

■ Economic Policy Program

Economic Policy Project

■ Health Program

Health Project

ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

ACKNOWLEDGEMENTS

BPC would like to thank the Peter G. Peterson Foundation and the Robert Wood Johnson Foundation for their generous support of the Health Care Cost Containment Initiative.



DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

Staff

G. William Hoagland

Senior Vice President

Katherine Hayes

Director, Health Policy

Loren Adler

Senior Policy Analyst, Economic Policy Project

Leah Ralph

Senior Policy Analyst, Health Project

Brian Collins

Policy Analyst, Economic Policy Project

Meredith Hughes

Policy Analyst/Writer, Health Project

Sara Friedman

Project Assistant, Health Project

Special Thanks

Lisel Loy

Director, Nutrition and Physical Activity Initiative

Laura Zatz

Policy Analyst, Nutrition and Physical Activity Initiative

Health Care Cost Containment Initiative

With this Initiative, BPC embarked on an effort to address unsustainable health care cost growth in the United States. Under the leadership of former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN), former Senator Pete Domenici (R-NM), and former White House and Congressional Budget Office Director Dr. Alice Rivlin, BPC's Health Care Cost Containment Initiative explored and evaluated strategies to contain health care cost growth on a system-wide basis, while enhancing health care quality and value. This report is the culmination of that work, and a joint product of BPC's Economic Policy Project, directed by Steve Bell, and Health Project, directed by Katherine Hayes.

Report

This report was produced by BPC staff, in collaboration with a distinguished group of senior advisors and experts, for the Health Care Cost Containment Initiative. BPC would like to thank Sheila Burke, Chris Jennings, Paul Ginsburg, Steve Lieberman, and Joe Minarik, who shaped and strengthened the content of this paper by providing substantial feedback, support, and direction. BPC would also like to thank Julie Barnes for her leadership in conceptualizing and launching this initiative. Special thanks to Shai Akabas with the Economic Policy Project, and Janet Marchibroda and Katie Golden with BPC's Health Innovation Initiative for their support and contributions. Additionally, BPC thanks the many experts and stakeholders we engaged throughout this process for their guidance and feedback, with particular appreciation to Dr. Jonathan Gruber, Dr. Thomas MaCurdy and the staff of Acumen LLC, Dr. Ron Goetzel, and American Institutes of Research for their thoughtful analysis.

Letter from the Co-Leaders

Our nation's health care system and our federal debt trajectory are on unsustainable paths. For too long, health and budget experts and policymakers have worked in silos rather than in collaboration. Such disjointed efforts have led to missed opportunities and falsely suggested that, in a time of limited resources, we must choose between investments in health care and fiscal health. We, the four leaders of the Bipartisan Policy Center (BPC) Health Care Cost Containment Initiative, came together to change the conversation around health and budget reform. A strong health care system, a stable federal budget, and a productive economy are complementary, not competing, priorities.

We can achieve a higher-value health care system—meaning both greater efficiency and higher quality. The enclosed report outlines our recommendations to achieve the critical goal of containing high and rising health care spending while improving the quality and affordability of care for all Americans. This report is the culmination of nearly a year of work, including stakeholder outreach, thorough research, and substantive analytics to quantify the impact of our proposed policies.

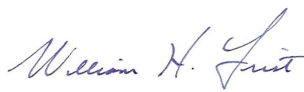
Our efforts embody the BPC approach—driving principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. As such, this report and its recommendations represent our broad consensus on comprehensive, system-wide health care and budget reforms. This comprehensive, systemic approach is key, and we as individuals do not necessarily endorse each piece in isolation.

This report is not the end of the story, but the beginning. By presenting this approach to federal, state, and private-sector leaders, we hope to promote a collaborative dialogue and a shared understanding of strategies to put our nation's health system, as well as our economic outlook, on a sounder and more sustainable path. No single set of recommendations can fix the health care system or the nation's debt and deficit crisis overnight, but we hope this report can start a constructive, pragmatic dialogue among policymakers and political leaders. We look forward to further refining and developing these ideas in collaboration with leaders, experts, and stakeholders across the health care system.

