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Bending the Curve: Effective Steps to Address Long-Term Healthcare Spending Growth

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Introduction

Reducing the growth of healthcare spending is a top priority of Congress and the Administration, but identifying specific, feasible steps that can achieve this goal has proven difficult. While the political debate has focused on several contentious issues, we believe there is a set of sustainable steps that together can slow spending growth significantly while building the high-value healthcare system our nation urgently needs. In combination with steps to cover the uninsured, reforms to constrain spending growth are feasible and essential for the nation's fiscal stability and economic well-being.

These steps are not meant to be exhaustive, but rather a set of mutually-reinforcing reforms that we collectively agree could lead to significant reductions in costs and spending growth and improve quality of care at the same time. If implemented together, the impact on spending growth could be substantial. Some of these steps will generate reductions in spending in the short run. Others may take more time to have an impact, but hold more promise for reducing the rate of increased spending over time.

Many of these steps work together to address a critical flaw in American healthcare policies today: the lack of accountability for costs and results. Providers, patients, insurers, employers, and governments all participate in a system with little incentive—or often adverse financial consequences—to improve quality or reduce overall costs. Transitioning to a system of greater accountability will require greater flexibility for private and public stakeholders to experiment with programs and measure results, to see what works best.

First, as a foundation for improving value, all stakeholders in the system need better information and tools to be more effective. Second, provider payments should be redirected toward rewarding improvements in quality and reductions in cost growth, providing support for healthcare delivery reforms that save money while emphasizing disease prevention and better coordination of care. Third, health insurance markets should be reformed and government subsidies restructured to create competition and improve incentives around value improvement rather than risk selection. This step requires near-universal participation in insurance markets to succeed. Finally, individual patients should be given greater support for improving their health and lowering overall healthcare costs, including incentives for achieving measurable health goals. Specific steps to accomplish these goals follow.

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Building the Necessary Foundation for Cost Containment and Value-Based Care

Rationale:

As an essential foundation for reform, constraining spending growth while improving value requires information and tools like health information technology (IT) systems. But providing these tools is not enough; stakeholders will also need better incentives to use them, including other reforms described in subsequent sections.

Key Reform 1: Ensure Investments in Health IT Are Effective

- **Link "meaningful use" health IT bonuses to achieving better results** as part of systems of quality measurement, quality improvement, and care coordination.
- **Create interoperability and provider communication standards,** with a focus on filling priority gaps in standards for practical exchange.
- **Fund technical support programs** to ensure provid-

ers adopting health IT have access to comprehensive support for overcoming implementation challenges.

Key Reform 2:
Make Best Use of Comparative Effectiveness Research (CER)

- **Create an entity to allocate CER funding** based on the expected value of the evidence to be developed, including the national burden of disease and the likelihood that the research will lead to real improvements in care.
- **Emphasize areas of medical uncertainty,** public health interventions, and broader provider practice patterns and the policies that influence them.
- **Protect providers and insurers from liability** when they follow best practices and implement safe systems, as identified by evidence.

Key Reform 3:
Improve the Healthcare Workforce

- **Create incentives for states to amend the scope of practice laws** to allow for greater use of nurse practitioners, pharmacists, physician assistants, and community health workers.
- **Align Medicare payments** to better support the use of allied health professionals.
- **Reform graduate medical education payments** to promote the teaching of high-value care practices, including training in ambulatory settings, team-based care, quality improvement tools, geriatrics, and complex patient care management.

Reforming Provider Payment Systems to Create Accountability for Lower-Cost, High-Quality Care

Rationale:

Reorienting providers' financial incentives and support toward improving value is essential and requires both a short- and long-term strategy. Adjustments in fee-for-service payments can rectify some problems initially, but simply reducing payment rates for "overpriced" services is insufficient. Fundamental change is needed through a timely transition to new payment systems that have accountability for reducing costs and increasing quality, reinforced by increasing pressure to make fee-for-service less attractive over time. Because experience with payment reform will lead to important refinements, it is also crucial to promote rapid learning and flexibility in responding to new evidence on the effectiveness of payment reforms.

Initial Reforms:
Adjust Medicare and Medicaid Fee-for-Service Payment Systems

It will take time to reform value-based payments and delivery systems; however, some payment adjustments within fee-for-service programs can be made more quickly. These can support providers in transitioning to more effective payment systems, and include:

- **Broaden bundled payments,** such as hospital and post-acute care, hospital and physician services, high-cost episodes of care.
- **Expand the use of pay-for-performance,** ideally using health outcome and patient experience measures, when evidence demonstrates that such reforms do not increase costs.
- **Increase payment rates for primary care,** offset by reductions for specialty care.
- **Provide additional payments during this transition period** to physicians whose practices serve as "patient-centered medical homes" responsible for first contact and coordination across all care received.
- **Ensure Medicare payments support the use of allied health professionals.**
- **Reduce payments for care of low value relative to cost**—for example, by reducing clearly inappropriate utilization and overpayments, as identified by the Medicare Payment Advisory Commission (MedPAC).
- **Increase spending on programs to reduce waste, fraud, and abuse in Medicare,** including provider education and guidance programs.
- **Enable Medicare Prescription Drug Plans (PDPs) to share in overall cost savings** created by more effective use of prescription drugs.
- **Establish a regulatory pathway for follow-on biologics.**

