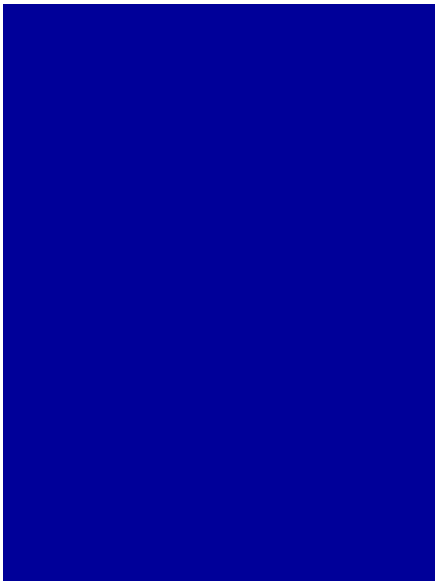
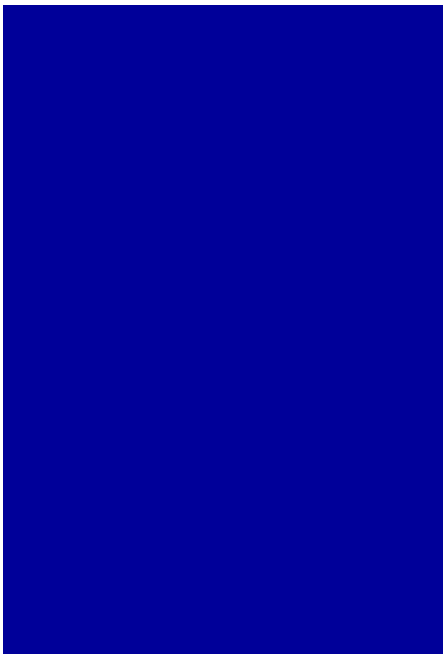


UnitedHealth®
Center for Health Reform & Modernization

US Deficit Reduction:

The Medicare and Medicaid Modernization Opportunity

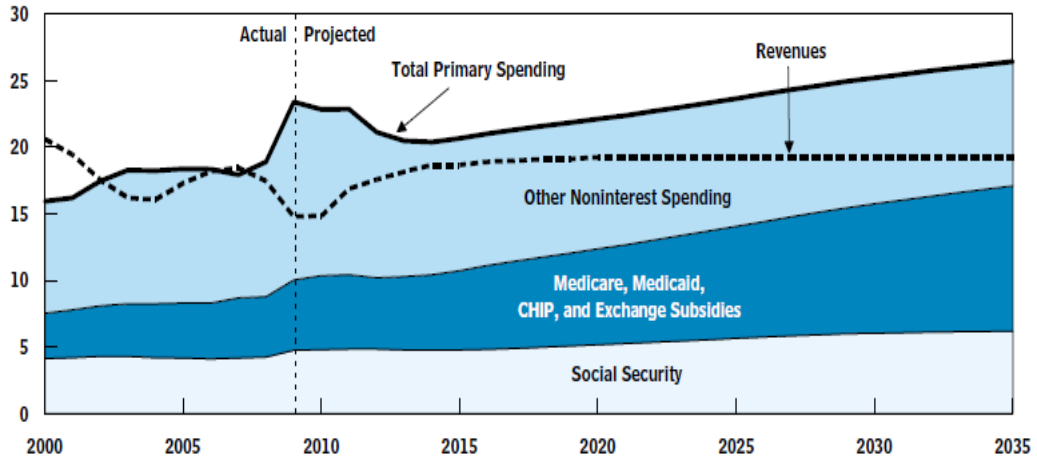
Working Paper 4
October 2010



Introduction

The US government's chief health actuary projects that national health spending is now set to grow from $2.6 trillion to $4.6 trillion by the end of this decade. And rising government health spending is likely to be a main cause of the expanding US budget deficit over the next twenty five years, according to the Congressional Budget Office.

US Revenues and Spending as Percent of GDP under CBO's Long Term Alternative Budget Scenario, June 2010



It is against this backdrop that the bipartisan National Commission on Fiscal Responsibility and Reform was appointed in February 2010, and tasked with recommending a new fiscal path for the United States.

This fourth working paper from the UnitedHealth Center for Health Reform & Modernization is intended as a constructive contribution to that discussion, serving to analyze three principal reform proposals for Medicaid and Medicare (plus two variations on the third proposal).

All told, the combined Federal and State net savings opportunities detailed in this working paper are potentially worth around $3.5 trillion over the next twenty five years. None of them involve crude cuts to provider reimbursements or cuts in consumers' benefits. Instead they focus on the opportunity to better coordinate care, providing holistic and proactive support for seniors and Medicaid beneficiaries.

They take as a starting point the consensus that emerged during the recent national health care reform debate that fee-for-service payment mechanisms are at the root of the US health care quality and efficiency problem. Yet over three quarters of Medicaid spending and an even higher share of Medicare spending is still funded this way. The ensuing structural flaws in these programs are well documented: siloed funding streams; an inability to influence geographical and other inappropriate variation; and a one-size-fits-all approach to managing costs through the crude lever of administered price controls.

For at least the past two decades or so, these weaknesses in traditional Medicare and Medicaid have been widely understood, but there has been something of a policy stand-off between those who nevertheless wanted to preserve them in their 1965 structural incarnation, versus those who favored a complete overhaul. Here we present some approaches that transcend that binary choice, identifying more modern, consumer-friendly approaches to running these public programs, while preserving what works well.

