Equalize Payments for All Office Visits

Payment for evaluation and management services is already adjusted for the complexity of patient needs, and the infrastructure required is similar in both the inpatient and outpatient settings.

RECOMMENDATION:

Equalize payment rates for evaluation and management services (known to most patients as office visits) to the rate in the lowest-cost setting, including facility payments.

(FY2014–2023 Budget Savings: $8.7 Billion)

Our reform, which is consistent with a March 2012 recommendation by MedPAC, would have substantial benefits for beneficiaries and taxpayers.[30] There is a strong existing trend toward consolidation in the health care system, and hospitals are increasingly acquiring physician practices. After these acquisitions take place, many beneficiaries have unhappily noticed that office visits that used to generate one bill and one coinsurance payment now result in two bills—one for physician services and another for a hospital facility fee—and two coinsurance payments, the sum of which is significantly higher than before. This illustrates the real cost impact of this payment distortion for beneficiaries, which also affects taxpayers in the form of higher Medicare spending. Equalization could immediately rectify this issue. Eliminating arbitrary and unjustified differentials in reimbursement would reduce incentives for hospitals to purchase practices simply to arbitrage distorted payment rules.

Equalize Payments for Some Procedures Conducted in Outpatient Departments and in Physicians' Offices

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Reform should not stop at evaluation and management services. Many, but not all, procedures should be reimbursed at the lowest rate across settings, whether in an outpatient department or a physician's office. The challenge is to determine which procedures have justifiable differentials and which do not. We believe that the criteria being considered by MedPAC are the right ones.[31]

RECOMMENDATION:

Equalize payments at the level of the lowest-cost site for procedures that are conducted in both the outpatient department and in the physician's office when:

- The procedure is performed more than half of the time in the office setting;
- The procedure is performed less than 10 percent of the time in the emergency department; and
- There is not a significant difference in patient severity between settings.

(FY2014–2023 Budget Savings: Not Estimated)

MedPAC estimates that this policy would generate $900 million in combined annual savings for beneficiaries and the Medicare program.[32] For hospitals serving a high proportion of uninsured patients, an equalization policy should include protections, such as limiting payment reductions to a percentage of hospital revenue. Additionally, the HHS Secretary should have the authority to grant exceptions in certain areas to ensure beneficiary access.

Higher payments to hospital outpatient departments have often been justified on the basis of contributing to "public-good" costs incurred by hospitals, such as the costs of standby capacity or uncompensated care. But as policy focuses more on paying for value, we should subsidize these costs directly rather than accept site differentials not related to direct costs. An example of this direct subsidization was when disproportionate share payments were implemented to compensate hospitals for the cost of serving uninsured patients.

3. REFORM THE BONUS PAYMENTS TO MEDICARE ADVANTAGE PLANS BASED ON QUALITY RATINGS

(FY2014–2023 Budget Savings: Not Estimated)

The Medicare Advantage Star Ratings provide beneficiaries with important, objective information on the performance of Medicare Advantage Plans on several measures of quality. Under current policy, four- and five-star plans get bonuses. But a CMS demonstration has increased the size of these bonus payments and expanded eligibility for them to three-star plans.

Because most plans are rated at three stars or more, under the demonstration, most plans are currently receiving bonus payments. The goal of this demonstration is unclear, and its bonus system renders the quality distinctions among plans essentially meaningless. In addition, new research indicates that beneficiary enrollment is influenced by star ratings.[33] As a result, the bonus payments may not be necessary to encourage plans to improve quality, and should certainly not be granted to plans with fewer than four stars.

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RECOMMENDATIONS:

1. **End the CMS demonstration and revert to the smaller bonus payments under current law, which are restricted to four- and five-star plans.**

2. **When regional markets convert to competitively bid payments, discontinue bonus payments entirely.**

Because the star ratings are effective in communicating information to beneficiaries about plan quality, they should be prominently displayed during plan selection, such as in our proposed redesigned Medicare Open Enrollment website.

4. ENCOURAGE THE USE OF HIGH-QUALITY, LOW-COST DRUGS IN MEDICARE AND SYSTEM-WIDE

Significant progress has been made in the adoption of high-quality, low-cost drugs, whether brand or generic, across the health care system. However, existing government policies, some specific to Medicare and others that impact all consumers, continue to discourage broader use of high-value drugs.

RECOMMENDATIONS:

1. Adjust the Part D LIS Cost-Sharing to Encourage the Use of High-Value Drugs (FY2014–2023 Budget Savings: $44.3 Billion)

Copayments for Medicare Part D beneficiaries who qualify for the LIS are set by law. While LIS copayments for generic and preferred multiple-source brand drugs are lower than copayments for non-preferred brand drugs, the differences are narrow relative to those experienced by other Medicare beneficiaries. Currently, LIS beneficiaries with incomes under 100 percent of the federal poverty level pay around $1.00 for generics and multi-source brand drugs and $3.50 for non-preferred brand drugs; those with incomes over the poverty line pay roughly $2.50 for lower-cost drugs and $6.50 for non-preferred drugs.

MedPAC has recommended that the HHS Secretary be given authority to modify copayments to establish stronger incentives for LIS beneficiaries to select generic and low-cost brand drugs and that the Secretary also review the therapeutic classes for each drug for appropriateness every three years.[34] We endorse this MedPAC recommendation, and further recommend that copayments be eliminated for LIS beneficiaries utilizing generic and low-cost drugs, while copayments for non-preferred brand drugs should be slightly increased, subject to a ceiling of $8.00.

In addition to providing a stronger incentive for LIS beneficiaries to select lower-cost drugs, we believe that Part D plans should have stronger incentives to ensure that lower-cost brand and generic alternatives are available for LIS beneficiaries. As such, we also recommend that LIS payments to Part D plans that subsidize the deductible and cost-sharing should be limited to the amount that the government would pay for a low-cost alternative, if available, unless a higher-cost drug is prescribed as medically necessary.

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2. Change the Part B Reimbursement for Provider-Administered Medications (FY2014–2023 Budget Savings: Not Estimated)

The current payment system for Part B drugs, which are administered by physicians, includes incentives to utilize higher-cost medications. Providers who administer medications in a physician office are reimbursed by Medicare at the medication's Average Sales Price

(ASP) plus 6 percent. This reimbursement is intended to cover the physician's cost to purchase the medication (the ASP part) plus handling costs (the additional 6 percent). The practical effect is that physicians earn more from prescribing and administering more expensive Part B drugs, when the actual cost of handling may remain essentially the same for drugs that are in the same therapeutic class. This payment incentive discourages the use of lower-cost drugs even when they are equally or more effective.

We recommend changing the reimbursement to equal the average sales price of the medication plus a flat payment, with the flat payment being set separately (and being payment neutral, before any behavioral change) for each therapeutic class (as designated by the HHS Secretary). This would remove the financial incentive for physicians to administer a more expensive medication. Budget savings would come from the shift to lower-priced drugs.

One of the consequences of the across-the-board sequestration cuts is that the entire Medicare payment for Part B drugs, not just the 6 percent for handling, is being cut by 2 percent. This cut has made it uneconomical for some oncologists to administer certain lifesaving drugs. Our proposed policy would be a far more sustainable way to reduce Medicare spending, without adverse effects on care.

3. Convert from Average Wholesale Price to Average Sales Price for Remaining Part B Drug and Vaccine Reimbursements (FY2014–2023 Budget Savings: Not Estimated)

While Medicare payments for most Part B drugs have moved to ASP, some provider-administered drugs and vaccines are still reimbursed according to the more expensive Average Wholesale Price (AWP), which by not reflecting various discounts and rebates, substantially overstates the acquisition cost to the provider. We propose converting reimbursements for the remaining drugs and vaccines to ASP beginning in 2014, and providing the HHS Secretary with the authority to phase in the change to ensure that there is no disruption in supply.

4. Address Anti-Competitive Settlements between Brand and Generic Drug Manufacturers (FY2014–2023 Budget Savings: $4 Billion)

Manufacturers of brand drugs sometimes enter into patent settlement agreements that delay the introduction of a lower-cost competitor into the market. The FTC has found that some of these agreements result in higher costs for patients, health plans, and federal and state governments.[35] Consumer groups (such as AARP), health plans (represented by America's Health Insurance Plans), and physician groups (such as the American Medical Association) have urged the Supreme Court and the Congress to remedy this situation and have supported two different bipartisan bills that would address these anti-competitive settlements. CBO has projected federal savings over ten years of approximately $4 billion for policies that target this issue. We support these bipartisan efforts to address anti-competitive settlements that delay access to lower-cost prescriptions.

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5. Close the REMS Loophole that Inhibits Development of Generic Drugs (FY2013–2022 Budget Savings: $753 Million)[vii]

Since 2007, the Food and Drug Administration (FDA) has had the authority to require that manufacturers of drugs with a high risk of abuse or dangerous side effects establish strict controls, known as REMS, to reduce the chance that such drugs are misused. This has been a positive development for patient safety; however, the regulation has resulted in an unintended consequence that is harming consumers with legitimate needs for these drugs. Manufacturers of brand drugs covered by REMS have been able to use the policies to prevent generic drug manufacturers from obtaining brand-drug samples, which are essential for development and testing of generics. In this manner, manufacturers have been able to prevent development of and consumer access to low-cost, high-quality generic alternatives.

There are two potential avenues to address the REMS loophole that we find promising. One option, which received bipartisan support in the U.S. Senate in 2012, would be to give FDA statutory authority to ensure that generic drug manufacturers can obtain samples of a brand drug covered by REMS. Alternatively, the FTC could be given authority to challenge manufacturers who refuse to provide samples of REMS-covered drugs to generic developers. We believe that either approach would improve competition in the drug market and speed consumer access to high-quality, low-cost drugs.

5. LIMIT THE IN-OFFICE EXCEPTION TO THE PHYSICIAN SELF-REFERRAL LAW

(FY2014–2023 Budget Savings: $6.1 Billion)

Physicians are generally prohibited from referring patients to providers in which they have a financial interest. However, the physician self-referral law includes an in-office exception for ancillary services, which include expensive advanced imaging, such as MRI scans. MedPAC has found that physicians who self-refer for imaging services prescribe more diagnostics than physicians who do not have an ownership interest in imaging equipment, and the Commission has opined that these higher levels of utilization likely include unnecessary tests.[36] The president's FY 2014 budget included a proposal to limit the in-office exception to providers who meet accountability standards. We are supportive of this approach. Limiting self-referral for imaging and other tests to providers who participate in advanced payment models, in which providers are accountable for cost and quality, is in alignment with our overall vision for health-system reform.

6. ENHANCE GRADUATE MEDICAL EDUCATION

A strong health professional workforce is needed to provide quality care to Medicare beneficiaries and non-Medicare patients, and to support integrated systems of care. The federal government, and Medicare specifically, is the single largest payer for graduate medical education (GME), annually investing approximately $9.5 billion in Medicare funds and $2 billion in Medicaid funds to train America's future health professional workforce. This

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[vii] This savings estimate reflects a CBO score of legislation that would close the REMS loophole and take other measures to reduce barriers to the introduction of low-cost drugs.

funding, along with state Medicaid contributions and private insurance dollars, supports about 115,000 residency positions in more than 1,000 teaching hospitals throughout the country.[37]

To support residency programs, Medicare makes two types of GME payments to teaching hospitals, ambulatory settings, and other entities:

- Direct graduate medical education (DGME) payments, which are calculated based on a historical, hospital-specific, per-resident amount (PRA) and are intended to cover resident stipends and benefits, supervisory physician costs, and administrative overhead; and
- Indirect medical education (IME) payments, which are a percentage increase to Medicare's inpatient payment rates—based in part on the ratio of residents to hospital beds—and are intended to cover higher patient care costs associated with teaching, including longer inpatient stays, more tests, and greater use of technologies.[38]

In 2010, of the estimated $9.5 billion that Medicare spent on GME, approximately $3 billion were allocated to DGME payments and $6.5 billion to IME payments.[39] A recent Kaiser Family Foundation report predicts that by 2022, IME payments will nearly double, totaling $12 billion.[40]

Practitioners and policymakers have long debated the level and methodology behind the financing of GME. Many experts believe that GME payments are far higher than the true cost of maintaining a residency program; while most provider organizations assert that an impending workforce shortage calls for more investment, not less.[41] Some advocates have suggested new and innovative approaches to GME, such as tying payments to certain performance metrics and patient outcomes or expanding GME beyond its traditional scope to train non-physician health professionals. Others have questioned whether the current capped number of federally subsidized residency slots will meet future workforce demands and how any increase in slots should be allocated.

RECOMMENDATIONS:

1. **Better align IME payments with actual costs associated with teaching.**
2. **Reward high-performing institutions with incentive payments.**
3. **Increase residency slots to meet anticipated demand.**
4. **Reduce variation in DGME payments.**
5. **Explore allocation of resources to train non-physician professionals.**

EMBARGOED

Our goal with the recommendations described in detail below is to better align Medicare's investment in GME with our overarching vision for health care system reform and to achieve a workforce that can efficiently and appropriately deliver care. The IME policy is structured

to be budget neutral, and although we expect moderate budget savings from the proposed DGME policy, those projected savings did not drive the recommendation.

1. Better Align IME Payments with Actual Costs Associated with Teaching

The IME formula essentially pays teaching hospitals an additional 5.5 percent per Medicare stay for every 10-percent increase in the hospital's "teaching intensity" (ratio of residents to beds). Recent estimates assert that the actual additional cost is roughly 2 percent for every 10-percent increase in a hospital's resident-to-bed ratio, or about one-third of the current level, making a strong argument to reduce IME payments.[42] Similarly, in its June 2010 report, MedPAC found that IME payments are significantly higher—$3.5 billion, or 54 percent of current IME spending—than empirically justified.[43] We recommend a more modest adjustment to IME payments, one that is ultimately intended to be budget neutral.

RECOMMENDATION:

Reduce the IME percentage add-on to inpatient hospital admissions from 5.5 percent to 3.5 percent. All savings should be repurposed for performance-based incentive payments and additional residency slots.

2. Reward High-Performing Institutions with Incentive Payments

Currently, GME payments are distributed without requirements for the quality of training, resident performance, or patient care outcomes. There are very few metrics in place to measure the results of federal investment in GME, limiting America's ability to improve, or even track, the quality of physicians completing residencies. Broader goals for Medicare and system-wide reform cannot be achieved without ensuring that tomorrow's health professionals are prepared with the skills needed to succeed in an emerging high-quality, high-value system of care delivery.

Through GME, Medicare has an opportunity to align health care professional education and training with the skills needed to support and accelerate delivery system reforms. To that end, and building on a 2010 MedPAC recommendation, we encourage Medicare to move away from IME payments that are linked to fee-for-service and services rendered, and move toward payments that reward certain educational standards and outcomes. Moreover, we believe that new systems of care will demand and drive the need for this kind of professional training.

RECOMMENDATION:

Repurpose 50 percent of the proposed reduction in IME funds for performance-based incentive payments. Restructure Medicare's investment to require that all recipients of IME funding be held accountable for reaching specified educational goals and outcomes. Only institutions that meet these standards should be eligible for the performance-based payments.

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This approach affords an opportunity for institutions to earn back IME dollars and is largely in step with current trends. For example, in 2001, the Accreditation Council for Graduate

Medical Education (ACGME), the central accrediting body for residency programs, established a set of core competencies and began to evaluate residency programs based on outcomes. This serves as an important signal that the methodology behind medical training and evaluation is shifting to better reinforce the skills needed to support delivery system reform. Given ACGME's experience in assessing medical education programs, we believe that the Council should be a critical partner in the development of any national performance standards. Additionally, to the extent possible, standards should rely on existing accreditation and quality metrics.

The HHS Secretary should work with ACGME to establish performance-based standards through a consensus-based process in consultation with other accrediting organizations, training programs, health care purchasers, patients, and consumers. Mirroring MedPAC's recommendation and various congressional proposals, the standards should, in particular, specify goals for: practice-based learning and improvement, including quality measurement; coordination of patient care across various settings; working in inter-professional and multidisciplinary care teams; the use of health information technology; and systems-based practice, including the integration of community-based care with hospital care.[44] The HHS Secretary would have three years to develop these standards and structure how future payments would be distributed. (Options could include providing the full amount of funding if certain levels of performance are surpassed or varying the levels of funding depending on the extent to which performance measures are met). Though intended to be budget neutral, the net effect of this policy would depend on program performance and the ability to meet new standards.

In addition, we encourage CMS to reimburse for generally accepted quality and improvement activities under GME. This is consistent with our overall approach, as training and incentives should reflect movement toward more integrated systems of care.

3. Increase Residency Slots to Meet Anticipated Demand

By seeking to reevaluate and realign Medicare's GME investment, we believe that our reforms would ultimately strengthen America's primary care workforce and enhance patient-centered care, which in turn, would create more cost-efficient care arrangements in the long term. Further, a renewed focus on primary care, through boosting residency slots and training, has the strong potential to improve care for the medically underserved and rural populations. Because these patient populations are more likely to suffer from uncoordinated and fragmented care, primary care-focused systems may narrow socially derived health inequities.[45]

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As of 2010, one-third of America's physician population was primary care and two-thirds were specialists, creating what the Health Resources and Services Administration (HRSA) estimated was a shortfall of approximately 7,000 primary care physicians.[46] The Association of American Medical Colleges projects a shortage of as much as 45,000 primary care physicians by 2020.[47] Further complicating workforce supply is the current cap placed on the number of Medicare-supported residency slots that teaching hospitals can claim for

reimbursement, passed in the Balanced Budget Act of 1997 and effectively freezing the number of federally funded residencies at 1996 levels. The ACA partially addresses resident shortfalls by requiring CMS to lower the residency cap for hospitals with unused residency slots and redistribute 65 percent of those spots to other qualifying hospitals. At least 75 percent of the additional positions must be allotted to primary care or general surgery residency programs. In 2011, CMS announced that it had redistributed roughly 1,354 Medicare residency slots under this program.[48] In addition to continuing this redistribution, we believe that CMS should invest in additional residency slots.

RECOMMENDATION:

Repurpose the remaining 50 percent of savings from IME payment reduction to additional residency slots, one-third of which should be made available to teaching hospitals that are training above their cap. Half of the additional slots should be allocated to programs that train primary care physicians and other providers for which there are identified specialty shortages.[viii]

4. Reduce Variation in DGME Payments

DGME payments vary widely among teaching hospitals, in large part due to substantial hospital and geographic variations in per-resident amounts (PRA).[49] Generally, for DGME payments, Medicare pays a portion of a hospital's PRA, which reflects historic, base-period per-resident DGME amounts.[ix] [50]

Past legislative efforts have attempted to minimize this variation, including the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act in 2000, which implemented a DGME floor of 85 percent of the locality-adjusted national average PRA. In 2003, the Medicare Prescription Drug, Improvement and Modernization Act established that hospitals with PRAs above 140 percent of the locality-adjusted national average would not receive updates through FY 2013.[51] We recommend that the PRA ceiling be reduced for the purposes of calculating DGME payments.

