To: Third Way

From: Avalere Health

Date: October 30, 2015

Re: Estimated Federal Impact of Target Pricing Policy for Medicare

Summary

Third Way asked Avalere Health to estimate the cost or savings on the federal budget of a target pricing policy for certain services covered under Parts A and B of the traditional Medicare program. This proposal would allow providers to bid and agree to accept payment for certain services below typical Medicare rates in exchange for potential increased utilization and volume. Beneficiaries would be encouraged to choose providers offering services at a lower price by receiving a share of the savings.

We estimate this proposal would decrease federal spending by $9.1 billion over the 2017-2026 federal budget window. This amount reflects the combination of an estimated $18.2 billion in savings due to reduced rates paid to providers for certain services offset by an estimated $9.1 billion in incentives paid to beneficiaries and costs associated with changing patterns of referral and provider selection over the next 10 years.

Table 1. Estimated Change in Federal Spending due to a Target Price Policy for Medicare
($ in billions, by fiscal year)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2026
Net change due to proposed legislation	-0.0	-0.2	-0.5	-0.7	-0.9	-1.2	-1.3	-1.4	-1.5	-1.6	**-9.1**

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Background

There are large variations in the prices paid by private insurers for similar services among providers. Some research has shown that within an insurer's network, higher cost providers can often charge upwards of 300 percent more than the lowest cost providers for similar services. This pattern is seen across a number of high and low cost procedures.[1]

Target pricing (sometimes called reference pricing) has been used by commercial insurers and employers to address wide variation in the pricing of services and to bring down overall costs by encouraging enrollees to select lower cost providers. Payers identify a maximum amount that the plan will pay for a given service. If the enrollee selects a provider that charges an amount higher than this maximum, referred to as the "target price", he or she is responsible for the entire excess cost. Any amount paid out of pocket to a provider charging more than the target price often does not count towards deductibles, out-of-pocket maximums, or other cost sharing limits within a plan. Target pricing requires the beneficiary to consider cost when they select a provider. However, some research suggests is only appropriate when services can be easily compared or "shopped" across various providers and the patient has the opportunity to do this research and planning in anticipation of the scheduled procedure.[2]

There are a number of successful examples of target pricing programs implemented among commercial insurers in the United States. The California Public Employees' Retirement System (CalPERS) and Anthem Blue Cross implemented target pricing for knee and hip replacement surgery with a target price of $30,000, a limit higher than what approximately 2/3 of hospitals in their network were charging. Safeway, a chain of grocery stores with nearly 200,000 insured lives, implemented target pricing for imaging, lab tests, and colonoscopies.[3] Kroger was able to save 32 percent on certain imaging procedures, saving $4 million and CalPERS was able to save $5.5 million, a reduction of overall expenses of 1.6 percent.[4]

Medicare reimbursements do not have the level of variation experienced by private payers. Under most payment models, including fee-for-service, providers receive the same general rate for a given procedure. Furthermore, beneficiary cost sharing is more limited in Medicare than many commercial health insurance plans and many beneficiaries have supplemental coverage to further limit their out of pocket costs. While price variation is an issue to a much lesser extent under Medicare and beneficiaries are typically much less accustomed to consumer-oriented cost sharing measures than those under commercial insurance, there may still be an opportunity to use the principles of target pricing to reduce costs in the Medicare program.

Policy Proposal

We analyzed a policy under which providers are encouraged to bid and accept payment rates below current Medicare reimbursement rates for certain medical procedures. A portion of the resulting savings would be given to the beneficiary in the form of a direct payment or other incentive to encourage the use of the lower-cost provider. A portion of the savings would also be allocated to informing beneficiaries about the program, promoting the lower cost providers,

[1] "Healthcare Transparency Index 2014 Q1 Report." Change Healthcare Corporation. August 1, 2014.
[2] Robinson, James C., and Kimberly MacPherson. "Payers test reference pricing and centers of excellence to steer patients to low-price and high-quality providers." Health Affairs 31, no. 9 (2012): 2028-2036.
[3] Robinson, James C., and Kimberly MacPherson. "Payers test reference pricing and centers of excellence to steer patients to low-price and high-quality providers." Health Affairs 31, no. 9 (2012): 2028-2036.
[4] "Help Consumers Shop for High Value Health Care." Third Way. May 20, 2015.

and otherwise directing individuals to actively consider the providers participating in the program. In return for accepting a lower payment rate, providers have the potential to gain additional patient volume. For the analysis presented here, we assume that half (50 percent) of the savings is directed towards beneficiary incentives and the promotion of participating providers.

Data Sources

We used the following data sources to develop our estimate:

