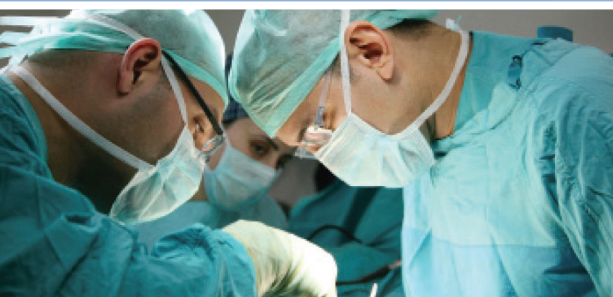


BENDING THE CURVE

Person-Centered Health Care Reform:
A Framework for Improving Care and
Slowing Health Care Cost Growth



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About Engelberg Center for Health Care Reform:

The Brookings Institution is committed to producing innovative policy solutions to our nation's most difficult challenges. The country may face no more important domestic policy challenge than the much-needed reform of our health care system. To help turn ideas for reform into action, the Brookings Institution established the Engelberg Center for Health Care Reform. The Engelberg Center's mission is to develop data-driven, practical policy solutions and recommendations that promote broad access to high-quality, affordable, and innovative care in the United States. The Center also facilitates the development of new consensus around key issues and provides technical support to implement and evaluate novel solutions in collaboration with a broad range of stakeholders with the keen focus on reform that will improve not just the health care system, but the health of individual patients.

Acknowledgements:

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Support for "Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth," the third report in our "Bending the Curve" series, was generously provided by the Robert Wood Johnson Foundation and the Irene Diamond Fund. We would like to gratefully acknowledge and thank the Engelberg Center project team for their tireless efforts and many contributions to this project. Specifically, we want to recognize Christine Dang-Vu, Erica Socker, Sara Bencic, and Sean McBride for their research and analytical contributions along with Larry Kocot and Keith Fontenot for their expert advice and counsel.

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EXECUTIVE SUMMARY

We propose a framework for health care reform that focuses on supporting person-centered care. With continued innovation toward more personalized care, this is the best way to improve care and health while also bending the curve of health care cost growth.

Our health care system holds great promise. As a result of fundamental breakthroughs in biomedical science, improvements in data systems and network capabilities, and continuing innovation in health care delivery, care is becoming increasingly individualized and prevention-oriented. The best treatment for a patient involves not just specific services covered under traditional approaches to health insurance financing, but also includes new technologies and new kinds of care and support at home and in other settings different from traditional medical care. These advances require health care providers to work with patients and their caregivers to target increasingly sophisticated treatments and to coordinate care effectively in ways that works best for each patient.

Our report's person-focused reforms aim to support these changes in care—not as an afterthought or as an addition to our health care financing and regulation, but as the core goal. Instead of having to work around fee-for-service (FFS) payments and regulations that can complicate getting the highest-value care in each case, providers and patients will be able to receive more support for the specific approaches to care delivery that can make the most difference. The support comes from aligning reforms in provider payment, benefit design, regulation, and health plan payment and competition. To avoid short-term disruptions, our systematic framework involves a clear path that builds on existing reforms in the public and private sector, supports transitional steps to assist providers, and includes close evaluation and opportunities for adjustments along the way. While our primary goal is better health through better care, we estimate that our reforms would achieve

an estimated \$300 billion or more in net federal savings in the next decade, and provide a path to sustaining per capita cost growth that is much more in line with per capita growth in Gross Domestic Product (GDP). After the proposed reforms are implemented in the coming decade, long-term savings from achieving better health and sustainable spending growth will exceed \$1 trillion over 20 years. Our proposals can be scaled up or down, and can also be combined with other proposed reforms to achieve additional reductions in health care costs. Our approach enables Congress to focus on overall cost, quality, and access goals that are very difficult to address under current law—so that whatever the spending level, that spending will do more for health.

