



## A FRAMEWORK FOR CUTTING COSTS

---

Rebecca Pizzitola  
September 2009

With support from the Robert Wood Johnson Foundation, the Engelberg Center for Health Care Reform at Brookings developed a paper describing ways to reduce health care spending.<sup>1</sup> The paper presents a range of interlinking ideas, which the bipartisan groups of esteemed experts argue would have the greatest impact in moving to better quality at a reduced cost in the short- and long-term. The specific changes are improved information collection and sharing, payment reform and delivery system reorganization, insurance market reforms, and individual responsibility and empowerment. This is not presented as a menu of policy choices; this set of recommended reforms must be implemented together rather than individually.

The main outcomes are to increase accountability in the health system and to change the systemic incentives in order to produce high-value care—in other words, to get more bang for each buck spent. Many of the authors' suggestions would apply first to public insurance programs like Medicare and Medicaid, although the principles can be applied to other parts of both the public and private sectors.

### **Information Collection and Sharing**

At the forefront of health care reform is the need to continuously collect, analyze and share data on health care quality and costs. Increasing information includes comparative effectiveness research through an independent institute, with liability protections for those providers following best practices supported by scientific evidence. Investing in and incentivizing the meaningful use of health information technology (HIT) that is fully interoperable and coupled with effective technical support programs are also vitally important. Regardless of the specific endeavor, collaboration is central to establishing consistent and relevant measures of quality and cost, to determining best practices, and to ensuring HIT is used effectively.

### **Payment Reform and Delivery System Reorganization**

Reforms that better orient payments to reimburse appropriate care and align them with actual costs are critical to improving value. One key reform involves adjusting overpriced fee-for-service reimbursements, beginning with Medicaid and Medicare. Payments for primary care and prevention should be increased with a correlated decrease for specialty care. Payments for care that is of low value relative to its cost should be reduced as well. Additionally, the authors recommend establishing an approval pathway for follow-on biologics, similar to efforts to expedite the approval of generics for costly pharmaceuticals, along with the use of Prescription Drug Plans to reduce the growth rates in price and utilization for pharmaceuticals.<sup>2</sup> Bundling payments for hospital and physician services for high-cost episodes of care and using pay-for-

---

<sup>1</sup> Antos, J. et al. (2009). Bending the curve: Effective steps to address long-term health care spending growth. Retrieved September 14, 2009 from [http://www.brookings.edu/~media/Files/rc/reports/2009/0826\\_btc/0826\\_btc\\_fullreport.pdf](http://www.brookings.edu/~media/Files/rc/reports/2009/0826_btc/0826_btc_fullreport.pdf).

<sup>2</sup> Biologics are medicines that are made using living organisms. Follow-on biologics are biosimilar to the initial innovator drug.



performance can ensure payments are further linked to and incentivize improved patients' health outcomes.<sup>3</sup>

The authors recommend a broad transition to new payment systems over the long-term to better encourage accountability for both quality improvements and cost effectiveness, starting with Medicare pilot programs. Better integrating physicians and hospitals and aligning their financial incentives are recommended. This would allow them to reap the cost savings of the improved health outcomes they participated in achieving through coordinated and continuous care. Accountable care organizations (ACOs) may be a method to do this and should be piloted to rein in spending growth and increase the quality of care. An ACO is defined as a group of providers, including physicians and hospitals, held accountable for the quality and cost of care for a population. The authors suggest testing whether partially capitated payments coupled with bonuses can improve patient outcomes at a lower cost. To allow these pilots to work, exemptions would need to be given from the Stark laws that govern physicians' abilities to refer patients to facilities with which they have shared financial interests. With resources devoted to swift implementation and evaluation of such pilots, successful payment system reforms could quickly be replicated and expanded.

The authors also recommend that a body be authorized to put forth policies decided with fast track, up-or-down votes in Congress—the so-called MedPAC with teeth.<sup>4</sup>

Payment incentives should be used widely, emphasizing pathways for all stakeholders to share in the cost savings, for instance, patients being rewarded for healthy behaviors or using tiered copayments to promote using the most effective ACOs. Further, bonuses should be linked to a diversity of measures and activities—from improved health outcomes to pay-for-data-reporting, from physician practices serving as successful medical homes to those adopting HIT. Specific types of stakeholders could share in savings they generate in their sectors; for example, Medicare Prescription Drug Plans could share in cost savings from more effective use of pharmaceuticals.