RECOMMENDATION:

Limit the PRA to 120 percent of the locality-adjusted national average PRA when calculating direct graduate medical education payments.

(FY2014–2023 Budget Savings: Not Estimated)

5. Explore Allocation of Resources to Train Non-Physician Professionals

As discussed in the scope of practice section below, health care delivery involves a diverse array of professionals. There are a number of initiatives in the ACA that encourage GME to move beyond physician-only training. The Teaching Health Centers program, for example, appropriates $230 million for FYs 2011–2015, some of which is available for the training of

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[viii] Additionally, CMS should prioritize hospitals in states with new medical schools, hospitals that emphasize training in community health centers, and hospitals that are eligible for electronic health record (EHR) incentive payments.

[ix] PRAs generally represent per-resident DGME costs incurred in 1984 or 1985.

nurse practitioners and physician assistants.[52] Information about the effectiveness and quality of these programs is not yet available, but we believe that they are promising steps in the right direction. CMS should evaluate the effectiveness of new efforts to fund GME that make funding available to train non-physician professionals and allocate resources accordingly.

7. ENSURE THAT HEALTH IT INVESTMENTS MEET THE INFORMATION-SHARING NEEDS OF NEW DELIVERY AND PAYMENT MODELS

New delivery-system and payment models, including the Medicare Networks and payment bundles described in this report, require advanced health information technology capabilities and a robust health information-sharing foundation to be successful. As explored in BPC's 2012 report, *Transforming Health Care: The Role of Health IT*, in order to deliver coordinated, accountable, patient-centered care, those who deliver care to patients, as well as patients themselves, must have access to information that resides in the multiple settings where care and services are delivered, including offices of primary care physicians and specialists, hospitals and clinics, laboratory and radiology centers, pharmacies, and post-acute and institutional long-term care providers. Much of this information is also needed to calculate clinical quality measures, which support performance measurement and improvement.

Per our proposed reforms, the expansion of new delivery-system and payment models that realign incentives to encourage greater accountability and coordination create a stronger case for providers to begin exchanging information electronically. The strengthening of standards and interoperability for EHR products as part of Stage 2 of the Medicare and Medicaid EHR Incentive Programs increases providers' capability to electronically share information. Both of these changes lay the groundwork for increased expectations among providers to share information electronically to support coordinated, patient-centered care. At the same time, implementation support will be needed to enable providers—particularly those operating within small physician practices and community hospitals— to effectively transmit and receive health information using electronic means.

RECOMMENDATION:

Prioritize electronic sharing of information among providers in the next stage of the Medicare and Medicaid EHR Incentive Programs. HHS should provide implementation support for such information sharing, with a particular focus on the needs of small physician practices and community hospitals.

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Chapter 2: Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition

While Medicare reform has the potential to catalyze system-wide changes to health care payment and delivery, the tax code also has a profound influence on the private health insurance market. By modifying the tax treatment of health care, we can help push the private sector toward more-efficient care delivery.

A. Limit and Rationalize the Tax Exclusion for Covered Insurance

($262 Billion Revenue Increase FY2014–2023)

Under current law, employer contributions to employee health benefits, including ESI premiums and various tax-advantaged health care spending accounts, are excluded from an employee's taxable income. Employee premium contributions are also paid with pre-tax dollars in most cases.[53] The ESI tax exclusion is the single largest tax expenditure, reducing *annual* federal income and payroll tax revenue by about $250 billion—which necessitates higher marginal tax rates on everyone, and it also reduces revenues for state governments.[54]

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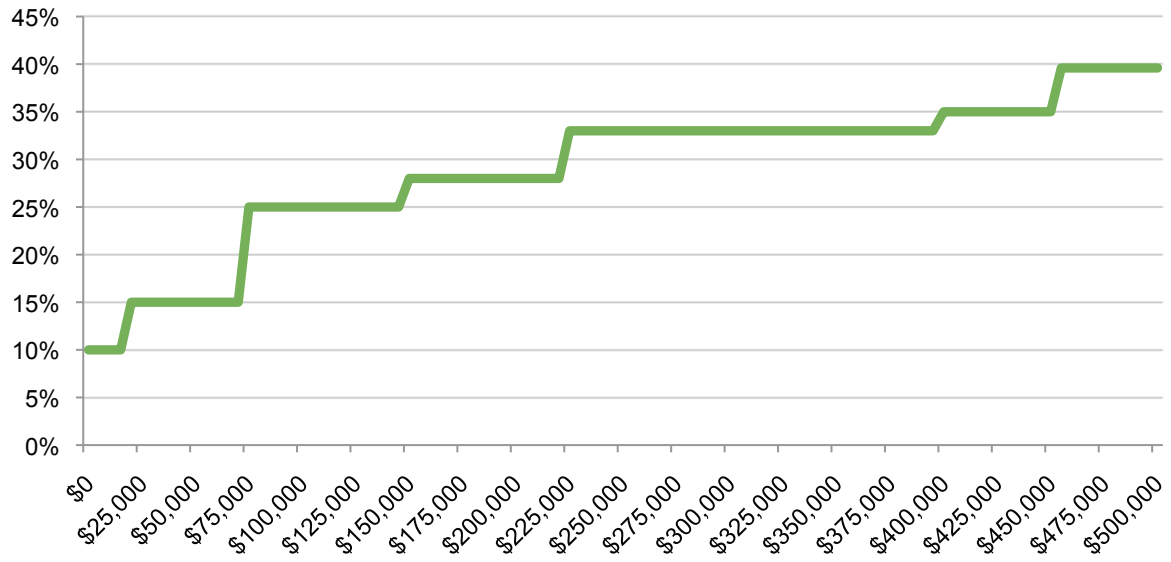
The tax exclusion for ESI makes benefits, including high-cost health insurance, a more-attractive form of employee compensation than cash wages, thereby blunting incentives to deliver health care more efficiently. This has a profound effect on health-insurance design. Because the tax exclusion provides a federal subsidy as high as 43.4 percent of the cost of a

policy (and an additional subsidy for people living in state and/or localities with income taxes), insurance plans are likely to have weak controls on utilization, little patient cost-sharing, and provider choice so broad as to undermine health-plan leverage in negotiating payment rates with providers.[x]

Moreover, the exclusion is regressive; it generally subsidizes high-income individuals more than those at lower incomes (especially with respect to income taxes; payroll taxes for Social Security are capped). (See chart below.[55]) For example, the federal income-tax subsidy to a multimillionaire corporate executive with a gold-plated $40,000 family health insurance plan is $15,840, or 39.6 percent of the cost of the policy; whereas a family earning $50,000 with a typical $15,000 employer-provided health plan receives a federal subsidy of only $2,250, or 15 percent.[xi]

Particularly given the current budget stress, our nation would not enact such an open-ended subsidy mainly for upper-income people. Indeed, the debate over the ACA labored over whether to extend subsidies to purchase insurance to individuals with incomes up to 300 percent versus 400 percent of the federal poverty level.

Chart 4. Federal Income Tax Subsidy for Employer-Sponsored Health Insurance (2013)



Note: The above graph depicts the subsidy provided by the ESI income-tax exclusion for married couples by ordinary income.
Source: IRS

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[x] For a high-income individual, 43.4 percent is the sum of her marginal federal tax rate (39.6 percent) and marginal payroll tax rate (3.8 percent).

[xi] The CEO faces a 39.6-percent marginal federal income tax rate and the family with income of $50,000 faces a 15-percent marginal federal income tax rate.

To address these problems, the ACA establishes an excise tax, popularly known as the "Cadillac tax," on high-cost health plans. It is scheduled to take effect in 2018. Although we believe that the Cadillac tax will address the unlimited, regressive subsidy for ESI, a different approach could better achieve the same objectives.

RECOMMENDATION:

Replace the Cadillac tax on high-cost health insurance plans with a limit on the income-tax exclusion for ESI at the dollar amount equivalent to the 80th percentile of single and family ESI premiums in 2015 (age- and gender-adjusted).

- Employee health benefits would remain deductible as a normal business expense for the employer for the purposes of the corporate income tax.
- The limit would be indexed to GDP per-capita growth through 2023, and to GDP per-capita growth plus half a percentage point (GDP + 0.5 percent) thereafter.
- The payroll-tax exclusion for ESI would remain unchanged, increasing the proposal's progressivity.
- The limit would apply to pre-income-tax employer and employee contributions to health-insurance premiums (including premiums for dental, vision, and supplemental indemnity insurance), health reimbursement arrangements, and health savings accounts; flexible spending arrangements for health expenses would be disallowed.[xii]
- The health insurance deduction for the self-employed would be subject to the same limits.

Limiting the income-tax exclusion to the cost of the 80th percentile plan in 2015 would end the current open-ended subsidy, while leaving most people unaffected. (By definition, 80 percent of singles/families would be unaffected in 2015.) For example, the average premium for employer-provided health insurance ($5,615 for singles/$15,745 for families in 2012) is significantly less than the proposed limit.[xiii]

The existing tax break encourages employers to over-insure their employees—that is, to buy additional health insurance rather than to pay more cash wages. Thus, increases in health insurance premiums tend to crowd out cash wages over time, even though this trend is not intuitively apparent.[56] The nonpartisan Joint Committee on Taxation, which estimates the revenue effects of tax legislation, concurs, and its estimate of the effects of the Cadillac tax assumed that higher resulting cash wages would generate additional tax revenue.

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[xii] Budget savings estimates assume that all health-related tax-advantaged spending accounts would be included under the limit; the estimates do not include the elimination of health FSAs.

[xiii] Moreover, the average annual premiums for each of employer-provided HMO ($5,668 single / $15,729 family), PPO ($5,850 single / $16,356 family), POS ($5,507 single / $15,378 family), and HDHP/SO ($4,928 single / $14,129 family) plans would all be significantly less than the proposed limit of the ESI tax exclusion.

Employer health benefits: 2012 annual survey. Kaiser Family Foundation and Health Research & Educational Trust. 2012. Available at: http://ehbs.kff.org/pdf/2012/8345.pdf.

In addition to encouraging both more-efficient delivery of health care in the private sector and increased real-wage growth, this policy would raise $262 billion to help reduce the deficit, according to a BPC-commissioned analysis by MIT economist Jonathan Gruber. While much of this additional revenue would come directly from the tax on contributions to plans with very high premiums, some would result from a shift in employee compensation from untaxed health benefits to taxable wages. The additional revenue would derive predominantly from those with higher incomes (see table below). Indeed, nearly 60 percent of the additional revenue would come from the top 20 percent of income recipients, and more than 75 percent would come from the top 30 percent. The cap would have a very small effect on low-income Americans; only 2 percent of the revenue would come from the 30 percent with the lowest incomes.

Table 9: Distributional Implications in 2020

Replacing the "Cadillac Tax" with a Limit on the Income-Tax Exclusion for Employer-Sponsored Health Insurance at the 80th Percentile of Single and Family Premiums in 2015, Indexed to GDP Per-Capita Growth through 2023, and GDP Per-Capita Growth plus 0.5 Percentage Points Thereafter

INCOME PERCENTILE	% SHARE OF DISTRIBUTIONAL IMPACT
Bottom 30%	2%
Middle 40%	22%
Top 30%	76%

Source: Estimates performed by Dr. Jonathan Gruber, Professor of Economics, Massachusetts Institute of Technology

The progressivity of our proposal is all the more noteworthy considering that the additional wages that would be received by employees would constitute a much higher-percentage raise for those with lower incomes. In fact, many lower-income individuals who are affected would see higher *after*-tax wages (although their health insurance would be somewhat less generous). For instance, under our proposed policy, Americans with the lowest 30 percent of incomes would, on average, see their annual after-tax income increase by about 2 percent (around $350 in 2020). In the same year, middle-income people would see a 3 percent increase in after-tax income (around $2,000).

Moreover, few low-income households would pay more tax under the proposed limit than they would under the Cadillac tax. Of American households with the lowest 30 percent of incomes, in 2020, only approximately 1 percent would be affected by the proposed limit. About 3 percent of middle-income American households would be affected. Among households in the top 10 percent, almost 7 percent would pay more under the limit than they would under the Cadillac tax.

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Such a cap on the exclusion would have no meaningful effect on the widespread provision of employer health benefits.[xiv] This is because the vast majority of people with typical insurance plans would receive the exact same tax benefit that they do today. Employers would continue to utilize this benefit to recruit and retain a qualified, competitive workforce.

Why is capping the income-tax exclusion for employer-provided health benefits a better policy than the Cadillac tax?

The ACA contains a provision, often called the Cadillac tax, which is set to begin in 2018. It would impose a 40-percent excise tax on high-cost employer-provided health insurance plans. Although it aims to fix many of the same problems that our proposal would address, the Cadillac tax would severely distort employer choices. It is not deductible as a business expense for insurers' corporate income taxes, and so would necessitate a premium increase of almost six times the amount of the initial tax for the insurance company to maintain the same after-tax profits. Therefore, in practice, the Cadillac tax goes well beyond changing incentives for employers and employees; it will make health insurance coverage above the threshold prohibitively expensive. Furthermore, the Cadillac tax is less progressive than our proposed cap.

For employees who retain high-cost health insurance, particularly those with moderate incomes, a cap on the income-tax exclusion would be far less severe than the Cadillac tax. For example, even if the Cadillac tax were deductible for insurers under the corporate income tax, an individual or family in the 15-percent federal income tax bracket (with 2013 taxable incomes, after exemptions and deductions, up to $36,250 for individuals and $72,500 for joint filers) with an employer-sponsored plan that is $1,000 over the threshold could be exposed to approximately $400 in additional costs, akin to a 40-percent tax, under the Cadillac tax. Under our proposal, the additional cost to the employee would only be roughly $213.

Another critical issue is that the Cadillac tax thresholds are indexed not to GDP growth but to general inflation (Consumer Price Index), which tends to increase more slowly. Few believe that it is feasible or even desirable to simply cap the growth in health spending, which accommodates advancing medical technology as well as increasing prices of health services, to a rate substantially below the growth of GDP. A simple cap without fundamental reform risks a crisis like the one caused by the Medicare SGR target, and could eventually force even modest health insurance policies from the market, such that the Congress may feel compelled to provide relief. Indeed, under current policy and if ESI premiums increase at the projected growth rate of National Health Expenditures of 5.7 percent annually (which is lower than their historical growth), the Cadillac tax would effectively prohibit half of today's employer-sponsored health plans by 2029. Moreover, the minimum coverage that

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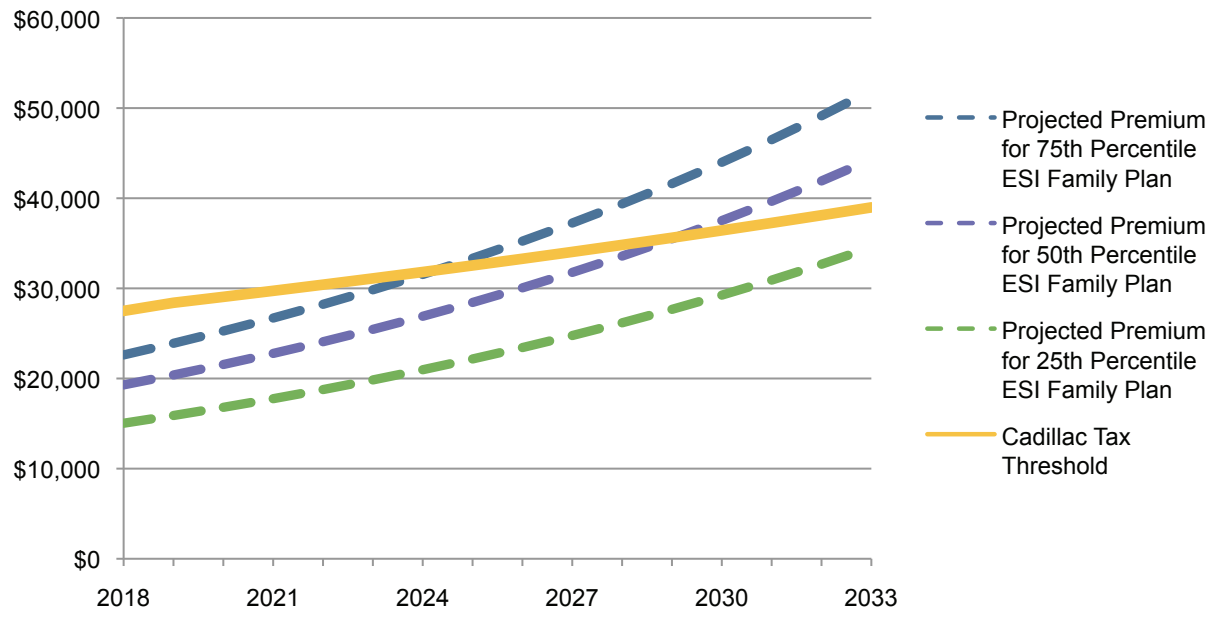
[xiv] According to the Gruber analysis, in 2023, the number of workers covered by employer-provided health insurance would decrease by less than half a percentage point from what it otherwise would be.

employers are mandated to provide under the ACA eventually would become more expensive than the Cadillac tax threshold, thereby creating an oxymoronic scenario in which employers would be both mandated to and effectively banned from offering health coverage to workers.

Chart 5. Cadillac Tax Could Effectively Prohibit Half of Today's Employer Health Plans by 2029



Source: Bipartisan Policy Calculations, assuming that ESI premiums grow at the same rate as national health expenditures, as projected by the CMS Office of the Actuary

B. Amend Health Care Excise Tax to Correct Distortions

The Health Insurance Providers Fee, created by the ACA, is set to go into effect in 2014, and it is expected to raise more than $100 billion over ten years. This fee functions like an excise tax on fully insured health plans and is likely to be passed on to purchasers of health insurance, raising costs for consumers. In our view, the design of the tax is problematic because it applies only to fully insured plans, exempting many other health plans entirely, and offers preferential rates to not-for-profit plans. Thus, the tax creates distortions in the health insurance market that are difficult to justify from a policy perspective. For example, the health insurer fee would apply to a fully insured product purchased by a self-employed business owner, but not to the self-insured health insurance product in which many Fortune 500 company employees are enrolled. The fee also applies to Medicare Advantage Plans and Medicaid managed care organizations, meaning that this tax may actually increase government expenditures in some cases.

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RECOMMENDATION:

Replace the ACA tax on fully insured plans with a paid-claims tax.