Key Reform 1:
Build New Payment Systems for Provider Accountability

In conjunction with adjusting fee-for-service, new payment systems are needed that promote accountability for health outcomes and overall costs. The following are the most promising ideas that—because they are not yet well

developed—should be rapidly piloted, refined, and expanded if effective:

- **Pilot Accountable Care Organizations (ACOs),** which integrate a group of physicians, hospitals, and other providers around the ability to receive shared savings bonuses by achieving measured quality targets and reducing overall spending growth for a population of Medicare beneficiaries. Advanced ACOs could also receive partially capitated payments with quality bonuses, as in the "Alternative Quality Contract" model developed by Massachusetts Blue Cross/Blue Shield. The Centers for Medicare & Medicaid Services (CMS) would facilitate public-private collaborations in which private plans adopt payment incentives for ACO providers based on consistent measures. Expedited processes for exemptions from Stark and anti-gainsharing laws are necessary for ACO pilots to work.
- **Pilot "enhanced episode-based payment" systems and other promising payment systems.** Payment rates for certain types of episodes of care would be set through competitive bidding with risk-adjustment, with public reporting of provider outcomes and quality bonuses. On the beneficiary side, tiered copayments should be implemented, to encourage use of providers that deliver more efficient bundles of services. Other promising reforms that might be piloted include new pay-for-performance models or care-coordination bonuses. These payment reform pilots must be accompanied by an effective measurement capability, so that the impact of each reform on improving quality and reducing costs for a population of patients can be demonstrated quickly and reliably.
- **Incorporate other bonuses into a transition to accountable payment systems,** including health IT payments, medical home payments, pay-for-reporting bonuses, pay-for-performance bonuses, and other payment reforms described above in *Initial Reforms*. These multiple payment reform initiatives should all be aligned to the common goal of measurable impact on quality and costs.

Key Reform 2:
Apply Pressure to "Non-Accountable" Medicare Payments

As accountable payment systems become available, traditional fee-for-service payments should be made less attractive through reduced payment updates:

- **Establish "Virtual ACO" incentives** several years after implementing reforms, in which providers outside of accountable payment systems would be grouped based on the utilization patterns of the Medicare beneficiaries that they treat, and virtual ACOs with high cost growth or poor quality would receive market basket update penalties.
- **Freeze market basket updates for two years**—several years after reforms are implemented, for example, 2013-14—for providers not participating in accountable payment systems.

Key Reform 3:
Improve Payment/Coverage Flexibility and Rapid Learning to Achieve Lower Costs and Better Quality

- **Expand and streamline CMS's piloting authority and resources** to support the rapid testing, evaluation, and expansion or elimination of new payment models in Medicare and Medicaid, through the availability of timely and meaningful quality and spending measures and resources for enhanced evaluation capacity. With compelling and timely measures of cost and quality impacts, CMS would have a greater capability to expand payment and coverage changes that improve care while reducing costs.
- **Support public-private regional collaborations** with Medicare, Medicaid, and private payers using consistent quality and cost measures for payment, in order to increase providers' incentives for value improvement and delivery reform.
- **Empower an entity to improve the value and ensure the long-term sustainability of Medicare and Medicaid** by proposing policy changes that are subject to fast-track, up-or-down votes in Congress.
- **Reform medical liability** to increase support for providers and insurers to make decisions based on high-value, evidence-based practices. This could be achieved through: (1) health courts with specialized expertise in medical liability; (2) a rebuttable presumption of non-liability for providers with consistently high measured safety or who demonstrate adherence to evidence-based guidelines; and (3) a legal pathway for early communication, apology, and remuneration.
- **Reform anti-trust laws and create processes for expedited waivers from anti-gainsharing and Stark laws,** which would be backed by the documented evi-

dence on cost and quality impacts described above, to facilitate shared-savings reforms.

Improving Health Insurance Markets

Rationale:

Governments should ensure proper incentives for non-group and small-group health insurance markets to focus on competition based on cost and quality rather than selection. Achieving this requires near-universal coverage and insurance exchanges to pool risk outside of employment, augment choice, and align premium differences with differences in plan costs. Existing inefficient subsidies for employer-provided insurance and overpayments for Medicare Advantage should also be reformed to improve incentives for lowering costs.

Key Reform 1:
Restructure Non-Group and Small-Group Markets Around an Exchange Model That Promotes Competition on Cost Reduction and Quality Improvement

- **Focus insurer competition on cost and quality** through requirements for guaranteed issue without —or with very limited—pre-existing condition exclusions; limited health rating, such as those related to age and behaviors only; and full risk-adjustment of premiums across insurers based on enrollees' risk. For market stability, these reforms must be undertaken in the context of an enforced mandate that individuals maintain continuous, creditable basic coverage.
- **Establish health insurance exchanges**—at a state or regional level, for example—that pool risk across non-group and across small-group participants, increase plan choices, and align premium differences with differences in plan costs. Tie plan participation in exchanges to administrative claims standardization and simplification and to public reporting of consistent performance measures.