- “2013 Medicare Standard Analytic Files.” Centers for Medicare & Medicaid Services.
- “2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.” Centers for Medicare & Medicaid Services, July 22, 2015.
- "Appropriate Use of Reference Pricing Can Increase Value." Health Affairs. July 7, 2015.
- Brand, Keith, Christopher Garmon, and Martin Gaynor. "Reference Pricing Is Not a Substitute for Competition in Healthcare." Federal Trade Commission, 2014.
- "California Healthcare Compare." Consumer Reports. http://www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm
- "CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report." Centers for Medicare & Medicaid Services, 2015.
- Connor, Kayla, and David Cusano. "Reference Pricing: An Overview and Suggested Policy Considerations." State Health Reform Assistance Network Issue Brief, 2015.
- De Brantes, Francois, Suzanne Delbanco, and Andrea Caballero. "Reference Pricing and Bundled Payments: A Match to Change Markets." Catalyst for Payment Reform & Health Care Incentives Improvement Institute, 2013.
- "Evaluation of the Medicare Acute Care Episode (ACE) Demonstration Final Evaluation Report." Centers for Medicare & Medicaid Services, 2013.
- Fronstin, Paul, and M. Christopher Roebuck. "Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits." Employee Benefit Research Institute Issue Brief, no. 398 (April 2014).
- “Geographic Variation Public Use Files.” Centers for Medicare & Medicaid Services, February 2015.
- "Healthcare Transparency Index 2014 Q1 Report." Change Healthcare Corporation. August 1, 2014.
- "Help Consumers Shop for High Value Health Care." Third Way. May 20, 2015.
- "March 2015 Medicare Baseline." Congressional Budget Office. March 9, 2015.
- Meng, Hongdao, Bruce Friedman, Andrew W. Dick, Brenda R. Wamsley, Gerald M. Eggert, and Dana Mukamel. "Effect of a voucher benefit on the demand for paid personal assistance." The Gerontologist 46, no. 2 (2006): 183-192.
- Miller, David C., Cathryn Gust, Justin B. Dimick, Nancy Birkmeyer, Jonathan Skinner, and John D. Birkmeyer. "Large variations in Medicare payments for surgery highlight savings potential from bundled payment programs." Health Affairs 30, no. 11 (2011): 2107-2115.

- Newhouse, Joseph P., and Alan M. Garber. "Geographic variation in Medicare services." New England Journal of Medicine 368, no. 16 (2013): 1465-1468.
- "Report to the Congress: Medicare Payment Policy." Medicare Payment Advisory Commission, 2015.
- Robinson, James C., and Kimberly MacPherson. "Payers test reference pricing and centers of excellence to steer patients to low-price and high-quality providers." Health Affairs 31, no. 9 (2012): 2028-2036.
- White, Chapin, and Megan Eguchi. "Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle." National Institute for Health Care Reform Research Brief 18 (2014).

Assumptions and Methodology

Baseline Estimate for Medicare Costs

We first created a baseline estimate for the population enrolled in the Medicare fee-for-service program by projecting enrollment growth and per capita cost trends. Our assumptions for these projections relied on those used by the Medicare Boards of Trustees Annual Report, the Congressional Budget Office, and the 2013 Geographic Variation Public Use Files provided by the Centers for Medicare & Medicaid Services (CMS).

Proportion of Utilization Affected By Policy

Next we estimated the proportion of care that might be affected by the policy. We used a list of procedures that would be appropriate for target pricing published by the Employee Benefit Research Institute that included hip/knee replacement, colonoscopy, magnetic resonance imaging (MRI) of the spine, computerized tomography (CT) scan of the head or brain, nuclear stress test of the heart, and echocardiogram. These services are largely elective, which would allow beneficiaries to “shop” for providers because they are relatively standardized and typically scheduled in advance. We analyzed the five percent Medicare Standard Analytic Files to estimate the number of claims and amount of spending that these procedures represent as a portion of all Medicare spending. Based on this analysis, we assume that seven percent of inpatient hospital spending, seven percent of outpatient hospital spending, and three percent of physician spending are appropriate to be included under this policy.

Changes in Cost and Utilization

To estimate the savings that this policy would yield, we analyzed data on payment rate variation from private payers from Change Healthcare and California Healthcare Compare. Using information from the Medicare Payment Advisory Commission on average differences between commercial and Medicare reimbursement rates, we created an estimate of the proportion of providers offering services at prices below the Medicare rates. We found, in certain instances and certain markets, between 20-30 percent of providers are accepting commercial payment rates below the Medicare fee schedule amount.

We assumed that some of the providers who accept lower rates from commercial payers would bid and receive lower rates from Medicare while all other providers continue to receive the baseline Medicare reimbursement rate. We also assumed that the beneficiary incentives and promotions under the program would gradually double the utilization of the low cost providers

and that these incentives would gradually induce 5 percent increased use of the services based on a study of the effects of providing vouchers to Medicare beneficiaries.

Table 2: Select Assumption Values by Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Inpatient Affected Utilization	2.3%	4.7%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
Outpatient Affected Utilization	2.3%	4.7%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
Physician / Carrier Affected Utilization	1.0%	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Savings from Reduced Provider Reimbursement & Increased Use of Low-Cost Providers	2.9%	5.7%	8.6%	11.5%	14.4%	17.2%	17.2%	17.2%	17.2%	17.2%
Effect on Utilization of Covered Services	1.0%	2.0%	3.0%	4.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

Results

We estimate that this policy will produce $18.2 billion savings in payments to providers for the period 2017 to 2026. The cost for incentives to beneficiaries and promotion of participating providers is estimated to be $9.1 billion over the same period. We estimate the overall impact to the Medicare program across these years to be savings of $9.1 billion.

Table 3: Estimated Impact on Medicare Program Spending ($ billions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2026
Provider Payments	(0.1)	(0.4)	(0.9)	(1.3)	(1.7)	(2.4)	(2.6)	(2.7)	(2.9)	(3.1)	**(18.2)**
Incentives & Promotion	0.0	0.2	0.5	0.7	0.9	1.2	1.3	1.4	1.5	1.6	**9.1**
Total Impact	(0.0)	(0.2)	(0.5)	(0.7)	(0.9)	(1.2)	(1.3)	(1.4)	(1.5)	(1.6)	**(9.1)**