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# The Senior Protection Plan

\$385 Billion in Health Care Savings Without  
Harming Beneficiaries

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The Center for American Progress Health Policy Team    November 2012

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# Introduction and summary

Many proposals to reduce federal spending on health care would simply shift that spending to individuals, businesses, and states. Such proposals would fail to reduce overall spending on health care without rationing care. In some cases they would actually increase overall health care costs.

In this report we present a superior approach: the Senior Protection Plan. Instead of harming seniors and others, the Senior Protection Plan would improve the efficiency of the health care system, eliminate waste, and improve the quality of care. This approach would reduce overall health care costs—the best way to reduce federal health care spending.

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## The wrong approach

The Senior Protection Plan is a comprehensive alternative to the following proposals that would simply increase costs for seniors, children, disabled people, businesses, and states:

- **Proposals to transform Medicare into a voucher program.** Under this year's House Republican budget, seniors turning 65 in 10 years would pay about \$60,000 more for Medicare over their retirement.<sup>1</sup> Since the vouchers would not keep pace with health care costs and Medicare would become increasingly privatized over time, those who are currently under age 50 would pay over \$124,600 more for Medicare over their retirement.<sup>2</sup>
- **Proposals to raise Medicare's eligibility age to 67.** This policy would affect coverage for 5.4 million seniors, increasing costs for seniors, employers, and states.<sup>3</sup> In fact, these cost increases would be twice as large as the federal savings, increasing overall health spending.<sup>4</sup> About 270,000 seniors would become uninsured.<sup>5</sup> Moreover, shifting younger, healthier seniors from Medicare to new health insurance marketplaces under the Affordable Care Act would increase premiums in both insurance pools.<sup>6</sup>

- **Proposals to increase cost-sharing substantially.** Under several recent proposals, cost-sharing would increase by an average of \$780 for almost 6 million beneficiaries—including 2.1 million beneficiaries in poor or fair health and more than 3 million beneficiaries with incomes below 200 percent of the federal poverty level.<sup>7</sup>
- **Proposals to slash Medicaid and increase the costs of long-term care for seniors.** Medicaid is a lifeline for millions of seniors, children, pregnant women, and disabled people—the most vulnerable people in our society. This year’s House Republican budget would cut benefits for seniors who rely on Medicaid by an average of \$2,500 per year.<sup>8</sup>

Such proposals represent the wrong approach to reducing health care spending. As George C. Halvorson, chairman and chief executive officer of Kaiser Permanente, an integrated managed care company, put it, “There are people right now who want to cut benefits and ration care and have that be the avenue to cost reduction in this country and that’s wrong... it’s an inept way of thinking about health care.”<sup>9</sup>

All told, the Senior Protection Plan would produce federal savings of about \$385 billion over 10 years.

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## Estimates of savings from the Senior Protection Plan

We estimate how much our proposals would reduce federal health care spending, relying on estimates by the Congressional Budget Office and the Medicare Payment Advisory Commission wherever possible. These are conservative estimates, and in many cases we did not attribute any savings to a proposal—even though the proposal would likely produce at least some savings.

The Senior Protection Plan proves that it is possible to produce substantial savings, as scored by the Congressional Budget Office, without harming beneficiaries. All told, the plan would produce federal savings in excess of \$385 billion over 10 years. In addition to the plan’s savings, its tax policies related to health care would generate up to \$100 billion over 10 years. But most importantly, the plan includes an array of reforms that would bend the cost curve over the long term.

The Senior Protection Plan is aggressive; it would be difficult to secure additional savings without harming beneficiaries. The plan’s savings must be combined with substantial revenues to achieve a fair and balanced debt-reduction package.<sup>10</sup>

This report details the following proposals:

- Enhance competition based on price and quality
- Increase transparency of price and quality information
- Reform health care delivery to provide better care at lower cost
- Repeal the Sustainable Growth Rate mechanism
- Reform graduate medical education and the workforce
- Reform Medicare premiums and cost-sharing
- Reduce drug costs
- Bring Medicare payments into line with actual costs
- Cut administrative costs and improper payments
- Reduce the costs of defensive medicine
- Reform the tax treatment of health insurance
- Promote better health

# Enhance competition based on price and quality

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## Use competitive bidding for all health care products<sup>11</sup>

As an alternative to the government setting prices administratively, competitive bidding harnesses market forces to obtain the best prices. In 2011 competitive bidding for durable medical equipment, such as hospital beds and wheelchairs, reduced Medicare spending by more than 42 percent.<sup>12</sup> The Affordable Care Act requires Medicare to expand competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies to all regions by 2016.<sup>13</sup>

To further harness market forces, the federal government should:

- Expand competitive bidding by 2014 for durable medical equipment, prosthetics, orthotics, and supplies nationwide.
- Extend competitive bidding by 2015 to medical devices, laboratory tests, advanced imaging services, and all other health care products. For instance, President George W. Bush proposed competitive bidding for clinical laboratory services in his budget for fiscal year 2009.<sup>14</sup>
- Establish a panel of business and academic experts to govern the process.
- Extend competitively-bid prices to Medicaid and all other government health programs.<sup>15</sup>

Competitive bidding for medical devices in particular would produce substantial savings. The Government Accountability Office found that prices for cardiac implantable medical devices vary substantially, by several thousand dollars.<sup>16</sup>

## Estimated savings from competitive bidding for these products and services

Nondurable medical products	\$3 billion
Durable medical equipment nationwide by 2014	\$7.5 billion
Clinical laboratory services	\$4.2 billion
Durable medical equipment for Medicaid	\$2.8 billion
Medical devices	\$20.5 billion
<b>Total estimated savings</b>	<b>\$38 billion</b>

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### Require health insurance exchanges to offer tiered insurance plans<sup>17</sup>

Tiered insurance plans designate a tier of providers with high quality and low costs and lower cost-sharing for patients who choose these high-value providers. For instance, in Massachusetts, one product lowers copayments by as much as \$1,000 if patients choose from among 53 high-value hospitals and outpatient centers.<sup>18</sup>

Exchanges and state employee plans should offer at least one tiered product at the bronze and silver levels of coverage by 2016. To encourage participation in the tiered product, it should achieve a minimum premium discount. For instance, in Massachusetts, insurers must offer at least one tiered product to individuals and small businesses with a premium that is at least 12 percent lower than the premium for a nontiered product with comparable providers and actuarial value.<sup>19</sup>

Transparency and consumer education are essential to increase awareness and trust in tiered products.<sup>20</sup> Quality and cost measures should be standardized and publicly disclosed, and standards should be set for how they are used to create tiers. Whenever possible, quality measures should use data from all payers. In contracts between insurers and providers, clauses that inhibit tiered products should be prohibited.

