Technical Report
Modeling the Impact of Health Care Payment, Financing, and System Reforms

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January 10, 2013

This report was prepared for The Commonwealth Fund by the Actuarial Research Corporation under grant number 20120510. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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INTRODUCTION

This report describes the basis of the estimates by Actuarial Research Corporation of the impacts of policy options developed by Commonwealth Fund staff to address the need to slow the rate of U.S. health spending growth while improving health outcomes and protecting both access and affordability for individuals and families. These policies analyzed relate to Medicare, Medicaid, and private insurance, as well as market policies that would apply across both public and private sectors.

Modeling focused on illustrating potential impacts of aggressive implementation of these policy options over a 10-year window. The illustrated effects for each option draw on the relevant literature and current examples of related policies. Impacts are shown relative to a baseline that reflects current policy (rather than current law), as described below.

The primary source for the baseline was the National Health Expenditure (NHE) Accounts developed by the Centers for Medicare and Medicaid Services Office of the Actuary (OACT). The NHE Accounts include detail by type of service (e.g., hospital care, physician and clinical services), payer (e.g., private health insurance, Medicare, Medicaid), and sponsor (e.g., private business, household, federal government).

Since a number of the policy options are applicable only to the Medicare population, our baseline was split into two populations: Medicare and non-Medicare. In addition, the private health Insurance category was broken into employer-sponsored insurance (ESI) and other private (including government subsidies through the exchanges), and the Medicare category was broken into traditional Medicare and Medicare Advantage. Finer service splits were also created, including more detailed hospital and physician splits and components of other professional services.

Once a current law detailed baseline was created, we modified it to reflect the assumption that the precipitous drop in the physician payment rate under the Medicare sustainable growth rate (SGR) formula would never occur. Specifically, we modeled a scenario wherein a 1 percent update to the basic Medicare physician payment rate is presumed in 2013 and it is held at the 2013 level through 2023. All the simulations in this project are applied to this "current policy" baseline.

Figure A.1 -- "Current Policy" Baseline: By Sponsor													
	Spending											Cumulative Spending 2014-2018	Cumulative Spending 2014-2023
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023		
National Health Expenditure	2,942	3,158	3,336	3,542	3,752	3,982	4,240	4,522	4,819	5,134	5,468	17,770	41,952
Federal Government	813	962.0	1011.7	1077.8	1142.1	1222.1	1308.6	1407.3	1516.2	1632.5	1755.3	5,416	13,036
State and Local Government	540	570.8	605.3	643.0	682.4	722.3	768.2	821.8	876.0	934.3	995.2	3,224	7,619
Private Employers	577	604.9	638.9	672.4	701.0	733.1	776.8	822.0	867.3	913.8	967.9	3,350	7,698
Households	821	822.0	869.1	923.4	985.6	1048.3	1113.5	1182.5	1254.6	1329.6	1410.8	4,648	10,939
Note: Other Private Revenue	190	198.5	210.5	225.4	240.6	256.6	272.5	288.6	304.7	323.4	339.0	1,132	2,660

Figure A.2 -- "Current Policy" Baseline: By Payer													
	Spending											Cumulative Spending 2014-2018	Cumulative Spending 2014-2023
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023		
National Health Expenditure	2,942	3,158	3,336	3,542	3,752	3,982	4,240	4,522	4,819	5,134	5,468	17,770	41,952
Medicare	620	658	690	730	779	834	895	964	1,038	1,120	1,207	3,691	8,915
Medicaid	492	581	622	674	721	771	828	890	959	1,034	1,114	3,369	8,195
PHI	926	999	1,061	1,131	1,192	1,254	1,330	1,413	1,497	1,585	1,680	5,637	13,142
OOP	323	318	330	341	360	382	404	427	450	475	500	1,731	3,987
Note: Other Payers	580	602	633	666	700	741	783	828	874	920	966	3,342	7,713

Figure A.3 -- Current Policy Baseline: By Service													
	Spending											Cumulative Spending 2014-2018	Cumulative Spending 2014-2023
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023		
National Health Expenditure	2,942	3,158	3,336	3,542	3,752	3,982	4,240	4,522	4,819	5,134	5,468	17,770	41,952
Hospital Care	902	961	1,016	1,081	1,143	1,209	1,284	1,367	1,454	1,547	1,646	5,410	12,708
Physician and Clinical Services	597	647	681	721	766	815	870	928	989	1,053	1,122	3,631	8,593
Other PHC and Admin	1,190	1,284	1,358	1,443	1,528	1,624	1,731	1,851	1,978	2,112	2,255	7,237	17,164
Note: Public Health, Research, Structures, Equipment	253	266	281	297	315	335	355	376	398	421	446	1,492	3,487

Additional detail on the baseline sources and methodology can be found in Appendix A.

All policies are assumed to be implemented beginning in 2014; year-by-year results are shown for 2014–2023, broken out by major payer category (national health expenditure (NHE) total, Medicare, Medicaid,

private health insurance (PHI), and out-of-pocket) and by sponsor (federal government, state and local government, private employers, and households).

The potential policies analyzed were the following:

I. Improved Provider Payment

II. Primary Care: Medical Homes

III. High-Cost Care Management Teams

IV. Bundled Payments

V. Modified Payment Policy for Medicare Advantage

VI. Medicare Essential Benefits Plan

VII. Private Insurance: Tightened Medical Loss Ratio Rules

VIII. Reduced Administrative Costs and Regulatory Burden

IX. Combined Estimates

X. Setting Spending Targets

I. IMPROVED PROVIDER PAYMENT

Policy Description

The purpose of this option is to eliminate the distortions in Medicare payment policy created by the SGR formula, establish a new payment mechanism for physician services, and improve or adjust payments for other providers to better align incentives with program goals and generate savings to offset the cost of eliminating the SGR.

The proposed policy assumes the SGR formula is repealed and replaced with a policy that holds basic Medicare physician fees at their 2012 levels through 2023, producing a small savings relative to the "current policy" baseline which assumes a 1 percent update in 2013 and constant Medicare payment rates thereafter. (For a description of how the current policy baseline was developed, see Appendix A). The proposed policy also calls for recalibration of the relative values for overpriced services and volume price adjustment for high-cost diagnostic tests, which should bring physician payments more in line with the cost of the services produced. In addition, malpractice reform is to be implemented to reduce malpractice insurance premiums and reduce the use of defensive medicine by instituting a process for addressing malpractice claims that rewards the adoption of best practices while continuing to protect patients from avoidable adverse outcomes.

This option calls for a number of additional provisions that are not directly related to physician payments, including repealing the Medicare Advantage quality bonus demonstration; expanding competitive bidding to all durable medical equipment categories; enhancing payment comparability across settings; increasing the compliance threshold for inpatient rehabilitation facilities; rebasing payment rates for clinical laboratory, skilled nursing facility, and home health services; collecting ambulatory surgery center cost and quality data; requiring prior authorization for imaging services, Medicaid-level drug rebates for dual eligibles; and encouraging the use of generic drugs among low-income subsidy (LIS) program enrollees in the Medicare Prescription Drug Coverage program.

Assumptions

- Data collection and recalibration of relative values—no scoreable impact modeled, but improves payment incentives.
- Updating physician payment rates—estimated impact of holding physician fees constant by adjusting baseline physician fee schedule spending by the ratio of the conversion factor under the proposed policy to the conversion factor under the current policy baseline.
- Malpractice reform:
    - Estimates assume universal savings of 0.1 percent based on Thomas et al. (see below).

- For savings to be credited in an official scoring, it is likely that a failsafe provision will be required (e.g., caps if estimated effects less than a threshold). Otherwise, the concern would be that the implementation would leave room for avoidance.
- Literature considered:
    - J. W. Thomas, E. C. Ziller and D. A. Thayer, "Low Costs of Defensive Medicine, Small Savings from Tort Reform", *Health Affairs,* Sept. 2010 29(9):1578–84, available at http://content.healthaffairs.org/content/29/9/1578.abstract.
    - A. Kachalia and M. M. Mello, "New Directions in Medical Liability Reform," *New England Journal of Medicine,* April 21, 2011 364(16):1564–72, available at http://www.nejm.org/doi/full/10.1056/NEJMhpr1012821.
    - CBO letter providing updated analysis on effects of proposals to limit costs related to medical malpractice, Director Douglas Elmendorf to Senator Orrin G. Hatch, October 9, 2009.

- Other provider payment options—using estimates from Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2012), Appendix B, Table A-4 (http://www.medpac.gov/chapters/Mar12_AppB.pdf):
    - Repeal the Medicare Advantage quality bonus demonstration
    - Competitive bidding—expand competitive bidding to all durable medical equipment categories
    - Payment comparability across settings
    - Compliance threshold for inpatient rehabilitation facilities
    - Rebase payments for clinical laboratory services
    - Rebase payments for skilled nursing facility services
    - Rebase payments for home health services
    - Ambulatory surgery center cost and quality data
    - Prior authorization for imaging services
    - Drug rebates for dual eligibles
    - Encouraging the use of generic drugs

In addition to the changes to Medicare, we estimated the effects on cost-sharing and administrative costs of each of these options, and distributed the changes pro-rata across the different payer channels by service.