Sincerely,



Former Senate Majority Leader
Tom Daschle



Former Senate Majority Leader
Bill Frist, M.D.



Former Senate Budget
Committee Chairman Pete Domenici



Former Congressional Budget Office Director
Dr. Alice Rivlin

Executive Summary

Background

In the United States, nearly a fifth of all spending is currently devoted to health care. High and rising health care costs consume a large and rapidly growing portion of the federal budget, crowding out investments in other crucial priorities such as education, defense and infrastructure and putting pressure on other priorities of households, businesses and governments. This trend will only accelerate with the aging of the population and its increased dependence on federal and state financing of health care. Yet despite our high national spending, health care in the United States is uneven in quality and often wasteful, uncoordinated and inefficient. Leaders on both sides of the political aisle, and in the health and economic policy communities, recognize the urgency of improving the quality and effectiveness of care, while slowing the growth of spending. However, far too often, attempts to address our nation's health and budget issues have been fragmented and unproductive, frequently due to partisan disagreements over how to approach these highly sensitive issues.

We, the four leaders of the Bipartisan Policy Center (BPC) Health Care Cost Containment Initiative, came together to bridge this divide—to start a constructive dialogue on strengthening the U.S. health care system. We focused our efforts on what is necessary to improve quality and eliminate waste. We feel that budget-driven efforts to achieve health care savings alone will fail; public and private health care savings must be an outgrowth of health reform, not the underlying reason for it. We believe our policy analysis and recommendations reflect this principle.

Our Vision

After decades of very rapid increase, health care spending growth has slowed somewhat in the last few years. Experts attribute this slowdown to the economic downturn, recent structural health system changes, a slower pace of technological innovation, and other factors. This cost slowdown is welcome, but we believe temporary. Longer-term, affordable care will require meaningful reform, which will take substantial time to enact and implement. If policymakers wait until the economy recovers, and unsustainable health spending growth resumes, the lead time required for real reform will be gone—forcing rushed, less-effective health-spending cuts, or severe revenue increases and spending cuts elsewhere in the budget. Moreover, to ensure greater value and affordability from our health care investment, we believe our nation should always be working to improve quality and eliminate waste and overpayments. The United States must act now to begin the transformation to a higher quality, more sustainable health care system.

In the long term, we envision health care that is value-driven and coordinated through organized systems, rather than volume-driven and fragmented. These systems will be developed and evolve through a process of innovation and improvement, based on collaborative structures of care delivery and payment with accountability, coordination, competition, and patient choice. The tools and incentives built into these systems will ensure that patients receive high-quality, coordinated care across multiple settings. They will avoid unnecessary or redundant treatments and services, engage patients in decisions about their care, and pay physicians for the services that patients want—including more time talking with their doctors. The recommendations in this report seek to align today's good work in the public and private sectors. Our Medicare reforms include steps toward greater coordination in care delivery and payment, such as shared savings, bundled payments, and competitively-bid, capitated health plans.

We are convinced that reforming our nation's health care system to prioritize quality and value over volume will not only improve health outcomes and the patient experience, but also constrain cost and produce system-wide savings. Such an outcome would be a real cost benefit to consumers, businesses and taxpayers, while helping to reduce our federal deficit. Our policy recommendations for Medicare and federal health-related tax policy were scored by nationally-respected, independent experts. Although we do not have estimates of the private sector savings that would be certain to evolve from our recommendations, we do estimate that our policies would achieve approximately \$560 billion in federal deficit reduction over the next 10 years, growing significantly in the years beyond. Our quality and efficiency improvements will make a major contribution toward addressing our nation's indisputable demographic as well as federal debt and deficit challenges; we acknowledge, however, that additional revenue will be needed to meet these challenges from a policy-sound and politically viable perspective. However, comprehensive tax reform is beyond the scope of this report.