With time, the less effective payment systems within Medicare should be discouraged. One suggestion is to freeze reimbursement rates for two years for providers not participating in accountable care systems after they have been in place and demonstrated their merit for several years. Another suggestion is to group non-participating providers as “virtual” ACOs; those providers with high costs and low quality would be penalized for poor performance, while high performers would be rewarded.

### *Workforce*

---

<sup>3</sup> The authors further suggest the possibility of holding providers with large market shares of patients accountable for broader public health measures of disease incidence.

<sup>4</sup> Unlike organizations like the Medicare Payment Advisory Commission (MedPAC) that have only an advisory role, such a body would have the power to put forth legislation in consultation with Congress; Congress would have to then vote on this legislation within a certain period of time without requesting amendments. This would allow ample input but expedite the process of reforming the system through statute by overcoming some of the obstacles of passing a law through the traditional means, which requires it to travel through committees and subcommittees and both houses with several rounds of amendments over a potentially prolonged period of time.



To make better use of the existing health workforce, nurse practitioners, physician assistants and similar professionals could take on greater responsibilities under amended scope of practice laws. Further, payments could be changed to support the greater use of allied health professionals, starting within Medicare.

A future physician workforce could be trained to practice high-value care by reforming graduate medical education (GME) payments. Specifically, payments could be realigned to support a framework of integrated, team-based care, complex patient care management, care in ambulatory settings, and care for an aging baby-boomer population. This would prepare the system to better prevent and manage burgeoning chronic disease and the needs of an aging population in a more cost effective manner.

### **Insurance Market Reforms**

Competition to contain costs and improve the quality of care must be fostered. This requires mandating that most people have basic health coverage—coverage with no exclusions for preexisting conditions and limited health ratings (e.g., for age and certain risky behaviors, such as tobacco use).

Health exchanges should be used to give individuals and small groups access to affordable coverage options. Caps should be placed on the tax exclusion for employer-sponsored insurance so those with this type of coverage may be encouraged to choose more cost-effective coverage. These caps should phase out geographic adjustments to put pressure on high-cost regions to cut their costs.

Overpayments to Medicare Advantage plans need to be reformed through competitive bidding and local benchmarks—with rewards and incentives for low bidders. Moving Medicare fee-for-service into a competitive bidding system should also be considered.

### **Individual Responsibility and Empowerment**

Starting with Medicare, patients should be incentivized to make better choices for their health. To promote more conscious use of one's health coverage, first-dollar coverage should be eliminated. There would be a global deductible and a catastrophic out-of-pocket maximum for Medicare Parts A and B. Copayments could be tiered by the value of the care, rewarding patients for choosing high-value treatments and providers. Additionally, Medicare's supplemental plans should be restricted to covering only up to 50% of Medicare copayments tiered by value. Changes to copayments would encourage patients to use higher value care, such as providers with more efficient bundles of services and better health outcomes.

Additional incentives and rewards should be devised to encourage patients to make healthier lifestyle choices. For instance, savings from disease prevention or better management of chronic conditions should be passed back to patients in the form of reduced premiums. Allowing Medicare patients to regularly update their advanced directives and assuring physicians the safe harbor from liability if they follow them would guarantee that patients get the type of end of life care they request and desire.



Improvements in information collection and sharing would facilitate individual responsibility by empowering patients with the information they need to make choices based on quality and cost. Further, comparative effectiveness research would bring to light those services, treatments and prevention efforts that are of the highest value.<sup>5</sup> Given flexibility, Medicare subscribers, providers and health plans could change care and treatment patterns over time to reflect newly emerging scientific evidence of the best treatments available.

---

<sup>5</sup> Comparative effectiveness research can be used to study the efficacy of everything from specific treatment protocols and prescription drugs to broader public health initiatives, such as efforts to cut obesity through a soda tax or to implement school or worksite health interventions.