**Estimated savings: \$10 billion**



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## Use competitive bidding for Medicare Advantage

In Medicare Advantage—which offers a choice of private plans—Medicare pays private plans based on a benchmark, which averages 112 percent of spending under traditional Medicare.<sup>21</sup> The Affordable Care Act phases in reductions to the benchmark over six years to an average of 101 percent of spending under traditional Medicare.<sup>22</sup> But in many counties the benchmark will remain up to 115 percent of spending under traditional Medicare.<sup>23</sup>

Since overpayments to private plans will remain, competitive bidding offers potential for additional savings. Instead of linking the benchmark to spending under traditional Medicare, Medicare should base the benchmark for private plans on their average bid by 2014. Such competition among private plans would not undermine or erode traditional Medicare.

**Estimated savings: \$10 billion**

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## Require Medicaid managed care programs to use competitive bidding and pay-for-performance

Three-quarters of states that operate Medicaid managed care programs set rates administratively.<sup>24</sup> Only 15 states use competitive bidding, with plans competing to offer the lowest rate, which can produce substantial savings.<sup>25</sup> By 2014 all Medicaid managed care programs should use competitive bidding. In states that currently set rates administratively, programs would solicit bids below those rates.

In addition, just more than half of states that operate Medicaid managed care programs provide financial incentives to plans based on their performance on quality measures.<sup>26</sup> For instance, Texas withholds up to 5 percent of payments to plans if they do not meet quality targets and uses any savings to provide bonus payments to high-performing plans.<sup>27</sup> By 2015 all Medicaid managed care programs should adopt this or a similar pay-for-performance model for plans, with rigorous and transparent metrics of quality and access.

# Increase transparency of price and quality information

Prices for the same health care services vary substantially across providers within the same geographic area.<sup>28</sup> Yet consumers and physicians who make referrals almost never get price information before treatment.

Price transparency would allow consumers and physicians to plan ahead and choose lower-cost providers, which may lead high-cost providers to lower prices. While price transparency could facilitate collusion, this risk could be addressed through aggressive enforcement of antitrust laws. Moreover, both private and public models can achieve meaningful price transparency without leading to collusion.<sup>29</sup>

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## Require private insurers to make prices transparent<sup>30</sup>

By 2014 all private insurers should implement price transparency initiatives that at a minimum:

- Provide price information that reflects negotiated discounts with specific providers
- Bundle together into one price all costs associated with a service
- Provide individualized estimates of out-of-pocket costs electronically, including at the point of care
- Include information on the quality of care, patient satisfaction, and patient volume so that consumers can make informed decisions based on value

In contracts between insurers and providers, many providers prohibit insurers from releasing price information to their members.<sup>31</sup> These so-called “gag clauses” and other anticompetitive clauses should be prohibited.

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## Require price transparency for medical devices

Many hospitals cannot obtain the best prices for medical devices partly because a lack of price transparency inhibits competition. The Government Accountability Office found that device manufacturers often require hospitals to include confidentiality clauses in contracts that prohibit them from sharing price information.<sup>32</sup> These clauses should be prohibited.

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## Publicly release claims data

Claims data are critical to improving the quality of care and reducing health care costs. Data can be used to evaluate the performance of providers and suppliers based on quality and cost and help identify fraud and abuse. Like all other federal spending, Medicare and Medicaid spending should be fully transparent. The Affordable Care Act took a positive step by authorizing the release of Medicare claims data, but only to “qualified entities” for a fee, and only if the data are combined with data from other sources.<sup>33</sup>

The Centers for Medicare & Medicaid Services, or CMS, should publicly release Medicare and Medicaid claims and payment data through a searchable database. This policy is reflected in bipartisan legislation.<sup>34</sup> Of course, any release of claims data must ensure the privacy of beneficiaries and the security of the data. In addition, CMS should provide innovation funding to states so they can combine Medicare claims data with data from Medicaid and private insurers in an All-Payer Claims Database.

# Reform health care delivery to provide better care at lower cost

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## Form “accountable care states”<sup>35</sup>

Under the Affordable Care Act, teams of providers can form “accountable care organizations” that are accountable for all of a patient’s care. Medicare sets a target for Medicare spending for each accountable care organization. If actual spending falls below the target, accountable care organizations can keep up to 60 percent of the savings. They must meet performance targets on measures of the quality of care, and can keep higher shares of savings for higher performance.

Similarly, at a macro level, states should have the option to form “accountable care states.” Accountable care states would have a global target for all health care spending by both public and private payers. They would be encouraged and empowered to achieve savings by implementing innovative payment and delivery system reforms (including reforms to scope of practice), price transparency initiatives, and administrative efficiencies. Accountable care states would receive enhanced flexibility and implementation grants to develop and implement savings plans.

If actual health care spending falls below the global target, states would be eligible for substantial bonus payments. To receive bonus payments, states would need to meet performance targets on publicly reported measures of cost, quality, and access—and would receive higher bonus payments for higher performance. The measures should include the rate at which generic drugs are substituted for brand-name drugs and the supply of expensive diagnostic technologies. Both of these measures substantially impact health care costs, but only states can effectively influence them.<sup>36</sup>

As with Medicare’s Shared Savings Program, accountable care states that agree to pay back Medicare and Medicaid if spending exceeds targets would be eligible for even higher bonus payments. Greater risk would bring the potential for greater reward.

In accountable care states, funding for research, training, and uncompensated care—currently embedded in Medicare and Medicaid payments—should be sep-

arated out and increased with growth in the global target. These payments should be transparent and determined through negotiations or competitive bidding.

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### Accelerate use of alternatives to fee-for-service payment<sup>37</sup>

Fee-for-service payment leads to wasteful use of high-cost tests and procedures. Instead of paying a fee for each service, Medicare and Medicaid should pay a fixed amount to doctors and hospitals for a bundle of services or for all of a patient's care. Medicare and Medicaid should accelerate use of alternative payment methods:

- By 2014 Medicare should expand the current bundle of inpatient hospital services. Currently, this bundle includes services provided to patients up to three days prior to admission. That three-day window should be expanded to seven days.
- By 2014 Medicare should expand the Acute Care Episode Program—which bundles payments for 37 cardiac and orthopedic procedures—nationwide.<sup>38</sup> The bundles should also include related post-acute care, such as rehabilitative and home health services, provided up to 90 days after discharge.
- By 2017 Medicare should make bundled payments for at least two chronic conditions, such as adjuvant therapies for five leading cancers and care for coronary artery disease.
- Within 10 years Medicare and Medicaid should base at least 75 percent of payments in every hospital referral region on alternatives to fee-for-service payment.

Medicare and Medicaid should adjust all bundled payments based on the quality of care and health status to prevent providers from skimping on care or avoiding high-risk patients. Together these policies would remove uncertainty about transitions from fee-for-service payment, allowing sufficient time for investment in infrastructure and technology.

**Estimated savings: \$10 billion**

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## Use the Federal Employees Health Benefits Program to reform health care delivery<sup>39</sup>

The Federal Employees Health Benefits Program, which provides private health insurance to 8 million federal employees, retirees, and their families, should lead reform of health care delivery. While the program has encouraged or required various reforms to improve the quality of care,<sup>40</sup> it should be much more aggressive by:

- Requiring plans participating in the program to transition to alternative payment methods, aligning them with Medicare
- Conducting competitive bidding for all health care products on behalf of participating plans
- Requiring participating plans to provide price information to their enrollees
- Prohibiting so-called “gag clauses” or other anticompetitive clauses in plan contracts with providers
- Requiring participating plans to reduce payments to hospitals with high rates of readmissions and hospital-acquired conditions
- Requiring participating plans to adjust payments to hospitals and physicians based on their performance on measures of the quality of care

At a minimum the Federal Employees Health Benefits Program should completely align with Medicare on payment reforms, metrics, and value-based purchasing as soon as possible.