Why Our Initiative is Different

Our effort breaks with approaches that prioritize or even focus solely on federal health-costs and deficit reduction. Although health spending is growing rapidly, we cannot simply shift costs to generate public budgetary savings. Our nation needs a comprehensive, sustainable policy that addresses system-wide health care cost growth. Thus, we focus on improving the entire system of care. Our primary motivation is to improve the health system for patients and families. A higher quality health care system for all would reduce the current system's substantial inefficiency and waste, effectively constraining cost growth.

We have also brought bipartisanship to the table, dedicating nearly a year to reasoned negotiations to break through the partisan rhetoric surrounding health care. We sought policy options around which both sides of the political aisle could realistically coalesce, and we prioritized political and economic realities over discrete options that achieve budget savings in the near term.

Key Recommendations

Our policies would engage both beneficiaries and providers with incentives to pursue a more coordinated, accountable, and sustainable health care system. These recommendations span four broad categories:

1. Improve and Enhance Medicare to Incent Quality and Care Coordination;
2. Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition;
3. Prioritize Quality, Prevention, and Wellness; and
4. Incent and Empower States to Improve Care and Constrain Costs Through Delivery, Payment, Workforce, and Liability Reform.

Our recommendations would improve how health care is delivered and financed in both the public and private sectors. Focusing only on federal health programs runs the risk of shifting costs to the private sector or state and local governments without achieving higher-quality care. Each policy recommendation requires trade-offs to improve care as we constrain cost growth. Though all four policy pillars are essential, the two with the most-immediate delivery and cost impact are our recommendations on Medicare policy and the federal tax exclusion for employer-sponsored health insurance (ESI).

Improve and Enhance Medicare to Incent Quality and Care Coordination

Medicare has been and can continue to be a leader in demonstrating and promoting system-wide health reform. Therefore, we carefully constructed policies to strengthen and improve Medicare – to preserve traditional Medicare’s promise of beneficiary choice, basic guaranteed benefits, and financial security from potentially catastrophic health care costs. We also add new choices and new protections for beneficiaries, while strengthening and modernizing the traditional Medicare benefit.

A NEW OPTION IN TRADITIONAL MEDICARE: “MEDICARE NETWORKS”

Our policies would encourage beneficiaries to engage more actively in choosing the coverage that best suits their needs. In addition to fee-for-service Medicare and Medicare Advantage, we would offer a new option within traditional Medicare called “Medicare Networks,” wherein providers could share the savings from higher quality, more cost effective care. Beneficiaries could choose to enroll in a Medicare Network and would receive a premium discount if they do so. They and their providers also could share in savings that result from greater quality and efficiency of care. To encourage physicians, hospitals, and other health care providers to participate, we would provide financial rewards for joining these Medicare Networks and disincentives for staying in the less efficient fee-for-service system.

MEDICARE ADVANTAGE

We also propose to bring market forces to bear on Medicare Advantage by implementing a competitive-bidding structure, while providing transitional protections for beneficiaries as we do so. Competitively-bid payments to plans would only take effect in regions where it costs less than current law, therefore guaranteeing savings for the Medicare Trust Funds. Initially, a portion of the savings would be allocated to finance reduced beneficiary premiums and cost-sharing. To help beneficiaries navigate plan selection, we propose a user-friendly, up-to-date Medicare Open Enrollment website.

FEE-FOR-SERVICE MEDICARE

Beneficiaries would also be free to remain in an improved fee-for-service Medicare. Our report identifies inefficiencies, misaligned incentives, and fragmented care delivery in the current fee-for-service reimbursement system that have both undermined quality and increased costs.¹ We would modernize the program through a greater commitment to competitive bidding, bundling, and other reforms that make health systems more accountable and affordable. We also offer “carrot-and-stick” incentives to encourage both beneficiaries and providers to move toward organized systems of care, such as our Medicare Networks. We believe that these organized systems would give patients and families better, more coordinated care, while reducing overall spending growth. For those geographic areas of the nation that could not set up alternative delivery systems, the Department of Health and Human Services (HHS) Secretary would be authorized to ensure adequate reimbursement levels to fee-for-service providers.