Cost Impacts

Figure 1.1—Improved Provider Payment: Impact by Sponsor													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-18.4	-16.5	-17.5	-18.6	-19.8	-23.8	-25.5	-27.4	-29.4	-31.5	-90.7	-228.3
Federal Government	0	-12.8	-11.1	-11.8	-12.6	-13.4	-16.1	-17.2	-18.5	-19.9	-21.4	-61.7	-154.8
State and Local Government	0	-0.8	-0.8	-0.9	-1.0	-1.0	-1.2	-1.3	-1.4	-1.5	-1.7	-4.6	-11.8
Private Employers	0	-0.8	-0.8	-0.9	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-4.3	-10.9
Households	0	-3.9	-3.7	-3.9	-4.2	-4.4	-5.4	-5.7	-6.1	-6.6	-7.0	-20.0	-50.8

Figure 1.2 – Improved Provider Payment: Impact by Payer													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-18.4	-16.5	-17.5	-18.6	-19.8	-23.8	-25.5	-27.4	-29.4	-31.5	-90.7	-228.3
Medicare	0	-14.6	-12.5	-13.3	-14.1	-15.0	-18.0	-19.3	-20.8	-22.3	-23.9	-69.4	-173.6
Medicaid	0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.8	-1.9	-2.1	-2.2	-2.4	-6.5	-16.9
PHI	0	-1.7	-1.8	-1.9	-2.0	-2.1	-2.5	-2.7	-2.9	-3.1	-3.3	-9.4	-23.9
OOP	0	-1.0	-1.0	-1.1	-1.1	-1.2	-1.5	-1.6	-1.7	-1.8	-1.9	-5.4	-13.9

Figure 1.3 – Improved Provider Payment: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-18.4	-16.5	-17.5	-18.6	-19.8	-23.8	-25.5	-27.4	-29.4	-31.5	-90.7	-228.3
Hospital Care	0	-4.7	-3.8	-4.0	-4.3	-4.6	-4.3	-4.6	-4.9	-5.2	-5.6	-21.3	-46.0
Physician and Clinical Services	0	-2.9	-2.8	-3.0	-3.2	-3.2	-3.4	-3.6	-4.0	-4.3	-4.6	-15.1	-35.1
Other PHC and Admin	0	-10.7	-9.9	-10.5	-11.2	-12.0	-16.1	-17.3	-18.5	-19.8	-21.3	-54.3	-147.3

II. PRIMARY CARE: MEDICAL HOMES

Policy Description

This policy option aims to help primary care practices deliver high-quality, well-coordinated, patient-centered care at lower cost. The goal is to create incentives for health care providers to be accountable for the total care of their patients, including health outcomes and efficient use of resources. Additionally, a key objective is to encourage patients to establish a relationship with a primary care provider (PCP) and, over time, seek out top-notch, efficient providers who can help reduce fragmentation and slow the growth of national health care spending.

This set of policies would, over the next 10 years, change Medicare and Medicaid payment policies for primary care providers to offer a new hybrid-payment approach that blends core payments per member per month with fees for services provided. Starting in 2013, Medicare would offer a modest per member per month payment for each beneficiary that designates a primary care practice as their primary source of care for preventive care, primary care, and referrals. Beneficiaries registering with practices would have reduced cost-sharing.

In return for this entry-level additional payment, practices would be expected to provide or have arrangements to provide access by phone or in person 24/7, be accountable for preventive care and basic primary care, coordinate care for patients, and institute an action plan for patients with chronic conditions. After three years, in 2016, practices would have to report on their performance, based on a core set of quality and efficiency metrics (consistent with Medicare's Physician Quality Reporting System) to maintain the per member per month payment.

Medicare also would offer a higher, enhanced per member per month care management fee for practices meeting external criteria to serve as patient-centered medical homes (PCMHs). The criteria would require that practices submit documentation and data that attest to the practice's information systems, ability to work in teams, capacity to manage care, and ability to coordinate care. This higher payment would be available only for practices that include shared networks with the ability to track and monitor care received by their patients, including care from other providers and capacity to help coordinate referrals and care received from specialists. Performance bonuses would be available to officially designated PCMHs that report high performance on core, standardized quality, utilization, and efficiency criteria.

Medicare would provide incentives for beneficiaries to register with a primary care provider by waiving the deductible. In exchange, Medicare beneficiaries will allow Medicare to give the designated PCP access to all medical records related to the care of the beneficiary. Medicare beneficiaries are expected to consult their PCPs about specialists, but are not penalized if they do not do so. Medicare will provide

additional, increased incentives to beneficiaries who select PCPs who are also officially designated at PCMHs, by lowering copayments and coinsurance. Expectations about coordinating and notifying the PCP about care provided by other physicians remain, but there is still no penalty.

Medicaid policies would generally follow a similar path and be coordinated with Medicare for practices that provide care to beneficiaries of both programs. From 2015 through 2020, the Affordable Care Act (ACA) provision that Medicaid primary care payment rates be at least equal to Medicare's would continue beyond the two-year ACA period with full federal support.

Provider incentive payments and beneficiary incentives for Medicare and Medicaid are shown in Table 2.1 below:

Table 2.1: Illustration of Potential New Primary Care Provider Payment Policy and Beneficiary Incentives for Both Medicare and Medicaid, 2013-2022

	PCP NOT SELECTED AS PRIMARY CARE PROVIDER	PCP SELECTED BY PATIENT BUT PROVIDER IS NOT PCMH		PCP SELECTED AND PCMH	
MEDICARE PCP PAYMENT					
SGR-related components					
Part B Fee Payment	Revised RBRVS	Revised RBRVS		Revised RBRVS	
Updates	No updates	No updates		No Updates	
Medical Home-related components					
		2013-15	2016-	2013-15	2016-
Per Member Per Month	**Current policy: No PMPM**	$5.00 for each beneficiary (accessible, record-keeper) Assume beneficiary will receive most primary care from this provider)	$5.00 PMPM continues if practice reports performance (quality and efficiency) consistent with current Medicare-Physician Quality Reporting System (PQRS) program.	$10.00-$15.00 for each beneficiary, adjusted for medical home capacity (advanced level of medical home only). In addition, they can earn bonuses (see below).	$11.00-$16.00 for each beneficiary, adjusted for PCMH capacity. In addition they can earn bonuses (see below). The PMPM is inflation-adjusted.
Standards	NA	NA		National or state-based measures of medical home capacity (advanced levels only, e.g., at least "Level II" of NCQA)	National or state-based recognition standards plus performance on a quality, efficiency and [patient experience] measures
Bonus	NA	NA		Up to $5.00 PMPM available to primary care sites that show above average performance on quality and efficiency measures.	Up to $10.00 PMPM available to primary care sites that show above average performance on quality and efficiency measures or meet targets.
MEDICARE BENEFICIARY INCENTIVE					
Incentive to designate primary care provider	Current policy: Pay deductible + co-insurance. No provision for primary care	Waive deductible and reduced cost-sharing (See Table 2)		Waive deductible and reduced cost-sharing to $10.00 (see Table 2) and specialist co-payment $30.00	Waive deductible and reduced cost-sharing

Table 2.1: Illustration of Potential New Primary Care Provider Payment Policy and Beneficiary Incentives for Both Medicare and Medicaid, 2013-2022

(continued)

	PCP NOT SELECTED AS PRIMARY CARE PROVIDER	PCP SELECTED BY PATIENT BUT PROVIDER IS NOT PCMH		PCP SELECTED AND PCMH	
MEDICAID PCP PAYMENT					
		2013-15	2016-	2013-15	2016-
Per Member Per Month	No PMPM.This option phases out. Beneficiaries must register with a PCP by December 31, 2013	$5.00 for each beneficiary (accessible, record-keeper, if we see you bounce around , you lose it)	$5.00 PMPM continues only if practice reports performance (quality and efficiency) consistent with current Medicare-Physician Quality Reporting System (PQRS) program.	$10.00-$19.00 for each beneficiary, adjusted for medical home capacity (advanced level of medical home only)	$11.00-21.00 for each beneficiary, adjusted for PCMH capacity. In addition they can earn bonuses (see bonuses below). PMPM is inflation adjusted.
Standards	NA	NA		National or state-based measures of medical home (Middle- high level of capacity must be achieved, e.g., "Level II NCQA")	National or state-based recognition standards plus performance on a quality, efficiency and measures
Bonus	NA	NA		Up to $5.00 PMPM available to primary care sites that show above average performance on quality and efficiency measures consistent with Physician Quality Reporting System.	Up to $10.00 PMPM available to primary care sites that show above average performance on quality and efficiency measures consistent with Physician Quality Reporting System.
Other				Federal government would match the new Medicaid PMPM by 90 percent and enhanced base primary care rates by 90 percent.	
MEDICAID BENEFICIARY INCENTIVE					
Incentive to designate primary care provider	Co-pays, if applicable, remain	No co-pays		No co-pays	

Estimation Process

The estimated impacts were developed in two steps. First, additional costs associated with the medical homes were generated, using illustrative participation rates from the specifications for some years, and interpolated values for the rest. The basic participation assumptions illustrated a case with 25 percent of Medicare enrollees designating a primary care provider within the first three years, 50 percent within five years, and 75 percent within eight years. Within these groups, the portion assumed to be in a PCMH rises from 12 percent in 2014 to 67 percent by 2023. Medicaid beneficiaries were assumed to be required to have selected a primary care provider, and the percentage in a PCMH matches the assumed Medicare percentage. Costs were the product of the potential population times the participation rate times the specified additional payments to be made per participant. These were done separately by beneficiary type. Second, the savings by payer were generated by applying savings rates (3.8%) consistent with Momany (2006) to the baseline spending for the assumed population in a medical home. For the population only registering with a primary care provider, the savings assumption is reduced to 1 percent, reflecting the substantially diminished expectations of coordination for this arrangement, relative to a medical home. The net cost change was then the savings minus the additional costs of the incentives. The savings for private payers, employers, and households were based on the implied reductions in Medicare costs, and reflected the lower cost-sharing leading to lower employer and household supplemental insurance costs.