With future projections of high and unsustainable budget deficits, repealing this health insurance tax without offsetting revenues or spending cuts would be unrealistic. Therefore, we propose that the tax be replaced, on a deficit-neutral basis over ten years, with a paid-claims tax, which we believe would have several advantages. A paid-claims tax would have a lower rate applied to a broader base because the tax would be levied on all paid health insurance claims, whether paid by a commercially insured plan or by a third-party administrator working on behalf of a self-insured employer. This tax would not differentiate among the organizational form of the plan, and it would not further unbalance the playing field. Paid claims taxes have been demonstrated successfully in the states. Most recently, Michigan adopted a paid-claims tax in replacement of a more narrowly targeted tax.

Additionally, a paid-claims tax could be designed to encourage plans to adopt alternatives to fee-for-service reimbursement, which we have identified as a key driver of health care costs. Since capitated payments to providers are, by definition, not paid based on claims, those payments would be exempt from the tax. We also recommend that a partial exemption, such as a 50-percent reduction in the tax rate, be granted for claims paid in the context of two-sided shared-savings arrangements (where providers can benefit from savings but are also at risk for losses). This would encourage private-sector payers to move aggressively toward new payment and delivery system models, just as we are recommending for Medicare. In this manner, plans would be able to avoid the tax by taking action to help control health care costs.

C. Encourage Competition and Consolidation

Increasing provider consolidation has been an ongoing trend in the current health care landscape, with powerful momentum independent of a push for more coordinated and accountable care. Provider consolidation, which has included hospital mergers, the employment of physicians by hospitals, and the consolidation of physician organizations, can help lay the necessary groundwork for financial and/or clinical integration. Many private-sector providers and payers have shown their ability to be pioneers in the creation of coordinated, high-performing care systems, and we believe this progress should be encouraged.

However, increasing consolidation does not necessarily lead to more coordinated care delivery or better care. Some consolidation can limit consumer choice and decrease the incentives for providers to innovate and strive for cost efficiency. We support value-driven systems of care that benefit consumers, but we are cognizant of the potential for these consolidated systems to engage in anti-competitive behavior that could harm consumers. Balancing the need for flexibility to allow innovative, high-quality care delivery models with the need to prevent potential anti-competitive behavior, and at the same time reduce the risk of fraud and abuse, is a complex task for state and federal regulators. Just as

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purchasers have legitimate concerns about the impact of provider consolidation on affordability and accessibility, provider uncertainty about the application of antitrust policy and laws intended to fight fraud and abuse to clinically and financially integrated health care organizations can impede the development of these new, high-quality systems of care.

To address these issues, we make the recommendations below, which are discussed in the following pages.

RECOMMENDATION:

Streamline and clarify the application of existing federal legal and regulatory guidance for private-sector entities seeking to form integrated, coordinated systems of care delivery.

- Review effectiveness of current fraud and abuse laws in today's changing care delivery and payment environment.
- Authorize the FTC to gather market data on a routine basis.

PROVIDE REGULATORY CLARITY FOR ACCOUNTABLE SYSTEMS OF CARE

Both horizontal integration (in which competing organizations, such as two hospitals or cardiology groups, align) and vertical integration (in which dissimilar entities, such as a hospital, physicians' group, and ambulatory care facility, align) may give rise to liability under antitrust laws even where the intention is to form consolidated, coordinated, and accountable systems of care. Large provider entities, including clinically and financially integrated systems of care, may wield considerable power over local markets and pricing for health care service delivery. For example, an arrangement in which competing providers join together to implement value-based purchasing, paying for quality instead of quantity of care, may trigger antitrust liability.[57]

In addition to federal antitrust laws, providers seeking greater financial and clinical integration also must consider the requirements of three other federal laws that govern provider arrangements. The federal health care program civil monetary penalty (CMP) law, the federal anti-kickback law, and the federal physician self-referral or "Stark" law (also known collectively as the federal "fraud and abuse laws") specifically apply to provider arrangements that seek reimbursement for services from most federal health care programs (e.g., Medicare and Medicaid, but not the Federal Employees Health Benefits Program). Violations of these federal laws may lead to liability under the Civil False Claims Act.[58] Furthermore, many state laws mirror these federal statutes and similar requirements are also included in private payer arrangements.

- The **CMP law** prohibits financial arrangements that may induce a provider to reduce or limit services to patients.[59]
- Unless an exception applies, the **anti-kickback statute** prohibits the offer or receipt of anything of value (e.g., money, special benefits) for the referral of patients or services that are reimbursable by a federal health care program.[60]

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- Unless an exception applies, the **Stark law** addressing physician self-referral prohibits physicians from referring patients to providers from which they receive financial remuneration and providers may not bill for the services delivered.[61]

These laws are designed to separate financial arrangements from medical decision-making. Notably, there are a number of exceptions to both the anti-kickback and the physician self-referral law that protect arrangements that are deemed to be low risk for fraud and abuse, such as employment relationships. However, together these laws govern the majority of provider arrangements. Failure to comply with these requirements can lead to significant criminal (e.g., prison) and civil (e.g., financial) liability, as well as exclusion from participation in the Medicare or Medicaid programs.

This separation of financial considerations from medical decision-making may pose challenges to the design and implementation of new integrated models of care that by their very nature are intended to align the financial interests of different providers with high-quality care delivery. Liability under these fraud and abuse laws may be triggered by relationships that involve payments to physicians (such as shared-savings arrangements) to encourage the delivery of higher-quality care or to reduce unnecessary or wasteful care, thus limiting the total volume of services provided. For example, incentive payments from private-sector entities to providers to encourage electronic information sharing and facilitate care coordination could run afoul of the anti-kickback statute.[xv] Additionally, gainsharing, which can violate the CMP law, allows physicians to share in savings that are obtained from reductions in hospital costs associated with physician activity. In the past, CMS implemented a number of demonstrations that explicitly permitted gainsharing, such as the Acute Care Episode Demonstration, which tested a global payment scheme for acute care hospitalization for specific cardiovascular and orthopedic procedures under Medicare Parts A and B.[62]

The fraud and abuse laws were created several decades ago to address physician behavior and reimbursement in a fragmented, volume-driven, fee-for-service environment and do not necessarily support the goals of new payment models and coordinated, high-performing systems of health care delivery. Furthermore, these laws do not account for the growing integration of quality metrics into provider reimbursement schemes. As the nation transitions away from fee-for-service, a continual focus on historic patterns of inappropriate behavior within this inefficient payment structure will become increasingly less relevant and less useful, and indeed, may even impede the transition toward a value-driven health care system. For instance, allowing providers to share in savings is a key component of incentivizing better-quality, lower-cost care, however, the CMP law can restrict this practice. Instead, new or different protections may be needed to address the potential for abuse or inappropriate behavior within a new delivery and payment environment. For example, in a more integrated system of care delivery where providers receive capitated payments, a

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[xv] athenahealth, which offers electronic practice management and care coordination services to providers, received a favorable advisory opinion from OIG to this effect. Letter from HHS Office of the Inspector General to Daniel Orenstein, General Counsel, athenahealth, Inc., RE: OIG Advisory Opinion No. 11–18. November 30, 2011.

potential risk to patients is that providers will underperform on quality improvement efforts while limiting needed care to increase profits.

The MSSP provides an example of the potential liability triggered by arrangements that are governed by the fraud and abuse laws. The federal agencies responsible for the enforcement of these laws worked together to issue comprehensive and coordinated guidance about forming coordinated systems of care as well as protection from enforcement under the antitrust and fraud and abuse laws, provided that certain requirements are met. This information indicated how a number of federal laws, rules, and policies would apply to provider groups seeking to form an ACO—one example of a coordinated delivery system—under Medicare. Guidance accompanying the MSSP included:

- Policy guidance from the FTC and the Antitrust Division of the Department of Justice on antitrust regulation;
- Guidance from CMS and the HHS Office of Inspector General on conditions for exemption from fraud and abuse laws (which include the CMP, anti-kickback, and Stark laws); and
- Guidance from the Internal Revenue Service (IRS) on the treatment of § 501(c)(3) tax-exempt organizations, such as charitable hospitals.

This guidance provided relatively clear expectations for providers participating in the MSSP. Currently, 250 ACOs are participating in this program.[63] How to apply this guidance to enhanced Medicare ACOs (the proposed Medicare Networks described in the preceding sections of this report) should become relatively clear over time. However, on the commercial side, uncertainty about the application of antitrust, fraud and abuse, and other relevant laws can impede advances toward clinical and financial integration.[64] This presents a barrier to the widespread implementation of more coordinated and accountable systems of care. Permissible levels of and strategies for health information sharing under current laws and regulations are not always clear to private insurers, plan sponsors and administrators, and providers; this can create uncertainty about participation in value-based purchasing initiatives and discourage activities such as testing new payment mechanisms, sharing information about best practices, and acting on information about the relationship between price and quality.[65]

Clarification of current legal and regulatory guidance for entities seeking to participate in advanced public- and private-sector care delivery and payment arrangements would be beneficial and could help facilitate the formation of coordinated systems of care. The Department of Justice and FTC should work toward this goal in coordination with CMS, the HHS Office of Inspector General, and the IRS. Federal regulators should decide the most productive form for this guidance to take, but its purpose should be to centralize, streamline, and clarify the application of existing guidance for commercial entities seeking to form integrated, coordinated systems of care delivery, such as an ACO. For example, among other activities, the Department of Justice and FTC could update and expand the

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Statements of Antitrust Enforcement Policy in Health Care released in 1996. This guidance should at least address the legal and regulatory issues that were noted in the guidance for the MSSP, including fraud and abuse laws, antitrust, and the tax status of providers and ACOs. Clinically integrated, private-sector entities should be able to safely assume—within reason—that they are behaving legally if they follow this federal regulatory guidance. This policy could help ease some of the uncertainty faced by entities seeking to form coordinated delivery systems, while maintaining federal oversight of potential anti-competitive activity, as well as fraud and abuse.

Furthermore, HHS, along with other relevant agencies, should conduct a comprehensive review of the role and effectiveness of the fraud and abuse laws to decide whether they should be replaced or revised substantially.

Though many coordinated delivery systems will form with the primary goal of providing better care to patients and consumers, ACOs and consolidated provider entities are likely to hold considerable power over local markets. As more systems with the potential to exercise significant market power emerge, regulating these entities effectively without stifling innovation will require the development of knowledge and resources. Instead of seeking to slow or limit clinical and financial integration, the nation should strengthen tools to address potential antitrust abuses in a manner that can facilitate an improved health care practice structure. One possible strategy is to provide additional information resources to the FTC, by authorizing the agency to gather market data on a more proactive and routine, rather than case-by-case, basis.

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Chapter 3: Address Other Federal Policies that Block Efforts to Enhance Care and Constrain Costs

A. Prioritize, Consolidate, and Improve the Use of Quality Measures by Consumers and Practitioners

Meaningful quality measures can offer a wide variety of benefits to health care providers and consumers. Quality metrics are critical to organized systems of care where performance determines a provider's ability to share in savings, avoid penalties, or receive bonus payments. Additionally, these measures can be utilized to facilitate public reporting of information that consumers can use to make decisions about where to spend their health care dollars and to help providers understand how their performance relates to their peers', so that strategies to improve quality and patient safety can be designed and implemented.

Achieving these objectives is essential to creating a sustainable future for the U.S. health care system. Over time, the desire to realize these aspirational goals, promote transparency, and shore up the infrastructure needed to support integrated systems of delivery and payment has led to a great deal of activity in the area of quality metric design, evaluation, and reporting, as well as a proliferation of different quality metrics.

Whether quality reporting actually delivers on the promise of a positive impact is dependent on many factors: Do providers have the capacity to transmit and receive quality data in real-time, so that they can proactively work to improve care? Do quality metrics offer the right amount of detail (i.e., in such a way that they are not burdensome to report)? Is the information clinically actionable for providers? Is the quality information comprehensive enough to be helpful, while also being presented in a way that is meaningful and not overwhelming for patients and consumers?

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Providers are asked to report on a variety of quality measures mandated by different entities, including physician registries that are designed to maintain specialty board certification, Medicare and Medicaid as a condition of reimbursement, and private plans as a precondition to participation, just to name a few. Often, the roles and responsibilities of organizations such as health plans and accrediting bodies are ill-defined in the area of quality reporting, leading to confusion and inefficiencies. This lack of clarity can place an unnecessary administrative burden on health care providers, forcing them to use resources to report on redundant, conflicting, or irrelevant metrics. Moreover, these inefficiencies with the current disjointed reporting system do little to address the more critical goals of allowing providers to objectively assess their own performance and strive to improve the quality and safety of care.

Repairing this current, dysfunctional system will require a cooperative effort among all quality stakeholders, a clear vision with defined priorities, and a willingness to work toward common goals.

As quality metrics proliferated over the years, payers including the federal government expressed concern that there was no complementary strategy to ensure that these measures were relevant, useful, and comparable. Congress, as part of the ACA, sought to bring coherence to the implementation of quality measures by requiring the HHS Secretary to establish a National Quality Strategy that sets priorities to guide this effort and includes a strategic plan for how to achieve it. Although the NQF was tasked with prioritizing, aligning, and endorsing measures, in the three years since passage of the ACA, providers, payers, and consumers are frustrated with the slow progress.

RECOMMENDATIONS:

1. **NQF should refocus efforts to convene accrediting and certifying bodies—including the NCQA, the Joint Commission, and the ABMS—to identify common measures used for value purchasing by public and private purchasers, to identify barriers to alignment of current metrics, and to deliver a minimum set of requirements for providers that are clinically relevant, understandable to consumers, and useful for improvement.**

2. **NQF should develop pathways that allow physician-created and clinically relevant quality measures to be accelerated in the process toward an endorsement for use.**

3. **The MAP should place a greater emphasis on public-private collaboration.**

4. **NQF should convene a group to create consensus metrics for commercial ACOs and other integrated delivery systems.**

5. **In endorsing specific quality measures, NQF should assure that they are accessible to consumers as they make decisions regarding providers or treatment options.**

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6. **Support the electronic capture of data for measurement through the use of common standards.**

1. COLLABORATE TO ALIGN QUALITY METRICS

The NQF was formed in 1999 with express goals, including: planning an implementation strategy for quality measurement, data collection, and reporting standards throughout the health care community; establishing measurement priorities; endorsing standardized methods for measurement; and ensuring public access to this data.[66] However, many of these goals remain unrealized in the current U.S. health care system. Furthermore, a variety of entities, such as the NCQA and the Joint Commission, create or certify quality measures and metrics. Rather than adding to this already long list, NQF is uniquely positioned to play a significant role in developing a national strategy to streamline and prioritize quality metrics.

To accomplish this, NQF should convene accrediting and certifying bodies—including NCQA, the Joint Commission, and ABMS—to align current metrics and deliver a minimum set of measures for providers that are clinically relevant, understandable to consumers, and useful for improvement. The NQF-facilitated discussion should include how metrics are actually *used* by consumers and other payers, including employers and health plans, in practice. Detailed technical specifications for each metric are not necessarily helpful to consumers who want to know, in a broad sense, whether a physician is performing well on most indicators of quality. NQF must be more flexible in considering the value and relevancy of metrics and cannot get bogged down in irrelevant technical details. However, in streamlining quality metrics, balancing simplicity and detail is important—subspecialists, for example, need more granular quality metrics to quantify performance improvement. The creation of registries for specialty and subspecialty specific metrics would help ensure that all types of physicians are able to access clinically actionable data that will facilitate quality improvement.

2. DEVELOP PATHWAYS FOR APPROVAL AND USE OF PHYSICIAN-CREATED QUALITY MEASURES

As part of the alignment effort described above, NQF should develop pathways that allow physician-created and clinically relevant quality measures to be accelerated in the process toward an endorsement for use. In addition to promoting safety and clinical improvement, quality metrics enable accountability for health care dollars flowing from public and private payers. NQF is in an excellent position to ensure the process for creating these pathways is balanced and includes input from relevant stakeholders, such as the federal government, employers, and consumers.

3. EMPHASIZE PUBLIC-PRIVATE COLLABORATION IN MAP

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With respect to Medicare, CMS has made some progress in the area of streamlining quality metrics, but current efforts must be strengthened. The ACA, through the HHS Secretary, establishes a "pre-rulemaking" process for the selection of quality measures for federal health programs.[67] HHS contracted with NQF to fulfill the statutory requirement for multi-stakeholder input into this selection process. NQF subsequently convened the MAP, a public-

private partnership, for this purpose. The goal of this endeavor is essentially to streamline performance metrics—examining which metrics are relevant for various applications, providing input to HHS, and encouraging alignment of public-private-sector measurement initiatives.[68] As with NQF, MAP should not prioritize the technical details of quality metrics over their usefulness. To this end, a greater emphasis on the need for public-private collaboration would help clarify the utility and applicability of metrics beyond federal health programs.

4. CREATE QUALITY METRICS TO SUPPORT ACOs

As part of the MSSP, CMS issued a list of 33 quality metrics for which participating ACOs should be held accountable. We believe these metrics provide a strong foundation for quality measurement in Medicare ACOs and should be applied in our vision for enhanced Medicare ACOs (Medicare Networks). However, we are aware of the concerns raised by the participants in the Medicare Pioneer ACO initiative about being subjected to standards for relatively new metrics. Therefore, we acknowledge the importance of building a robust base of credible data over the next couple years, so that we are able to phase in these metrics in a methodologically sound way.[69]

For private-sector ACOs and other integrated delivery systems, NQF could convene MSSP participants, stakeholders, consumers, and relevant experts to create a core set of physician measures that are appropriate for the kind of integrated, team-based practice that the ACO model demands. We believe that private-sector integrated delivery systems should have as much flexibility as possible to innovate and use whatever quality measures are appropriate, but these consensus metrics could provide a helpful reference or starting point.

5. DESIGN STRATEGIES TO PROMOTE THE ACCESSIBILITY OF QUALITY METRICS TO PATIENTS

To help consumers make informed choices about the *value* of a health care service, not just the cost, data on quality performance is essential. However, as with pricing data, this information must be presented to consumers in an accessible and actionable format. In the past, attempts to offer quality "report cards" to consumers have resulted in confusion, and studies show that previous report cards have been disconnected with consumer decision-making due to weaknesses in design, content, and accessibility.[70-71]

NQF should work with patient advocates and consumer groups, as well as other relevant stakeholders, to articulate a path forward for promoting the accessibility and usability of quality information for consumers. For example, for both beneficiaries and payers, quality metrics can be meaningless if they do not allow for clear comparisons across different settings and organizations. One potential strategy to address this issue is to promote transparency in specialty physician quality registries—this information should be made publicly available in an understandable format.

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6. SUPPORT OF ELECTRONIC CAPTURE OF DATA FOR MEASUREMENT THROUGH THE USE OF COMMON STANDARDS

The increase in health information technology adoption in the United States creates an opportunity to improve both the efficiency and effectiveness of data collection in order to support measurement for improvement and reporting. Ideally, clinical information should be collected once, as part of the care delivery process, and used for multiple federal, state, and private-sector reporting requirements. To promote electronic data capture, performance measurement specifications should be unambiguous, adhere to a common set of federally adopted data standards, and be field-tested before widespread adoption.