BENEFIT MODERNIZATION

As we propose to improve the Medicare benefit by providing long-overdue catastrophic protections, we also would offer a modernized cost-sharing design. Our proposal would ensure that beneficiaries could visit their doctors without facing high out-of-pocket costs; however, we also would prohibit first-dollar supplemental coverage because it can lead to greater use of services without necessarily producing better outcomes. We pursue further balance by providing additional cost-sharing support to low-income beneficiaries while reducing federal subsidies for higher-income individuals.

Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition

We propose to target our nation’s limited financial resources on health care coverage and services that are valuable. The nation cannot achieve affordable care with an open-ended, overly generous subsidy for the purchase of private health insurance. The tax exclusion for ESI makes providing health benefits cheaper than paying cash wages, and thereby encourages high-cost benefit designs and blunts incentives to deliver care more efficiently. We therefore propose to reform and rationalize the current ESI tax exclusion and make it

¹ For more information, see *What Is Driving U.S. Health Care Spending? America’s Unsustainable Health Care Cost Growth*, Bipartisan Policy Center, September 2012.

less regressive. We recommend replacing the flawed “Cadillac tax” on high-cost health insurance plans with a limit on the income-tax exclusion for employer-sponsored health benefits. We also support replacing the current excise tax on fully insured plans with a paid-claims tax, to avoid creating additional distortions in the health insurance market.

Another strategy for aligning incentives to support high-quality, coordinated care delivery and payment is to ensure that private-sector payers and providers who want to form integrated delivery systems have clear guidance on how to do so without violating antitrust or fraud and abuse laws. We believe that guidance should be provided in this area just as we believe that there should be strong enforcement against consolidation that leads to anti-competitive behavior and increases costs.

Prioritize Quality, Prevention and Wellness

Our other recommendations would complement our strategies for strengthening Medicare and rationalizing health-related taxes, and remain consistent with our core vision. Many proposed policies would lower barriers to implementing more integrated systems of care or would provide resources and supports for these systems. Additionally, we recommend exploring the potential of prevention to improve health and contain costs, as well as eliminating barriers to wider implementation of prevention approaches, such as workplace wellness programs, that are found to be effective.

QUALITY

Effective quality metrics are essential to accountability in organized systems of care. Quality-performance metrics must be precise and clinically relevant to incent better delivery, to show providers how their performance relates to their peers’, and to facilitate the real-time design and implementation of strategies to improve quality and safety. Quality metrics must also provide the meaningful data needed for patients and families to make informed choices. Attempting to achieve these goals, providers have pursued quality metric design, evaluation, and reporting, as well as the identification of new and different quality metrics. However, the quality-reporting roles and responsibilities of organizations such as health plans and accrediting bodies are ill-defined, leading to confusion and inefficiencies. We would strengthen the quality-reporting system and the validity of available metrics by identifying barriers to better alignment of current metrics and promulgating minimum requirements that are clinically relevant and useful to providers, and understandable and accessible to consumers.

Encourage and Empower States to Pursue Needed Reforms to Improve Care and Value

The nation must transform the entire health system, and in doing so must engage leaders at all levels of government and in all sectors of the health care industry, as well as patients, consumers, and families. States should actively promote health-system innovation and transformation. We support resources and incentives, rather than top-down mandates, to engage state leaders in supporting coordinated and accountable models of health care delivery and payment. To this end, we recommend policies to strengthen the primary care workforce and make greater use of non-physician practitioners; to create safe harbors for physicians to improve our nation's medical liability system and reduce the practice of defensive medicine; to address consolidation in the financing and delivery systems; and to promote price and quality transparency for consumers, families, and businesses.

A more detailed list of recommendations follows this executive summary. We believe that the vision and recommendations articulated in this report, if enacted together, would help to put our nation's health system, as well as our economic outlook, on a more sustainable, healthy path for the future.