Literature considered:

1. Group Health Cooperative: R. J. Reid, K. Coleman, E. A. Johnson et al., "The Group Health Medical Home at Year 2: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs,* May 2010 29(5):835–43; and R. J. Reid, P. A. Fishman, O. Yu et al., "A Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation," *American Journal of Managed Care,* Sept. 2009 15(9):e71–e87.
2. Geisinger Health System: D. D. Maeng, J. Graham, T. R. Graf et al., "Reducing Long-Term Cost by Transforming Primary Care: Evidence from Geisinger's Medical Home Model," *American Journal of Managed Care,* March 2012 18(3):149–55; and R. J. Gilfillan, J. Tomcavage, M. B. Rosenthal et al., "Value and the Medical Home: Effects of Transformed Primary Care," *American Journal of Managed Care,* Aug. 2010 16(8):607–14.
3. Blue Cross Blue Shield of Michigan: A. Markovitz, M. Paustian, A. Harrier et al., "Patient Centered Medical Homes Continue to Show Distinguished Performance Compared to Peers" (Blue Cross Blue Shield of Michigan, July 2011); C. Lemak et al., "From Partisanship to Partnership: Evaluating the Physician Group Incentive Program" (New York: The Commonwealth Fund, forthcoming 2013).
4. Illinois: M. Han, Presentation at Medical Home Summit, Feb. 2012.
5. Iowa: E. T. Momany, S. D. Flach, F. D. Nelson et al., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Services Research,* Aug. 2006 41(4 Part 1):1357–71.

Cost Impacts

Figure 2.1 – Primary Care -- Medical Homes: Impact by Sponsor													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-7.1	-7.7	-9.8	-13.8	-19.2	-24.6	-31.4	-38.3	-42.3	-49.4	-57.6	-243.6
Federal Government	0	-4.8	-5.2	-6.6	-9.4	-13.2	-17.0	-21.7	-26.6	-29.4	-34.4	-39.2	-168.3
State and Local Government	0	-1.9	-2.1	-2.7	-3.7	-5.0	-6.3	-7.9	-9.4	-10.3	-12.0	-15.5	-61.4
Private Employers	0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-2.8
Households	0	-0.3	-0.3	-0.4	-0.5	-0.8	-1.1	-1.4	-1.8	-2.0	-2.4	-2.3	-11.1

Figure 2.2 – Primary Care -- Medical Homes: Impact by Payer													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-7.1	-7.7	-9.8	-13.8	-19.2	-24.6	-31.4	-38.3	-42.3	-49.4	-57.6	-243.6
Medicare	0	-2.3	-2.4	-3.1	-4.5	-6.8	-9.1	-11.9	-15.0	-16.8	-19.8	-19.1	-91.7
Medicaid	0	-4.8	-5.3	-6.7	-9.3	-12.4	-15.5	-19.4	-23.3	-25.5	-29.6	-38.5	-151.9
PHI	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
OOP	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Figure 2.3 – Primary Care -- Medical Homes: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-7.1	-7.7	-9.8	-13.8	-19.2	-24.6	-31.4	-38.3	-42.3	-49.4	-57.6	-243.6
Hospital Care	0	-2.8	-3.0	-3.9	-5.4	-7.5	-9.5	-12.1	-14.8	-16.3	-19.1	-22.5	-94.4
Physician and Clinical Services	0	-1.2	-1.2	-1.5	-2.2	-3.1	-4.0	-5.1	-6.3	-7.0	-8.1	-9.2	-39.8
Other PHC and Admin	0	-3.2	-3.5	-4.4	-6.2	-8.7	-11.1	-14.1	-17.2	-19.0	-22.1	-25.9	-109.4

III. HIGH-COST CARE MANAGEMENT TEAMS

Policy Description

This payment policy option would support multidisciplinary teams to care for and coordinate care for high-cost patients with multiple chronic conditions or disabilities, with the goal of improving outcomes and lowering costs. The payment reform would provide financial support for primary care teams and redesigned care systems that would be accountable for care across a continuum.

Starting in 2014, Medicare would offer a new payment option for primary care practices or teams that would provide an enhanced per member per month (PMPM) payment for beneficiaries identified as high risk because of chronic, mental or physical disabilities. The federal government would also provide an enhanced match of 90 percent for state Medicaid programs to adopt a similar policy. The payment would be risk-adjusted and range from $30 to $50 PMPM. This payment would be in addition to current fee-for-service payments for visits and care provided by primary care teams. It would cover the extra time for care management and coordination, expanded teams (including community workers), and information systems to track and monitor care.

The new high-cost care management team (HCCMT) payment category for Medicare and Medicaid would be available starting in 2014. For Medicaid patients, there would be additional federal support for development of care networks through "health home" network payments pending state applications and participation of practices. The Medicaid enhanced payment and the health home network costs would be matched at a 90 percent federal rate, and 100 percent for beneficiaries dually eligible for Medicare and Medicaid.

Continued provision of the enhanced payment would be contingent on care and cost outcomes performance, with accountability for providing easy access 24/7 by phone or in person without resorting to hospital emergency department care except in the event of acute illness or injury.

Medicare and Medicaid beneficiaries would be encouraged to register and seek care from such teams. Medicare would lower cost-sharing for care received under a care management plan and limit total out-of-pocket costs. Medicaid would provide enhanced support for family caregivers, home care, and transportation for this targeted group.

Targeted patient surveys would focus on access and care experiences specific to this high-risk group. Medicare and Medicaid would coordinate and adopt the same payment and reporting policies for practices that see high-risk patients for both programs.

In addition to the new HCCMT payment/care system category and policy, Medicare would support regional training of nursing home teams to improve frontline care and manage primary care—with

training targeted on homes with a history of high rates of admissions to hospitals. This would accelerate the use of the INTERACT II program with a goal of reaching at least 50 percent of high-admission-rate homes over the first five years.

Estimation Process

The estimates here are based on the analysis of this area shown in John Holahan, Cathy Schoen, and Stacey McMorrow, *The Potential Savings from Enhanced Chronic Care Management Policies*, Urban Institute Health Policy Center, November 2011. While these savings levels are likely upper bounds for such a policy, they ought to be a reasonable illustration of the potential for an aggressive implementation of this approach.

This payment policy option is presumed to be phased in beginning in 2014 and fully implemented by 2016. For Medicare beneficiaries with five or more chronic conditions and those in the two-year waiting period categorized as disabled (e.g., non-duals), we assume participation rates of 25 percent in 2014, 40 percent in 2015, and 50 percent in 2016. For Medicaid beneficiaries that are non-dual disabled, we estimate the same participation rates as Medicare beneficiaries (25% in 2014, 40% in 2015, and 50% in 2016). For Medicare beneficiaries that are dually eligible for Medicaid but *not* in a skilled nursing facility or nursing home, we estimate participation rates of 33 percent in 2014, 50 percent in 2015, and 66 percent in 2016. For the privately insured, we assume participation rates of 10 percent in 2014, 15 percent in 2015, and 25 percent in 2016.

In general, the mechanical calculation process is analogous to the medical home analysis. First, costs associated with additional payments on behalf of the different groups are calculated as the product of the estimated participants and the per-person payment, for Medicare, Medicaid, and privately insured persons. In HCCMT programs, $30 PMPM payments were assumed for eligibles who were not long-term care users, and $60 PMPM for those who were. The savings are calculated as the product of the baseline spending in each group and the savings percentage for the associated group (either 7% or 5%, consistent with Holahan).

Cost Impacts

Figure 3.1 – High Cost/High Risk Primary Care Teams and Care Systems: Impact by Sponsor													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-14.1	-22.9	-32.5	-35.4	-37.1	-39.8	-42.8	-46.1	-49.7	-53.5	-142.0	-374.0
Federal Government	0	-9.9	-16.1	-22.6	-24.7	-25.9	-27.8	-29.9	-32.2	-34.7	-37.4	-99.2	-261.2
State and Local Government	0	-2.1	-3.5	-4.9	-5.3	-5.6	-6.1	-6.5	-7.0	-7.6	-8.1	-21.6	-56.9
Private Employers	0	-0.5	-0.7	-1.1	-1.2	-1.3	-1.4	-1.4	-1.6	-1.7	-1.8	-4.8	-12.6
Households	0	-1.6	-2.6	-3.8	-4.1	-4.3	-4.6	-5.0	-5.3	-5.7	-6.2	-16.5	-43.3

Figure 3.2 – High Cost/High Risk Primary Care Teams and Care Systems: Impact by Payer													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-14.1	-22.9	-32.5	-35.4	-37.1	-39.8	-42.8	-46.1	-49.7	-53.5	-142.0	-374.0
Medicare	0	-8.3	-13.4	-19.0	-20.8	-21.8	-23.4	-25.2	-27.1	-29.2	-31.5	-83.4	-219.7
Medicaid	0	-4.9	-8.1	-11.2	-12.1	-12.8	-13.7	-14.8	-15.9	-17.2	-18.5	-49.0	-129.1
PHI	0	-0.9	-1.4	-2.3	-2.5	-2.5	-2.7	-2.9	-3.1	-3.3	-3.5	-9.6	-25.2
OOP	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Figure 3.3 – High Cost/High Risk Primary Care Teams and Care Systems: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-14.1	-22.9	-32.5	-35.4	-37.1	-39.8	-42.8	-46.1	-49.7	-53.5	-142.0	-374.0
Hospital Care	0	-6.2	-10.0	-14.3	-15.5	-16.1	-17.2	-18.5	-19.8	-21.4	-23.0	-62.1	-162.0
Physician and Clinical Services	0	-2.6	-4.2	-5.9	-6.4	-6.7	-7.2	-7.7	-8.3	-8.9	-9.6	-25.7	-67.5
Other PHC and Admin	0	-5.3	-8.7	-12.3	-13.5	-14.3	-15.4	-16.7	-18.0	-19.4	-20.9	-54.1	-144.5

As described in Section IX on combined estimates, the PCMH and HCCMT options have substantial overlap in terms of how efficiencies are achieved (to the extent the savings from both policies are disproportionately attributable to the sicker patients). On the other hand, there would also be some synergies from simultaneous implementation with respect to hastening population shifts into such plans. For the combined effect, we use the HCCMT estimates as the starting point, and then add 50 percent of the PCMH option.