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## Coordinate care for beneficiaries eligible for both Medicare and Medicaid

More than 9 million Americans eligible for both Medicare and Medicaid are known as “dual eligibles.”<sup>41</sup> The programs share responsibility for these beneficiaries: Medicare generally covers and pays for primary and acute care services, and Medicaid helps pay for their cost-sharing under Medicare and for most long-term care. According to one estimate, Medicare and Medicaid could spend up to \$3.7 trillion on dual eligibles over the next 10 years.<sup>42</sup>

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Dual eligibles include some of the sickest and poorest Americans, and they must navigate two systems with different eligibility, coverage, payment, appeals, and consumer protection requirements. Better care and administrative coordination has the potential to reduce preventable hospital admissions, delay the need for institutional care, and reduce administrative costs.

Medicaid should allow all dual eligibles to choose a primary care medical home—a primary care team that will coordinate all care for patients, including medication management, as well as claims submissions and interactions with Medicare and Medicaid. The Center for Medicare and Medicaid Innovation and state Medicaid programs should make payments to primary care medical homes that meet rigorous and transparent quality standards. The Center should also develop online care plan and management tools that primary care medical homes can access for free.

To encourage state Medicaid programs to coordinate care, states should be allowed to keep a share of the savings to Medicare if their programs meet minimum quality standards. Specifically, states should be allowed to keep 60 percent of the savings in the first three years and 75 percent of the savings starting in the fourth year.

If states achieve a minimum level of savings, they must share the savings with primary care medical homes, depending on their performance on quality measures. In turn, primary care medical homes should be allowed to keep a share of the savings, but must reinvest the rest to further improve care coordination.

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### Expand Medicare's ban on physician self-referrals<sup>43</sup>

When physicians self-refer patients to facilities in which they have a financial interest, they may drive up costs and adversely affect the quality of care. The independent Medicare Payment Advisory Commission, along with several other studies, found that physician self-referral for imaging leads to higher use and spending.<sup>44</sup> Similarly, self-referral by urologists leads to more tests but lower prostate cancer detection rates.<sup>45</sup>

Most recently, the Government Accountability Office found that from 2004 through 2010, the number of self-referred MRI services per beneficiary increased by about 85 percent, and the number of self-referred CT services per beneficiary more than doubled.<sup>46</sup> Self-referring providers refer about twice as many advanced imaging services, and providers substantially increase their referrals immedi-

ately after purchasing or leasing their own imaging equipment.<sup>47</sup> Overall, the Government Accountability Office found that self-referral for advanced imaging services increases Medicare spending by more than \$109 million per year.<sup>48</sup>

Under the so-called Stark law, physicians are prohibited from referring Medicare and Medicaid patients to facilities in which they have a financial interest. But an exception allows physicians to provide “in-house ancillary services” such as diagnostic imaging, physical therapy, and anatomic pathology in their own offices.<sup>49</sup>

The Stark law should be expanded to prohibit physician self-referrals for services that are paid for by private insurers. Within three years, the loopholes for in-office imaging, pathology laboratories, and radiation therapy should be closed. An exception should apply to physicians who use alternatives to fee-for-service payment, which reduce incentives to increase the volume of services.

**Estimated savings: \$1.5 billion**

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## Promote shared decision-making in Medicare

Shared decision-making uses patient decision aids to help patients understand their treatment options and decide which treatments are best for them. Studies have shown that patient decision aids can reduce the use of more invasive treatment options without harming health outcomes.<sup>50</sup> The most recent study found that patient decision aids reduced hip replacement surgeries by 26 percent, knee replacement surgeries by 38 percent, and health care costs by 12 percent to 21 percent.<sup>51</sup>

The Affordable Care Act requires the secretary of health and human services to contract with a consensus-based organization to develop standards for patient decision aids and certify aids that meet the standards.<sup>52</sup> In addition, the new Center for Medicare and Medicaid Innovation may test payment models that pay providers for using patient decision aids,<sup>53</sup> although the center has not yet done so.

Medicare should prioritize and accelerate use of patient decision aids. For a minimum number (perhaps 20) of high-cost conditions (such as lumbar spine surgery for low-back pain), Medicare should adjust payments to providers based on whether they document use of patient decision aids. In addition, Medicare should require primary care medical homes and accountable care organizations to use patient decision aids.



The Commonwealth Fund estimated that such a policy could produce federal savings of \$7.6 billion over 10 years,<sup>54</sup> but we conservatively assume only half as much savings.

**Estimated savings: \$3.8 billion**

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### Strengthen value-based purchasing for hospital readmissions and complications

The Affordable Care Act reduces Medicare payments to hospitals with high rates of readmissions (starting in October 2012) and hospital-acquired conditions (starting in October 2014).<sup>55</sup> Medicare should strengthen these policies in several ways that are consistent with recommendations by Community Catalyst.<sup>56</sup>

The readmission policy applies to readmissions for only three conditions but allows the secretary of health and human services to expand the list starting in fiscal year 2015. The secretary should be *required* to apply the policy to readmissions for all conditions.

Hospital-acquired conditions include some serious medical errors known as “never events,” such as when a foreign object is left in a patient after surgery. But this list of hospital-acquired conditions is far too limited. The secretary should be required to expand the list to include a steadily increasing number of potentially preventable patient injuries and complications that result from hospital care.

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### Reduce Medicare payments to skilled nursing facilities with high rates of rehospitalization

The Affordable Care Act reduces Medicare payments to hospitals with high readmission rates. A comparable policy should apply to skilled nursing facilities—mostly nursing homes providing nursing and rehabilitation to patients after a hospital stay—which would align incentives across providers.

The independent Medicare Payment Advisory Commission, or MedPAC, estimates that the median readmission rate from skilled nursing facilities for potentially avoidable conditions exceeds 17 percent.<sup>57</sup> A readmission policy would encourage facilities to improve their management of care transitions and

The Affordable Care Act will reduce Medicare payments to hospitals with high rates of readmissions and hospital-acquired conditions.

medications. Preliminary results indicate that better care can achieve savings of 17 percent to 24 percent.<sup>58</sup>

The readmission policy should impose penalties of up to 3 percent of Medicare payments on facilities with above-average readmission rates. To ensure effective care transitions from a facility to home, the policy should count readmissions that occur up to 30 days after discharge from the facility. This policy is consistent with MedPAC recommendations.