These issues of health care quality and cost must be addressed. If a clear framework like ours is not implemented, the alternative is likely to be continued reliance on short-term cost controls, including across-the-board cuts in payments like sequestration, or delays and restrictions in both needed coverage updates for vulnerable populations and new types of innovative care—perpetuating large gaps in quality of care.

Our proposals represent an alternative to such care disruptions, cost-shifting, and threats to more innovative, person-focused care. We include proposals for Medicare, Medicaid, and private health insurance. We also propose a set of system-wide regulatory reforms and other initiatives, including antitrust and liability reforms. While some of these proposals are specific to particular programs and regulations, they are all grounded in our core goal of supporting quality care resulting in lower costs. This means a clear path for moving away from FFS payments and benefits and open-ended subsidies for insurance plan choices toward a direct focus on supporting better care and lower costs at the person level. Our proposals encompass significant reforms—such as modifications in Medicare payment mechanisms and

benefits, and a change in the tax exclusion for employer-provided health insurance. The proposals reflect ideas that have gathered broad support in the past, but also include new approaches for addressing some of their shortcomings. Implementing our reforms together enables them to reinforce each other and create much more momentum for improving care while bending the cost curve.

Reforms for Medicare

» Transition to *Medicare Comprehensive Care* (MCC)

- MCC organizations include collaborations of providers that receive a globally capitated, comprehensive payment for their attributed beneficiaries and must meet a set of care quality and outcome performance measures for full payment.
- Structural requirements for these contractual organizations would be flexible; the organizations could include integrated systems or networks of providers working together.
- Providers would also be able to participate in MCC by accepting a case-based or bundled payment for their services and by meeting similar care quality and outcome performance standards for full payment.
- The initial benchmark for the MCC comprehensive payment would be based on current beneficiary spending and quality of care, and the spending target will be increased over time according to a statutory limit on per capita growth (GDP plus 0 percent per capita). MCC providers would also be expected to sustain or improve quality of care over time, as reflected in increasingly sophisticated performance measures, facilitated by information systems used to support a beneficiary-level focus in care delivery.
- Providers can continue to receive traditional FFS payments, though those payments will likely continue to tighten over time and become

less optimal for covering the costs of delivering effective care.

- Within 5 years, Medicare should offer beneficiaries the opportunity to choose MCC providers to receive their care. In conjunction with this choice, MCCs could offer beneficiaries incentives such as reductions in their Medicare premiums and/or co-pays.
 - The MCC reforms would be phased in over 10 years with a set of milestones for measuring progress. By that time, we expect the vast majority of Medicare beneficiaries to be treated by providers who are paid using MCC methods.
- ### » Reform Medicare benefits to support more comprehensive care and lower costs
- Medicare benefits would be updated to have an out-of-pocket (OOP) maximum and reforms in co-pays and deductibles similar to proposals by the Medicare Payment Advisory Commission (MedPAC) and other expert groups. These reforms would lower beneficiary costs on average and provide more protection. Medicare beneficiaries would also receive clear information about their OOP costs for different options for care.
 - Medigap coverage would be reformed to eliminate “first dollar” coverage. This could be accomplished through a surcharge on Medigap plans that have average co-pays higher than 10 percent based on their additional costs to Medicare. Medigap plans would be able to offer lower co-pays for high-value services and providers.
 - MCCs could offer lower co-pays and premiums for Medicare beneficiaries who choose to receive care from them.
- ### » Reform Medicare Advantage to promote high value health plan competition
- Medicare Advantage payment updates would be the same as for MCC plans—that is, equal to GDP growth per capita, or less if overall Medicare spending grows more slowly.

- Medicare Advantage plans would be allowed to return the full difference between their bids and the benchmark to beneficiaries in the form of lower premiums.
- » Use Medicare savings to create predictable payments in traditional Medicare and support the transition to MCC
 - Specific elements of our proposed Medicare reforms would achieve over \$200 billion in gross federal savings in the coming decade. Our framework calls for redirecting these savings within the Medicare program to support the transition to MCC models and provide a more predictable and sustainable long-term financing framework for Medicare. This includes reforming Medicare physician payment to replace the “sustainable growth rate” (SGR) with a payment system that increasingly includes elements of case-based payments, making similar changes in other FFS payment systems, and providing other incentives and support for the transition to MCC.