IV. BUNDLED PAYMENTS

Policy Description

To introduce incentives to restrain the cost of providing care, Commonwealth Fund staff developed a bundled payments policy. The policy was directly specifically at Medicare benefits, but an expectation exists that there will be spillover effects into Medicaid and private insurance as well.

The policy is focused on episodes of care. An episode is defined by a trigger event—in this case a hospital admission. The episode is expanded to include subsequent admissions that are for the same principal diagnosis group or for a principal diagnosis of medical or surgical misadventure and that occur within 30 days of the previous discharge. The episode is then expanded further to include diagnostic tests conducted within three days of the first admission and 30 days following the final discharge. For purposes of estimating the potential impact of this policy, principal diagnoses were grouped using the Clinical Classifications Software (CCS) developed as part of the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project (HCUP).[1]

Bundled payments cover up to three levels of spending:

I. Acute inpatient care, including outpatient Part A services provided up to three days prior to the beginning of the episode's inpatient boundaries (and including readmissions).

II. Level I care, plus Part B practitioner services provided in an inpatient setting within the episode's inpatient boundaries.

III. Level II care, plus Part B practitioner services provided in the inpatient setting, inpatient postacute care, Skilled Nursing Facility (SNF) care, home health care, and durable medical equipment (DME) provided within a specified period of time after the inpatient discharge.

For all but seven CCS categories, we restricted our attention to Level II care. The seven CCS categories where we used Level III care are:

- 0096: Heart valve disorders
- 0100: Acute myocardial infarction
- 0106: Cardiac dysrhythmias
- 0107: Cardiac arrest and ventricular fibrillation
- 0225: Joint disorders and dislocations; trauma-related
- 0226: Fracture of neck of femur (hip)
- 0230: Fracture of lower limb

[1] http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp.

The database used for these simulations was built using the Medicare 5-percent sample limited data set standard analytic files.[2]

The policy operates as follows:

1. A "cutpoint" is determined for each category of episodes. Here, the cutpoint is set to be the 65th percentile of the wage-adjusted cost of bundles grouped by CCS code of the trigger hospitalization.
2. This cutpoint dollar amount grows over time (see below). The relative contribution of components of the initial bundle—inpatient, outpatient, physician, and DME—is used in combination with the respective price index to create a Laspeyres index for the bundle cutpoint.
3. In each year, if an episode cost exceeds the cutpoint, payment is reduced by 40 percent of the excess.

Estimation Process

Establishing the cutpoint

As noted above, episodes were grouped based on the CCS category of the principal diagnostic code of the triggering hospital stay, and each episode was adjusted using the CMS inpatient wage adjustment. Episodes in each group were ranked from lowest to highest in terms of wage-adjusted overall payment; the cutpoint was determined to be the lowest-cost bundle that that exceed the 65th percentile of the cumulative distribution of costs. As noted, we restricted our attention to Level II care except for seven CCS categories where we used Level III care.

Moving the cutpoint through time

The cutpoint for the policy was allowed to grow over time to reflect inflation expressed in price indexes developed at CMS (Table 4.1). We calculated baseline (2010) shares of bundle costs for each CCS category, for inpatient, outpatient, SNF, home health, carrier, and DME, and used those shares to develop an update factor for the CCS category cutpoint.

As a matter of practice, the growth of the cutpoint was driven by the inpatient input price index. The weight assigned to this item was overwhelming: the case-weighted mean weight across CCS categories was .90, with an interquartile range of (.89, .92).

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/StandardAnalyticalFiles.html.

Table 4.1. Inflation Factors for Components of Medicare Costs, 2011-2023					
Index	1. Input Price Index	2. Medical Economic Index	3. Consumer Price Index	4. SNF Market Basket	5. Home Health Market Basket
Affects	Inpatient	Carrier	DME, Outpatient	SNF	Home Health
Year	Annual Percentage Change				
2011	2.80%	0.40%	3.70%	2.40%	2.00%
2012	2.60%	0.60%	2.00%	2.30%	2.20%
2013	3.40%	0.60%	1.90%	2.70%	2.70%
2014	3.70%	1.60%	2.00%	3.00%	2.90%
2015	3.70%	2.10%	2.10%	3.20%	2.90%
2016	3.60%	2.90%	2.20%	3.20%	2.90%
2017	3.70%	3.00%	2.40%	3.00%	2.80%
2018	3.80%	3.10%	2.60%	3.00%	2.80%
2019	3.80%	3.20%	2.80%	2.80%	2.70%
2020	3.80%	2.70%	2.80%	2.80%	2.60%
2021	3.70%	2.50%	2.80%	2.90%	2.70%
2022	3.70%	2.50%	2.80%	2.90%	2.70%
2023	3.70%	2.50%	2.80%	2.90%	2.70%

SOURCES:

1. Trustees Report Table IV.A1

2. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/mktbskt-economic-index.pdf

4. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-snf.pdf

5. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-hha.pdf

NOTE: In all cases, 2021-2023 are extensions of the 2020 inflation factor

Computing savings over time

We then simulated the effect of the proposed bundling policy over time. For each bundle, we used the price factors shown in Table 4.1 to inflate the components of the bundle. We then compared this inflated bundle cost to the wage-adjusted cutpoint, found by multiplying the CCS-category cutpoint for the forecast year by the episode's occupational-mix-adjusted-wage index. If the former exceeded the latter, we computed 40 percent of the excess and reduced payment by that amount.[3]

An example of the computation is shown in Table 4.2. For the sake of exposition, we have assumed only two components of bundle costs; the algebra is the same for more components but is less appealing visually.

[3] Note that in this simulation, the cutpoint was established for wage-adjusted bundle costs, but the calculation of savings was carried out using nominal bundle costs. Algebraically, we could have performed the calculations at the wage-adjusted level and then adjusted the results to return to nominal values; the result would have been the same.

Table 4.2. Example of Cutpoint and Savings Calculations				
			2010	2015
a	Aggregate shares of costs within CCS category xxx	Inpatient	90%	
b		Outpatient	10%	
c	Price indexes	Inpatient	100	150
d		Outpatient	100	116
e	Composite index	a*c + b*d	100	146.6
f	Cutpoint	grows by e	$10,000	$14,660
g	Nominal cost of Bundle k in CCS category xxx	Inpatient	$11,000	$16,500
h		Outpatient	2,000	2,320
i		Total	12,000	18,820
j	Bundle k wage index		1.05	
k	Wage-adjusted cutpoint	j*f		$15,393
m	Excess cost for bundle k	i-k		$3,427
n	Reduced payment	40% of m		$1,371

Over time, the policy being simulated reduces spending in the bundles by 11.3 percent. This percentage does not vary over the years being studied for two reasons. First, the cutpoint for each CCS category grows at almost the same rate as the cost of each bundle in the category, because of the overwhelming weight assigned to inpatient care and the relatively small spread in growth rates for the component pieces. Second, we have implicitly assumed the same mix of CCS-category episodes over time.

Savings in context

The nature of the bundles being constructed limits the potential effect of the bundling savings. For example, although most hospital spending is included (see Table 4.3), only those physician services provided in an inpatient setting are included. Further, the policy is limited to fee-for-service spending. As shown in Table 4.4, FFS benefits under Parts A and B account for just under two-thirds of total Medicare spending. Thus, the proposed bundle would reduce overall Medicare spending by .113 x .176 x .639, or 1.3 percent—a figure that increases when MA payments are adjusted to reflect this lower spending.

Table 4.3. CCS Bundles as a Percent of Total FFS Payments			
Claim type	Bundled Costs	Total FFS Costs	Bundled share of total
Inpatient	$7,282,185,978	$7,547,511,443	96%
Outpatient	491,552,591	31,295,799,779	2%
Carrier	426,207,650	5,533,904,811	8%
SNF	189,739,599	1,640,996,029	12%
DME	536,562	632,530,430	0.10%
Home health	30,178,952	1,133,951,371	3%
Total	8,420,401,233	47,784,693,862	17.60%
Based on 2010 LDS SAF tabulations			

Table 4.4. Medicare Data for Calendar Year 2011				
	HI	Part B	Part D	Total
Total expenditures	$256.70	$225.30	$67.10	$549.10
Benefits	252.9	221.7	66.7	541.3
Hospital	132.7	35.1		167.8
Skilled nursing facility	32.9			32.9
Home health care	7.3	12.4		19.6
Physician fee schedule services		67.6		67.6
Private health plans (Part C)	64.6	59.1		123.7
Prescription drugs			66.7	66.7
Other	15.4	47.5		62.9
Administrative expenses	3.8	3.6	0.4	7.8
FFS A/B benefits xcl Part C	$188.30	$162.60		$350.90
Percent of total				63.90%
SOURCE: 2012 Trustee Report, Table II.B1				

Cost Impacts

The estimates for this policy assume that it is implemented in conjunction with the other policies described here. The initial impact on Medicare as a percent of all Medicare is –1.74 percent (including impacts on MA payments associated with lowering FFS costs). This policy assumes Medicaid will follow a similar path, but the impacts illustrated are predicated on imposing smaller reductions on Medicaid providers (given lower payment rates to begin with). Medicaid reductions are assumed to be at 0.4 times the Medicare value, or –0.69 percent. The assumed extent to which private payers would extract savings if moved to bundling logic is between those two values, 0.6 times the Medicare value, or –1.04 percent. The impacts are assumed to rise through 2023, reaching ultimate reductions of –4.5 percent, –1.8 percent, and –2.7 percent, respectively.