**Estimated savings: \$1.4 billion**

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### Implement value-based purchasing for ambulatory surgical centers

Ambulatory surgical centers provide surgical procedures to patients outside the hospital. Since 2005 the volume of these services and spending per beneficiary have increased rapidly.<sup>59</sup> Starting this year, a Quality Reporting Program requires surgical centers to submit quality data to Medicare. Medicare should publicly report the data and require surgical centers to submit cost data to determine whether payments are excessive.

By 2016 Medicare should adjust payments to surgical centers based on their performance on measures of the quality of care: rewarding centers that exceed quality benchmarks or improve care, and penalizing centers that have high rates of hospital transfers or admissions. These policies are consistent with recommendations by the independent Medicare Payment Advisory Commission.

# Repeal the Sustainable Growth Rate mechanism

The Sustainable Growth Rate mechanism limits Medicare spending on physician services based on growth in the economy per person. But this spending limit is flawed because it applies to all physicians equally when not all physicians are responsible for excessive growth in spending. The mechanism is also flawed because it limits payment rates without addressing the volume of services. While Congress has enacted a series of temporary fixes to override payment cuts, these fixes create uncertainty for physicians and increase administrative costs substantially.

Repeal of the Sustainable Growth Rate mechanism must be fiscally responsible. Despite the temporary fixes, the mechanism has still exerted modest downward pressure on payment rates. In 2002 a 4.8 percent cut in payment rates actually went into effect.<sup>60</sup> Moreover, the temporary fixes did not provide for full payment increases: From 2000 to 2010 actual payment rates increased by only 8 percent, when full payment increases would have increased payment rates by 22 percent.<sup>61</sup>

Repeal of the Sustainable Growth Rate mechanism should:

- Provide stability and certainty to physicians
- Incentivize alternatives to fee-for-service payment
- Promote primary care
- Protect low- and moderate-income beneficiaries from premium increases
- Identify and correct Medicare payments for overpriced services
- Be fiscally responsible

The overall cost of the reforms below should be limited to \$245 billion over 10 years.<sup>62</sup> With this limitation the reforms would not cost or save more than the current policy of freezing payment rates for physicians. This current policy was the baseline used by the National Commission on Fiscal Responsibility and Reform, led by former Sen. Alan Simpson (R-WY) and President Bill Clinton's former Chief of Staff Erskine Bowles.<sup>63</sup>

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## Repeal the Sustainable Growth Rate mechanism

The Sustainable Growth Rate mechanism should be repealed in its entirety. Repeal would prevent a 27 percent cut in physician payment rates scheduled for January 1, 2013.

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## Incentivize alternatives to fee-for-service payment

Repeal of the Sustainable Growth Rate mechanism should be conditioned on a transition from fee-for-service payment. Starting in 2017 Medicare should reduce fee-for-service payments to specialists by 3 percent. Medicare should also reduce fee-for-service payments to primary care physicians who are not participating in a certified primary care medical home by 3 percent.

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## Permanently increase Medicare fees for primary care by 10 percent

Repeal of the Sustainable Growth Rate mechanism presents an opportunity to improve access to primary care, which is at particular risk. For both Medicare beneficiaries and privately insured individuals, finding a new primary care physician is more difficult than finding a new specialist, and primary care physicians are less likely to accept new patients than specialists.<sup>64</sup>

The Affordable Care Act increases Medicare payments for primary care services by 10 percent but only for five years.<sup>65</sup> That boost should be made permanent. According to one study, a permanent increase would reduce hospitalizations and post-acute care, reducing Medicare spending by 2 percent over the long term.<sup>66</sup>

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## Protect low- and moderate-income beneficiaries from premium increases

Since repeal of the Sustainable Growth Rate mechanism would increase Medicare spending, and premiums are linked to program spending, repeal would normally increase premiums. Currently, beneficiaries pay higher premiums if their incomes are at least \$85,000 for an individual and \$170,000 for a couple. Beneficiaries with incomes below these income levels should be held harmless from any premium increases resulting from repeal.

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## Identify and correct Medicare payments for overpriced services

To set payment rates for physicians, Medicare must determine the input costs of a given physician service compared to other physician services. To do this, Medicare relies heavily on the American Medical Association's Relative Update Value Committee, accepting about 90 percent of its recommendations.<sup>67</sup> But this committee is dominated by specialists—of its 31 members, only one represents primary care—creating an inherent financial conflict of interest.<sup>68</sup>

This process is problematic in many ways. Medicare pays specialists much more per hour than primary care physicians, contributing to a large and growing income gap that influences career choices.<sup>69</sup> Moreover, the profitability of overpriced services contributes to growth in the volume of services. Finally, according to the independent Medicare Payment Advisory Commission, the data used by the Relative Update Value Committee are biased, outdated, and inaccurate.<sup>70</sup>

Medicare should direct the Relative Update Value Committee to identify overpriced services and recommend payment corrections that save at least 1.5 percent of Medicare spending for physician services. At the same time, Medicare should be required to regularly collect its own data and use it to identify overpriced services. If the committee fails in its task, Medicare should be required to make payment corrections that save at least 1.5 percent of spending for physician services. This policy is consistent with MedPAC recommendations.

Correcting Medicare payments for overpriced services is an interim step while Medicare transitions to value-based purchasing and alternatives to fee-for-service payment. Since fee-for-service prices are often the components of bundled payments, it is essential to ensure they are accurate.<sup>71</sup> A broader problem with basing payments on input costs, however, is that input costs do not reflect the clinical value of services, which the transition to alternative payment methods should address.

**Estimated savings: \$0**

# Reform graduate medical education and the workforce

The vast majority of financing for graduate medical education comes from Medicare, Medicaid, and other federal programs. Medicare is the major source of funding, spending more than \$9.5 billion per year.

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## Reduce excessive Medicare payments to hospitals for graduate medical education

Medicare makes payments to teaching hospitals for the costs of resident salaries and benefits, salaries for teaching physicians, and administrative expenses. These payments are based on per resident costs, but they should be limited to a percentage of the national average cost per resident.

To account for the higher costs of care at teaching hospitals, Medicare also increases payments to teaching hospitals. But the independent Medicare Payment Advisory Commission found that these increases are twice as high as can be empirically justified, costing \$3.5 billion in waste per year.<sup>72</sup> Medicare should reduce these payments to reflect actual costs, consistent with MedPAC recommendations.

The National Commission on Fiscal Responsibility and Reform, led by former Sen. Alan Simpson (R-WY) and President Bill Clinton's former Chief of Staff Erskine Bowles, recommended similar proposals.<sup>73</sup>

**Estimated savings: \$28 billion**

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## Bring accountability and transparency to graduate medical education

Despite Medicare's significant investment, it does not require graduate medical education programs to meet any goals or standards, and the funding is not transparent. The independent Medicare Payment Advisory Commission found

that program curricula do not meet standards recommended by the Institute of Medicine.<sup>74</sup> Moreover, programs have significant gaps in training that is essential for reform of health care delivery, such as training in multidisciplinary teamwork, cost awareness in clinical decision-making, health information technology, and patient care in nonhospital settings.<sup>75</sup>

By 2014 Medicare should adjust payments to programs based on their performance on training that:

- Is essential for delivery system reform, such as training in health information technology
- Meets other priorities, such as training in geriatric care

In addition, Medicare should publicly report all payments to programs on its website to increase transparency. These concepts are broadly consistent with MedPAC recommendations and bipartisan legislation.<sup>76</sup>

For the most part, graduate medical education programs are based in teaching hospitals, and experience in nonhospital settings is extremely limited.<sup>77</sup> While some accreditation organizations have requirements for nonhospital experience, many programs satisfy these requirements through rotations in hospital outpatient departments. Yet most health care is provided in nonhospital settings, and experience in nonhospital settings is necessary to coordinate care effectively. For these reasons, Medicare should require training and experience in nonhospital settings, especially teaching health centers, for at least one-third of residents' time.

