III. Health Care Savings

Federal health care spending represents our single largest fiscal challenge over the long-run. As the baby boomers retire and overall health care costs continue to grow faster than the economy, federal health spending threatens to balloon. Under its extended-baseline scenario, CBO projects that federal health care spending for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the health insurance exchange subsidies will grow from nearly 6 percent of GDP in 2010 to about 10 percent in 2035, and continue to grow thereafter.

These projections likely understate true amount, because they count on large phantom savings – from a scheduled 23 percent cut in Medicare physician payments that will never occur and from long-term care premiums in an unsustainable program (the Community Living Assistance Services and Supports Act, or "CLASS Act").

The Commission recommends first reforming both the formula for physician payments (known as the Sustainable Growth Rate or SGR) and the CLASS Act, and finding savings throughout the health care system to offset their costs. In addition, we recommend a number of other reforms to reduce federal health spending and slow the growth of health care costs more broadly.

Over the longer term (2020 and beyond), the Commission recommends setting targets for the total federal budgetary commitment to health care and requiring further structural reforms if federal health spending exceeds the program-specific and overall targets. We recognize that controlling federal health spending will be very difficult without reducing the growth of health care costs overall. To that end, the Commission's recommendations on tax reform regarding reducing and potentially eliminating the exclusion for employer-provided health insurance will help decrease growth in health care spending, according to virtually all health economists.

RECOMMENDATION 3.1: REFORM THE MEDICARE SUSTAINABLE GROWTH RATE. Reform the Medicare Sustainable Growth Rate for physician payment and require the fix to be offset. ***(Saves $3 billion in 2015, $26 billion through 2020, relative to a freeze)***

The Sustainable Growth Rate (SGR) – known as the "doc fix" – was created in 1997 to control Medicare spending by setting payment targets for physician services and reducing payment updates if spending exceeded the targets. The SGR formula has required reductions in physician payments every year since 2002, but beginning in 2003 Congress blocked the reductions each year, requiring even larger reductions every subsequent year. Because of the accumulated shortfall from deferred reductions, the SGR formula would require a 23 percent reduction in 2012 payments, and will increase every year the problem is not fixed.

Freezing physician payments from 2012 through 2020, as we assume in our baseline, would cost $267 billion relative to current law. The Commission believes that this amount – or the cost of any "doc fix" – must be fully offset, and recommends enforcing this principle by eliminating its exemption in statutory PAYGO. In the near term, we also recommend replacing the reductions scheduled under the current formula with a freeze through 2013 and a one percent cut in 2014.

For the medium term, the Commission recommends directing the Centers for Medicare and Medicaid Services (CMS) to develop an improved physician payment formula that encourages care coordination across multiple providers and settings and pays doctors based on quality instead of quantity of services. In order to maintain pressure to establish a new system and limit the costs of physician payments, the proposal would reinstate the SGR formula in 2015 (using 2014 spending as the base year) until CMS develops a revised physician payment system. The Medicare actuary would be required to certify the new payment system would not cost more than would have been allowed under the SGR formula.

This proposal would cost about $22 billion less than simply continuing to freeze physician payments, and therefore would reduce the deficit by that amount relative to our baseline.

RECOMMENDATION 3.2: REFORM OR REPEAL THE CLASS ACT.
(Costs $11 billion in 2015, $76 billion through 2020)

The Community Living Assistance Services and Supports (CLASS) Act established a voluntary long-term care insurance program enacted as part of the Affordable Care Act (ACA). The program attempts to address an important public policy concern – the need for non-institutional long-term care – but it is viewed by many experts as financially unsound. The program's earliest beneficiaries will pay modest premiums for only a few years and receive benefits many times larger, so that sustaining the system over time will require increasing premiums and reducing benefits to the point that the program is neither appealing to potential customers nor able to accomplish its stated function. Absent reform, the program is therefore likely to require large general revenue transfers or else collapse under its own weight, Commission advises the CLASS Act be reformed in a way that makes it credibly sustainable over the long term. To the extent this is not possible, we advise it be repealed. Technically, repealing the CLASS Act will increase the deficit over the next decade, because the program's premiums are collected up front and its benefits are not paid out for five years. To address this, we would replace the deficit reduction on paper from the CLASS Act with real options that truly save the federal government money and put it on a more sustainable path.