List of Recommendations

Chapter 1: Improve and Enhance Medicare to Incent Quality and Care Coordination

A. PRESERVE AND IMPROVE MEDICARE CARE DELIVERY AND PAYMENT SYSTEMS

1. **MEDICARE NETWORKS:** Promote quality and value through an improved version of Accountable Care Organizations (ACOs) that encourages providers to meet the full spectrum of their patients' needs. In doing so, replace the Sustainable Growth Rate (SGR) formula for physician reimbursement, and offer all Medicare providers strong financial incentives to participate in new payment models.
2. **MEDICARE ADVANTAGE:** Establish a standardized minimum benefit for Medicare Advantage Plans—including all services covered by traditional Medicare, a cost-sharing limit to protect against catastrophic expenses, and slightly lower cost-sharing—and pay plans using a competitive-pricing system.
 - a. Incorporate a measure of functional status in Medicare's risk adjustment.
 - b. Implement a reinsurance system for Medicare Advantage by 2016.
 - c. Require all Medicare Advantage Plans to include prescription drug coverage.
 - d. Allow Medicare Advantage Plans to adopt tiered network designs.
 - e. Replace the Medicare Plan Finder with a user-friendly, up-to-date Medicare Open Enrollment website that beneficiaries could use to make coverage selections upon enrollment and during the annual open-enrollment period.
3. **BUNDLED PAYMENTS:** Expand the voluntary payment bundling demonstration into a standard Medicare payment method. Bundles—including inpatient, physician, and post-acute care, and any readmissions within 90 days—should be established nationwide no later than 2018 for certain diagnosis-related groups (DRGs).
4. **FALLBACK SPENDING LIMIT:** No earlier than 2020, implement a fallback spending limit that would restrain annual standardized (age-adjusted) per-beneficiary spending growth to a target of GDP per-capita growth + 0.5 percentage points (over a five-year moving average), and apply separately to fee-for-service, Medicare Networks, and Medicare Advantage.

B. STRENGTHEN AND MODERNIZE THE MEDICARE BENEFIT

1. **BENEFIT DESIGN:** In 2016, implement a new traditional Medicare benefit structure for Parts A and B that would:
 - a. Maintain the same aggregate cost-sharing for beneficiaries as today;
 - b. Provide beneficiaries with protection from catastrophic medical costs by establishing an annual, beneficiary cost-sharing limit of \$5,315 for Medicare-covered services (all additional covered services would be at no-charge to the beneficiary);
 - c. Replace the two existing deductibles with a single, combined (Parts A and B) annual deductible of \$500;
 - d. Replace coinsurance on most covered services with copayments similar to those proffered by Medicare Payment Advisory Commission (MedPAC);
 - e. Maintain preventive care and the annual wellness visit with no beneficiary cost-sharing; and
 - f. Exempt physician office visits from the combined deductible. (Beneficiaries would only pay the copayment for an office visit, even if the deductible has not yet been met.)
2. **SUPPLEMENTAL COVERAGE:** To lower costs for Medicare beneficiaries and encourage more appropriate utilization of care, beginning in 2016, all supplemental coverage from medigap plans and employer-provided plans (including Tricare-for-Life and the Federal Employees Health Benefits Program) should:
 - a. Include a deductible of at least \$250;
 - b. Include an out-of-pocket maximum no lower than \$2,500 (out of the beneficiary's pocket); and
 - c. Cover no more than half of beneficiary copayments and coinsurance.
3. **LOW-INCOME SUPPORT:** Beginning in 2016, expand cost-sharing assistance to Medicare beneficiaries with incomes up to 150 percent of the federal poverty level.
4. **HIGH INCOME REFORMS:** Establish lower thresholds beginning in 2016 so that approximately 17 percent of beneficiaries would pay income-related premiums.