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### Require private insurers to contribute their fair share for graduate medical education

Graduate medical education provides important benefits to society and to patients of all ages. But for the most part, private insurers do not make any payments to providers to support graduate medical education.<sup>78</sup>

Private insurers are required to contribute modest financing for research on the comparative effectiveness of treatments—research that will benefit all payers.<sup>79</sup> Similarly, private insurers should contribute modest financing for graduate medical education: \$2 per enrollee by 2014. This contribution would amount to

less than 5 percent of total financing for graduate medical education each year. Medicare payments for graduate medical education should be reduced by a commensurate amount.

**Estimated savings: \$3.6 billion**

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## Expand use of nonphysician providers<sup>80</sup>

Restrictive state scope-of-practice laws prevent nonphysician providers from practicing to the full extent of their training. For instance, 34 states do not allow advanced-practice nurses to practice without physician supervision.<sup>81</sup> Expanding use of these providers would expand the workforce supply, which would increase competition and lower prices.

The federal government should provide bonus payments to states that meet scope-of-practice standards delineated by the Institute of Medicine. In addition, Medicare and Medicaid payments to nonphysician providers should allow them to practice to the full extent permitted under state law.



# Reform Medicare premiums and cost-sharing

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## Rationalize cost-sharing to ensure access to needed care

Medicare coverage is less generous than the coverage of large employer plans or the Federal Employees Health Benefits Program standard plan, which is available to members of Congress. On average, Medicare beneficiaries pay 26 percent of costs, whereas enrollees in large employer plans and the Federal Employees Health Benefits Program pay 15 percent or 17 percent of costs respectively.<sup>82</sup> In fact, Medicare's benefit value would rank in the bottom 10 percent of large employer plans.<sup>83</sup>

Medicare has higher cost-sharing mainly because it does not limit total out-of-pocket costs. Medigap, however, provides supplemental coverage to about 20 percent of beneficiaries, and almost all of these policies provide first-dollar coverage that eliminates cost-sharing.<sup>84</sup>

Several recent proposals would increase Medicare cost-sharing by implementing the following benefit design or a similar design:

- \$550 combined deductible for hospital and physician services
- Twenty percent coinsurance for all services
- \$5,500 or \$7,500 limit on total cost-sharing
- Prohibition on first-dollar Medigap coverage for the first \$500 of costs

Such reforms could have serious adverse consequences for beneficiaries, especially those who are lower-income or in poor health. According to modeling by the Kaiser Family Foundation, the benefit design specified above would increase cost-sharing for 50 percent of beneficiaries in traditional Medicare.<sup>85</sup> Cost-sharing would increase substantially, by an average of \$780, for almost 6 million beneficiaries—including 2.1 million beneficiaries in poor or fair health and more than 3 million beneficiaries with incomes below 200 percent of the federal poverty level.<sup>86</sup> Many of these seniors would likely be forced to forgo needed care.

The independent Medicare Payment Advisory Commission recently rejected such proposals in favor of a benefit design that does not increase cost-sharing overall.<sup>87</sup>

A more careful and targeted benefit design is possible:

- Limit total cost-sharing to \$5,000 per year for beneficiaries with incomes below 400 percent of the federal poverty level; \$7,500 per year for beneficiaries with incomes between 400 percent and 600 percent of the federal poverty level; and \$10,000 per year for beneficiaries with incomes above 600 percent of the federal poverty level. Such limits would help ensure access to care for those who need it the most, as well as provide peace of mind and financial security to all beneficiaries. Currently, 13 percent of beneficiaries incur cost-sharing of \$5,000 or more in at least one year over a four-year period.<sup>88</sup>
- Prohibit Medigap coverage of the first \$500 of costs for beneficiaries with incomes above 400 percent of the federal poverty level. First-dollar coverage of primary care and care for chronic disease, however, should be exempt from this prohibition.
- Direct the Institute of Medicine to recommend additional improvements to align incentives with high-quality care. Cost-sharing could vary based on evidence of clinical effectiveness and use of providers that deliver high-quality and efficient care.

Overall, average cost-sharing should not increase, and the value of the benefit package should not decline.

**Estimated savings: \$0**

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## Increase premiums for high-income Medicare beneficiaries

Medicare beneficiaries pay a monthly premium for physician services under Part B and for prescription drug coverage under Part D. But they pay higher premiums if their incomes are at least \$85,000 for an individual and \$170,000 for a couple. In 2012 monthly premiums for Part B are:<sup>89</sup>

- \$99.90 for individuals with incomes below \$85,000 and couples with incomes below \$170,000
- \$139.90 for individuals with incomes between \$85,000 and \$107,000 and couples with incomes between \$170,000 and \$214,000

- \$199.80 for individuals with incomes between \$107,000 and \$160,000 and couples with incomes between \$214,000 and \$320,000
- \$259.70 for individuals with incomes between \$160,000 and \$214,000 and couples with incomes between \$320,000 and \$428,000
- \$319.70 for individuals with incomes above \$214,000 and couples with incomes above \$428,000

In 2012, 5.1 percent of beneficiaries enrolled in Part B and 3 percent of beneficiaries enrolled in Part D pay higher premiums.<sup>90</sup> Under the Affordable Care Act, which will lower the income thresholds gradually over time, the share of beneficiaries who pay higher premiums for each part will rise to nearly 10 percent by 2019, but then fall back down to about 6 percent in 2021.<sup>91</sup>

Instead, the share of beneficiaries who pay higher premiums for each part should remain constant at 10 percent beyond 2019. In addition, the higher premium amounts should be increased by 15 percent starting in 2014. This premium increase would amount to less than 1 percent of these beneficiaries' annual income.<sup>92</sup>

**Estimated savings: \$25 billion**

# Reduce drug costs

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## Extend Medicaid drug rebates to low-income Medicare beneficiaries

Drug manufacturers pay rebates for drugs provided to Medicaid beneficiaries, resulting in significant price discounts. Before Congress created the prescription drug program under Medicare Part D, drug manufacturers paid rebates for drugs provided to beneficiaries who are eligible for both Medicare and Medicaid—known as “dual eligibles.”