Reforms for Medicaid and Care for Vulnerable Populations

- » Current state Medicaid waivers would transition to *Person-Focused Medicaid*, a standard process for states to implement Medicaid reforms
 - The Centers for Medicare and Medicaid Services (CMS) would implement a long-term, system-wide strategy for *Person-Focused Medicaid* that includes extensive support, monitoring, and evaluation. This systematic approach would replace negotiating one-off waivers with states.
 - This process would routinely track quality of care and per capita cost growth for Medicaid beneficiaries. States that improve quality of care and reduce per capita beneficiary cost trends would keep a disproportionate share of the savings (for example, 50 percent of the federal savings in our simulations).

- States would be encouraged to combine funding streams and to support innovative, efficient strategies for care delivery for both low-income uninsured populations and for dual-eligible beneficiaries.
- » Medicaid reforms would be aligned with other initiatives and financial support for health care for lower-income individuals to facilitate care continuity and improve efficiency
 - States and CMS would facilitate the participation of Medicaid managed care plans in state insurance marketplaces to help mitigate shifts in and out of Medicaid eligibility that disrupt both coverage and in how individuals receive their care.
 - CMS would facilitate state reforms that coordinate funding streams and the delivery of services across programs to assist lower-income individuals (e.g., local safety-net initiatives and supports for mental health, Federally Qualified Health Centers, etc).
- » CMS would make permanent and expand its “Financial Alignment Demonstration” for Medicare-Medicaid Enrollees into a reformed program for *Medicare-Medicaid Aligned Care*. This permanent, person-focused program would enable the development of strong and systematic ongoing support, performance measurement, and evaluation capacity to provide a stronger foundation for effective and efficient comprehensive care for Medicare-Medicaid beneficiaries (“dual-eligible” beneficiaries)
 - This permanent program would include a substantial quality improvement and evaluation infrastructure at CMS. The infrastructure would:
 - 1) provide timely access to readily usable Medicare data on dual-eligible beneficiaries to the states and their provider and health plan partners;
 - 2) produce more meaningful and consistent measures of quality of care and costs for dual-eligible beneficiaries; and
 - 3) share evidence and best practices with states on effective steps for improving care for dual-eligible beneficiaries.

- Performance measures would include increasingly meaningful measures of quality of care as well as combined per capita expenditures across Medicare and Medicaid. States that improve performance and reduce overall cost trends would receive at least a proportionate share of the total savings (Medicare and Medicaid). State reforms that do not improve quality while lowering costs would be phased out, with increasing incentives over time for states to switch to effective programs.

Reforms for Private Health Insurance Markets and Coverage

- » Limit the exclusion of employer-provided health insurance benefits from taxable income by imposing a cap that would grow at the same per-capita rate as federal subsidies in Medicare and the insurance marketplaces
 - A cap on the employer-provided health insurance subsidy would be phased in over time by capping the exclusion at a high level initially (e.g., at the 80th to 90th percentile plan) and then indexing the cap by GDP growth once its subsidy value aligns more closely with other subsidy programs. This subsidy level would be designed to achieve significant health care savings from choosing lower-cost plans while still providing substantial incentives for employees to remain in employer-sponsored coverage.
- » Encourage and support employer leadership in driving innovative reforms in health care coverage and delivery
 - Support employer efforts to engage employees in reducing overall health care costs through the Employment Retirement Income Security Act (ERISA) and other health plan regulations that promote value-based insurance designs and tiered benefit designs, narrow networks of providers that demonstrate high performance, and employees' ability to share in the savings from health care choices and changes in behavior that reduce costs.
- Promote transparency by making standard measures of provider performance available from Medicare and Medicaid that could be more easily combined with similar measures constructed by employers from their own data on health care costs and quality.
- Facilitate the adoption of payment reforms by providers in Medicare and Medicaid to match value-based payment reforms used by the private sector.
- » Promote insurance market competition to support high-quality, lower-cost health plans, and that provides appropriate incentives for state regulation
 - Implement regulations for the insurance marketplaces that allow flexibility in plan choices with actuarially equivalent benefit designs.
 - All options would be required to meet meaningful minimum requirements for essential benefits for creditable coverage, but given the disparities in covered benefits across states, offset state-specific subsidy growth that is attributable to increases in the impact of state-required benefits over time.
- » Facilitate stable non-group and small-group health insurance marketplaces by taking steps to reduce adverse selection and encourage broad participation for more affordable insurance
 - Enhance participation through effective broad-based outreach and default enrollment for individuals who are eligible for subsidies.
 - Limit open enrollment periods to one to two months per year.
 - Impose limits on individuals' ability to shift from a plan with relatively low actuarial value to higher value (for example, allowing movement from a "bronze" to a "silver" plan in terms of actuarial value during open enrollment, but not a "bronze" to a "gold" plan).