C. MAKE MEDICARE AND RELATED SYSTEM REFORMS THAT IMPROVE CARE AND LOWER COST GROWTH

1. **DURABLE MEDICAL EQUIPMENT:** Implementation of the durable medical equipment (DME) competitive-bidding program should continue apace for all urban markets nationwide, but for some equipment types, benchmarks should be set lower.
2. **SITE OF CARE DIFFERENTIALS:** Equalize payment rates for evaluation and management services (known to most patients as office visits) to the rate in the lowest-cost setting, including facility payments. Equalize payments at the level of the lowest-cost site for procedures that are conducted in both the outpatient department and in the physician's office when:
 - a. the procedure is performed more than half of the time in the office setting;
 - b. the procedure is performed less than 10 percent of the time in the emergency department; and
 - c. there is not a significant difference in patient severity between settings.
3. **MEDICARE ADVANTAGE STAR RATINGS:**
 - d. End the CMS demonstration and revert to the smaller bonus payments under current law, which are restricted to four- and five-star plans.
 - e. When regional markets convert to competitively bid payments, discontinue bonus payments entirely.
4. **HIGH-QUALITY, LOW-COST DRUG UTILIZATION:** Encourage use of high-quality, low-cost drugs in Medicare and system-wide:
 - a. Adjust the Part D LIS cost-sharing to encourage the use of high-value drugs;
 - b. Change Part B reimbursement for provider-administered medications;
 - c. Convert from average wholesale price to average sales price for remaining Part B drug and vaccine reimbursements;
 - d. Address anti-competitive settlements between brand and generic drug manufacturers; and
 - e. Close the REMS loophole that inhibits development of generic drugs.
5. **PHYSICIAN SELF-REFERRAL LAW:** Limit the in-office exception to the Stark Law to providers who meet accountability standards.
6. **GRADUATE MEDICAL EDUCATION:** To better align Medicare's investment with our overarching vision for reform and to achieve a workforce that can efficiently and appropriately deliver care:

- a. Reduce the indirect medical education (IME) percentage add-on to inpatient hospital admissions from 5.5 percent to 3.5 percent. All savings should be repurposed for performance-based incentive payments and additional residency slots.
 - b. Repurpose 50 percent of the proposed reduction in IME funds for performance-based incentive payments. Restructure Medicare's investment to require that all recipients of IME funding be held accountable for reaching specified educational goals and outcomes. Only institutions that meet these standards should be eligible for the performance-based payments.
 - c. Repurpose the remaining 50 percent of savings from IME payment reduction to additional residency slots, one-third of which should be made available to teaching hospitals that are training above their cap. Half of the additional slots should be allocated to programs that train primary care physicians and other providers for which there are identified specialty shortages.
 - d. Limit the PRA to 120 percent of the locality-adjusted national average PRA when calculating direct graduate medical education payments.
7. **HEALTH INFORMATION TECHNOLOGY:** Prioritize electronic sharing of information among providers in the next stage of the Medicare and Medicaid EHR Incentive Programs. HHS should provide implementation support for such information sharing, with a particular focus on the needs of small physician practices and community hospitals.

Chapter 2: Reform Tax Policy and Clarify Consolidation Rules to Encourage Greater Efficiency and Competition

1. **EMPLOYER-SPONSORED HEALTH INSURANCE TAX EXCLUSION.** Replace the Cadillac tax on high-cost health insurance plans with a limit on the income-tax exclusion for employer-sponsored health benefits at the dollar amount equivalent to the 80th percentile of single and family ESI premiums in 2015 (age- and gender-adjusted).
2. **PAID-CLAIMS TAX:** Replace the ACA tax on fully insured plans with a paid-claims tax.
3. **COMPETITION AND CONSOLIDATION:** Streamline and clarify the application of existing federal legal and regulatory guidance for private-sector entities seeking to form integrated, coordinated systems of care delivery.

- a. Review effectiveness of current fraud and abuse laws in today’s changing care delivery and payment environment.
- b. Authorize the Federal Trade Commission (FTC) to gather market data on a routine basis.