RECOMMENDATION 3.3: PAY FOR THE MEDICARE "DOC FIX" AND CLASS ACT REFORM. Enact specific health savings to offset the costs of the Sustainable Growth Rate (SGR) fix and the lost receipts from repealing or reforming the CLASS Act.

To offset the cost of the SGR fix and recover lost receipts in the first decade from repealing or reforming the CLASS Act, the Commission proposes a set of specific options for health savings that, combined, total nearly $400 billion from 2012 to 2020.

Medicare Savings

3.3.1 Increase government authority and funding to reduce Medicare fraud.
(Saves $1 billion in 2015, $9 billion through 2020)

The Commission recommends increasing the ability of CMS to combat waste, fraud, and abuse by providing the agency with additional statutory authority and increased resources (through a cap adjustment in the discretionary budget.)

3.3.2 Reform Medicare cost-sharing rules.
(Saves $10 billion in 2015, $110 billion through 2020)

Currently, Medicare beneficiaries must navigate a hodge-podge of premiums, deductibles, and copays that offer neither spending predictability nor protection from catastrophic financial risk. Because cost-sharing for most medical services is low, the benefit structure encourages over-utilization of health care. In place of the current structure, the Commission recommends establishing a single combined annual deductible of $550 for Part A (hospital) and Part B (medical care), along with 20 percent uniform coinsurance on health spending above the deductible. We would also provide catastrophic protection for seniors by reducing the coinsurance rate to 5 percent after costs exceed $5,500 and capping total cost sharing at $7,500.

3.3.3 Restrict first-dollar coverage in Medicare supplemental insurance.

(Medigap savings included in previous option. Additional savings total $4 billion in 2015, $38 billion through 2020.)

The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by the purchase of supplemental private insurance plans (Medigap plans) that piggyback on Medicare. Medigap plans cover much of the cost-sharing that could otherwise constrain over-utilization of care and reduce overall spending. This option would prohibit Medigap plans from covering the first $500 of an enrollee's cost-sharing liabilities and limit coverage to 50 percent of the next $5,000 in Medicare cost-sharing. We also recommend similar treatment of TRICARE for Life, the Medigap policy for military retirees, which would save money both for that program and for Medicare, as well as similar treatment for federal retirees and for private employer-covered retirees.

3.3.4 Extend Medicaid drug rebate to dual eligibles in Part D.

(Saves $7 billion in 2015, $49 billion through 2020)

Drug companies are required to provide substantial rebates for prescription drugs purchased by Medicaid beneficiaries. We recommend extending these rebates to Medicaid beneficiaries who are also eligible for Medicare (individuals known as "dual eligibles") and who receive prescription drug coverage through the Medicare Part D program.

3.3.5 Reduce excess payments to hospitals for medical education.

(Saves $6 billion in 2015, $60 billion through 2020)

Medicare provides supplemental funding to hospitals with teaching programs for costs related to residents receiving graduate medical education (GME) and indirect costs (IME). The Commission recommends bringing these payments in line with the costs of medical education by limiting hospitals' direct GME payments to 120 percent of the national average salary paid to residents in 2010 and updated annually thereafter by chained CPI and by reducing the IME adjustment from 5.5 percent to 2.2 percent, which the Medicare Payment Advisory Commission has estimated would more accurately reflect indirect costs.

3.3.6 Cut Medicare payments for bad debts.

(Saves $3 billion in 2015, $23 billion through 2020)

Currently, Medicare reimburses hospitals and other providers for unpaid deductibles and copays owed by beneficiaries. We recommend gradually putting an end to this practice, which is not mirrored in the private sector.

3.3.7 Accelerate home health savings in ACA.

(Saves $2 billion in 2015, $9 billion through 2020)

The Affordable Care Act included several policies changing reimbursements for home health providers. The Commission recommends accelerating these changes to incorporate productivity adjustment beginning in 2013 and directing the Secretary of Health and Human Services (HHS) to phase in rebasing the home health prospective payment system by 2015 instead of 2017.