Figure 4.1 – Bundled Payments: Impact by Sponsor													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-25.8	-30.4	-36.0	-42.5	-50.2	-59.6	-71.0	-84.5	-100.6	-119.7	-184.9	-620.3
Federal Government	0	-12.1	-14.2	-16.8	-19.9	-23.7	-28.2	-33.8	-40.5	-48.5	-58.1	-86.6	-295.6
State and Local Government	0	-2.6	-3.1	-3.7	-4.4	-5.2	-6.2	-7.4	-8.8	-10.5	-12.5	-19.1	-64.4
Private Employers	0	-2.8	-3.3	-3.9	-4.6	-5.4	-6.4	-7.6	-8.9	-10.6	-12.5	-20.2	-66.1
Households	0	-8.3	-9.8	-11.6	-13.6	-15.9	-18.8	-22.3	-26.3	-31.1	-36.7	-59.1	-194.1

Figure 4.2 – Bundled Payments: Impact by Payer													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-25.8	-30.4	-36.0	-42.5	-50.2	-59.6	-71.0	-84.5	-100.6	-119.7	-184.9	-620.3
Medicare	0	-11.4	-13.3	-15.6	-18.6	-22.1	-26.4	-31.6	-37.8	-45.3	-54.3	-81.0	-276.4
Medicaid	0	-4.0	-4.8	-5.8	-6.9	-8.2	-9.8	-11.7	-14.0	-16.7	-20.1	-29.7	-101.8
PHI	0	-10.4	-12.3	-14.6	-17.0	-19.9	-23.5	-27.8	-32.7	-38.5	-45.4	-74.2	-242.0
OOP	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Figure 4.3 – Bundled Payments: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-25.8	-30.4	-36.0	-42.5	-50.2	-59.6	-71.0	-84.5	-100.6	-119.7	-184.9	-620.3
Hospital Care	0	-11.9	-13.9	-16.5	-19.5	-22.9	-27.1	-32.2	-38.2	-45.6	-54.3	-84.7	-282.2
Physician and Clinical Services	0	-5.3	-6.2	-7.3	-8.6	-10.2	-12.1	-14.5	-17.2	-20.4	-24.3	-37.6	-126.1
Other PHC and Admin	0	-8.7	-10.3	-12.2	-14.4	-17.1	-20.3	-24.3	-29.1	-34.6	-41.2	-62.6	-212.0

V. MODIFIED PAYMENT POLICY FOR MEDICARE ADVANTAGE

Policy Description

The Medicare Advantage (MA) program offers Medicare beneficiaries the option of obtaining their benefits through a private plan. While the Affordable Care Act has revised the rules under which MA plans are paid, further modifying that payment policy to provide Medicare beneficiaries with positive incentives to choose high-value health systems could improve the incentives for both traditional Medicare and private plans to improve their performance and further level the playing field between traditional Medicare and private plans, with the goal of focusing competition on better outcomes and lower program costs. This policy also seeks to protect access and avoid shifting costs onto future Medicare beneficiaries by providing positive incentives to choose more effective care, while encouraging both the public and private plans to compete by providing more effective, coordinated, and integrated care.

This policy would be implemented in two phases.

Phase I (2014 through 2018)

The first phase of this policy would represent a transition from the current Medicare payment methodology to an approach that produces program savings, emphasizes the choice of high quality plans, and provides a positive incentive to beneficiaries who choose more efficient plans.

- The current benchmarks or payment reference points, as well as those to be established under the ACA, would be replaced by a new set of local reference prices. These reference payment levels for plans bidding to participate in the exchange would be set at:
    - A maximum of 105 percent of projected per capita spending under traditional Medicare for low-cost areas (the 785 counties with the lowest spending levels under traditional Medicare);
    - A maximum of 100 percent of projected per capita spending under traditional Medicare for medium-cost areas (the next 1,570 counties); and
    - A maximum of 95 percent of projected per capita spending under traditional Medicare for high-cost areas (the 785 counties with the highest spending levels under traditional Medicare).
- Private plans would continue to submit bids that represent their costs of providing the traditional Medicare benefit package to the average Medicare beneficiary.
- For plans with bids below the local reference price, the plan would receive their bid amount plus a bonus payment equal to 25 percent of the difference between the reference price and the plan bid (payments for each enrollee would be risk-adjusted), for which they would continue to be required

to provide additional benefits (lower cost-sharing or additional coverage) equal in value to the bonus payment.

- For plans with quality performance ratings of four stars or more, beneficiaries enrolling in those plans would receive an incentive payment equal to 25 percent of the difference between the plan's bid and the local reference price. The incentive payment could be made through a reduction in Part B premium payments.

Phase II (2019 onward)

The second phase of this policy would shift the basis for setting local reference payment levels from Medicare Advantage projected average costs per capita to average bids associated with a new Medicare Essential benefits plan (described below). This new plan would be more comparable to private MA plans, including current Part A, Part B, and Part D benefits, as well as an out-of-pocket spending cap.

- The local reference prices for payment prices described in Phase I would be modified to:
    - 100 percent of projected per capita spending under the Medicare Essential plan for the 1,570 counties with spending levels at or below the median; and
    - 95 percent of projected per capita spending under the Medicare Essential plan for the 1,570 counties with spending levels above the median.
- Private plans would submit bids that represent their costs of providing the benefit package under the Medicare Essential plan to the average Medicare beneficiary.
- For plans with bids below the local reference price, the plan would receive their bid amount plus a bonus payment equal to 25 percent of the difference between the reference price and the plan bid (payments for each enrollee would be risk-adjusted), for which they would continue to be required to provide additional benefits (lower cost-sharing or additional coverage) equal in value to the bonus payment.
- For plans with quality performance ratings of four stars or more, beneficiaries enrolling in those plans would receive an incentive payment equal to 25 percent of the difference between the plan's bid and the local reference price. This incentive would be paid by lower monthly Part B premiums.

Estimation Process

Estimates were based on data obtained from Giselle Casillas and Brian Biles of George Washington University (GWU), which they had run on a post-ACA world for the rules described above. The percentage impacts generated by their model were applied to the current policy baseline to estimate the effect of the reform. These estimates did not take into account potential shifts in enrollment among MA plans or between MA plans and traditional Medicare or the Medicare Essential plan.

Using the GWU MA payment file

The GWU MA payment file reflects estimated impacts on MA payments, weighted by enrollment, of moving from ACA to Phase 1 and from ACA to Phase 2. In 2009 terms, implementing Phase 1 relative to ACA policy results in a 3.74 percent reduction in MA payments and implementing Phase 2 relative to ACA policy results in a 5.28 percent reduction in MA payments.

Estimate the projected savings to Medicare

The savings (3.74% and 5.28% for Phases 1 and 2, respectively) are then applied to our current policy baseline to project an estimate of savings to Medicare.

Baseline Medicare expenditures from the current policy baseline were split into traditional Medicare and MA expenditures; the MA expenditures were modified by the savings percentages from GWU MA payment file, with the Phase 1 change applied to 2014–2018 and the Phase 2 change applied to 2019–2023.

Cost Impacts

Figure 5.1 – Modified Payment Policy for Medicare Advantage: Impact by Sponsor

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-6.3	-6.6	-7.0	-7.5	-8.0	-12.1	-13.0	-14.1	-15.2	-16.3	-35.4	-106.1
Federal Government	0	-5.2	-5.5	-5.8	-6.2	-6.6	-10.1	-10.8	-11.7	-12.6	-13.6	-29.4	-88.0
State and Local Government	0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.7	-2.0
Private Employers	0	-0.2	-0.2	-0.2	-0.2	-0.2	-0.4	-0.4	-0.4	-0.5	-0.5	-1.1	-3.2
Households	0	-0.8	-0.8	-0.8	-0.9	-1.0	-1.5	-1.6	-1.7	-1.8	-2.0	-4.3	-12.8

Figure 5.2 – Modified Payment Policy for Medicare Advantage: Impact by Payer

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-6.3	-6.6	-7.0	-7.5	-8.0	-12.1	-13.0	-14.1	-15.2	-16.3	-35.4	-106.1
Medicare	0	-6.3	-6.6	-7.0	-7.5	-8.0	-12.1	-13.0	-14.1	-15.2	-16.3	-35.4	-106.1
Medicaid	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHI	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
OOP	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Figure 5.3 – Modified Payment Policy for Medicare Advantage: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-6.3	-6.6	-7.0	-7.5	-8.0	-12.1	-13.0	-14.1	-15.2	-16.3	-35.4	-106.1
Hospital Care	0	-2.4	-2.5	-2.7	-2.8	-3.0	-4.6	-4.9	-5.2	-5.6	-6.1	-13.4	-39.8
Physician and Clinical Services	0	-1.5	-1.6	-1.6	-1.7	-1.8	-2.8	-3.0	-3.2	-3.5	-3.7	-8.3	-24.5
Other PHC and Admin	0	-2.4	-2.5	-2.7	-2.9	-3.1	-4.8	-5.2	-5.6	-6.0	-6.5	-13.7	-41.7

VI. MEDICARE ESSENTIAL BENEFITS PLAN

Policy Description

This policy option would offer a new plan choice to Medicare beneficiaries that would enable them to buy a comprehensive insurance plan, including prescription drugs, without the need to buy supplemental coverage. Offering this new option would allow beneficiaries to remain in traditional Medicare, with its broad access to physicians and other providers across the country, while incorporating improved benefits and new incentives aligned with better value. The integration of benefits would also lower insurance administrative costs and enhance Medicare's leverage in purchasing prescription medications for beneficiaries. This new plan would be able to compete on a more even footing with private Medicare Advantage plans, to further encourage improvements in both and provide more choice for Medicare beneficiaries. A premium would be charged to offset the cost of the richer benefit package and improved protection against catastrophic out-of-pocket costs, but this additional premium would be more than offset by the reduced costs of wrap-around coverage that most Medicare beneficiaries now obtain, either through their employers, Medicaid, or individually.