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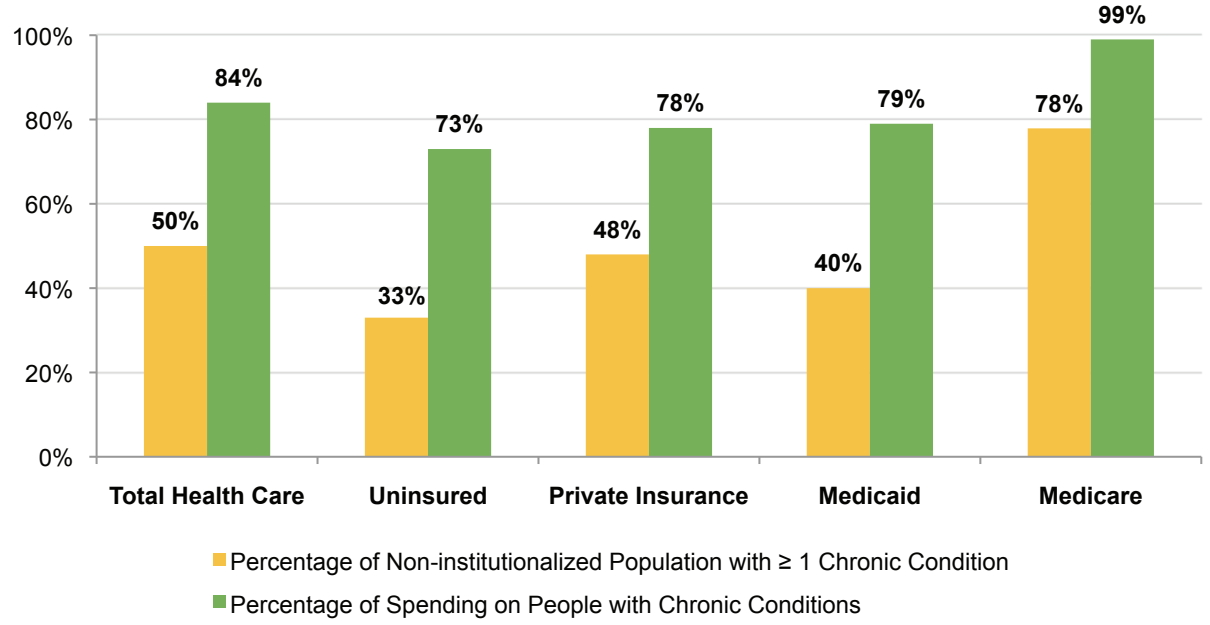
B. Advance Understanding and Use of Prevention in Cost Containment

Any discussion of U.S. health care costs must include a focus on the high cost of treating conditions related to obesity and chronic disease, which account for roughly 75 percent of all national health care spending.[72] Approximately $147 billion in direct medical costs can be attributed to obesity alone.[73] Many common chronic disease risk factors can be reduced through appropriate prevention measures.[74-75-76] As a result, increasing the emphasis on prevention is often viewed as one strategy to both improve health outcomes and to address these costs, but these efforts have not reached scale for a number of reasons. Experts disagree about the precise relationship between prevention and cost containment and the potential for cost savings. And, under our current system, incentives to finance and deliver services that can reduce or prevent the incidence of many chronic disease risk factors are often lacking.

Chart 6. People with Chronic Conditions Account for 84% of National Health Care Dollars and 99% of Medicare Spending



Source: Medical Expenditure Panel Survey, 2006 and Robert Wood Johnson Foundation, Chronic Care: Making the Case for Ongoing Care, February 2010

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The term "prevention" covers a range of activities and can occur in a variety of settings, from clinical prevention (e.g., mammograms or immunizations) to non-clinical, community-based interventions (e.g., weight-management programs for pre-diabetics). Prevention activities are typically classified into three tiers: health-promotion activities that encourage healthy living and limit the initial onset of diseases (e.g., nutrition education); early

detection efforts, such as screening at-risk populations (e.g., testing blood sugar to diagnose diabetes); and strategies for appropriate management of existing diseases and related complications (e.g., appropriate medication management for hypertension). According to the Centers for Disease Control and Prevention (CDC), to be most effective, prevention must occur in multiple settings and across individuals' entire life spans.[77] Education, social support, and a supportive physical environment are among several factors that can combine to motivate the health behavior changes needed to address many chronic diseases, including healthy eating, physical activity, and smoking cessation.

To test the value of prevention in improving health and containing costs, both public and private institutions have begun implementing prevention-oriented strategies and evaluating their impacts. At the federal level, for example, the ACA contains multiple funding provisions for prevention, including the Prevention and Public Health Fund (PPHF), which funds a number of pilot and demonstration projects. As the nation's first mandatory fund dedicated to prevention, the PPHF is helping to bolster expanded research and implementation of prevention strategies in diverse settings and populations. A growing body of literature demonstrates the value of evidence-based prevention in improving health outcomes in specific settings.[78-xvi]

While evidence about positive health impacts from specific interventions is building, the economic evidence base for prevention is less developed than for other more traditional health care interventions. In part, this is because of limited data: specifically, to date, the amount of money spent on non-clinical prevention has been limited, the scope of the programs relatively narrow, and the timeframe relatively short. Investment has been limited, to a certain extent, because the potential economic savings that can result from prevention may not accrue for years or even decades. While the evidence base is growing, there continues to be a healthy debate about which programs are most effective at generating savings through lower medical and non-medical costs (including, for example, reduced disability claims) and other benefits (such as increased productivity). Better understanding of the economics is crucial to informing sound public and private investment in prevention and facilitating the proliferation of successful strategies.

In this report, we do not attempt to quantify specific savings associated with particular prevention policies, nor project federal budget savings associated with prevention. Rather, we examine the barriers to better understanding the impact of prevention on cost containment, along with barriers to the broader implementation of prevention approaches that are found to be effective. We propose several policies to address these barriers, with a focus on enabling public and private institutions to rigorously evaluate the impact of prevention strategies on both health outcomes and cost, as well as to increase investment in those strategies that are shown to be effective.

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[xvi] For example, a clinical trial of the Diabetes Prevention Program, a lifestyle intervention to decrease weight through healthy eating and exercise, reduced participants' risk of developing diabetes by 58 percent. See: Diabetes Prevention Program Research Group. REDUCTION IN THE INCIDENCE OF TYPE 2 DIABETES WITH LIFESTYLE INTERVENTION OR METFORMIN. New England Journal of Medicine. 2002 February 7; 346(6): 393–403.

1. INCENTIVES AND BARRIERS TO WIDER USE OF PREVENTION STRATEGIES

Under the current system of health care delivery and financing, incentives to invest in preventive services are often lacking. Identifying and addressing the barriers to greater investment in prevention is critical if we seek to better align existing incentives and position America to capture the potential savings from curbing costly chronic conditions.

Current Incentives

To better understand the relationship between existing delivery and financing systems and incentives that affect the adoption of prevention approaches, we commissioned economic analyses by outside researchers in two areas that have some of the most developed data: workplace wellness and community-based diabetes prevention.[79] These analyses provide several relevant takeaways about the opportunities and challenges associated with prevention programs.

Comprehensive Workplace Wellness Programs

Dr. Ron Goetzel of Emory University examined the potential economic impacts of expanding comprehensive workplace health-promotion programs. (For more background on what constitutes a comprehensive workplace wellness program, please see the appendix.) Goetzel concludes that high-quality, comprehensive workplace-wellness programs implemented in large organizations can have a positive net present value, meaning that those programs can generate economic benefits for employers—after discounting future savings—through lower health care costs and higher productivity.[80]

However, there are significant barriers to wider adoption of these programs among employers, including: a lack of awareness about the programs; a dearth of organizational capacity to implement, monitor, and evaluate such programs in complex operating environments; and inadequate evidence to determine the minimum components of such programs.[81] Because of the potential promise of these programs, our recommendations focus on ways to address the barriers outlined above and to spur additional investment and innovation.

Community-Based Diabetes Prevention Programs

The American Institutes of Research (AIR) examined community-based diabetes prevention programs, one of several kinds of relatively new, low-cost, community-based nutrition and physical activity interventions. These innovative designs are contributing to a growing body of research about the potential for savings from such approaches. (For further information on community-based prevention, please see the appendix.) Though initial results appear promising and simulations suggest that there could be long-term savings, at this point, there is insufficient long-term empirical data to demonstrate whether these group diabetes prevention programs will generate net savings when discounted over time.

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Specifically, AIR explored the financial incentives for public and private payers to fund such programs, even where they were demonstrated to be effective, under current and proposed

future payment and delivery arrangements. AIR's key finding is that, even if there were strong evidence showed that a particular prevention-oriented service would yield a net reduction in medical costs over time, the current delivery and payment systems do not necessarily ensure that the payer funding the intervention can benefit from these savings.[82]

Unsurprisingly, the age of a beneficiary greatly affects a payer's ability to capture savings from prevention investments. AIR finds that private plans generally have a stronger financial incentive to invest in a successful prevention intervention for younger beneficiaries, whereas the federal government achieves a better return on older beneficiaries (who are closer to enrolling in Medicare).

A plan's member turnover rate also affects the incentive structure. If more integrated, at-risk delivery systems, such as ACOs, were to display lower patient turnover than typically seen today among private insurance companies, AIR's findings suggest that investing in prevention across age groups would more-consistently benefit these organizations, since they have a longer period of time to recoup their investment.[xvii]

Because any shift toward new payment and care delivery models will unfold slowly, our recommendations focus on interim actions that governments, private-sector organizations, community organizations, and providers can take to advance knowledge of prevention strategies and accelerate the wider adoption of interventions that are shown to be effective.

Barriers

The two studies discussed above illustrate some of the key barriers impeding both the provision of prevention services and the analysis of their impact. These barriers, which our recommendations aim to address, include:

- *A nascent evidence base for the cost-effectiveness of prevention.* The evidence base linking prevention strategies to economic savings is still emerging. Success stories certainly exist, but in order to draw conclusions, we require additional data sets from large populations over long follow-up periods that link savings to program costs. More rigorous research is needed to identify and quantify the program elements that are most effective at improving health and saving money.
- *Up-front costs and a deferred return on investment, if it accrues at all.* The cost of investing in prevention may be a significant barrier for certain sectors, such as small businesses. Even where demonstrated savings were achieved over time, the payout from that investment may be on a longer timeframe than payers or government agencies typically use for cost-effectiveness evaluation. In some cases, the turnover rate of employees and health plan enrollees undermines returns to such an extent that investment in health promotion activities cannot be recouped.
- *The potential for benefits to accrue to a different party than the one who invests in prevention.* The costs of prevention programs and the amount and timing of benefits

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[xvii] Despite a lower assumed shared-savings percentage.

(e.g., medical cost savings and reduced disability) are divided unevenly among disparate parties. For example, if a private health plan pays to prevent high blood pressure in a 60-year-old, the federal government will likely be the party that ultimately reaps the potential cost savings during the years in which that person is a healthier Medicare beneficiary.

- *Historically limited levels of investment in public health and prevention initiatives.* Community-based prevention and public health initiatives traditionally account for only 3 to 8 percent of total health care spending, which has limited the ability to implement programs and capture data on their effectiveness. [83-84]

These barriers suggest a need for public and private investment to increase understanding of which existing prevention strategies work best, develop new innovative approaches based on the evidence, and better align incentives to invest in effective interventions. Our recommendations identify ways to address the identified barriers and accelerate a shift toward greater investment in evidence-based, cost-effective prevention strategies.

Generally, we favor increased investment in demonstration programs with rigorous evaluation to determine effectiveness, build the evidence base, and position all stakeholders to make more informed investments in proven programs that improve health and control costs. We recognize that a successful national prevention strategy requires strong leadership and a broad, multifaceted approach involving all sectors. We focus on the workplace and the community as two key points of intervention that complement preventive services within the traditional medical system.

RECOMMENDATIONS:

1. **Invest the Prevention and Public Health Fund in demonstration programs to help identify the most cost-effective prevention strategies.**
2. **Support collection, analysis, and dissemination of data from prevention programs, both governmental and nongovernmental.**
3. **Provide financial incentives to help spur investment and innovation among small businesses in comprehensive worksite health promotion.**
4. **Support health promotion strategies for the federal workforce to accelerate the generation of additional data on effective interventions**.

1. INVEST THE PREVENTION AND PUBLIC HEALTH FUND IN DEMONSTRATION PROGRAMS TO HELP IDENTIFY THE MOST COST-EFFECTIVE PREVENTION STRATEGIES

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To better understand the potential for cost containment from prevention, we must continue current investment in preventive care and services. The PPHF serves as one important resource to support prevention investments and should continue to be used for its intended purpose: "expanded and sustained national investment in prevention and public health programs that will improve health and help restrain the rate of growth in private- and

public-sector health care costs."[85] The fund provides direct financial support for the private, non-profit, and public sectors (at local, tribal, state, and federal levels) to implement a range of public health initiatives, such as community-based prevention efforts to reduce tobacco use, increase physical activity, improve nutrition, and expand mental health and injury programs. Additionally, funding for research and evaluation of these initiatives is specifically included in the PPHF in order to boost the evidence base for prevention strategies. The use of the fund must be targeted and strategic, reflecting a cogent vision of the goal that the nation is trying to achieve through investments in prevention.

RECOMMENDATION:

The PPHF should be invested in programs that continue to build the evidence base around prevention activities.

Prime examples include the Community Transformation Grant program, which strengthens public-private partnerships to deliver community-based prevention, and the National Diabetes Prevention Program, which authorizes CDC to develop a national network of evidence-based, diabetes prevention programs in communities across the country through public-private partnerships. These are two among many government-supported efforts that are currently investing in demonstration projects with rigorous evaluation components, focused on a goal of building the evidence base for effective prevention programs.

2. SUPPORT COLLECTION, ANALYSIS, AND DISSEMINATION OF DATA FROM PREVENTION PROGRAMS, BOTH GOVERNMENTAL AND NONGOVERNMENTAL

Investing in demonstration projects in public and private institutions enables stakeholders to generate data, synthesize the findings to identify the most promising interventions, and then share those best practices for others to learn from and adapt for their particular setting. Additional evidence would help establish with greater certainty which evidence-based programs merit further investment and are most likely to lead to cost savings.

The ACA recognizes the importance of data collection and analysis from federal and non-federal initiatives. Two specific provisions are particularly relevant, and we recommend that they be funded and fully implemented under existing statutory authority. First, Section 4402 of the law requires the HHS Secretary to evaluate the effectiveness of existing federal health and wellness initiatives and requires a report to Congress. We recommend that HHS establish a timeline for this evaluation and that the PPHF be used to fund this work.

Second, for non-government institutions, Section 4303 requires CDC to provide technical assistance in evaluating employer-based wellness programs, as well as to conduct a survey of existing programs. However, no money was allocated for these activities. We recommend the funding of this provision from the PPHF to make implementation possible.

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We also recommend the establishment of a clearinghouse of best practices for workplace wellness. CDC already plays an important role in collecting, evaluating, and disseminating quality information that can be used to guide decision-makers in the real world. For example, the CDC-supported *Guide to Community Preventive Services* provides results from

systematic, scientific reviews of existing community-based prevention programs to identify which interventions have proven effective.[86] Additional federal investment in building out a central clearinghouse of evidence-based, best practices specifically for workplace wellness could similarly propel the adoption of promising worksite-based prevention practices by employers.

Beyond knowing what interventions work, all stakeholders—including employers, payers, and community groups—would benefit from greater availability of objective information about how to implement and evaluate high-quality prevention programs. Moving forward, more resources should be directed at validating and improving the current tools, consolidating and making available the materials in user-friendly formats, and keeping the information up to date.[xviii] Once this evidence is collected, analyzed, and organized, it could be used to further refine evaluation of worksite health promotion programs.[xix]

3. PROVIDE FINANCIAL INCENTIVES TO HELP SPUR INVESTMENT AND INNOVATION AMONG SMALL BUSINESSES IN COMPREHENSIVE WORKSITE HEALTH PROMOTION

One hundred fifty million Americans are employed, and many of those employees are covered by ESI. Employee health status and productivity affect businesses large and small, making the workplace an important venue to address health and health care costs. A number of large private-sector employers have invested in workplace health promotion, and most of the available data comes from the large, private-employer setting. Yet about half of Americans working in the private sector are employed by small companies, about which relatively little real-world data exists.[87] Given the particular hurdles that many small businesses face—for example, less capital, fewer human resources, and lack of economies of scale—some financial support is warranted to spur investment by these organizations to generate more data on what works in these settings. More research is needed to determine the best ways to design, implement, and evaluate workplace wellness programs in the small business setting, as well as how health plans, community resources, and government can help small employers offer successful health-promotion programs to their employees.

RECOMMENDATIONS:

1. Explore providing access to wellness vendors through a limited number of state small-business insurance exchanges.

Access to quality third-party resources, such as consultants, vendors, and information resources, could help overcome barriers to initial adoption among small businesses, which typically lack the capabilities to design, implement, and evaluate programs in-house.

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[xviii] Several tools and resources for workplace health promotion have already been developed with the support of government funding. These include the CDC Worksite Health ScoreCard, a tool designed to help employers assess existing health promotion interventions in their worksites. Available at: http://www.cdc.gov/dhdsp/pubs/worksite_scorecard.htm. Also Available at CDC's Lean Works! Employer Toolkit: www.cdc.gov/leanworks/.

[xix] For example, the CDC Worksite Health ScoreCard enables employers to calculate a score for their worksite health program (out of 215 points), but there is not yet research to establish quantitative cutoffs for what constitutes a high-performing program.

Because workplace wellness programs can include incentives for participation, and health insurers may tailor offerings to combine with workplace health promotion strategies, the small-business state insurance exchanges may be useful platforms for small businesses to access workplace wellness vendors in a more cost-effective way. These exchanges could contract with workplace wellness vendors to offer employee wellness programs and services to participating small businesses.

2. Fund authorized ACA grants to small businesses.

Government should fully fund and implement the workplace wellness provision of the ACA that provides limited grants to small businesses for comprehensive workplace health promotion programs, with the goal of building out the evidence base of what works within the range of small-business settings. The ACA authorized $200 million to be appropriated over five years for comprehensive workplace wellness programs. Over the last two years, only about $20 million has been allocated to establish and evaluate comprehensive workplace health programs in 70 to 100 small, medium, and large employers, through the National Healthy Worksite Program.[88-xx] Some of the authorized but not yet allocated funding could be used to support implementation of these programs at more organizations with fewer than 500 employees and to establish demonstration projects to test innovative programs. Additionally, the funding should extend beyond two years to allow for long-term evaluation of program impact. These grants could provide small businesses with the funds needed to make an upfront investment in prevention and help expand the sample of small businesses in the workplace wellness literature.