Medicaid Savings

3.3.8 Eliminate state gaming of Medicaid tax gimmick.
(Saves $5 billion in 2015, $44 billion through 2020)

Many states finance a portion of their Medicaid spending by imposing taxes on the very same health care providers who are paid by the Medicaid program, increasing payments to those providers by the same amount and then using that additional "spending" to increase their federal match. We recommend restricting and eventually eliminating this practice.

3.3.9 Place dual eligibles in Medicaid managed care.
(Saves $1 billion in 2015, $12 billion through 2020)

Approximately nine million low-income seniors and disabled individuals are covered by both Medicaid and Medicare. The divided coverage for dual eligibles results in poor coordination of care for this vulnerable population and higher costs to both federal and state governments. We recommend giving Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in Medicaid managed care programs. Medicare would continue to pay its share of the costs, reimbursing Medicaid. Medicaid has a larger system of managed care than does Medicare, and this would result in better care coordination and administrative simplicity.

3.3.10 Reduce funding for Medicaid administrative costs.
(Saves $260 million in 2015, $2 billion through 2020)

We recommend asking states to take responsibility for more of Medicaid's administrative costs by eliminating Medicaid payments for administrative costs that are duplicative of funds originally included in the Temporary Assistance for Needy Families (TANF) block grants.

Other Savings

3.3.11 Allow expedited application for Medicaid waivers in well-qualified states.

In order to give states new flexibility to control costs and improve quality, we recommend increasing the availability of state Medicaid waivers. Specifically, we recommend establishing presumptive eligibility criteria for up to 10 states over the next decade. These eligible states would be required to proactively seek out the waiver and to meet certain objective threshold criteria, including: improved quality, efficiency, and cost of care; and not increasing the uninsured population. Applications would be evaluated and overseen by the Medicaid Center for Innovation.

3.3.12 Medical malpractice reform.
(Saves $2 billion in 2015, $17 billion through 2020)

Most experts agree that the current tort system in the United States leads to an increase in health care costs. This is true both because of direct costs – higher

malpractice insurance premiums – and indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as "defensive medicine"). The Commission recommends an aggressive set of reforms to the tort system.

Among the policies pursued, the following should be included: 1) Modifying the "collateral source" rule to allow outside sources of income collected as a result of an injury (for example workers' compensation benefits or insurance benefits) to be considered in deciding awards; 2) Imposing a statute of limitations – perhaps one to three years – on medical malpractice lawsuits; 3) Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury; 4) Creating specialized "health courts" for medical malpractice lawsuits; and 5) Allowing "safe haven" rules for providers who follow best practices of care.

Many members of the Commission also believe that we should impose statutory caps on punitive and non-economic damages, and we recommend that Congress consider this approach and evaluate its impact.

3.3.13 Pilot premium support through FEHB Program.

(Saves $2 billion in 2015, $18 billion through 2020)

The Commission recommends transforming the Federal Employees Health Benefits (FEHB) program into a defined contribution premium support plan that offers federal employees a fixed subsidy that grows by no more than GDP plus 1 percent each year. For federal retirees, this subsidy could be used to pay a portion of the Medicare premium. In addition to saving money, this has the added benefit of providing real-world experience with premium support.

Several Commissioners support transforming Medicare into a "premium support" system – such as one proposed by Representative Paul Ryan and Alice Rivlin – that offers seniors a fixed subsidy (adjusted by geographic area and by individual health risk) to purchase health coverage from competing insurers. A voucher or subsidy system holds significant promise of controlling costs, but also carries serious potential risks. To assess the balance of benefits and risks, we recommend a rigorous external review process to study the outcomes of the FEHB premium support program to determine its effects on costs, health care utilization, and health outcomes. Although the population covered by FEHB is different from the Medicare population, if this type of premium support model successfully holds down costs without hindering quality of care in FEHB program, that experience would be useful in considering a premium support program for Medicare.

RECOMMENDATION 3.4: AGGRESSIVELY IMPLEMENT AND EXPAND PAYMENT REFORM PILOTS. Direct CMS to design and begin implementation of Medicare payment reform pilots, demonstrations, and programs as rapidly as possible and allow successful programs to be expanded without further congressional action.