The new plan choice would include a single deductible and an out-of-pocket maximum for all Medicare-covered services, cover preventive care in full, and vary copayments and coinsurance for primary care and more specialized services to provide positive incentives to seek care from high-value providers and care systems. Certain services (such as physician and emergency room visits and laboratory tests) would have nominal copayments. The prescription drug benefit would be provided by a nationwide pharmacy benefit manager (PBM), selected by competitive bid, and the PBM would be authorized to negotiate prices on behalf of Medicare.

All Medicare beneficiaries would have positive incentives to register with a primary care practice or a "medical home." High-risk, multiple-chronic-condition beneficiaries would have enhanced support at home if they select a primary care team designated as a high-risk, high quality care team. Over time, the benefit design would also include positive incentives to seek care from high-value accountable care networks (such as ACOs) with a proven track record for improving outcomes and controlling costs of care. In return for choosing this high-value care option, enrollees would have reduced cost-sharing.

Traditional Medicare would still be available to all current beneficiaries. Future newly eligible Medicare beneficiaries would be automatically enrolled in the essential benefits option, although they could alternatively opt to enroll in a Medicare Advantage plan or traditional Medicare. However, beginning in 2014, all Medigap policies would be required to have minimum cost-sharing limits, including a $250 deductible and copays for physician and emergency room visits ($20 and $50, respectively).

For traditional Medicare and well as the new essential benefits plan, there would be a new requirement to engage in "shared decision-making" using patient-decision aids in nonemergent situations in which there are alternative choices of treatment available, and there would be a requirement that specialists engage beneficiaries in shared decision-making to discuss available treatment options. Failure to do so would result in reduced pay for the procedure/treatment for the specialist (10% reduction).

Estimation Process

For this option, two extremes were modeled: the entire population of enrollees in the Medicare Essential benefits plan having the standard option and the entire population having the high-value care option, assuming a corresponding 10 percent increase in efficiency under the latter. To calculate the effects of the two packages, ARC used its in-house Medicare micromodel. The model uses three years of data from the Medical Expenditure Panel Survey (MEPS) maintained by the Agency for Healthcare Research and Quality, which is a nationally representative survey which provides information on health care spending by service and payer, health services utilization, and insurance coverage, among others. In addition to the MEPS service categories, ARC imputed skilled nursing facility services. The entire microfile is controlled to our NHE current policy baseline in 2014. The data are run through programs that simulate the changes in cost-sharing under the two options. The model performs an iterative induction calculation, with induction applied separately by service and what type of supplemental insurance the enrollee has.

The results were tabulated to show the change to Medicare and cost-sharing by service for each option. We applied these changes to the current policy baseline by service. For outlying years, we applied the same percent change by cell (service and channel) to the NHE detailed baseline for each year.

At the bottom line, we assumed that 10 percent of the Medicare population (excluding Medicare Advantage enrollees) were enrolled in the Medicare Essential plan in 2014, and of that population, 10 percent of the population were in the high-value care option and the rest in the standard option. Enrollment in Medicare and the proportion which are in the managed option are increased gradually, until 92 percent of the traditional Medicare population are enrolled in Medicare Essential plan by 2023 and 100 percent of those are in the high-value care option.

The spending by payer channel was broken out by sponsor using the relationships in Table 16 of the OACT NHE projections report (Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, "National Health Expenditure Projections 2011–2021," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf). Although the cost of the Medicare Essential plan premiums is generally placed onto the household category, there were a few exceptions:

- The cost of additional Part D coverage (for persons joining the Medicare Essential plan who did not have Part D coverage under current law) is distributed pro-rata consistent with current law Medicare spending.
- For Medicaid enrollees, their Medicare Essential plan premiums and cost-sharing continues to be paid by Medicaid.
- The Medicare Essential plan premium was set to keep the proposal budget neutral for the federal government over the period 2014 through 2023 as a whole.

Cost Impacts

Figure 6.1 – Medicare Essential Benefits: Impact by Sponsor

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	1.3	1.7	-0.2	-5.2	-10.4	-16.3	-23.8	-32.2	-41.8	-52.8	-12.9	-179.9
Federal Government	0	2.4	5.7	9.1	9.1	6.3	3.1	-1.0	-5.8	-11.2	-17.6	32.6	0.0
State and Local Government	0	-0.3	-0.8	-1.8	-2.5	-2.7	-3.0	-3.4	-3.7	-4.1	-4.6	-8.1	-26.9
Private Employers	0	-0.9	-2.7	-5.9	-8.4	-9.2	-10.0	-11.2	-12.5	-13.8	-15.3	-27.1	-89.9
Households	0	0.0	-0.4	-1.7	-3.4	-4.8	-6.3	-8.2	-10.3	-12.7	-15.4	-10.3	-63.1

Figure 6.2 – Medicare Essential Benefits: Impact by Payer

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	1.3	1.7	-0.2	-5.2	-10.4	-16.3	-23.8	-32.2	-41.8	-52.8	-12.9	-179.9
Medicare	0	8.5	26.5	55.1	77.0	83.0	89.6	97.0	105.1	113.9	123.5	250.1	779.3
Medicaid	0	-2.4	-8.7	-19.5	-29.0	-33.1	-37.5	-42.1	-47.4	-53.3	-59.9	-92.6	-332.8
PHI	0	-4.0	-12.6	-27.1	-38.7	-42.3	-46.4	-51.9	-57.6	-63.9	-70.8	-124.7	-415.4
OOP	0	-0.8	-3.5	-8.8	-14.5	-18.1	-22.1	-26.8	-32.3	-38.5	-45.5	-45.7	-210.9

Figure 6.3 – Medicare Essential Benefits: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	1.3	1.7	-0.2	-5.2	-10.4	-16.3	-23.8	-32.2	-41.8	-52.8	-12.9	-179.9
Hospital Care	0	0.1	-0.1	-1.8	-5.1	-8.5	-12.6	-17.6	-23.3	-30.0	-37.8	-15.3	-136.6
Physician and Clinical Services	0	0.3	0.9	0.4	-0.9	-2.4	-4.1	-6.2	-8.6	-11.5	-14.9	-1.7	-47.1
Other PHC and Admin	0	0.8	0.9	1.1	0.8	0.5	0.4	0.0	-0.2	-0.3	-0.2	4.2	3.8

VII. PRIVATE INSURANCE: TIGHTENED MEDICAL LOSS RATIO RULES

Policy Description

This option has two main features. First, medical loss ratio (MLR) standards are increased to 90 percent in the large-group market and 85 percent in the small-group/individual market. This applies inside and outside the health insurance exchanges. Second, the prohibition on exchanges selling to undocumented individuals is repealed as of 2015. Exchanges would not have to require proof of citizenship, except for purposes of the premium tax credit. Exchanges would expand to the entire individual and small-group market as of 2018.

Estimation Process

This policy would raise MLR standards by 5 percentage points, but it is uncertain what portion of the insurance markets are going to be positioned at the regulatory limit after 2014. It would be plausible that enough plans were bound by the current limit that the impact could be a 1 percentage point reduction on the non–employer-sponsored insurance market (doubtful there is more than a minimal impact on either the small-group or large-group markets), which would translate to a 0.11 percent reduction in private health insurance spending, given the current policy baseline.

Cost Impacts

Figure 7.1 – Private Insurance: Tightened Medical Loss Ratio Rules: Impact by Sponsor

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-1.1	-1.2	-1.2	-1.3	-1.4	-1.5	-1.6	-1.6	-1.7	-1.8	-6.2	-14.5
Federal Government	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.3
State and Local Government	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	-1.1
Private Employers	0	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-1.5	-3.5
Households	0	-0.7	-0.8	-0.8	-0.9	-0.9	-1.0	-1.0	-1.1	-1.2	-1.2	-4.1	-9.6

Figure 7.2 – Private Insurance: Tightened Medical Loss Ratio Rules: Impact by Payer													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-1.1	-1.2	-1.2	-1.3	-1.4	-1.5	-1.6	-1.6	-1.7	-1.8	-6.2	-14.5
Medicare	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicaid	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PHI	0	-1.1	-1.2	-1.2	-1.3	-1.4	-1.5	-1.6	-1.6	-1.7	-1.8	-6.2	-14.5
OOP	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Figure 7.3 – Private Insurance: Tightened Medical Loss Ratio Rules: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-1.1	-1.2	-1.2	-1.3	-1.4	-1.5	-1.6	-1.6	-1.7	-1.8	-6.2	-14.5
Hospital Care	0	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-0.6	-1.9	-4.4
Physician and Clinical Services	0	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-0.6	-1.9	-4.4
Other PHC and Admin	0	-0.4	-0.5	-0.5	-0.5	-0.5	-0.6	-0.6	-0.6	-0.7	-0.7	-2.5	-5.7

VIII. REDUCED ADMINISTRATIVE COSTS AND REGULATORY BURDEN

Policy Description

The U.S. health care system currently has very high administrative costs because of a fragmented, complex insurance and regulatory system that adds to total health system costs without value. This policy option seeks to lower these costs for payers (insurers) and for providers by reducing duplication and waste, simplifying processes, and taking advantage of electronic systems to reduce paperwork.