4. SUPPORT HEALTH PROMOTION STRATEGIES FOR THE FEDERAL WORKFORCE TO ACCELERATE THE GENERATION OF ADDITIONAL DATA ON EFFECTIVE INTERVENTIONS.

Several pilot programs are currently underway within government agencies, and we encourage support for these kinds of demonstration programs, which generate valuable data to help better understand what strategies are most effective. For example, in 2010, the Office of Personnel Management, the Department of the Interior, and the General Services Administration launched WellnessWorks, a comprehensive health promotion program that includes health risk assessments, biometric screenings, group education classes, and individual health coaching, among other elements. The federal government should rigorously evaluate the health and cost impacts of these initiatives as a first step in making informed investments to improve the health and productivity of the federal workforce. Funding for the HHS Secretary to evaluate and report on the effectiveness of existing federal health and wellness initiatives (as noted in recommendation number 2) is important to shaping an evidence-based, comprehensive strategy for testing and further implementing health-promotion strategies in the government. The data generated by these programs will

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[xx]For the National Healthy Worksite Program (NHWP), a small employer is defined as less than 100 full-time employees, medium is defined as 101–250, large is defined as more than 250. Available at: http://www.cdc.gov/nationalhealthyworksite/docs/nhwp-employer-faq.pdf.

also help illuminate the value proposition of workplace wellness programs in the private sector.

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Chapter 4: Encourage and Empower States to Pursue Needed Reforms to Improve Care and Value

Our vision for reform hinges on the shift over time toward value-based, rather than volume-based, reimbursement and on the creation of more integrated and coordinated systems of care delivery and payment. The move toward this vision will require action within states and communities, as well as at the federal level. States should take an active role in promoting health system innovation and transformation. We support resources and incentives, rather than top-down mandates, to engage state leaders in supporting coordinated and accountable models of health care delivery and payment.

A. Pursue Greater Use of Integrated Care in Medicaid for Patients with Complex Needs

The Medicaid program provides coverage to approximately 60 million low-income Americans including pregnant women, low-income parents, children, and individuals with disabilities.[89] Medicaid is administered by the states under federal guidelines. The federal government shares financial responsibility for the program with the states, providing federal matching payments based on a formula that includes state per-capita income. Federal rules require states to cover certain "mandatory" populations, including low-income pregnant women and families receiving cash assistance, but also give states the flexibility to include other "optional" populations, such as pregnant women or families with slightly higher incomes. Likewise, Medicaid rules require that states offer a range of "mandatory" services, including inpatient and outpatient hospital services and physician office visits, with an option to provide additional services, such as prescription drugs and durable medical equipment.

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States may also request waivers from federal requirements in order to test alternative models of care or to cover other populations or benefits. These waivers have been used to

expand benefits to certain individuals within an eligibility group and to offer particular services only in certain areas of a state. Consequently, Medicaid programs vary considerably from state to state, from region to region within a state, and within categories of eligible individuals who may have similar incomes and assets. Medicaid is a significant component of every state budget, representing 24 percent of total state expenditures nationwide.[90] In 2011, Medicaid comprised approximately 15 percent of all national health care expenditures.[91]

Over the years, states have used managed care to better coordinate care, to slow the rate of growth in costs, or both. Today, 74 percent of Medicaid enrollees are in some type of managed care model, whether primary care case management or a fully capitated health insurance plan.[92] To enroll Medicaid beneficiaries in managed care, states may submit a state-plan option, or they may apply for a waiver of federal requirements, which involves a negotiation between states and the federal government on a number of issues, ranging from individual program requirements to the federal budgetary impact. BPC's Governors' Council has issued recommendations in the past that would strengthen the waiver process, such as developing templates to help states advance and accelerate innovations that work.[93]

DUAL ELIGIBLES

In 2008, 9.2 million individuals were eligible to enroll in both Medicare and Medicaid, a group commonly referred to as "dual eligibles" (or "duals"). Approximately two-thirds of this population qualifies due to age and one-third qualifies due to disability.[94] Chronic disease and comorbidities are highly prevalent in the dual eligible population, and the care for those individuals is both costly and poorly coordinated. This shortcoming is further complicated by the lack of integration of services covered by the Medicare and Medicaid programs. Some policymakers have suggested that better integration of Medicare and Medicaid services would improve care outcomes and lower cost for the dual population.[95] In 2008, dual eligibles comprised 20 percent of the Medicare population but nearly 31 percent of Medicare spending, and 15 percent of the Medicaid population but nearly 39 percent of Medicaid spending (or $128.7 billion).[96-97]

"Full-benefit duals" qualify for the full range of Medicare covered benefits and Medicaid benefits offered by the state, plus coverage for Medicare premiums and cost-sharing. For full-benefit duals, Medicare covers the cost of acute care services, such as physician and hospital services, lab and x-ray services, and prescription drugs, while Medicaid covers the cost of long-term care services and supports. Many full-benefit duals qualify for Medicaid because they are eligible for cash assistance under the Supplemental Security Income program. However, states may also choose to cover certain higher-income Medicare beneficiaries under Medicaid, including those who are institutionalized, are receiving home- or community-based care, have spent down their assets due to health care costs, or have incomes just below the federal poverty level (FPL).

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Certain low-income individuals are eligible to receive Medicare premium and cost-sharing assistance through their state Medicaid program, but are not eligible for Medicaid-covered items and services. These individuals are often referred to as "partial duals." Individuals

below 100 percent of the FPL receive both Medicare premium and cost-sharing assistance, and individuals between 100 and 120 percent of the FPL receive Medicare premium assistance only.

Prior to the passage of the ACA, distinct federal law, regulation, program administration, and financing for Medicaid and Medicare constrained opportunities to better integrate care between the two programs. Notably, the bifurcated nature of these programs offers little in the way of financial incentives to integrate services. If states, for example, decided to offer additional services—such as care coordination or home- and community-based services—to help preserve beneficiary health status and prevent avoidable hospital readmissions, any resulting savings would flow to the federal government through reduced Medicare spending.[98] Thus, states argue that there is little financial incentive to offer additional services that would improve patient care.

Path Forward For Greater Integration of Dual Eligible Care

The debate over how best to care for duals intersects with the discussion over a number of other important, unmet needs within our health care system. First, the United States does not have an adequate system for the provision of long-term care services and supports, a problem that is discussed in more detail in the following section of this report. Additionally, our current, fragmented system of care delivery and payment does not appropriately meet the care coordination needs of individuals with multiple chronic conditions. Because the Medicare and Medicaid programs were established as separate programs and designed with different eligibility and benefits to address two distinct populations, coordination of those benefits is not easily achieved.

Overcoming barriers to integration in Medicare and Medicaid would require coordinating different rules for each program, including the development of a single benefit package that incorporates all Medicare and Medicaid covered services, determining the best standard of medical necessity for clinical services. Further, integration would require the development of an appropriate standard for long-term care services and supports, in instances in which medical necessity may not be the best standard. In addition, an integrated program would need to create uniform rules for grievances and appeals, establish appropriate payment methodologies and risk-adjustment mechanisms, uniform rules for enrollment and disenrollment, uniform rules for marketing and enrollee communications, the development of appropriate quality measures, and uniform network adequacy requirements, including geographic accessibility.[99] Furthermore, states that have experience with integrating Medicare and Medicaid services have included contract requirements to specify the scope and responsibly of care coordinators, required plan coordination with social service agencies, assured continuity of care, required plans to work with enrollees and their families to develop individualized care plans, and set minimum standards for after-hours care and minimum wait times for services.[100]

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Finally, although some states have sought and received waivers to require dual eligibles to enroll in managed care as a condition of receipt of Medicaid services, until passage of the

ACA, Congress and HHS had been unwilling to provide a legal or regulatory pathway to require Medicare beneficiaries to enroll in managed care for Medicare services.

Recognizing the challenges of coordinating services for those eligible for Medicare and Medicaid, Congress established the Medicare-Medicaid Coordination Office as part of the ACA, and provided additional demonstration authority to the newly established Center for Medicare and Medicaid Innovation to develop demonstration projects to better coordinate care for dual eligibles.[101-102] CMS, working through these two offices, has sought to implement these demonstrations and is using both fully capitated plans and coordinated fee-for-service.[103]

Dual eligibles are a diverse population with complex care needs. According to MedPAC, the costliest 5 percent of dual eligibles account for over 40 percent of total Medicare spending for this population, and the costliest 20 percent account for 80 percent of total Medicare spending on dual eligibles. In contrast, the least costly 50 percent of dual eligible beneficiaries account for only 3 percent of Medicare spending on dual eligibles. This wide distribution in annual spending underscores the diversity of the dual eligible population.[104] We believe that this group would benefit greatly from integration of Medicare and Medicaid services and that the demonstrations under the ACA, with appropriate consumer protections, have the potential to improve the quality of care provided to these vulnerable populations. There may in fact be opportunities over the long-term to achieve integrated models of care that slow the rate of cost growth in both programs. In addition to those currently being tested, the HHS Secretary should explore additional models that permit the full integration of financing under the demonstrations, including for prescription drugs under Medicare Part D.

Further, we are concerned that the current financial model does not provide adequate opportunity for states to share in savings that are achieved under the Medicare program. One strategy to provide greater shared-savings opportunities for states would be to require Medicare to pay at normal rates, and then allocate any savings that are related to reductions in acute care costs based on Federal Medical Assistance Percentages (FMAP). Finally, CMS should consider testing a model that permits states to contract with CMS to provide the full range of Medicare and Medicaid services through the Medicare program.

Our suggested approach to dual eligible care supports current CMS demonstration projects, but also proposes a number of strategies for improvement (working within the existing Center for Medicare and Medicaid Innovation authority), such as:

- Allowing states more robust shared-savings opportunities;
- Looking at alternative care delivery models (beyond the current demonstrations), and including all Medicare benefits—such as financial integration of prescription drugs covered under Medicare Part D—within the current demonstration structure; and

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- Permitting a state to contract with CMS to provide a fully integrated benefit through the Medicare program.

In the years since enactment of the ACA, there has been considerable debate over whether full integration of dual eligibles could be best achieved through a continuation of the joint state-federal partnership established under the Medicaid program or by administering all services at the federal level through the Medicare program. While we do believe that it is critical to improve coordination of these programs through a single integrated model of care, we are not prepared at this time to make a recommendation as to how this should be achieved, and will continue to work in this area.

RECOMMENDATION:

Adopt a broad strategy to deliver Medicare and Medicaid services to dual eligible individuals through a single program.

PROVISION OF LONG-TERM CARE

We as a nation need a more comprehensive and coherent strategy for the financing and delivery of long-term care. Currently, nearly 11 million community residents—only 13 percent of whom receive paid assistance—and 1.8 million nursing home residents require long-term care.[105] The demand for long-term care is expected to increase dramatically in the coming decades, as the baby boomers age. The number of elderly individuals with disabilities is forecast to more than double between 2000 and 2040, increasing from ten million to approximately 21 million.[106]

Under current law, Medicare does not cover long-term care services, except in limited circumstances, and Medicaid provides long-term care only for low-income disabled individuals. As part of the American Taxpayer Relief Act of 2012, Congress authorized the establishment of a Commission on Long-Term Care, which is charged with creating a plan for the "establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system" to ensure the availability of long-term services and supports (LTSS) to individuals who need them.[107] The Commission includes a variety of experts and stakeholders, representing employers, insurers, state officials, health professionals, consumers, and individuals with cognitive or functional limitations, among others. The Commission is charged with examining the provision of LTSS in the context of existing health programs, the requisite health professional workforce, and the anticipated demand for services. We will follow the work of the Commission with interest and expect to continue work in this area at BPC.

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B. Improving Program Integrity and State Flexibility

1. TEST AND EVALUATE ALTERNATIVES TO MEDICAID PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTER PAYMENT

Federally Qualified Health Centers (FQHCs) provide comprehensive primary care to low-income patients in medically underserved areas. FQHCs—which include community health centers, tribal health programs, urban Indian health programs, select public outpatient clinics, and rural health clinics—are reimbursed by states under either a prospective-payment system or an alternative-payment methodology that is negotiated between a state and its FQHCs.[108] The prospective-payment rate varies based on the scope of "FQHC services" covered by a specific center. Federal rules for FQHC reimbursement were established to assure that private grant dollars appropriated for uninsured patients were not used to subsidize losses incurred as a result of Medicaid underpayments.[109]

States argue that the current reimbursement system can be a barrier to improving value and quality and to developing organized systems of care under the Medicaid program, and many are negotiating waivers with the HHS Secretary. Experts have also contended that changes in FQHC reimbursement could facilitate the ability of health centers to form and participate in organized systems of care, such as patient-centered medical homes.[110] Adoption of an enrollment-based, rather than an attribution-based delivery model, as described in our Medicare Networks approach above, could further facilitate FQHC participation in organized systems of care. FQHCs will remain critical points of access for both insured and uninsured individuals.

RECOMMENDATION:

The HHS Secretary, using authority provided to the Center for Medicare and Medicaid Innovation (CMMI), should test alternative models of reimbursement to assure quality and value in the Medicaid program. Changes to FQHC payment methodology should carefully evaluate the impact on access to care in medically underserved areas for both Medicaid and uninsured patients, and should ensure that reductions in Medicaid payments do not cost-shift to public and private grant dollars intended to finance the cost of uninsured patients.

2. REDUCE FRAUD AND ABUSE

RECOMMENDATION:

Implement the Medicaid and Children's Health Insurance Program Payment and Access Commission's (MACPAC's) recommendations to strengthen Medicaid program integrity.

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The total cost of fraud and abuse in Medicare and Medicaid is unknown, but estimates range from $50 billion to over $100 billion annually.[111-112] In general, federal and state dollars lost to fraud and abuse offer no benefit to patient health. Additionally, program integrity efforts,

which fight fraud and abuse in federal health programs, demonstrate a measurable return on investment.[113] As such, these efforts typically enjoy broad bipartisan support.

However, some policymakers and stakeholders have criticized the administrative burden that these programs can place on providers and states.[114-115] Program integrity activities can include identifying fraudulent or inappropriate billing, ensuring that individuals who are ineligible for Medicaid are not enrolled, and analyzing payment data to detect errors and prevent fraud. Because responsibility for Medicaid spending is shared between states and the federal government, over the years, well-intentioned efforts to strengthen Medicaid program integrity have created redundancies and inefficiencies, such as overlapping initiatives at the state and federal level.

Recently, MACPAC called for a number of changes to strengthen program integrity in Medicaid.[116] These recommendations call on the HHS Secretary to minimize the burden that current program integrity efforts place on states or providers and also to enhance states' ability to detect fraud and abuse through activities such as streamlining regulatory requirements, determining which program integrity efforts are most effective, eliminating redundant or ineffective programs, disseminating best practices, and enhancing educational and training opportunities for addressing program integrity in managed care.[xxi] We support MACPAC's call to strengthen Medicaid program integrity. Efforts to eliminate administrative burdens and redundancies, as well as to ensure accountability for public health care dollars, should be supported within the context of health care cost containment.

3. INCREASE AND IMPROVE SUPPORT FOR LOW-INCOME MEDICARE BENEFICIARIES

As noted in the Medicare section of this report, certain low-income Medicare beneficiaries who do not qualify for full Medicaid benefits are eligible to receive assistance with premiums and cost-sharing for hospital and physician services through Medicaid, yet less than one-third of eligible beneficiaries are enrolled in that program.[117] States could encourage greater enrollment by streamlining application processes and easing or eliminating asset tests, which often serve as a barrier for low-income seniors and people with disabilities who are otherwise eligible.

Additionally, there is no physician or hospital cost-sharing help available for beneficiaries with incomes that are just above the poverty level. This is a significant gap in the safety-net, and we propose an expansion of federally funded and administered cost-sharing assistance to Medicare beneficiaries with incomes between 100 percent and 150 percent of the FPL, as detailed earlier in the report.

RECOMMENDATION:

Beginning in 2016, expand cost-sharing assistance for Medicare beneficiaries with incomes up to 150 percent of the federal poverty level.

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[xxi] A complete list is available in MACPAC's March 2012 Report. See Recommendations 4.1 and 4.2 on page 204.

C. Promote Transparency that Is Meaningful to Consumers, Families, and Businesses

Health care cost and quality information can help consumers make prudent decisions about where and how to spend their health care dollars.

RECOMMENDATIONS:

1. **Encourage pro-competitive rules for insurer-provider contracting:**
   a. **Prohibit providers from requiring placement in the preferred tier as a condition of contracting;**
   b. **Restrict "all-or-nothing contracting" for providers that have multiple distinct units; and**
   c. **Ban "most-favored-nation" contracting between providers and insurers.**
2. **Promote price transparency that will help consumers better understand and anticipate health care costs.**

1. ENCOURAGE COMPETITIVE INSURANCE CONTRACTING RULES

One strategy to promote price and quality transparency that helps consumers decide how to best spend their health care dollars is the creation of tiered networks, which rank health care providers—including physicians and hospitals—based on quality and cost information. Typically, consumers in health plans that incorporate this design are offered lower cost-sharing when using providers in the preferred, or high-value, tiers—which consist of those providers with high-quality scores and lower costs. Tiers can be constructed in many different ways, but are frequently organized by some combination of cost, quality, or safety measures.[118] Ideally, consumers in tiered plans are empowered to make more-informed choices about which provider to visit. Tiered networks must be negotiated through contracts between payers and providers.

To support broader implementation of tiering, we suggest a number of pro-competitive insurance contracting rules. We believe that tiered network approaches have broader potential for adoption than arrangements that sharply limit provider choice. In the same manner that tiers for prescription drugs have become the dominant benefit design rather than closed formularies (which provide no payment for drugs that are not on the formulary), tiered designs might also have more potential than narrow networks to incorporate value incentives into provider choice.

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Although tiered networks have been used extensively for specialty physician services (sometimes called "high performance networks"), hospital resistance has limited the use of this approach for providing incentives to choose high-value hospitals. Prominent hospitals, those in which all plans consider essential to include in their networks, often demand placement in the preferred tier as a condition of contracting with a payer.

The following change would facilitate expanded use of tiered approaches:

a. Prohibit hospitals from demanding to be in "preferred" tiers (often indicated by lower patient cost-sharing) as a condition of contracting with a payer.

A comparable recommendation was adopted by Massachusetts in 2010 legislation, and the prohibition is believed to have led to the offering of a popular tiered design by Blue Cross Blue Shield in that state. [119] Hospitals in Massachusetts are grouped into three tiers based on assessments of cost and quality. Deductibles vary by hospital tier, from $0 for the preferred (highest-value) tier, to $500 for the middle tier to $1,000 for the least-preferred tier.

Two other approaches have the potential to lead to lower prices for care:

b. Restrict "all-or-nothing contracting," in which a health system demands that a payer include all of its member providers in-network, regardless of their performance or payer preference; and

c. Ban most-favored-nation clauses, in which payers, in return for a higher payment rate, require providers to guarantee that other payers will not receive rates any lower.