Chapter 3: Address Other Federal Policies that Block Efforts to Enhance Care and Constrain Costs

1. **QUALITY:** Prioritize, consolidate, and improve the use of quality measures by consumers and practitioners:
 - a. The National Quality Forum (NQF) should refocus efforts to convene accrediting and certifying bodies—including the National Committee for Quality Assurance (NCQA), the Joint Commission, and the American Board of Medical Specialties (ABMS)—to identify common measures used for value purchasing by public and private purchasers, to identify barriers to alignment of current metrics, and to deliver a minimum set of requirements for providers that are clinically relevant, understandable to consumers, and useful for improvement.
 - b. NQF should develop pathways that allow physician-created and clinically relevant quality measures to be accelerated in the process towards an endorsement for use.
 - c. The Measures Application Partnership (MAP) should place a greater emphasis on public-private collaboration.
 - d. NQF should convene a group to create consensus metrics for commercial ACOs and other integrated delivery systems.
 - e. In endorsing specific quality measures, NQF should assure that they are accessible to consumers as they make decisions regarding providers or treatment options.
 - f. Support the electronic capture of data for measurement through the use of common standards.
2. **PREVENTION:**
 - a. Invest the Prevention and Public Health Fund in demonstration programs to help identify the most cost-effective prevention strategies.
 - b. Support collection, analysis, and dissemination of data from prevention programs, both governmental and nongovernmental.

- c. Provide financial incentives to help spur investment and innovation among small businesses in comprehensive worksite health promotion.
- d. Support health promotion strategies for the federal workforce to accelerate the generation of additional data on effective interventions.

Chapter 4: Encourage and Empower States to Pursue Needed Reforms to Improve Care and Value

1. **DUAL ELIGIBLES:** Adopt a broad strategy to deliver Medicare and Medicaid services to dual eligible individuals through a single program.
2. **FEDERALLY QUALIFIED HEALTH CENTERS:** The HHS Secretary, using authority provided to the Center for Medicare and Medicaid Innovation, should test alternative models of reimbursement to assure quality and value in the Medicaid program. Changes to federally qualified health center (FQHC) payment methodology should carefully evaluate the impact on access to care in medically underserved areas for both Medicaid and uninsured patients and should ensure that reductions in Medicaid payments do not shift cost-shift to public and private grant dollars intended to finance the cost of uninsured patients.
3. **MEDICAID FRAUD AND ABUSE:** Implement the Medicaid and Children’s Health Insurance Program Payment and Access Commission’s recommendations to strengthen Medicaid program integrity.
4. **TRANSPARENCY:**
 - a. Encourage pro-competitive rules for insurer-provider contracting:
 - i. Prohibit providers from requiring placement in the preferred tier as condition of contracting;
 - ii. Restrict “all-or-nothing contracting” for providers that have multiple distinct units; and
 - iii. Ban “most-favored nation contracting” between providers and insurers.
 - b. Promote price transparency that will help consumers better understand and anticipate health care costs. Insurers should share pricing data that will help individuals in consumer-directed plans to better understand out-of-pocket costs before accessing care and should provide estimates for the average cost of out-of-network care for various types of providers, locations, and services.

5. MEDICAL LIABILITY:

- a. The Institute of Medicine (IOM) should convene a panel of providers, consumers, and quality-measurement groups to determine whether evidence-based quality measures could be used as a basis for provider defense in medical liability cases and, if so, to provide guidance on a process for the adoption of appropriate measures through a quality-certification organization. Adoption of measures should be consistent with efforts to create a uniform set of quality measures used for provider reimbursement and quality improvement.
 - b. Provide continued opportunities for states to test alternative models designed to reduce insurance and utilization costs associated with medical liability litigation by appropriating the \$50 million in state demonstration grants authorized in the ACA for the development, implementation, and evaluation of promising alternatives to current tort litigation.
- 6. HEALTH PROFESSIONAL WORKFORCE:** Eliminate outdated statutory or regulatory requirements in Medicare and Medicaid that interfere with states' abilities to regulate and determine scopes of practice.
- 7. INCENTIVES FOR STATE REFORM:** The federal government should consider offering a financial incentive to states that enact the following reforms:
- a. Adoption of evidence-based quality measures that could be used as a provider defense in medical liability cases;
 - b. Pro-competitive insurance contracting rules; and
 - c. National Council of State Boards of Nursing Advanced Practice Registered Nurse Consensus Model Act.



BIPARTISAN POLICY CENTER

1225 Eye Street NW, Suite 1000
Washington, DC 20005
(202) 204-2400

WWW.BIPARTISANPOLICY.ORG