This set of policies below aims to lower administrative and regulatory costs for providers and insurers. The policies would focus on the following to reduce administrative costs:

- Standardized benefit design, claims forms, coding, and electronic submission of claims, using shared format.
- Smart card insurance cards: bar codes, swipe to indicate cost-sharing, billing in advance.
- Shared credentialing central database and central repository, with information shared across state lines and with all insurers. This would be required for any insurance plan participating in Medicare, Medicaid, insurance exchanges, or qualified as meeting national standards for the insurance mandate.
- Stipulate a core set of quality and cost metrics, measured in the same way across public and private payers. Shared reporting in common format.
- Coordinate and streamline coverage policies and enrollment. This includes presumptive eligibility for related programs.
- A lead regulatory authority, with focused inspections and review by “exception” (outliers). This should result in reduced duplicative private, local, state and federal (Medicare and Medicaid) regulatory visits and reporting requirements as one inspection from a lead agency with common metrics for providers (i.e., Joint Commission, Medicare, Medicaid, City coordinated) could reduce the number of visits and resources needed for inspections.
- Review of regulatory requirements for evidence-base and internal costs.
- Regulatory relief for high-performance ACO networks (outcomes and costs).
- Multipayer negotiations to align payment methods and reporting requirements—reducing costs of one-on-one negotiations.
- Simplification of prescription drug formularies, evidence-based designs to reduce complexity for clinicians operating with multiple plan formularies.
- Integration of clinical and administrative data through electronic health records.

Estimation Assumptions

It will be difficult to get scoreable savings for these reforms, to the extent the policies are mandating activities that in many cases appear to be rational business practices. The strong coordination/standardization implied by the analysis in "Paper Cuts: Reducing Health Care Administrative Costs," by Elizabeth Wikler, Peter Basch, and David Cutler, Center for American Progress, June 2012, plausibly would translate into scoreable savings. The estimates illustrated here take their $40 billion savings claim as representing 2014 levels. It should be noted, however, that larger savings would certainly be possible, with ultimate administrative costs moving down toward international levels, if a system of the sort suggested in the single-payer literature were implemented.

Cost Impacts

Figure 8.1 – Reduce Administrative Costs and Regulatory Burden: Impact by Sponsor

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-37.8	-40.0	-42.6	-45.2	-48.0	-51.2	-54.7	-58.4	-62.4	-66.6	-213.5	-506.7
Federal Government	0	-13.6	-14.3	-15.3	-16.4	-17.5	-18.8	-20.2	-21.8	-23.5	-25.3	-77.1	-186.6
State and Local Government	0	-4.7	-5.1	-5.4	-5.8	-6.2	-6.6	-7.1	-7.6	-8.2	-8.8	-27.2	-65.5
Private Employers	0	-3.8	-4.1	-4.3	-4.6	-4.8	-5.1	-5.4	-5.8	-6.1	-6.5	-21.6	-50.4
Households	0	-15.7	-16.5	-17.5	-18.4	-19.5	-20.7	-21.9	-23.2	-24.6	-26.1	-87.6	-204.1

Figure 8.2 – Reduce Administrative Costs and Regulatory Burden: Impact by Payer

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-37.8	-40.0	-42.6	-45.2	-48.0	-51.2	-54.7	-58.4	-62.4	-66.6	-213.5	-506.7
Medicare	0	-9.7	-10.2	-10.8	-11.5	-12.3	-13.2	-14.3	-15.4	-16.6	-17.9	-54.6	-131.9
Medicaid	0	-8.6	-9.2	-10.0	-10.7	-11.4	-12.2	-13.2	-14.2	-15.3	-16.5	-49.9	-121.3
PHI	0	-14.8	-15.7	-16.7	-17.6	-18.6	-19.7	-20.9	-22.1	-23.5	-24.9	-83.4	-194.5
OOP	0	-4.7	-4.9	-5.0	-5.3	-5.7	-6.0	-6.3	-6.7	-7.0	-7.4	-25.6	-59.0

Figure 8.3 – Reduce Administrative Costs and Regulatory Burden: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-37.8	-40.0	-42.6	-45.2	-48.0	-51.2	-54.7	-58.4	-62.4	-66.6	-213.5	-506.7
Hospital Care	0	-12.2	-12.9	-13.8	-14.6	-15.5	-16.4	-17.5	-18.7	-20.0	-21.4	-69.0	-163.0
Physician and Clinical Services	0	-8.4	-8.8	-9.4	-10.0	-10.6	-11.3	-12.1	-12.9	-13.8	-14.7	-47.2	-112.1
Other PHC and Admin	0	-17.2	-18.3	-19.4	-20.6	-21.9	-23.4	-25.0	-26.8	-28.6	-30.5	-97.4	-231.6

IX. COMBINED ESTIMATES

Basic Logic

The combined effect of implementing all of the individual policies would be expected to have substantial overlaps. Thus, the same savings through different policies would have to be subtracted out in order to avoid double-counting. There may also be synergistic effects when combining the policies. For example, doing all of the policies at once could hasten transitions and offer opportunities for choosing more aggressive implementation parameters.

We use a mechanical calculation essentially following a thread of logic through the policies. That is, we add each of the policies together one at a time, making a net reduction/increase assumption relative to the pieces already reflected. This makes the adjustment assumptions conditional on the order followed. Below we describe the order and assumptions used to combine the estimates from each of the provisions.

Assumptions

1. Starting with High-Cost Care Management Teams, by definition the factor used for the proportion of savings carried through to the combined effect is 1.0.
2. Adding the Primary Care: Medical Homes policy next, there should be substantial overlap (to the extent the savings from both policies are disproportionately attributable to the sicker patients), although there would also be some synergies from simultaneous implementation with respect to hastening population shifts into such plans. Factor used: 0.5.
3. Adding Medicare Essential Benefits Plan next, there should be substantial overlap (long-term savings in Medicare Essential largely come from more enrollees moving to the high-value care option), but here too there would be synergies from simultaneous implementation for faster transitions. Factor used: 0.5.
4. Bundled Payments—in the combined analysis, we explicitly assume the bundling policy will be associated with increased savings over time, and that the higher assumed savings reflect the interactions. Factor used: 1.0.
5. Improved Provider Payment—there should be limited overlap since these are largely specific reductions on particular services. Factor used: 0.95.
6. Modified Payment Policy for Medicare Advantage—the savings relative to baseline would be diminished to the extent the underlying payments to MA would have been reduced mechanically with the cuts to FFS costs associated with the other policies. Factor used: 0.8.
7. Private Insurance: Tightened Medical Loss Ratio Rules—the savings from this option should be only minimally affected by the other policies. Factor used: 1.0.

8. Reduced Administrative Costs and Regulatory Burden—the savings here come largely from standardizing processes, so there would be limited overlap. Factor used: 0.95.

Cost Impacts

Figure 9.1 – Combined Estimates: Impact by Sponsor

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-102.4	-116.4	-137.4	-155.2	-174.3	-202.2	-229.6	-260.2	-293.3	-332.5	-685.7	-2003.7
Federal Government	0	-52.5	-58.6	-68.6	-77.1	-87.7	-104.1	-119.3	-136.5	-154.8	-176.7	-344.6	-1036.0
State and Local Government	0	-11.3	-13.9	-17.1	-19.5	-21.8	-24.7	-27.8	-31.3	-34.9	-39.2	-83.8	-241.7
Private Employers	0	-8.6	-10.5	-13.4	-15.8	-17.4	-19.5	-21.8	-24.4	-27.3	-30.6	-65.7	-189.4
Households	0	-29.9	-33.3	-38.2	-42.8	-47.4	-54.0	-60.6	-68.0	-76.4	-86.0	-191.7	-536.6

Figure 9.2 – Combined Estimates: Impact by Payer

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-102.4	-116.4	-137.4	-155.2	-174.3	-202.2	-229.6	-260.2	-293.3	-332.5	-685.7	-2003.7
Medicare	0	-44.8	-41.5	-37.2	-33.5	-38.1	-48.8	-56.5	-65.4	-75.0	-86.8	-195.1	-527.5
Medicaid	0	-21.8	-29.7	-40.8	-49.5	-56.0	-63.3	-71.6	-80.7	-90.0	-101.3	-197.8	-604.5
PHI	0	-30.0	-37.8	-49.3	-58.8	-64.6	-72.0	-80.6	-90.0	-100.7	-112.9	-240.6	-696.9
OOP	0	-5.8	-7.4	-10.2	-13.4	-15.5	-18.1	-20.9	-24.1	-27.6	-31.7	-52.3	-174.7

Figure 9.3 – Combined Estimates: Impact by Service

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	-102.4	-116.4	-137.4	-155.2	-174.3	-202.2	-229.6	-260.2	-293.3	-332.5	-685.7	-2003.7
Hospital Care	0	-37.7	-43.7	-53.0	-60.8	-68.9	-79.1	-90.9	-104.2	-119.1	-136.9	-264.2	-794.4
Physician and Clinical Services	0	-20.6	-23.2	-27.2	-30.8	-34.7	-40.1	-45.7	-52.1	-59.1	-67.3	-136.5	-400.9
Other PHC and Admin	0	-44.0	-49.5	-57.2	-63.6	-70.7	-83.0	-93.0	-103.9	-115.1	-128.3	-285.0	-808.4

X. SETTING SPENDING TARGETS

Policy Description

The policy used here to estimate the potential effects of spending targets would go into effect in 2017 if, by 2016, overall health spending growth from 2014 through 2018 is projected to exceed the growth in gross domestic product (GDP). This policy could be implemented on a subsystem basis to focus specifically on geographic areas, types of providers or services, and/or groups of payers (Medicare, Medicaid, private) with high levels of per capita spending or rates of per capita spending growth. Policies could be implemented to provide an incentive for local authorities and stakeholders, provider groups, and payers to devise alternative approaches to control total health spending, so long as they meet the relevant targets.