While Medicare prescription drug plans negotiate rebates with manufacturers, these rebates are substantially lower than Medicaid rebates. For selected brand-name drugs, the Office of Inspector General found that rebates reduce Medicaid spending by 45 percent, but reduce Medicare Part D spending by only 19 percent.<sup>93</sup>

As a result, shifting dual eligibles’ drug coverage from Medicaid to Medicare has produced an enormous windfall to drug manufacturers. Medicaid rebates should be extended to brand-name drugs purchased by low-income Medicare beneficiaries.

**Estimated savings: \$137.4 billion**

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## Maximize use of generic drugs in Medicare and Medicaid

Generic drugs are much cheaper than brand-name drugs: The average price savings is about 75 percent in Medicare, for example.<sup>94</sup> In both Medicare and Medicaid, when a drug has a generic version, the generic drug is used more than 90 percent of the time, on average.<sup>95</sup>

While this generic substitution rate is impressive, these programs could save more. The Congressional Budget Office estimates that over 10 years, maximizing generic drug substitution could save Medicare up to \$6.5 billion and beneficiaries up to \$2.5 billion.<sup>96</sup> Similarly, the American Enterprise Institute estimates that maximizing

generic drug substitution could save Medicaid up to \$7.6 billion over 10 years—with about 60 percent of that savings, or \$4.6 billion, accruing to the federal government.<sup>97</sup>

Since 1987 Medicaid has used a form of “generic reference pricing,” in which insurers pay for a brand-name drug by referencing the market price of its generic version. If a drug has three or more versions that are therapeutically and chemically equivalent, Medicaid limits reimbursement to a “federal upper limit”—175 percent of the average price (the reference price) of these equivalent drugs.<sup>98</sup> This policy should be strengthened in a number of ways:

- The reference price should be the *lowest* price of equivalent drugs. Using the average price includes the price of the brand-name drug.
- The policy should apply to drugs with *two* or more versions that are therapeutically and chemically equivalent. More than 800 additional drugs would be subject to the policy.<sup>99</sup>
- The federal upper limit should be reduced so that payments more accurately reflect actual costs. According to the Government Accountability Office, the limit is more than 35 percent higher than actual costs.<sup>100</sup>

Medicaid should also provide financial incentives for states to boost generic drug utilization. If a state increases its rate of generic drug substitution, it should be able to keep a share of the Medicaid savings. This concept is reflected in bipartisan legislation.<sup>101</sup>

Medicare should also do much more to capture savings from generic drugs. Under Part D, the prescription drug program, private plans encourage generic drug use by charging lower cost-sharing for generic drugs and higher cost-sharing for brand-name drugs. Cost-sharing for low-income enrollees, however, is set by law, and the financial incentives are not as strong. As a result, the independent Medicare Payment Advisory Commission found that generic drug use is lower among low-income enrollees.<sup>102</sup>

For low-income enrollees, when a drug has a generic version, Medicare should eliminate cost-sharing for the generic drug and increase cost-sharing for the brand-name drug. As under current law, exceptions and an appeals process would still ensure access to brand-name drugs for clinical reasons. This policy is consistent with MedPAC recommendations.

Generic drugs are much cheaper than brand-name drugs. In both Medicare and Medicaid, when a drug has a generic version, the generic drug is used more than 90 percent of the time, on average.

Medicare also covers outpatient prescription drugs, such as injectable drugs and vaccines, under Part B. When a drug has a generic version, Medicare bases payment on the average price of all equivalent drugs. It should instead base payment on the *lowest* price of all equivalent drugs.

In addition, there is a significant time lag of six months or more from when a generic drug becomes available until Medicare adjusts payment to reflect the lower price. During this delay, Medicare pays brand-name drug prices for generic drugs. The Office of Inspector General estimates that this delay wastes up to \$1.1 billion over 10 years.<sup>103</sup> When a generic drug becomes available, Medicare should adjust payment to the price of the generic drug as soon as possible.

### Estimated savings

Medicare	\$2.5 billion
Medicaid	\$2 billion
<b>Total estimated savings</b>	<b>\$4.5 billion</b>

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### Require the Federal Employees Health Benefits Program to reduce drug costs

Most federal agencies such as the Department of Defense and the Public Health Service can obtain the best deal on prices for brand-name drugs that manufacturers negotiate with commercial customers. But drug prices are far higher under the Federal Employees Health Benefits Program.<sup>104</sup> FEHBP should have access to the same drug prices that are available to all other federal programs. This policy does not require any formulary that would restrict patient choice, and FEHBP should be prohibited from imposing any formulary.

**Estimated savings: \$10 billion**

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### Prohibit “pay for delay” agreements to expand access to generic drugs

Brand-name drug manufacturers increasingly pay off generic drug manufacturers if they agree to keep generic drugs off the market. While these anticompetitive agreements—known as “pay for delay” agreements—allow both parties to share monopoly profits, they harm consumers and taxpayers because generic

drugs cost up to 90 percent less than brand-name drugs. In fact, the Federal Trade Commission estimates that these agreements cost consumers \$3.5 billion per year.<sup>105</sup> The FTC should be granted the authority to stop these agreements.

**Estimated savings: \$5 billion**

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### Reduce the exclusivity period for brand-name biologics to expand access to generic biologics

Biologics are drugs made from living organisms, and they can cost hundreds of thousands of dollars per year. To make these drugs more affordable, the Affordable Care Act grants authority to the Food and Drug Administration to approve generic versions.<sup>106</sup> But brand-name biologics are still entitled to a monopoly—known as “exclusivity”—for at least 12 years. By contrast, traditional brand-name drugs made from chemicals are entitled to a monopoly for only five years. This differential is not justified because biologics take only 7.4 months longer to develop and approve than chemical drugs on average.<sup>107</sup> Congress should reduce the exclusivity period to seven years, and prohibit additional exclusivity periods for minor changes to the drug, an abuse known as “evergreening.”

**Estimated savings: \$3.3 billion**

# Bring Medicare payments into line with actual costs

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## Reduce excessive Medicare payments to home health providers

Home health agencies provide nursing or therapy to patients in their homes. But Medicare payments to home health providers substantially exceed the actual costs of treating beneficiaries.

The independent Medicare Payment Advisory Commission estimates that providers reaped profits from Medicare averaging more than 17 percent since 2001.<sup>108</sup> Excessive payments may drive fraud and abuse in some areas, growth in the volume of services, and growth in the number of new for-profit providers. In addition, excessive payments accelerate the Medicare Trust Fund's insolvency and increase premiums for beneficiaries.

The Affordable Care Act will begin to bring Medicare payments in line with actual costs in 2014. Medicare should accelerate this reform, consistent with MedPAC recommendations.

**Estimated savings: \$15 billion**

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## Reduce excessive Medicare payments to skilled nursing facilities

Skilled nursing facilities—which are mostly nursing homes—provide nursing and rehabilitation to patients after a hospitalization. But Medicare payments to skilled nursing facilities substantially exceed the actual costs of treating beneficiaries.

The independent Medicare Payment Advisory Commission estimates that skilled nursing facilities reaped average profits from Medicare above 10 percent every year since 2000—and it projects that freestanding facilities' profits will exceed 14 percent in 2012.<sup>109</sup> In 2011 alone excessive payments increased spending for these services by more than 17 percent.<sup>110</sup>



Medicare should align payments with actual costs over a transition period starting in 2014, consistent with MedPAC recommendations.