Key Reform 2:
Reduce Inefficient Subsidies for Employer-Provided Health Insurance

- **Cap the existing income tax exclusion** for employer-provided insurance, to encourage carriers to design and workers to choose more cost-effective coverage.
- **Adjust the cap based on plan demographics and location,** but phase out geographic adjustments to put downward cost pressure on high-cost areas.

Key Reform 3:
Promote Competitive Bidding in Medicare Advantage

- **Set local benchmarks** at the average of bids, with plans bidding below the benchmark keeping the full difference and plans above the benchmark collecting the difference in additional premiums.
- **Establish a significant quality bonus** for attaining measured quality standards, with the full bonus returned to enrollees in enhanced benefits.
- **Consider a transition to including Medicare fee-for-service in the bidding system.**

Supporting Better Individual Choices

Rationale:

Individuals need support for making better choices as patients and consumers—choices that enable them to get better care and stay healthier at a lower cost. To help drive these reforms, Medicare should be redesigned to reward high-value choices and discourage first-dollar coverage. This can be done while achieving substantial healthcare savings, including savings for beneficiaries, and giving Medicare beneficiaries better protection against high out-of-pocket costs. Steps to prevent chronic diseases, particularly through bolder strategies to address obesity, and to reduce other spending that is not consistent with patient preferences or higher-value care are also important.

Key Reform 1:
Reform Medicare Benefit Design to Promote Value and Beneficiary Savings

- **Restructure Medicare Parts A and B** with a global deductible and catastrophic out-of-pocket maximum.
- **Establish tiered copays** consistent with the principles of value-based insurance design, to align Medicare cost-sharing with the value and overall cost of services (including pre-deductible coverage of high-value services and higher copays for low-value care, consistent with the payment reforms described on page 677).
- **Reform Medicare supplemental plans** (Medigap and retiree) to eliminate first-dollar coverage, restrict to 50% the coverage of Medicare's copays, and require that coverage maintain tiered copays based on value.
- **Enhance and publicize provider quality and cost information**—focusing on outcome and patient

experience information—to increase beneficiary confidence in choosing care based on measured quality and cost and to encourage provider quality and value improvement.

- **Increase flexibility to alter benefits** over time to reflect best available value-based standards through greater Medicare flexibility and liability safe-harbors for private plans adopting similar measures.
- **Assure that these steps are designed to result in lower beneficiary spending on healthcare** so beneficiaries share in the resulting savings.

Key Reform 2: Promote Prevention and Wellness That Reduces Costs

- **Target obesity reduction** through price incentives, such as sugar-sweetened beverage taxes, and through aggressive piloting and evaluation of other reforms that are designed to improve the evidence base of reforms that demonstrably reduce obesity—for example, community-, school-, and work-site interventions.
- **Allow premium rebates for measurable health and risk-factor improvements,** provided that all beneficiaries have an opportunity to save money.
- **Establish public health outcome-based accountability**—on local incidence of diabetes and smoking, for example—for locally dominant healthcare providers, enforced through bonuses/penalties in Medicare and Medicaid payment rates, to ensure that high levels of market share are balanced by responsibility to improve community health.

Key Reform 3: Support Patient Preferences for Palliative Care

- **Provide an opportunity for Medicare beneficiaries to file and regularly update advanced directives** that truly reflect their personal preferences for care, and make these directives available to providers with beneficiaries' electronic health records.
- **Create a liability safe-harbor for providers** adhering to advanced directives.

Conclusion

Slowing healthcare cost growth requires a systemic approach that addresses the need for change in provider payment methods, benefit design, regulation, and healthcare institutions. Healthcare reform should include comprehensive efforts to improve the tools, information, and incentives that are needed to achieve higher-value care. This document provides an overview of what such a strategy could look like, with four interrelated pillars designed to help advance a system that achieves better results at lower overall cost.

These four reform pillars are interdependent and reinforcing and thus are likely to work best if implemented simultaneously as a linked series of steps. Better functioning insurance markets can support better individual and employer choices to purchase efficient, value-based insurance. Improved insurance design and individual incentives can encourage better individual choices to reduce spending and improve health. In turn, better individual choices and incentives will likely be most effective with changes in provider payment and reorganized delivery systems that give more support to healthcare providers when they take steps to deliver higher-quality, coordinated care. Finally, all of these reforms depend on a foundation of better tools and information to guide stakeholders in taking the many small steps necessary to transition towards high-value healthcare.

While most of these reforms take some time before their full effect on spending growth is realized, they can be complemented by short-term steps that help achieve interim savings and that can promote a transition to higher-value care. With effective tools for piloting, evaluating, and learning from the best approaches to implementing these changes, these reforms can reduce healthcare spending growth and improve quality over the short and long term.

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