- Beginning in 2016, a determination would be made every three years if provisions are needed to reduce health spending growth. That is, if the projected growth in national health expenditures per capita for the five-year period ending two years after the determination year (e.g., 2014 through 2018 for determination year 2016) is greater than the growth in per capita GDP, policies would be developed to reduce health spending to meet that target. The policies would not begin to take effect until the year after the determination year.

- These policies, and subsystem targets consistent with the systemwide target, could apply differentially to geographic areas, types of providers or services, and/or groups of payers (Medicare, Medicaid, private) with high levels of per capita spending or rates of per capita spending growth. These specific policies would be aimed at narrowing the variations in prices, utilization, and total spending across geographic areas, types of providers and services, and payers, so that the signals sent through health care markets and the decisions that those signals elicit can be aligned with achieving greater value and efficient allocation of health care resources.

- Any state or groups of states could propose alternative approaches, if they could achieve the targets set for them. Overall system savings could be shared among stakeholders, with provider rewards based on high performance according to preestablished metrics of quality, efficiency, and patient experience. Models to be considered could include all-payer rate-setting (such as is currently in place for hospital inpatient services in Maryland) or other models that would reduce current discrepancies in payments and methods among payers.

Estimation Process

To model the effects of this policy, we assumed that some collection of policies to reduce health spending is developed each year to reach the goal with no shortfall. The baseline NHE per capita was taken from the current policy baseline, and the GDP per capita from CMS projections. The size of the

reduction was presumed to be the difference between the projected five year average of NHE per capita growth rate and the projected five-year average of the GDP per capita growth rate. The total NHE per capita savings were calculated as the difference between the baseline NHE per capita and the revised NHE per capita under the GDP growth target. This difference in per capita savings was multiplied by the total NHE population to obtain aggregate total NHE savings.

Source of Savings

The NHE savings were presumed to be implemented in such a way that the Medicare per capita growth rate is held to GDP per capita + 0 percent. Medicaid per capita growth rate is also presumed to be limited to GDP per capita + 0 percent. Any remaining savings come from private health insurance (PHI).

We also assumed additional out-of-pocket savings for households with Medicare beneficiaries associated with reduced Medicare spending, to reflect the lowered net cost-sharing enrollees will have if Medicare costs decline. We used a value equal to 6.4 percent of the Medicare savings, based on the Medicare population's observed out-of-pocket spending on hospital and physician services from our current baseline estimates. For the associated out-of-pocket savings for households with PHI, we assumed that 20 percent of the remaining savings (coming from PHI) is attributable to out-of-pocket spending.

Cost Impacts

Figure 10.1 – Setting Spending Targets: Impact by Sponsor

	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	0.0	0.0	0.0	-22.0	-58.7	-127.6	-221.0	-324.1	-431.9	-550.8	-80.7	-1736.1
Federal Government	0	0.0	0.0	0.0	-6.2	-14.2	-30.8	-56.4	-88.3	-123.6	-163.1	-20.4	-482.7
State and Local Government	0	0.0	0.0	0.0	-5.4	-13.2	-27.2	-45.5	-65.6	-86.8	-110.3	-18.6	-353.9
Private Employers	0	0.0	0.0	0.0	-4.7	-14.2	-31.3	-53.2	-75.4	-97.7	-121.8	-18.9	-398.4
Households	0	0.0	0.0	0.0	-5.7	-17.1	-38.3	-65.9	-94.7	-123.8	-155.5	-22.8	-501.1

Figure 10.2 – Setting Spending Targets: Impact by Payer													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	0.0	0.0	0.0	-22.0	-58.7	-127.6	-221.0	-324.1	-431.9	-550.8	-80.7	-1736.1
Medicare	0	0.0	0.0	0.0	0.0	0.0	-3.0	-11.6	-24.5	-39.5	-56.5	0.0	-135.1
Medicaid	0	0.0	0.0	0.0	-9.6	-21.6	-42.7	-70.5	-102.6	-137.5	-176.5	-31.3	-561.1
PHI	0	0.0	0.0	0.0	-9.9	-29.6	-65.3	-110.5	-156.3	-201.9	-251.4	-39.5	-825.0
OOP	0	0.0	0.0	0.0	-2.5	-7.4	-16.5	-28.4	-40.6	-53.0	-66.5	-9.9	-214.9

Figure 10.3 – Setting Spending Targets: Impact by Service													
	Annual Net Impact											Cumulative Net Impact	Cumulative Net Impact
$ billions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
National Health Expenditure	0	0.0	0.0	0.0	-22.0	-58.7	-127.6	-221.0	-324.1	-431.9	-550.8	-80.7	-1736.1
Hospital Care	0	0.0	0.0	0.0	-6.8	-17.5	-37.9	-66.0	-97.5	-131.0	-168.2	-24.3	-525.0
Physician and Clinical Services	0	0.0	0.0	0.0	-4.6	-12.9	-28.7	-49.8	-72.8	-96.4	-122.4	-17.5	-387.6
Other PHC and Admin	0	0.0	0.0	0.0	-10.6	-28.2	-61.0	-105.1	-153.8	-204.4	-260.2	-38.8	-823.4

APPENDIX A. CREATING THE "CURRENT POLICY" BASELINE

The primary source for the baseline was the National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds from the 2010 version of the NHE released in January 2012 (Centers for Medicare and Medicaid Services, Office of the Actuary, "NHE Historical and Projections, 1965–2021," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe65-21.zip). In addition to the basic structure by service and payer, we used additional detail found in the projections report (Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, "National Health Expenditure Projections 2011–2021," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf) for employer-sponsored insurance, other private health insurance (which is entirely Medigap after 2013), and the health insurance exchanges mandated by the Affordable Care Act to begin in 2014, plus spending by sponsor type, which was used to create a separate high-level baseline by sponsor. We also used NHE enrollment counts by supplemental insurance types.

Since a number of the policy options are applicable only to the Medicare population, our baseline was split into two populations: Medicare and non-Medicare. In addition, the private health insurance category was broken into employer-sponsored insurance and other private (including subsidies through the health insurance exchanges, for the non-Medicare population), and the Medicare channel was broken into traditional Medicare and Medicare Advantage. Finer service splits were also created, including:

- Hospital broken into inpatient, outpatient, and emergency room
- Physician and clinical services divided into preventive care, primary care, and specialist
- Other professional care broken into imaging, other diagnostic, lab, and other
- Nursing care facilities broken into Medicare SNF and all other
- Prescription drugs broken into brand and generic

To estimate the splits, both between the Medicare and non-Medicare populations and for the finer service splits, we used the Medicare Expenditure Panel Survey (MEPS) for 2009. In addition to the service splits in the household file, MEPS contains event-level data that can be used to classify services by type of provider. Additional sources of service split detail for the Medicare population included summary tables from the Medicare Current Beneficiary Survey (MCBS) for 2005 as well as tables from the Health Care Financing Review Statistical Supplement. We also used the 2012 Medicare Trustees Report for additional Medicare spending refinements, including using enrollment and benefit data for Part D to estimate Medicare benefit rates for prescription drugs across time, and to estimate the traditional Medicare versus Medicare Advantage splits.

Once a current law detailed baseline was created, we modified it to reflect the assumption that the 27 percent cut in the Medicare physician payment rates under the SGR formula would never occur. Specifically, we modeled a scenario wherein a 1 percent update in the conversion factor is presumed in 2013 and it is continued at its 2013 level thereafter, creating a "current policy" baseline. Physician fee schedule spending for each year in the current law baseline was adjusted by the ratio of the conversion factor under current policy to the conversion factor under current law to estimate the new spending levels.

In addition to estimating the effects on Medicare spending, we estimated the effects on Medicare cost-sharing and administrative costs as a result of this change. All the simulations in this project are applied to this current policy baseline.

The NHE projections extend only to 2021; for years 2022–2030, we projected based on the implied trends in the per capita spending. The overall per capitas (national health expenditures) were projected separately for Medicare and non-Medicare populations, because of their different growth rates, and aggregated based on population growth projections from the Medicare and OASDI Trustees Reports (Medicare: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf; OASDI Trustees Report supplemental single-year tables at http://www.ssa.gov/oact/tr/2012/lrIndex.html). These aggregates were then broken into the payer components in the NHE (Medicaid, PHI, etc.) for those years.