All-or-nothing contracting enables a system that includes a must-have flagship hospital to obtain inflated rates for other hospitals in the system. By restricting this practice, health plans can choose which of the hospitals in a system merit inclusion in networks, and then agree to a price that is appropriate for the value that each hospital offers.

Under a most-favored-nation clause, hospitals, in return for a higher payment rate from an insurer (typically the largest one in the market), agree that other insurers will not get any lower price. These agreements lead to higher prices and create a barrier to entry into an insurance market. Moreover, these arrangements may interfere with hospitals offering insurers a lower price to be classified in a more favorable tier. The Justice Department sued Michigan Blue Cross Blue Shield to end its most-favored-nation clause in hospital contracts. The suit was abandoned in response to a new Michigan law prohibiting this type of clause in hospital contracting.[xxii-120]

States, through legislatures and departments of insurance, are responsible for oversight of their insurance marketplaces, insurance laws, and budgets.[121] Thus, the rules suggested above must be implemented and adopted at the state level. The federal government should consider offering states an incentive to implement these pro-competitive contracting rules, which is discussed in more detail in the "Provide Incentives for State-Level Reform" section below.

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[xxii] Per Public Act 5 of 2013 of the Michigan Legislature, effective March 2013, an insurer or a health maintenance organization are not permitted to use or enforce a most-favored-nation clause in any provider contract.

2. PROMOTE PRICE TRANSPARENCY THAT HELPS CONSUMERS ANTICIPATE COSTS

There is considerable debate among health policy experts and economists on the implications of providing price information to consumers and other purchasers. Some analysts suggest that making prices available to consumers would allow them to choose lower-cost health care providers and thus drive down prices by high-cost providers.[122] Proponents of price transparency cite private insurance plans that make provider-specific pricing information available to members through their websites and suggest that all private insurers and states should provide price information that reflects negotiated discounts with specific providers.[123] The California Public Employee Retirement System, one of the nation's largest purchasers of health care, has also called for a policy to achieve pricing transparency by 2014.[124] This is especially critical to consumers with high-deductible health plans.

Conversely, other noted health policy experts argue that making price information available to consumers is not helpful in the decision-making process and that, without relevant quality information that is understandable to consumers, patients are reluctant to choose a provider on the basis of cost, fearing that lower prices equate to lower quality of care.[125] Further, antitrust experts are concerned that the potential unintended consequences of price transparency could lead to higher prices, arguing that payers are better able to collect and organize price information and use that information to contract with high-quality providers.[126] When concerns are raised about the competitive effects and potential cost increases associated with transparency, advocates often suggest that these concerns could be addressed through stronger antitrust laws.

Experts can agree, however, that price information made available to consumers typically offers too little or too much detail to be helpful in decision-making.[127] More meaningful pricing data would clearly illustrate for patients their anticipated financial liability under their insurance coverage and could allow consumers to make clear comparisons for different treatment options and providers. This would be a dramatic improvement over simply offering, for example, a list of average prices for all providers in a particular region.[128] Pricing data should be presented in a way that is useful to patient decision-making. While we will continue to work in this area, there are a few angles that we believe present opportunities to emphasize greater price transparency. Specifically, we recommend the following:

- Insurers should share pricing data that would help individuals who are enrolled in consumer-directed plans to better understand the out-of-pocket costs associated with seeing various providers *before* accessing care. To avoid sharing proprietary information, insurers could offer average anticipated costs of various services for each provider.
- Insurers should provide estimates for average costs of out-of-network care associated with various types of providers, locations, and services. This could be based on information from Fair Health (a university-based service created under a settlement between the New York State Attorney General and Ingenix), which has

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collected information on billed charges and provided it for insurers to develop screens for charges for out-of-network care.

D. Pursue Medical Liability Reform

Our nation's current medical liability system has long been criticized as ineffective, serving both patients and providers poorly. Patients deserve care that is safe and effective, and they should be fairly and promptly compensated if they are harmed by negligent or irresponsible care delivery. At the same time, physicians, hospitals, and other health care providers should be able to focus on providing high-quality care without having to worry about negligence claims. Problems with the current medical liability system are well documented:

- Patients with similar cases receive drastically different awards;
- Fifty-five cents of every dollar spent on malpractice premiums goes to administrative expenses and system overhead costs rather than to malpractice payouts; and
- Only 2 to 3 percent of injured patients actually file a claim.[129]

Consistent with our efforts to move toward high-quality, integrated systems of care, the medical liability system should encourage health care providers to improve quality of care and to adopt systems that result in fewer adverse events.

RECOMMENDATIONS:

1. **IOM should convene a panel of providers, consumers, and quality-measurement groups to determine whether evidence-based quality measures could be used as a basis for provider defense in medical liability cases, and if so, to provide guidance on a process for the adoption of appropriate measures through a quality-certification organization. Adoption of measures should be consistent with efforts to create a uniform set of quality measures used for provider reimbursement and quality improvement.**
2. **Provide continued opportunities for states to test alternative models designed to reduce insurance and utilization costs associated with medical liability litigation by appropriating the $50 million in state demonstration grants authorized in the ACA for the development, implementation, and evaluation of promising alternatives to current tort litigation**.

Medical liability reform could help to discourage the practice of "defensive medicine," whereby clinicians order unnecessary imaging scans, tests, or invasive procedures for their patients out of fear of litigation. Proponents of reform argue that defensive medicine can also lead to the avoidance of high-risk patients.[130] A majority of physicians—as many as 90 percent in some studies—report practicing defensive medicine.[131-132]

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The latest analysis from CBO acknowledges a link between tort reform and higher utilization of health care services; this represents a change from CBO's previous position.[133] Citing a number of studies, CBO concludes that tort reform can be empirically associated with a reduction in health care spending, lower insurance premiums for self-insured plans, and certain changes in provider practice patterns, such as ordering diagnostic services.[134-135-136] As an example of costly utilization of medical services associated with defensive medicine, CBO points to the use of a computerized tomography scan rather than a less expensive x-ray.[137]

CBO estimates that enacting a package of common tort reforms would reduce the federal deficit by $54 billion over ten years.[138] Unlike previous CBO estimates, which were relatively small, this projection includes savings from both lower medical liability insurance premiums *and* reduced utilization of health care services. CBO does note, however, that there are differing studies as to the effect of limiting damages on health outcomes. Some research suggests that a 10-percent reduction in costs related to medical liability would increase the nation's overall mortality rate by 0.2 percent, while other studies find that tort reform generates no significant adverse outcomes on patients' health.[139]

The Role of Quality in Liability Reform

The IOM should convene a panel of physician specialty groups, patient advocates, and organizations engaged in the development of quality measures, to determine whether these measures are appropriate to use as a rebuttable defense in medical liability cases, effectively providing a safe harbor for providers and institutions that adhere to appropriate and endorsed guidelines. Although states such as Maine and Oregon have attempted this approach in the past, it was not seen as particularly effective due to the lack of quality measures appropriate for this purpose.[140]

If the IOM panel concludes that this safe-harbor approach could improve quality of care and lower the costs of liability insurance and higher utilization that are associated with defensive medicine, a quality-accreditation or certification organization should convene health care providers, advocates, and other quality organizations to prioritize, identify, and endorse appropriate measures. These could include, if applicable, the evidence-based recommendations established by specialty societies as part of the Choosing Wisely campaign.[xxiii] The medical liability reform process should be consistent with our recommendation to establish a common set of measures to be used for quality improvement and reimbursement.

Under this safe-harbor approach, we seek to align and promote the use of quality metrics. Once a reasonable number of endorsed metrics are in place, states could adopt rules to establish a rebuttable presumption in medical liability cases. This safe harbor would serve as an alternative to the existing standard of professional negligence, which is generally, "the

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[xxiii] Choosing Wisely is an initiative of the ABIM Foundation. The campaign developed *Five Things Physicians and Patients Should Question*, lists of evidence-based recommendations physicians and patients should discuss to help make informed decisions about care. More information is available here: http://www.choosingwisely.org/.

failure to do something which a reasonably prudent person would do, under circumstances similar to those shown by the evidence."[141] Because there is no uniform, consensus-based standard for what constitutes best practice today, clinicians are left to choose among often-conflicting medical guidelines. Inside the courtroom, juries are asked to rely on dueling testimony between experts to determine negligence.

Although development of the measures will take time, the quality-certification organization should consider high-risk specialty groups, such as obstetrics, gynecology, general surgery, and emergency medicine, as a starting point for this effort. If successful, the initiative could expand to other specialties and sub-specialties, as well as to general internal medicine. Many initiatives that are already underway could help inform this work, including the Patient-Centered Outcomes Research Institute. We encourage HHS to incorporate these guidelines into the state demonstration project grants mentioned above.

State Models of Liability Reform

Although policymakers have sought a federal solution to medical liability reform, no single approach has garnered sufficient support to enact legislation establishing a national standard. Some legislators have advocated for federal caps on damages—such as non-economic awards for pain and suffering, and punitive damages, designed to punish negligent providers—or limits on contingency fees received by plaintiffs' attorneys. Other approaches have included the establishment of specialized courts to consider medical liability claims, or to provide safe harbors for physicians that incorporate quality measures into their practices or advocate enterprise liability.

The issue of medical liability is traditionally in the purview of states, and they should continue to seek innovative solutions to tort reform. There are a number of innovative malpractice reforms underway at the state level, but with the exception of caps on non-economic damages, there is little definitive evidence regarding the effectiveness of these policies.[142] However, there is concern that implementing caps on damages *alone* does not promote our goals of improving quality. Furthermore, caps can limit access to remedy for those who are in fact victims of negligence.

Some action at the federal level is needed to provide states with greater resources and support. Toward that end, the ACA establishes a grant program to provide funding for states to demonstrate and evaluate alternatives to the current tort system.[143] We support the appropriation of this $50 million in authorized funds in order to facilitate continued state testing and analysis of alternative models to reduce insurance and utilization costs that are associated with medical liability litigation.

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E. Strengthen and Promote the Health Professional Workforce

A strong health professional workforce is needed to support health system transformation, high-quality care, and cost-effective care delivery. Anticipating future demand for health

care services, while training and structuring a workforce with the right mix of skills, is a complicated task for educators and policymakers. Due to insufficient data-collection and analytical tools, the United States lacks a full understanding of our current supply of health professionals, and we do not have a comprehensive workforce planning strategy in place to help meet future demand.[xxiv]

While experts disagree on whether the nation faces a significant overall provider shortage in the coming years, there is a general consensus that we face a primary care provider shortage.[144-145-146-147] A strong primary care workforce—defined by CMS to include practitioners in family medicine, geriatrics, internal medicine, obstetrics and gynecology, and pediatrics—is critical to our nation's health.[148] Research shows that countries that lead in primary care—demonstrating strong coordination, continuity of care, and an ability to meet population health needs—achieve better health outcomes at a lower cost.[149]

With tens of millions of newly insured patients expected as a result of the ACA, and the entrance of millions of baby boomers into Medicare, we must consider strategies to ensure that all patients maintain access to primary care, while preserving care quality and efficiency. One such strategy is strengthening current graduate medical education policy by better aligning payments that support education with actual teaching costs, by rewarding high-performing institutions and by ensuring that opportunities for clinician training align with anticipated demand (as described above in the "Improve and Enhance Medicare to Secure System-Wide Reform" section). Another promising strategy is broader utilization of non-physician professionals, such as advanced practice nurses (APNs) and physician assistants. Both of these approaches can help shore up the nation's supply of primary care professionals. Though our focus in this report is on primary care physicians and nurse practitioners, policymakers should also consider innovative strategies to utilize other health care workers and professionals, such as pharmacists, psychologists, social workers, registered nurses, medical assistants, and technicians.

IMPLEMENT SCOPE OF PRACTICE REFORMS

Health care delivery involves a diverse array of professionals and services. Specialists, primary care physicians, APNs, physician assistants, direct care workers, medical assistants, and numerous other professionals and workers all complete varying levels and types of education and training. For some services, the skills and competencies among various types of health care professionals overlap, leading to an ongoing debate over appropriate "scope of practice." Ideally, all professionals should practice at the full extent of their licensure, education, and training. However, this is made difficult in practice by factors such as varying licensure across states and inconsistent reimbursement policy across public and private payers.

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[xxiv] For more information, read the reports produced by BPC and the Deloitte Center for Health Solutions discussing health professional workforce supply and demand, *The Complexities of National Health Care Workforce Planning* (February 2013) and *Better Health Care Worker Demand Projections: A Twenty-First Century Approach* (February 2013). Available at: http://bipartisanpolicy.org/projects/health-professional-workforce/about.

RECOMMENDATION:

Eliminate outdated statutory or regulatory requirements in Medicare and Medicaid that interfere with states' abilities to regulate and determine scopes of practice. For example, Congress should strike language from the Medicare statute that requires physician collaboration as a condition of direct nurse practitioner reimbursement.

Structuring an appropriate and efficient division of labor between APNs and physicians is a central concern in the national and state debate over scope of practice. Advanced practice nursing includes professionals such as nurse midwives, nurse anesthetists, clinical nurse specialists, and nurse practitioners (NPs). Though levels of education and training vary, a number of APN competencies and skills overlap with those of physicians. NPs are able to provide an array of primary care services, such as taking patient history, ordering tests, and performing physical examinations.[150] Some policy experts believe that NPs and other APNs should be given greater authority to practice and bill independently. Physician groups have historically opposed the idea that NPs or other professionals can provide an adequate substitute for physician care, citing safety and care-quality concerns.[151] However, current literature does not indicate that care delivered by APNs, for example, is less safe or effective than care delivered by a physician.[152]

The most cost-effective care delivery would utilize the professional that can deliver safe, high-quality care at the lowest cost. Ideally, a specialty physician should not provide a service that a primary care physician could supply at lower cost, just as a primary care physician should not provide a service that a physician assistant could deliver safely, effectively, and at lower cost. Furthermore, giving a physician assistant or NP the authority to perform basic but vital primary care services, such as prescribing an antibiotic to a patient suffering from a sinus infection or performing a routine physical exam, provides more time for primary care physicians to focus on the most complex cases.

To strengthen our primary care workforce, we encourage investments in both physicians and non-physician primary care professionals. Additionally, medical, nursing, and other educators should consider strategies to promote interprofessional training and competencies, which will help ensure that all professionals are equipped with the core skill sets needed for successful collaboration.[153]

Scope of practice for health professionals is determined by state law and regulation. These standards vary significantly across states: 16 states and D.C. currently allow nurse practitioners full independence to practice at the top of their license, including diagnosis, treatment, referrals, and prescriptions; eight states allow full independence with the exception of prescriptions; 26 states require some level of physician involvement in NP practice, and ten of those 26 require a "collaborative" relationship with a physician for "consultation, referral, and review of provided care."[154] Greater utilization of NPs could promote cost-efficient care delivery and improve access to care in underserved areas.

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Ultimately, we believe that health professional licensure, and decisions about how best to structure collaborative or supervisory requirements for care delivery, should continue to be left to the states. As such, changes in federal statute and regulation should support maximum flexibility for states, rather than impose a federal mandate or pre-emption on health care professional scope of practice laws.

Eliminate Outdated Statutory Language and Regulation that Interferes with States' Ability to Determine Scope of Practice

To address scope of practice issues, we endorse a recommendation similar to that suggested by the Center for American Progress, in that Medicare and Medicaid payments to non-physician providers should allow them to practice to the full extent permitted under state law.[155] HHS should review and remove regulatory requirements in Medicare and Medicaid that interfere with the ability of states to regulate and determine scope of practice.

To the same end, outdated or overly prescriptive language in the Medicare and Medicaid statute should be eliminated. For example, under Medicare, NPs are unable to order home health care or durable medical equipment for patients.[156] Additionally, Medicare requires some form of collaborative relationship between physicians and NPs as a condition of direct NP reimbursement. In some states, this undermines laws that allow NPs full authority to practice and bill independently, and adds a layer of uncertainty and unnecessary regulatory burden. Physician supervisory requirements in the Medicare statute for NPs and other APNs should not be *less* flexible than the supervisory requirements determined by each state. Independent reimbursement of NPs provides payments that are 85 percent of the physician fee schedule rate. We expect the cost of striking collaborative requirements for NPs from the Medicare statute would be minimal and could even generate savings.

Additionally, as part of the initiative to eliminate burdensome or unnecessary regulations (Executive Order 13563, "Improving Regulations and Regulatory Review"), CMS recently issued a rule that streamlined requirements for providers and suppliers. This rule was narrow in scope, but included changes, such as altering the conditions of participation for nuclear medicine services to remove the requirement for "direct" supervision of radiopharmaceutical preparation.[157] We encourage CMS to continue this work to eliminate unnecessary regulatory burdens and inefficiencies.

IOM Recommendations

We support an approach to health professional workforce reform that places states in the driver's seat. Greater independence for APNs is a positive and beneficial direction for the U.S. health care system, but we believe that the path toward that objective should include resources and incentives for states, rather than mandates or top-down requirements. Activity at the federal level should focus on the removal of barriers to greater APN flexibility, consistent with state scope of practice requirements, and avoid conflicting standards that create confusion and administrative complexity for health professionals.

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We endorse several of the scope of practice recommendations in the IOM "Future of Nursing" report (2010) that are consistent with this approach, including:

- Expand the Medicare program to include coverage of advanced practice registered nurse services that are within the scope of practice under applicable state law, just as physician services are now covered.
- Amend the Medicare program to authorize advanced practice registered nurses to perform admission assessments, as well as certification of patients for home health care services and for admission to hospice and skilled nursing facilities.
- The FTC and the Antitrust Division of the Department of Justice should review existing and proposed state regulations concerning advanced practice registered nurses to identify those that have anticompetitive effects without contributing to the health and safety of the public.

IOM also supports passage of the National Council of State Boards of Nursing (NCSBN) advanced practice registered nurse model rules and regulations regarding scope of practice (Article XVIII).[158] We support the NCSBN Model Act, but disagree with the prescriptive implementation mechanism in the IOM report. Rather than restricting nursing education funds, we suggest an incentive for states that move forward with scope of practice. Approximately 17 states have adopted or are considering legislative and regulatory changes consistent with the Model Act.[159] These states should qualify upfront for a financial incentive. Offering a financial incentive rewards states that are already on the path toward constructive scope of practice reform, and may help states that have not considered reforms break through local inertia.

NCSBN's Advanced Practice Registered Nurse Consensus Model Act provides clarity and uniformity across a number of areas related to APN licensure, accreditation, certification, and education of APNs. For example, the Act defines four categories of APN (nurse anesthetist, nurse midwife, clinical nurse specialist, and nurse practitioner) and six areas of population foci (such as pediatrics, women's health, and psychiatric health). The NCSBN Model Act is the result of a collaborative effort among an extensive group of nursing organizations, state boards of nursing, educators, experts, and other stakeholders.