**Estimated savings: \$15 billion**

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### Reduce excessive Medicare payments for hospital inpatient and outpatient services

Medicare overpaid hospitals in 2010, 2011, and 2012.<sup>111</sup> Under current law Medicare payments for inpatient services will increase by 2.8 percent in fiscal year 2013. To gradually recover past overpayments, Medicare should increase payments by 1 percent instead, consistent with recommendations by the independent Medicare Payment Advisory Commission.

Since 2004 the volume of hospital outpatient services increased by 28 percent, which may indicate that Medicare payments are excessive.<sup>112</sup> While some of that growth is due to patients shifting from inpatient to outpatient settings, much of it is from growth in highly-paid physician office visits at hospitals, which grew by 6.7 percent in 2010.<sup>113</sup> Medicare pays 80 percent more for a 15-minute office visit at a hospital than at a physician office.<sup>114</sup>

As a general principle, Medicare payments for the same service should be the same whether the service occurs at a hospital or at a physician office. The current policy leads to wasteful spending without any difference in patient care, and it increases premiums and cost-sharing for beneficiaries. At a minimum, Medicare should equalize payments for 15-minute office visits over a transition period of three years, consistent with MedPAC recommendations.

**Estimated savings: \$26 billion**

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### Reduce excessive Medicare payments for bad debt

By fiscal year 2015 Medicare will cover 65 percent of the “bad debt” of providers—amounts of cost sharing that providers have been unable to collect from beneficiaries.<sup>115</sup> That percentage should be gradually reduced to bring Medicare more into line with the private sector. But this policy should be strictly contingent on implementation of the coverage expansion under the Affordable Care Act.

Medicare pays 80 percent more for a 15-minute office visit at a hospital than at a physician office.

**Estimated savings: \$5 billion**

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### Reduce excessive Medicare payments to rural hospitals

Medicare makes special payments totaling \$4 billion per year to rural hospitals to ensure access to care in rural areas.<sup>116</sup> But as the independent Medicare Payment Advisory Commission found, these payments are not always well targeted and can be duplicative. On average, beneficiaries in urban and rural areas use similar volumes of care and report similar satisfaction with access to care.<sup>117</sup> In fact, rural hospitals now receive higher profits from Medicare than urban hospitals.<sup>118</sup>

Medicare makes payments to small rural hospitals known as “critical access hospitals.” Originally, critical access hospitals had to be at least 15 miles from the nearest hospital, but today 16 percent of critical access hospitals are less than 15 miles from another hospital.<sup>119</sup> This expansion undermines the original intent of supporting isolated hospitals. Hospitals that are less than 15 miles from another hospital should no longer qualify as critical access hospitals.

Medicare pays critical access hospitals 101 percent of costs each year—even if the growth rate is excessive. This payment structure provides little incentive to control costs. Starting in fiscal year 2014, Medicare should limit payment to 100 percent of costs in fiscal year 2012, updated for inflation each year.

**Estimated savings: \$3 billion**

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### Reduce excessive Medicare payments to end-stage renal disease facilities

Patients with chronic kidney disease leading to kidney failure (end-stage renal disease) are generally treated with dialysis, which filters waste from the body. In 2011 Medicare began paying dialysis facilities for a bundle of dialysis services, drugs, and laboratory tests. But since 2009, use of dialysis drugs known as erythropoiesis-stimulating agents—which account for 75 percent of dialysis drug spending—has declined substantially.<sup>120</sup> This lower use is appropriate because evidence shows that higher use is linked to increased risk of cardiovascular problems.<sup>121</sup>

Medicare should adjust the bundled payment rate to reflect the appropriate lower use of dialysis drugs. According to recent estimates, this policy could save Medicare more than \$400 million per year.<sup>122</sup>

**Estimated savings: \$3.6 billion**

# Cut administrative costs and improper payments

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## Simplify administration for all payers and providers<sup>123</sup>

The Affordable Care Act requires uniform standards and operating rules for electronic transactions between health plans and providers.<sup>124</sup> While plans must comply with these standards and operating rules, providers are not required to exchange information electronically. Much more can be done to simplify administration:

- By 2014 payers and providers should electronically exchange eligibility, claims, claims status, claims payments, and other administrative information.
- By 2014 payers and providers should use a single, standardized physician credentialing system. Currently, physicians must submit their credentials to Medicare, Medicaid, private insurers, state licensing boards, and hospitals—creating an enormous administrative burden.
- By 2015 payers should provide monthly explanation of benefits statements electronically but allow patients to opt for individual paper statements.
- By 2017 electronic health records should integrate clinical and administrative functions, such as billing, prior authorization, and payments. For instance, ordering a clinical service for a patient should automatically bill the payer, all in one step.

Finally, a taskforce composed of payers, providers, and vendors should set binding compliance targets, monitor use rates, and have broad authority to implement additional measures to achieve systemwide savings of \$30 billion per year by 2016.<sup>125</sup>

**Estimated savings: \$10 billion**

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## Improve the accuracy of adjustments to Medicare Advantage payments for beneficiary health status

To reduce financial incentives for private plans to cherry pick healthier beneficiaries, Medicare reduces payments to private plans with healthier enrollees—a process known as “risk adjustment.” But the Government Accountability Office found that the current adjustment is too small.<sup>126</sup> In 2010 this resulted in overpayments to private plans of at least \$1.2 billion. Since Medicare used the same adjustment in 2011 and 2012, it overpaid private plans by at least \$1.2 billion in each of those years.

Medicare should recover overpayments to private plans made in 2010, 2011, and 2012, and it should be required to improve its adjustment starting in 2013. Private plans tend to record more diagnoses than traditional Medicare, making their enrollees appear sicker and boosting their payments.<sup>127</sup> When Medicare corrects for this practice, it should use the most recent data available and account for beneficiary characteristics such as health status and sex, consistent with GAO recommendations.

**Estimated savings: \$5 billion**

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## Reduce Medicaid disproportionate share hospital payments in future years

The federal government provides supplemental “disproportionate share hospital payments” for hospitals that provide care to disproportionate numbers of low-income and uninsured people. But under the Affordable Care Act, the number of uninsured people will decline substantially, reducing the need for these payments. The Affordable Care Act reduces disproportionate share hospital payments under Medicaid each year from 2014 through 2020.<sup>128</sup> Since there will continue to be a reduced need for these payments beyond 2020, Medicaid payments should also be reduced in future years.

The secretary of health and human services should develop a methodology to reduce Medicaid payments in 2021 and beyond. Under that methodology, the largest payment reductions should apply to states that impose the highest taxes on health care providers, use the revenue to make payments to the providers, and draw down federal matching funds for the payments—thereby gaming the system. These states could choose to lower these provider taxes in exchange for smaller reductions in their payments.