The Affordable Care Act requires CMS to conduct a variety of pilot and demonstration projects in Medicare to test delivery system reforms which have the potential to reduce costs without harming quality of care. These pilots include Accountable Care Organizations (ACOs), bundling for post-acute care services, and other programs to pay for performance. We recommend CMS be directed to aggressively pursue these and other reforms, including introduction of downside risk to ACOs and bundled payment pilots. CMS should also

ensure that the private sector is an active partner in the research and design of payment reforms, building on concepts that have been proven to work at the state, regional, or federal level. In addition to Medicare pilots, we recommend that CMS be required to fast-track state Medicaid waivers that offer demonstrable promise in improving care and returning savings, such as Rhode Island's Global Consumer Choice Demonstration, which provides a capped federal allotment for Medicaid over five years; Vermont's all-payer advanced primary care practice reform, called Blueprint for Health; and Community Care of North Carolina, a provider-led medical home reform that has increased access to primary care, decreased emergency department usage, and saved money.

Pilots that succeed in controlling costs should be expanded as rapidly as is feasible. The Commission recommends shifting the presumption toward expanding reforms by requiring the Secretary to implement any pilot projects that have shown success in controlling costs without harming the quality of care by 2015. The Commission recommends utilizing the new Center for Medicare and Medicaid Innovation as the vehicle for accelerating these pilots. The Commission's plan does not assume any savings from expansion of these pilot projects in its deficit estimates, but believes that there could be substantial savings in Medicare, Medicaid, CHIP, and other health from aggressive implementation of successful pilots.

RECOMMENDATION 3.5: ELIMINATE PROVIDER CARVE-OUTS FROM IPAB. Give the Independent Payment Advisory Board (IPAB) authority to make recommendations regarding hospitals and other exempted providers.

The Affordable Care Act established the Independent Payment Advisory Board to recommend changes in Medicare payment policies if per-beneficiary Medicare spending grows too quickly. However, the law exempted certain provider groups, most notably hospitals, from any short-term changes from IPAB's authority. The Commission recommends eliminating these carve-outs.

RECOMMENDATION 3.6: ESTABLISH A LONG-TERM GLOBAL BUDGET FOR TOTAL HEALTH CARE SPENDING. Establish a global budget for total federal health care costs and limit the growth to GDP plus 1 percent.

Commission members, and virtually all budget experts, agree that the rapid growth of federal health care spending is the primary driver of long-term deficits. Some Commission members believe that the reforms enacted as part of ACA will "bend the curve" of health spending and control long-term cost growth. Other Commission members believe that the coverage expansions in the bill will fuel more rapid spending growth and that the Medicare savings are not sustainable. The Commission as a whole does not take a position on which view is correct, but we agree that Congress and the President must be vigilant in keeping health care spending under control and should take further actions if the growth in spending continues at current rates.

The Commission recommends setting up a process for reviewing total federal health care spending – including Medicare, Medicaid, the Children's Health Insurance Program, FEHB, TRICARE, the exchange subsidies, and the cost of the tax exclusion for health care – starting in 2020, with the target of holding growth to GDP plus 1 percent and requiring action by the President and Congress if growth exceeds the targets. This target should be adjusted to account for any changes in the health care exclusion enacted under tax reform. The target should be measured on a per-beneficiary basis if it is applied only to certain federal health programs, rather than globally. If health care costs continue to grow as fast as CBO

and the Medicare actuaries project, or even faster as some Commission members believe will be the case, this process will require Congress and the President to consider further actions that make more substantial structural reforms. If the reforms in ACA are more successful in controlling costs than the estimates by CBO and the Medicare actuary suggest, as some Commission members believe, spending growth should be within the targets and this process would not be triggered.

We recommend requiring both the President and Congress to make recommendations whenever average cost growth has exceeded GDP plus 1 percent over the prior five years. To the extent health costs are projected to grow significantly faster than that pace, we recommend the consideration of structural reforms to the health care system. Commissioners have suggested various policy options, including: moving to a premium support system for Medicare; giving CMS authority to be a more active purchaser of health care services using coverage and reimbursement policy to encourage higher value services; expanding and strengthening the Independent Payment Advisory Board (IPAB) to allow it to make recommendations for cost-sharing and benefit design and to look beyond Medicare; adjusting the federal-state responsibility for Medicaid, such as block grants for acute or long-term care; establishing a robust public option in the health care exchanges; raising the Medicare retirement age; and moving toward some type of all-payer system.