INCREASE THE SUPPLY OF HEALTH PROFESSIONALS

To strengthen the health professional workforce, the ACA calls for various demonstrations, pilot projects, and grant, loan, and scholarship programs that emphasize delivery system reform and innovative systems of care integration and coordination, increase the supply of primary care providers, and address issues of health professional shortages and maldistribution. As of December 2012, approximately $798 million in workforce and training funding had been distributed to states and private entities, well below the levels called for in the ACA.[160] A number of the workforce provisions in the law—such as the primary care extension programs and funding for training in certain areas including cultural competency, reduction of health disparities, and working with individuals with disabilities, among others—remain unfunded.

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The workforce funding in the ACA is largely discretionary, and thus highly vulnerable to ongoing budget battles and fiscal uncertainty. While we are not advocating that Congress move forward with all the programs authorized by the ACA, the government should be strategic about the best way to leverage limited financial resources. Defunding or disregarding a large number of these programs could result in missed opportunities to shore up the health care workforce, to provide support to vulnerable individuals with unique care needs, and to engage in strategic workforce planning at both the state and federal level. For example, the state health care workforce development planning and implementation grants authorized by Section 5102 of the ACA have thus far received only a tiny fraction of their authorized sums, and the National Healthcare Workforce Commission remains unfunded.[161]

Additionally, a more pointed health-professional-supply issue exists for the Indian Health Service (IHS), a division of the HHS that provides access to health care for nearly two million American Indians and Alaska Natives (AIANs). Compared with other racial and ethnic minority groups, AIANs face significant health disparities. Life expectancy is lower for AIANs and they experience greater mortality rates for chronic disease than the average American.[162] Moreover, the lack of qualified staff in IHS facilities creates gaps in the availability of necessary health care services.[163] The ACA permanently reauthorizes the Indian Health Care Improvement Act (IHCIA), which provides for many IHS services; sets goals for health improvement in the AIAN population; calls for initiatives to reduce the incidence of and prevent, treat, and control diabetes; and seeks to increase the IHS health professional workforce. Because IHCIA funding is discretionary, this vulnerable population stands to miss out on many critical opportunities for care quality and delivery improvement if funding is not appropriated.

F. Provide Incentives for State-Level Reform

We present the recommendations in this report to state leaders in the same way that we present them to federal leaders—as options that we believe would have a beneficial impact on health care cost and quality. However, there may be a few areas where federal implementation incentives would be helpful to states. In the discussion below, we prioritize several recommendations for which state-level implementation is essential to the effectiveness of our policy approach.

RECOMMENDATION:

The federal government should consider offering a financial incentive to states that enact the following reforms:

- Adoption of evidence-based quality measures that could be used as a provider defense in medical liability cases;
- Pro-competitive insurance contracting rules; and
- NCSBN Advanced Practice Registered Nurse Consensus Model Act.

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The federal government could use a number of financial incentives or grants to support and encourage state action. One potential incentive would be to forgive part of the state

"clawback" from the federalization of prescription drug coverage for low-income beneficiaries who qualify for both Medicare and Medicaid.

As part of the Medicare Modernization Act, which added Part D prescription drug coverage to Medicare, Congress created a low-income subsidy (LIS) that now assists low-income Medicare beneficiaries with their Part D premiums and cost-sharing. This new, federal subsidy for prescription drugs replaced assistance that was previously provided to low-income Medicare beneficiaries through state Medicaid programs. To help finance the LIS, states were required to pay a clawback based on their previous spending on prescription drugs for dual eligibles. Initially set at 90 percent of historical spending for each state, this clawback is scheduled to phase down to 75 percent of historical spending by 2015, at which point it will remain at that level indefinitely.[164] As an incentive for states to address important components of system-wide health cost containment, the HHS Secretary could be given authority to further reduce the contribution to this clawback for individual states that implement the reforms described above. Such a financial incentive could encourage state legislators and governors to prioritize these often-challenging reforms that are particularly important to health system improvement.

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List of Acronyms

ACO	Accountable Care Organization
ACGME	Accreditation Council for Graduate Medical Education
APN	advanced practice nurse
ACA	Affordable Care Act
ABMS	American Board of Medical Specialties
AIANs	American Indians and Alaska Natives
AIR	American Institutes of Research
BPC	Bipartisan Policy Center
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CMP	civil monetary penalty
CBO	Congressional Budget Office
DPP	Diabetes Prevention Program
DRG	diagnosis-related group
DGME	direct graduate medical education
DME	durable medical equipment
EHR	electronic health records
ESI	employer-sponsored health insurance
FPL	federal poverty level
FTC	Federal Trade Commission
FQHCs	Federally Qualified Health Centers
FDA	Food and Drug Administration
GME	graduate medical education
HHS	Health and Human Services
HRSA	Health Resources and Services Administration
IME	*indirect medical education*
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
IOM	Institute of Medicine
LTSS	long-term services and supports
LIS	Low-Income Subsidy
MAP	Measures Application Partnership
MLR	medical loss ratio
MACPAC	Medicaid and CHIP Payment and Access Commission
MEI	Medicare Economic Index
MedPAC	Medicare Payment Advisory Commission
MSP	Medicare Savings Program
MSSP	Medicare Shared Savings Program
NCQA	National Committee for Quality Assurance
NCSBN	National Council of State Boards of Nursing
NQF	National Quality Forum
NPs	nurse practitioners
PRA	per-resident amount
PPHF	Prevention and Public Health Fund
REMS	Risk Evaluation and Management Strategies
SGR	Sustainable Growth Rate
UHG	UnitedHealthGroup

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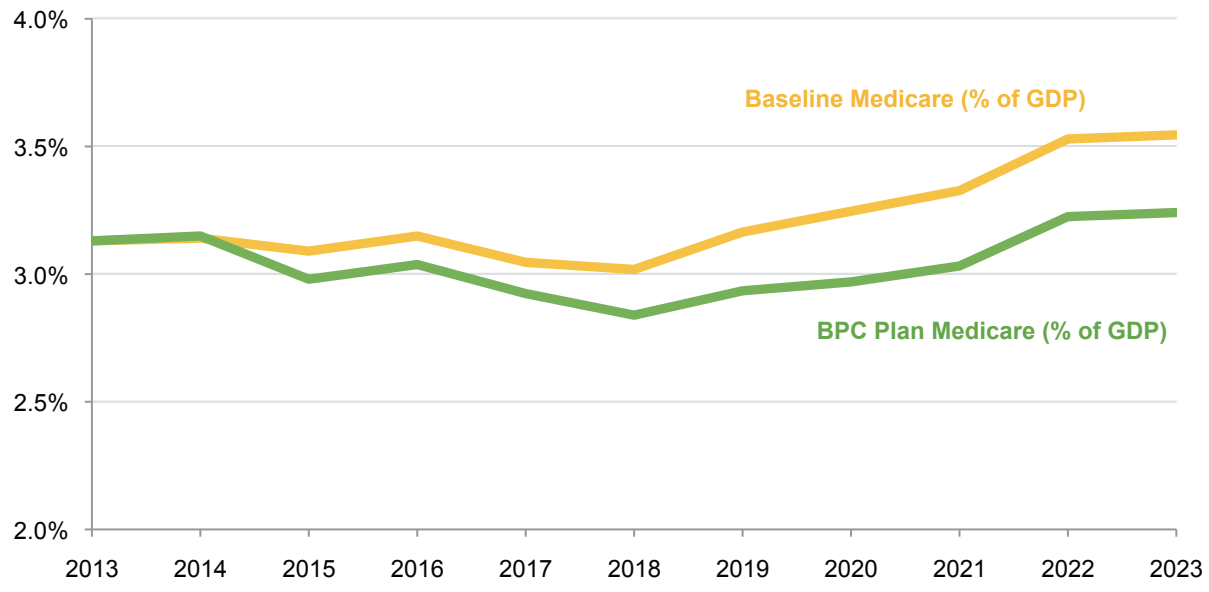
Appendix: Modeling Information and Additional Policy Specifications

Modeling Information

BPC commissioned Acumen, LLC to model and produce budget savings estimates for the long-term Medicare reforms and certain other Medicare proposals described in this report. Acumen is highly qualified for this work due to their substantial experience analyzing Medicare and other health data; the organization has served as a contractor for the Congressional Budget Office, MedPAC, and the Institute of Medicine.

Chart 7. Ten Year Impact of Proposals on Medicare Spending



Note: For this graph, "Medicare" refers to net Medicare spending. Baseline includes the cost of freezing physician payments at 2013 levels.
Source: Acumen, CBO, OMB

Estimate of the Federal Budget Effects of BPC Health Cost Containment Initiative Proposals

(Billions of dollars, by fiscal year)

All estimates from Acumen, LLC unless otherwise noted.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014-2023	Total 2014-2033
CHANGES IN DIRECT SPENDING												
Medicare												
1. Long-term Medicare reforms[a]	17.4	0.3	-0.2	-3.9	-15.1	-25.3	-33.1	-38.0	-40.0	-39.8	-177.6	
2. Limit first-dollar supplemental coverage	0.6	0.3	-4.6	-6.5	-7.0	-7.6	-8.2	-8.8	-9.6	-10.3	-61.6	
3. Expand low-income cost-sharing assistance	0.0	0.0	6.1	8.4	8.7	9.1	9.6	10.2	10.9	11.7	74.8	
4. Reduce subsidies to high-income beneficiaries	0.0	0.0	-3.4	-5.2	-6.2	-6.8	-8.8	-10.5	-11.9	-13.6	-66.3	
5. Equalize payments across sites for office visits	-0.5	-0.7	-0.8	-0.9	-0.9	-0.9	-0.9	-1.0	-1.0	-1.0	-8.7	
6. Encourage use of generic drugs in Part D LIS program	-2.1	-2.9	-3.5	-3.8	-3.9	-4.5	-5.1	-5.5	-6.2	-6.6	-44.3	
7. Expand payment bundles for post-acute care[b]	0.0	0.0	0.0	0.0	-0.3	-0.8	-1.5	-1.7	-1.9	-2.0	-8.2	
8. Limit in-office exception to the physician self-referral law[b]	0.0	-0.4	-0.6	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-6.1	
Net Medicare Deficit Reduction[c]	15.4	-3.4	-6.9	-12.4	-25.3	-37.4	-48.8	-56.1	-60.4	-62.5	-297.9	-1,250
Tax Policy	**CHANGES IN REVENUES**											
9. Limit exclusion for employer-provided health benefits[d]	0.0	33.9	36.2	39.5	25.8	26.3	26.0	25.5	24.9	23.7	261.6	n/a
Federal Budget Deficit Reduction[ef]	15.4	-37.3	-43.1	-51.8	-51.1	-63.6	-74.8	-81.6	-85.3	-86.2	-559.5	n/a

[a] Gross savings including $138 billion SGR fix of setting physician fee schedule rates at 2013 levels for 2014-23 (CBO) = $315.6 billion

[b] FY2014-2023 estimates from OMB. FY2014-2033 estimates based on BPC calulations assuming spending grows with projected enrollment.

[c] Gross savings including $138 billion SGR fix of setting physician fee schedule rates at 2013 levels for 2014-23 (CBO) = $435.9 billion

[d] Estimate from Dr. Jonathan Gruber, Professor of Economics, Massachusetts Institute of Technology

[e] Gross savings including $138 billion SGR fix of setting physician fee schedule rates at 2013 levels for 2014-23 (CBO) = $697.5 billion

[f] Federal budget deficit reduction does not include several policy recommendations for which 10 year savings estimates are not currently available, such as reform to payment for Part B drugs, equalization of payment across sites for procedures, and establishment of a limit on direct graduate medical education costs. It also does not include $96 billion of FY2014-2023 estimated savings from reduced interest payments on the federal debt.

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Additional Policy Specifications

MEDICARE NETWORKS

Transition from Historical to Regional Spending Targets

Spending targets based on historical spending for each Medicare Network have the advantage of reflecting the health needs of enrolled beneficiaries, but they also may reflect high spending that is the result of inefficiency and poor care. For this reason, we propose a five-year transition to spending targets based on regional per-beneficiary spending. The regional spending target would be risk-adjusted for each Medicare Network to reflect differences in the health status of their enrollees. This would provide strong incentives for networks with greater-than-average spending (adjusted for the health status of enrollees) to emulate the quality and efficiency of other providers within their region.

Differential Payment Levels for Providers

Permanent fix of Sustainable Growth Rate (SGR):

- For 2014, set physician payments at 2013 levels.
- For 2015 and 2016, payments to physicians in FFS would continue at 2013 levels; physicians participating in Medicare Networks accepting two-sided risk would receive a full MEI update; physicians participating in networks accepting only one-sided risk (only upside bonuses) would receive an update of one-half MEI.
- For 2017 and beyond, physicians participating in Medicare Networks (all of which must then accept two-sided upside and downside risk) would receive updates based on the full MEI, while FFS physician payment rates would not receive updates. The HHS Secretary would have authority to make any necessary adjustments to facilitate provider participation in Medicare Networks.

Every other provider type:

- Use current law for 2013 – 2016.
- For 2017 through 2023, FFS payment rates would not be updated. Providers participating in Medicare Networks would get the full updates scheduled under current law.

Medicare Network Formation and Payment

- For 2013-2016, new Medicare Networks could still form under the existing shared savings and Pioneer programs, except that any multi-year contracts would require networks to accept two-sided risk (savings and losses) starting in 2017.
- For 2017 and beyond, all networks would be required to participate in two-sided shared savings.

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- The shared savings spending target for each network would be calculated by establishing a baseline for spending in the previous three years (based on per capita Part A and B fee-for-service expenditures for beneficiaries who enroll in the network), which would then be trended forward using *national* Medicare growth rates projected by the CMS Office of the Actuary. The baseline would be reset at the end of the three-year contractual period.
    - The annual growth rate for each performance year would be uniform across all networks: a flat dollar per beneficiary increase to the spending target determined by the absolute amount of growth in national traditional Medicare expenditures.
    - A five-year transition from spending targets based on historical experience of the network's enrollees (see above) to regional targets (risk-adjusted) would begin in 2018. (First year, 80% historical, 20% regional; next year 60% historical, 40% regional, etc.) Regions would be Metropolitan Statistical Areas or grouping of rural counties within a state (Bureau of Economic Analysis Economic Areas). This approach would resemble the transition designed for the Inpatient Prospective Payment System, which started with DRG rates based on each hospital's costs to uniform national rates (adjusted for a wage index), except that the networks would be transitioning to regional rather than national rates.
- Two-sided risk networks would be able to share in 60% of savings once they meet the minimum savings rate (achieving spending reduction of at least 2% compared to the target). Maximum shared savings would be capped at 15% of the target, similar to the rules in the Medicare Shared Savings Program.
- Two-sided networks would pay shared losses if their average per beneficiary Medicare spending rises 2% above the target during the performance year. Shared losses could not exceed 60% of spending over the target and would be capped at 10% of the target by the third year of the contract.
- IME and DSH payments should be excluded from all calculations related to the shared savings spending target. This would align with Medicare Advantage (MA plans do not make IME or DSH payments) and ensure that Medicare Networks do not have an incentive to avoid hospitals that serve a significant population of uninsured patients.

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- Medicare Networks that are prepared to take insurance risk would have a pathway to accept full capitation for their existing enrollment, at which point they would be paid in the same manner as MA Plans.

Differential Premiums/Cost-sharing for Beneficiaries

Beneficiaries who enroll in a Medicare Network would receive a $5 per month discount on the standard premium (25% of program costs for most) for the first three years of enrollment. Persistently high performing networks (e.g., based on a 6 quarter rolling average) would generate a rebate for their enrollees from a portion of the government's share of savings, as described below.

Beneficiaries who enroll in a Medicare Network would pay different cost-sharing for in-network and out-of-network providers. This would be determined annually by the CMS actuary so that the weighted average cost-sharing remains equivalent to current law. For example, the actuary might establish a $15 copayment for in-network physician office visits and a $30 copayment for out-of-network office visits. This would effectively present beneficiaries with choices similar to those experienced by enrollees in PPO health plans.

As part of our supplemental insurance reform proposal, supplemental insurance plans would be prohibited from paying a greater portion of Medicare Network cost sharing than plans would pay for FFS cost sharing. The purpose of this prohibition is to prevent supplemental insurance from significantly reducing or eliminating the incentives caused by higher cost-sharing for out-of-network services. For example, if supplemental insurance would cover half of the copayment under FFS (beneficiary pays $10, supplemental plan pays $10), then under the $15 in-network/$30 out-of-network example differential, the copayment paid for by the beneficiary with supplemental insurance would be reduced to $5 in-network/$20 out-of-network.

Finally, if Medicare Networks are successful in generating savings, a portion of the government's share of savings (up to 25% of total savings) would be redirected to beneficiaries through lower Part B premiums, most likely through rebates. In the event there are not savings, Part B premiums for network enrollees would not increase; providers (along with the government) would be responsible for the normal share of the losses.

Powers to Control Utilization

Medicare Networks would be allowed to require beneficiaries to select a primary care provider and to require prior authorization for using services, but they would not be required to implement these provisions. Medicare Network enrollees would always have open access to any Medicare provider at the out-of-network rate.

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Medicare Networks: Governance, Operations, and New Models of Care

As Accountable Care Organizations, such as our proposed Medicare Networks, are established, we believe that they should have the flexibility to adopt different models of care and associated provider payment arrangements in pursuit of improved quality and

efficiency. We anticipate that providers would have one of two kinds of relationships to a Medicare Network. Some providers would be members who would be involved in the governance of the Medicare Network, such as contracting with CMS, determining how to use any shared savings, and other business decisions related to the network. Other providers might choose to contract with one or more Medicare Networks to provide services for their enrollees, but would not be a member involved in the network governance. Any Medicare covered services delivered in the context of a Medicare Network, whether by a member provider or a contracted provider, would be reimbursed by CMS at the higher (non-frozen) rate.

Medicare Networks could also contract with vendors to handle administrative tasks, such as finance and information technology. While Medicare Networks would be organized and led by providers (the governing majority of network members must be member providers), nothing would prohibit networks from contracting with health plans as vendors (in the case of providing administrative support) or payers (in the case of providing services to members of health plans, such as Medicare Advantage Plans).

Additionally, Medicare Networks would have the flexibility to adopt different payment approaches. In the simplest model a network could elect, CMS would continue to make payments directly to each individual provider. Alternatively, Medicare Networks could choose to have all payments from CMS assigned centrally to the network, which would then pay member providers as agreed to by the members and pay contracted providers according to contract terms. This would enable Medicare Network providers to adopt different compensation methods for both member and contracted providers, such as salaried arrangements, case rates, or other innovative systems.