**Estimated savings: \$4 billion**

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## Avoid and collect improper Medicaid payments from third parties

In general, Medicaid is the payer of last resort—if other insurers or programs are responsible for medical costs, they must pay before Medicaid pays. But there are certain exceptions to this rule, such as for preventive pediatric costs. These exceptions should be eliminated. State Medicaid programs, not doctors, should be responsible for collecting payments from third parties.

**Estimated savings: \$1.8 billion**

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## Root out improper payments and fraud in Medicare

Medicare and Medicaid make more than \$70 billion in improper payments each year.<sup>129</sup> This problem is not a result of program structure: The payment error rate is higher for private Medicare Advantage plans than for traditional Medicare.<sup>130</sup>

Currently, Medicare administrative contractors screen and enroll providers, review and pay claims, and audit claims for errors and fraud. The same entities that screen and enroll providers and review and pay claims should not audit those claims, since they have a conflict of interest. In addition, Medicare should require contractors to reimburse the program a percentage of improper payments—just as they must do for the Defense Department’s TriCare program.

Improper payments make up 7.5 percent of Medicare payments for durable medical equipment, such as wheelchairs and hospital beds.<sup>131</sup> Medicare uses “prepayment controls” to deny claims or flag them for review—avoiding improper payments in the first place. But these controls do not identify rapid increases in billing. In one instance, the Government Accountability Office found that 225 suppliers increased their billing by 50 percent over a three-month period.<sup>132</sup> Medicare should be required to strengthen its prepayment controls to identify such fraud schemes.

Home health care is another major source of improper payments in Medicare. The Government Accountability Office has found that fraud and abuse by home health providers contribute to higher spending and utilization.<sup>133</sup> Currently, Medicare revokes a provider’s billing privileges for submitting claims for services that could not have been provided—such as when a provider submits claims for a deceased beneficiary. But Medicare should be required to revoke billing privileges for any type of abusive or fraudulent billing.

# Reduce the costs of defensive medicine<sup>134</sup>

More than 75 percent of physicians—and virtually all physicians in high-risk specialties—face a malpractice claim over the course of their career.<sup>135</sup> While most claims do not result in liability, the risk of being sued may cause physicians to practice defensive medicine. Litigation costs are higher for claims that result in awards, but litigation costs for claims that do not result in awards are still significant (averaging \$17,130).<sup>136</sup>

But there is a right way and a wrong way to reduce the costs of defensive medicine. According to the Congressional Budget Office, arbitrary caps on damages would reduce national health spending by only 0.5 percent.<sup>137</sup> But while such caps would have a barely measurable impact on health care costs, they might adversely affect health outcomes.<sup>138</sup> Every year, about 200,000 severe medical injuries are caused by negligence.<sup>139</sup> With caps, these patients might not be able to obtain full and just compensation for their injuries.

A more promising strategy would provide a “safe harbor” to physicians. Physicians would be presumed to have no liability if they:

- Document adherence to evidence-based clinical practice guidelines
- Use qualified health information technology systems
- Use clinical decision support systems that incorporate guidelines

Under such a system, the physician could use the safe harbor as an affirmative defense at an early stage in the litigation and could introduce guidelines into evidence to avoid a “battle of the experts” and the need to establish a clinical standard of care anew in each case. The patient could still present evidence that the guidelines are not applicable to the particular situation, and the judge would still determine their applicability. The patient could also use guidelines to show that the defendant was negligent.

Evidence-based clinical practice guidelines should be developed and regularly updated by physicians. Under an initiative called “Choosing Wisely,” nine lead-

ing physician specialty groups recently released guidelines on 45 common tests and procedures that might be overused or unnecessary.<sup>140</sup> These include MRIs for complaints of back pain, routine stress cardiac imaging, imaging scans for simple headaches, and scans after fainting. Physicians who participate in developing guidelines should be completely free from any financial conflict of interest and should publicly disclose any other conflict of interest.

**Estimated savings: \$5 billion**



# Reform the tax treatment of health insurance

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## Limit the tax exclusion for employer-based health insurance

Under current law, employees can exclude the value of employer-based health insurance from income and payroll taxes. This exclusion is the largest tax break in the tax code, costing more than \$225 billion per year.<sup>141</sup> It is also highly regressive, providing a greater tax benefit to those in higher tax brackets. The Joint Committee on Taxation estimates that those with incomes below \$50,000 receive a tax benefit of \$600 to \$2,500, while those with incomes above \$200,000 receive a tax benefit of more than \$4,500.<sup>142</sup> Moreover, the exclusion encourages the purchase of more generous insurance coverage, which could lead to higher prices for medical services and the overconsumption of health care.

To address these issues, the income exclusion for families with incomes above \$250,000 should be limited to the value of the Silver level of coverage that will be subsidized in the new health insurance marketplaces, starting in 2018. But since this policy could lead to a small shift from employer-based coverage to coverage in the exchanges, it should be strictly contingent on implementation of the coverage expansion under the Affordable Care Act.

# Promote better health

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## Increase the federal excise tax on cigarettes

Smoking causes over 440,000 deaths per year and costs the economy \$193 billion per year.<sup>143</sup> The nonpartisan Congressional Budget Office estimates that smoking increases overall spending on health care by 7 percent.<sup>144</sup> But smoking also harms the economy in another way: Average earnings of adults are 4 percent to 7 percent lower because of smoking.<sup>145</sup>

To address this problem, the federal excise tax on cigarettes and small cigars should be increased from \$1.01 per pack to \$1.51 per pack starting in 2013 and should be adjusted each year for inflation.

Based on research showing the effects of price increases on smoking, CBO estimates that just a few years after this policy would go into effect, more than 4.5 percent fewer children and almost 4 percent fewer adults under age 40 would smoke.<sup>146</sup> Over the next 10 years, better health from not smoking would reduce spending on Medicare and Medicaid and increase incomes and workforce productivity.

**Estimated savings: \$42 billion**

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## Close the tobacco tax loophole

The federal excise tax rates for cigarettes, small cigars, and roll-your-own tobacco are the same, but the rate for large cigars is lower and the rate for pipe tobacco is 89 percent lower.<sup>147</sup> To exploit this difference, the tobacco market has shifted from higher-taxed roll-your-own tobacco to lower-taxed pipe tobacco and from higher-taxed small cigars to lower-taxed large cigars.<sup>148</sup> Tobacco companies simply re-label roll-your-own tobacco as pipe tobacco and make small cigars slightly heavier so that they qualify as large cigars. The Government Accountability Office

estimates that this tax evasion reduced federal revenue by up to \$1.1 billion from April 2009 through September 2011.<sup>149</sup>

The Tobacco Tax Equity Act would close the tobacco tax loophole, taxing all tobacco products at the same rate.<sup>150</sup> Congress should enact this legislation.

**Estimated savings: \$4 billion**

# Conclusion

To reduce federal spending on health care, the choice is clear. The wrong approach is to slash federal health care spending by simply shifting costs to seniors, children, and disabled people. The alternative approach—as reflected by the Senior Protection Plan—is to reduce overall health care costs and modernize the Medicare and Medicaid programs. This approach would actually solve the problem of cost growth while protecting and improving access to needed care.

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## Acknowledgements

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