- Relax the requirement for full community rating when consumers have not maintained continuous coverage and include late enrollment penalties (as in Medicare Part B and Part D).

Reforms for System-Wide Efficiencies

- » Simplify and standardize administrative requirements to support higher-value care
 - Implement an updated standardized claim form.
 - Promote standard methods for quality reporting by providers and plans, including clinical, outcome, and patient-level.
 - Promote standard methods for timely data sharing by plans with health care providers and patients who are involved in our proposed financing reforms.
 - Provide further support for state investments to update their Medicaid information systems, including standard quality measure reporting and access to CMS data for quality improvement.
- » Improve cost and quality transparency
 - Implement consistent methods across providers and payers for constructing quality measures and for plans to provide relevant out-of-pocket cost information (a core set of common measures and conditions, at minimum).
 - Require plans, as a condition of participation in insurance marketplaces, to provide a common set of cost and quality measures—at the plan- and provider-level.
 - Restrict “gag” clauses.
- » Promote effective antitrust enforcement
 - Require the ongoing production of a set of timely, comparable quality and cost measures at the level of major episodes of care and at the population level prior to integration and subsequently for clinical integration activities and mergers above a reasonable market-share threshold of concern.

Failure to achieve improvements in quality and cost would be a foundation for subsequent antitrust action.

- Update the antitrust enforcement framework to place greater emphasis on favoring clinical integration activities that are accompanied by financing reforms that move away from FFS payments and place providers at financial risk for quality gaps and higher costs.
- » Address outdated licensing barriers for more effective and efficient care
 - Reform scope of practice laws to allow all health professionals to practice at the top of their licenses and capabilities.
 - Remove barriers to telemedicine services caused by state-specific licensing restrictions to enable licensing reciprocity.
- » Encourage states to develop more efficient medical liability systems
 - Promote “safe harbor” or “rebuttable presumption” laws that establish legal protections for providers who achieve high quality and safety performance using valid measures.
 - Promote reforms that modify the existing judicial process for resolving tort claims with lower-cost and more predictable alternatives (e.g., a “Patient Compensation System”).
- » Enable states to implement system wide reforms
 - Use common performance measures and the MCC payment reforms to create a more straightforward pathway for Medicare to join in state-based financing reforms that have a “critical mass” of participants in a state including private plans, state/employee retiree plans, and Medicaid plans.
 - Provide enhanced opportunities for states to share in savings in Medicaid and Medicare that are generated as a result of state-led reforms affecting beneficiaries in these programs.