Ensuring that Medicare Networks have the flexibility to contract with providers in different ways will sweep away the barriers inherent in fee-for-service payment to the adoption of new models of care. These barriers include no accountability for quality and the inability to provide services that are not defined in existing payment codes. With their added flexibility, networks could finance services not currently reimbursed under the Medicare program. Many of these services could be oriented toward improving care coordination and a better patient experience, such as handling some patient needs over email and telephone, while providing more in-person patient time with their doctor for more complex matters. Just a few examples of the approaches Medicare Networks might adopt include: establishing patient-centered medical homes that provide enhanced primary care services, contracting with pharmacists to provide enrollees with medication therapy management, hiring community health workers to make home visits to patients with chronic health conditions, or investing in prevention strategies.

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Considerations as Medicare Networks are Formed

Rural Providers

We expect that rural providers will be able to form successful Medicare Networks. Networks could be a model for connecting dispersed providers with information technology,

telemedicine, and the resources of urban medical centers, while maintaining provider independence. However, we realize that forming networks in rural areas could pose unique challenges. Therefore, we recommend that the Secretary of HHS be authorized to provide additional technical and financial resources, such as low interest loans, to help networks form in rural areas.

Access to Capital for Medicare Networks

Access to capital may be a potential challenge for physician-led Medicare Networks, whether located in rural or urban areas. Establishing a new Medicare Network will require infrastructure that often does not exist in many communities, such as information technology including advanced electronic information sharing capabilities, enhanced primary care facilities, financial management systems, and quality monitoring processes. Building or upgrading this infrastructure will require initial investments. As financial institutions are most familiar with lending to hospitals and the ACO/Medicare Network concepts are new, we are concerned that access to capital could become a problem in the early part of this transition. Because we want to encourage the formation of a diverse array of Medicare Networks, we believe it would be appropriate to establish a federal loan-guarantee program for multi-specialty or primary care physician-led organizations seeking to form a Medicare Network.

Implementation Resources for CMS

Establishing new payment models is also a significant undertaking for the federal government. Contracting with ACOs/Medicare Networks, establishing systems to monitor spending and quality, and developing information infrastructure to ensure that today's ACOs and tomorrow's Medicare Networks have the data they need to coordinate care for beneficiaries all require resources. If leaders want to pursue these kinds of fundamental reforms to the Medicare program, it is essential that CMS be provided adequate resources for successful implementation.

Medicare Networks and Part D

Providers that successfully operate a Medicare Network would be able to progressively implement new payment and delivery models. Networks would be allowed, but not required, to partner with a preferred Part D Prescription Drug Plan, which could lead to efficiencies and lower costs for plans and beneficiaries. For instance, a recent MedPAC analysis showed that efforts to increase drug adherence for certain conditions can generate overall Medicare savings due to reduced acute care utilization.[165] However, because better drug adherence increases spending in Part D and generates savings in Parts A and B, the incentives are not aligned across programs to encourage these initiatives. Partnerships between Medicare Networks and Part D drug plans, which could include shared savings arrangements, could facilitate better management of prescription drugs, better patient

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outcomes, and lower overall costs.[xxv-xxvi] Additionally, because responsibility for and coordination among hospital and physician services is critical to quality care, we believe that enrollment in Part B (as well as Part A) should be a prerequisite for enrollment in a Medicare Network.

Opportunity for Progressively Advanced Payment Models

Medicare Networks that routinely surpass quality and patient satisfaction targets and share in savings would have the option to accept up to a 50/50 mix of fixed, per-beneficiary payments, known as partial capitation, and fee-for-service. Payments from Medicare could be made to the network rather than to individual providers, and networks could experiment with different compensation arrangements for members. Networks that consistently deliver high-quality care and develop the capability to accept insurance risk would also have a pathway to full capitation for their existing enrollment.

MEDICARE ADVANTAGE

Table 10. Illustrative Example of Benchmark Payments under Existing Administrative and Proposed Competitive Pricing Systems

EXAMPLE 1 (LESS THAN 40% OF THE MARKET)	EXAMPLE 2 (LESS THAN 40% OF THE MARKET)	EXAMPLE 3 (MORE THAN 40% OF THE MARKET)
Plan A bids $10,000	Plan A bids $8,000	Plan A bids $8,000
Plan B bids $9,500	Plan B bids $8,500	Plan B bids $8,500
Old system benchmark: $9,000	Old system benchmark: $9,000	Old system benchmark: $9,000
New system benchmark: $9,750	New system benchmark: $8,250	New system benchmark: $8,175
Use lower, old benchmark	**Use lower, new benchmark**	**Use lower, new benchmark**
Payment to plans: $9,000	Payment to plans: $8,250	Payment to plans: $8,175
Beneficiary premiums depend on bids entered under old system.	Beneficiary monthly premium for Plan A: $21 discount from Part B premium	Beneficiary monthly premium for Plan A: $14.50 discount from Part B premium
	Beneficiary monthly premium for Plan B: $21 in addition to Part B premium	Beneficiary monthly premium for Plan B: $27 in addition to Part B premium

Assumptions: Bids are under the new system. Each plan has 50% market share among MA Plans.

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[xxv] Because the achievement of savings in Parts A and B may require additional spending in Part D, and because drug adherence strategies may require the cooperation of Medicare Networks and Part D plans (to obtain prescription fill data, for instance), Medicare Networks may need to share some of their savings from adherence with Part D plans.

[xxvi] In the Competition and Consolidation section of this report, we address legal barriers to gainsharing arrangements of this type.

REPLACE THE SGR FORMULA AND BUILD ON ITS LESSONS

The recent experience with spending limits in Medicare – as exemplified by the failed Sustainable Growth Rate (SGR) formula for Part B services – has been poor. The spending limit we propose is different in important ways, and understanding the reasons SGR was ineffective is essential to the design of new approaches. In short, SGR failed because it held individual physicians accountable for costs beyond their control, did not provide physicians with any tools or incentives to reduce healthcare cost growth, did not incorporate quality outcomes in the approach, and demanded unrealistic savings. Our proposed spending target would apply to all providers, so no individual part of the health care system is singled out for responsibility for providing high-value care. In Medicare Networks, each network would be held responsible for excess cost growth for their own enrollees, something over which providers in the network do have some control, as opposed to SGR, which held physicians responsible for cost growth among Medicare beneficiaries nationwide. Additionally, Medicare Networks would facilitate the kind of coordination necessary to deliver high-value care that would contain the growth in health care costs, and member providers would have strong incentives to do so, because they would be able to keep up to 60 percent of the savings generated, but only if targets for quality and patient satisfaction are met. With SGR, the government kept all of the savings and physicians were not held accountable for quality outcomes or patient satisfaction.

Table 11. Comparing Sustainable Growth Rate (SGR) to Proposed Spending Limit

SGR	PROPOSED SPENDING LIMIT
Physicians held accountable for excess cost growth among traditional Medicare beneficiaries nationwide	Each Medicare Network held accountable for excess cost growth for its own enrollees
Savings accrue to federal government	Up to 60% of savings available to network
No incentive to improve quality or patient satisfaction	Savings accrue to network only if quality and satisfaction targets are met

Finally, we believe that GDP per-capita growth + 0.5 percentage points is a realistic goal for long term, per-beneficiary healthcare cost growth. Over the past few decades, health care cost growth has routinely exceeded GDP per capita growth by significant margins. This is not sustainable for long periods and, if allowed to continue, will continue to do damage to the economic competitiveness of the United States; it is also a major contributor to projected long-term federal budget deficits. Lowering the per-beneficiary growth rate so it is only slightly higher than GDP per-capita growth is a realistic goal, and a necessary one.

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PAYMENT BUNDLES FOR POST-ACUTE CARE

Post-acute care is characterized by great variation in spending across the nation for the same conditions and a lack of coordination among inpatient and post-acute providers. The goal of this policy is to incent acute and post-acute care providers to work together to deliver high quality, high value care for patients. Because this requires the development of

knowledge and infrastructure that does not currently exist, it will take time and resources to implement for both providers and CMS.

- As part of any expansion of payment bundles, government policies should be revised to explicitly allow gainsharing among bundle participants.
- The focus of the bundling proposal would be post-acute care (IRFs, LTACHs, SNFs, and Home Health; it would not include hospice) and readmissions.
- This program would apply to providers serving patients in FFS and within the context of a Medicare Network.
- Expand bundled payments for post-acute care nationwide for selected diagnoses by 2018.
    - Expand the inpatient DRGs to include a virtual payment bundle for post-acute services and any readmissions for a certain period
    - The expanded DRGs would apply to all patients who are coded under that particular DRG (whether they use post-acute care or not).
- This program would use a "virtual bundle" as a default (explained in the next item), but if a hospital and group of post-acute care providers agree to a formal relationship, they may enter into an agreement with the HHS Secretary to accept prospective payment for post-acute care. Under this optional arrangement, post-acute providers could agree to care for certain patients using different rates or payment methods (such as a case-rate).
- Under the virtual bundle, 5% of the payments to hospitals (under the relevant DRGs) and 5% of all payments to post-acute care providers would be withheld. At the end of the year, there would be reconciliation between the amount paid to all post-acute providers serving patients discharged from each hospital, plus any readmissions, and a spending target. If payments are below the spending target, providers receive a rebate equal to 50% of the savings (and would receive their withheld funds). If payments are above the spending target, providers would share in 50% of the losses; withheld funds would be retained to cover those losses.
- Within Medicare Networks, payment bundles would be used for calculations related to the budget target. Networks could enter into contracts with post-acute care providers using different payment methods, just as they could with any other provider type.
- The spending target would be established as follows:
    - In year one for each DRG, each hospital would be paid rates based on historical post-acute care costs for their patients.

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- There would be a ten year transition to a national rate, but that national rate would change over the course of the ten years. Initially, it would be assumed that the national rate target would be the 40th percentile of all post-acute care spending nationwide per DRG in the base year, trended forward ten years.
- However, CMS would monitor actual spending on post-acute care in each successive year. If average (mean) spending decreases, and mean spending trended forward to year ten would be below the initial target (the 40th percentile of spending from year one trended forward), then the target for year ten would decrease to capture 80% of the reduction in spending.
- Because providers would be partially at-risk, they would have a strong incentive to work together to reduce costs and share in savings. This structure would set a clear expectation that providers achieve a minimum level of savings (becoming at least as efficient as providers in the 40th percentile from the first year), but also provides an opportunity for additional savings for the Medicare program. In this way, the national rate by year ten would settle at whatever level of spending hospitals are able to achieve—but allow them to keep up to 20 percent of the savings they achieve.

- To help facilitate this bundling policy:
  - Allow and encourage hospitals (or third party vendors) to steer beneficiaries to high quality post-acute care providers (and to share quality data with patients), but do not allow hospitals (or vendors) to require that patients access post-acute care from a certain provider (patient choice would be preserved).
  - Provide the Secretary of HHS with authority to exempt small IPPS hospitals or facilitate regional bundling payment methodologies that would include multiple small IPPS hospitals.
  - Fund surveillance and quality systems to ensure beneficiary access and quality.
  - Fund improved data systems to ensure hospitals and post-acute care facilities have access to relevant CMS data for patients covered by payment bundles in order to facilitate care coordination.

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TRADITIONAL MEDICARE BENEFIT REDESIGN

Annual beneficiary cost-sharing limit: This benefit is even more valuable when considered over several years. MedPAC analysis shows that 13 percent of beneficiaries experience cost-sharing liability over $5,000 at least once over a four-year period, compared to only 6 percent in any given year.[166]

Updates: Once the new benefit design is implemented, the Secretary of HHS would be asked to monitor the impact of the new benefit design on utilization and quality outcomes and make appropriate modifications at least as often as every five years. Deductibles, copayments, and the out-of-pocket maximum would be updated annually to grow with program costs in the nearest $5 increments.

SUPPLEMENTAL COVERAGE REFORM

All supplemental coverage from medigap plans and employer-sponsored insurance (including Tricare-for-Life and FEHBP) must:

- Include a deductible equal to at least half of the (new) standard deductible.
- Set out-of-pocket maximum at or above $2,500 (out of the beneficiary's pocket).
- Cover no more than half of beneficiary copayments and coinsurance.

Special rule for Medicare Networks: Supplemental insurance may not reduce the spread between in-network and out-of-network cost sharing, nor reduce in-network cost sharing for any service below a $5 co-payment or 5% coinsurance.

This change would be implemented at the same time as the modernized Medicare benefit on January 1, 2016. As in the past, the National Association of Insurance Commissioners would be asked to develop standardized designs for medigap plans that would meet the new requirements. Current medigap policyholders would be allowed to switch into any of the new plan designs offered by their insurer for 2016. For policyholders who do not make a selection, the Secretary of Health and Human Services would have authority to allow plans to automatically enroll existing policyholders in the new plan that is most similar in design to the old plan. Employer-sponsored supplemental coverage plans could adopt any plan design that meets the restrictions. Tricare-for-Life would adopt the most generous allowable plan design.

Supplemental Coverage and Medicare Networks

Limitations on supplemental coverage are also essential to the success of our proposed Medicare Networks. To provide high quality care to their enrollees, Medicare Networks need tools to hold participating providers accountable and engage patients in healthcare decisions. Completely shielding seniors from the costs of their decisions about provider choice eliminates incentives to use more efficient providers, making it nearly impossible to hold a network of providers responsible for the care of a group of beneficiaries.

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EXPANDED ASSISTANCE FOR LOW-INCOME MEDICARE BENEFICIARIES

New, federally funded cost-sharing assistance for Medicare beneficiaries with incomes between 100 percent and 150 percent of the federal poverty level would be administered by the Social Security Administration (SSA). Enrollment would be automatic based on a beneficiary's modified adjusted gross income (MAGI). For beneficiaries with incomes below the tax-filing threshold, the SSA would request additional information to determine eligibility for cost-sharing assistance.

This assistance would be available for beneficiaries in both traditional Medicare and Medicare Advantage. For eligible beneficiaries in traditional Medicare, payments from the Medicare program to providers would be adjusted to include the additional cost-sharing subsidy. For Medicare Advantage, payments to plans enrolling eligible beneficiaries would be increased to reflect the cost-sharing subsidy as determined by the CMS actuary. In exchange for this payment, MA Plans would be required to reduce eligible beneficiary cost-sharing by the same percentages as in traditional Medicare.

HOW STATES WOULD BENEFIT FROM PROPOSED REFORMS

State and local governments, like the federal government and private-sector organizations, are also burdened by the growth in health care costs, as rising premiums for state employees, teachers, and municipal workers, along with the state share of the cost of the Medicaid program, pose difficult trade-offs. Longer-term reforms to the health care payment and delivery systems, as we propose, will be even more effective if other employers and health care purchasers commit to similar strategies. For instance, Oregon and Arkansas have pursued strategies to align various payers, including state government, Medicaid, and the private sector, behind reforms such as accountable care organizations and payment bundles.[167-168] The adoption of reforms by Medicare will help states, as well as private sector organizations, move toward similar models that have potential to control costs and improve quality outcomes.

PREVENTION AND WELLNESS

What is Comprehensive Worksite Health Promotion?

The term "workplace wellness" is increasingly used in the academic literature and popular press to refer to a wide variety of different health promotion efforts with varying intensity and approaches, so it is important to clarify what it means in this context. Recognizing there is no one-size-fits all approach – a successful program needs to be tailored to employee health needs and the organization's culture and environment – HHS' Healthy People 2010 health promotion and disease prevention agenda, states that a *comprehensive* workplace health promotion program includes the following five components:

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1. Health education, focused on skill development and lifestyle behavior change along with information dissemination and awareness building;
2. Supportive social and physical environments, reflecting the organization's expectations regarding healthy behaviors, and implementing policies promoting healthy behaviors;

3. Integration of the worksite program into the organization's benefits and human resources infrastructure;
4. Linking related programs like employee assistance programs (EAPs) into worksite health promotion; and
5. Screening programs followed by counseling, linked to medical care to ensure follow-up.[169]

Using the above framework, several studies have concluded that effective programs also require strong senior and middle management support, include employee input when developing goals and objectives, are grounded in behavior-change theory, are adequately resourced, have dedicated staff, include incentives for employees to participate, and are regularly evaluated using well-defined metrics of success.[170-171-172]

In terms of content (i.e., specific interventions and target behaviors), comprehensive workplace wellness programs include policies, programs, benefits, and environmental supports that address chronic disease risk factors such as nutrition, physical activity, and smoking.[173] Programs can incorporate multiple levels of prevention – primary (helping employees stay healthy and reduce their risk of disease), secondary (providing services to detect early stages of disease), and tertiary (helping individuals manage disease effectively and reduce disability caused by existing disease). Some examples of program offerings include: subsidized memberships to fitness centers or behavior modification programs such as Weight Watchers; healthy food options in cafeterias; incentives to walk or bike to work; on-site health services like blood pressure screenings and flu shots; and self-management coaching programs for diabetes control.

Community-Based Prevention

According to the CDC, to be most effective, prevention must occur in multiple sectors and across individuals' entire life spans.[174] While the doctor's office is an important touch point for health care and advice, it must be complemented by other venues. We spend more time outside of the physician's office than inside it so must think about the other settings that shape our health attitudes and behaviors on a daily basis—homes, schools, workplaces, and the community. Furthermore, community-based prevention interventions can address social and environmental factors that are not impacted by clinical services. A recent IOM committee defined community-based prevention as: "population-based interventions that are aimed at preventing the onset of disease, stopping or slowing the progress of disease, reducing or eliminating the negative consequences of disease, increasing healthful behaviors that result in improvements in health and well-being, or decreasing disparities that result in an inequitable distribution of health."[175]

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With this in mind, many stakeholders--from health plans to city governments to community groups--are developing and expanding community-based prevention strategies to provide health education, social support, and improvements to the physical environment. Often these initiatives utilize non-traditional providers, such as community health workers or

health educators, which can help decrease the cost of programs (relative to those employing clinical providers). Under the Affordable Care Act, the establishment of the National Prevention Council, National Prevention Strategy, and Prevention and Public Health Fund has created a framework for the government to encourage the evaluation and implementation of effective prevention strategies.

One example of a program receiving government support is the Diabetes Prevention Program (DPP), which grew out of a clinical trial and developed into a partnership between the CDC, YMCA, and UnitedHealthGroup (UHG). The Y-DPP is a year-long, group lifestyle intervention that relies on trained, lay health educators in a peer-supported environment to promote weight reduction through healthy eating and increased physical activity. A 16-session core curriculum is delivered over 20 weeks, followed by 6 monthly maintenance sessions for reinforcement to coach participants. The program uses trained health coaches in a group setting to teach healthy eating, provide structured physical activity, and train participants in behavior modification, including things like stress management and motivation. For this program, participants who achieved the program goal of 5 to 7 percent body weight loss saw a significant reduction in their risk for developing diabetes.[176] The original clinical trial demonstrated that weight loss was the single most important factor in reducing diabetes incidence—for every kilogram of bodyweight lost, diabetes incidence was reduced by 16 percent.[177]

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