COST SAVINGS FROM BENDING THE CURVE III PROPOSALS

Program	10-Year Savings (in billions)	Notes
Medicare		
Transition to Medicare Comprehensive Care with Per-Capita Growth of GDP+0	\$0 (2014-2018) \$120 billion (2019-2023)*	Over the next decade, Medicare spending growth is projected to average below GDP+0 per capita. To ensure that this growth rate is sustained throughout the decade while improving quality, the savings from our Medicare reform proposals (including physician payment reform and other reforms in traditional Medicare payments) would be directed back into Medicare to support the transition to Medicare Comprehensive Care. Limiting per capita spending growth to GDP+0 in MCC programs and in Medicare's traditional fee-for-service payment systems in the second half of the 10-year period (e.g., through IPAB or across-the-board reductions in payment updates) provides an additional estimated \$120 billion in savings that would be used for this purpose, in addition to savings from the Medicare reforms listed below.
Medicare Benefit and Medigap Reforms	\$60 billion*	Reform Medicare benefits with a limit on out-of-pocket payments, a single deductible, and more rational co-pays, as in MedPAC proposals. Eliminate "first dollar" Medigap coverage; Medigap plans will have actuarially-equivalent co-pays of at least 10%. MCC providers could offer lower co-pays and premiums to beneficiaries. These reforms would reduce average beneficiary out-of-pocket payments, provide better protection against high costs, and lead to additional beneficiary savings when beneficiaries use high-value providers.
Medicare Savings from Dual-Eligible Aligned Care Reforms	\$20 billion*	Medicare savings associated with the Dual-Eligible Aligned Care Program.
High-Value Health Plan Competition in Medicare Advantage	\$20 billion*	Limit MA plan subsidy growth to GDP+0 per capita. Plans should receive the entire difference between their bid and the benchmark if they return the difference to beneficiaries in the form of lower premiums and half of the difference if the difference is instead returned in the form of additional benefits.

* Savings are from the specific proposals and are directed to implementing MCC and other reforms that improve quality and sustain GDP+0 per capita spending growth over the coming decade. This includes reforming physician payment to replace the SGR with our proposed reforms.

Medicaid		
Person-Focused Medicaid Reforms, with Standard Process and Infrastructure for Medicaid Reforms that Reduce Per Beneficiary Cost Growth While Maintaining or Improving Quality of Care	\$100 billion	Reforms expected to reduce federal spending growth over the next decade by an average of 0.75% of GDP per capita relative to current law. This would involve achieving greater total Medicaid savings compared to current law (e.g., 1.5% per capita slower growth) with a larger share of the overall savings passed on to the states.
Dual-Eligible Aligned Care Program	\$20 billion	Expand the CMS Capitated Financial Alignment Demonstration to a permanent Dual-Eligible Aligned Care Initiative with supporting infrastructure and faster/clearer implementation pathway. A model for a payment structure that ensures savings would be specified and states would share in the savings.

COST SAVINGS FROM BENDING THE CURVE III PROPOSALS

Program	10-Year Savings (in billions)	Notes
Insurance Markets		
Cap the Employer-Sponsored Insurance Tax Exclusion and Limit Growth to Spending Target	\$120 billion	Phase in a cap on the tax exclusion somewhat below the level of the current excise tax (but significantly above marketplace subsidy caps), and constrain spending growth to GDP+0 per capita once a meaningful cap is established.
Encourage and Support Employer Leadership in Implementing Innovative Reforms in Health Care Coverage and Delivery, and Encourage Flexibility in Benefit Design		
Limit Marketplace Subsidy Growth to GDP+0 per capita Plus Further Reforms Affecting Benefit Design, Adverse Selection, and Other Insurance Market Issues	\$50 billion	Limited impact because current law constrains subsidies if total marketplace subsidy spending exceeds 0.504% of GDP after 2018. Specific mechanisms will be specified once the marketplaces and product offerings are known.
System-wide Reforms		
Simplify and Standardize Administrative Requirements	\$20-\$50 billion	
Improve Cost and Quality Transparency		
Promote Effective Antitrust Enforcement		
Address outdated licensing barriers		
Encourage States to Develop More Efficient Medical Liability Systems	\$20 billion	
Enable States to Implement System-wide Reforms	\$20 billion	Opportunity for states to share in Federal savings from system-wide reforms provides incentives for states to implement these reforms.