Option One examines the potential savings from providing coordinated care for all Medicaid beneficiaries who aren't also eligible for Medicare. Over twenty five years, savings are estimated at $580 billion, of which $350 billion are Federal savings. During the initial ten years - given transitional costs and phasing -

potential savings are estimated at $103 billion, of which $63 billion are Federal savings.

Option Two models the gains from ensuring that people 'dually eligible' for both Medicaid and Medicare have benefits and care that are properly integrated and coordinated between the two programs. Over twenty five years, savings are estimated at $1.62 trillion, including $1.27 trillion for the Federal government. In the first ten years, savings are estimated to be $250 billion, of which $206 billion are Federal savings.

Option Three calculates savings from providing Medicare FFS beneficiaries with the type of programs and approaches used by America's largest and most innovative 'self-insured' employers, who deploy 'ASO' approaches going well beyond the passive FFS indemnity approach currently embedded in Medicare Parts A & B. Over twenty five years these savings – all accruing to the Federal government - could be worth $1.9 trillion, of which $317 billion might arise in the first ten years. Options Four and Five are more limited alternatives to Option Three.

(The cumulative savings estimate can be calculated by combining Option One plus Option Two second scenario, plus approximately two thirds of the savings from Option Three so as to eliminate double counting of dual eligible savings.)

For Medicaid, these estimates draw on the track record of some of the most innovative states, as well as our own experience as America's largest Medicaid health plan. For Medicare, we have sought to ally our data and insights from serving one-in-five seniors nationwide, with our overall experience serving 70 million Americans, many of whom work for large national employers who have been at the forefront of health care modernization. We have therefore been able to contrast some of their care patterns and programs with those currently available to seniors, alongside making use of the external research evidence on effective cost-containing strategies and techniques. Although long-term estimates are inevitably uncertain and should be regarded as directional, they illustrate the size of the potential modernization 'dividend'.

These are practical options, which could now be tested at scale using the demonstration, piloting and other authority available to CMS under current law. They are intended as win-win solutions, with the potential to benefit both enrollees in these public programs, and the taxpayers who fund them.

October 2010

Summary of Selected Deficit Reduction Options from Medicare and Medicaid
Estimated Change in Federal and State Government Spending over 25 years (FY2011-35)

Modernizing Medicaid FFS, including for Dual-Eligible Populations	
Option 1: Provide coordinated care for all (non-dual) Medicaid beneficiaries. States still pay for around two-thirds of their non-dual Medicaid spending through uncoordinated and fragmented fee-for-service models. Under this option, states would enroll most of their fee-for-service Medicaid population in coordinated care programs. This would include non-dual eligible beneficiaries with disabilities and chronic conditions needing institutional long-term care services. The federal government could look at ways to incentivize state participation.	**Total $580 billion (of which Federal $350 billion)**
Option 2: Expand use of coordinated care for dual-eligible Medicaid and Medicare beneficiaries. Over the next 10 years, spending on dual eligible individuals could total around $5 trillion. Two structural problems undermine the efficiency of this spending: about 90% of it is on a fragmented fee-for-service basis, and funding responsibility is split between Medicaid and Medicare. Two scenarios for modernization are: first a) states fully deploy coordinated care models to better integrate *Medicaid* benefits for the dual-eligible population; or second b) all dual-eligible individuals would be required to choose a health plan providing their *combined Medicare and Medicaid benefits*. This would achieve full integration of benefits and would coordinate the complex care needs of the dual eligible population across two payment systems. (Savings total in column to the right is for second scenario.)	**Total $1.62 trillion (of which Federal $1.27 trillion)**
Modernizing Medicare FFS	
Option 3: Provide seniors in traditional Medicare with value-added comprehensive care management services. FFS Medicare beneficiaries would have access to the same type of ASO approaches the most successful large US employers have developed. CMS might contract with organizations to manage for a fee a defined geographical region, transforming the existing passive Medicare Administrative Contractor program. Opportunities for reduced cost sharing or direct rebates or benefits could provide consumers with incentives and decision-support tools to choose high-performing providers. This would be an additional option running alongside Medicare Advantage.	**Total/Federal $1.9 trillion**
Option 4: Provide information and incentives in Medicare to help seniors choose the best health care (alternative to Option 3). This option would introduce positive incentives for seniors who use high quality providers of appropriate care. Participation for seniors would be voluntary, and they might benefit from lower Part B premiums, lower cost sharing or rebates. The bulk of the remaining savings would accrue directly to Medicare.	**(Federal $370 billion)**
Option 5: Provide information and incentive 'nudges' to support Medicare patients improve their own health (alternative to Option 3). This option would provide timely 'nudges' or prompts to support seniors in making healthy lifestyle choices. These would include financial incentives such as premium or cost sharing reductions, rebates, or benefit enhancement for performance of certain activities or achievement of certain health goals. Savings would come from improvements in health status, prevention of chronic conditions such as diabetes, avoidance of unnecessary hospitalizations, and more effective use of surgical procedures and treatments.	**(Federal $450 billion)**
Cumulative Savings (Option 1 + Option 2b + approx two thirds of savings from Option 3)	**Total $3.5 trillion (of which Federal share is $2.9 trillion)**

Medicare and Medicaid Modernization Options for Deficit Reduction

Billions of Dollars, Fiscal Year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2011-20	2011-35
Baseline Spending Estimates for Medicare and Medicaid (ref 1)												
Medicare												
Outlays	560	563	611	645	677	733	764	797	869	929	7,148	**33,820**
Offsetting receipts (premiums, other)	-78	-84	-89	-95	-100	-107	-114	-122	-132	-141	-1,060	**-5,100**
Medicaid	418	462	489	546	604	669	728	772	826	883	6,398	**29,350**
Federal	276	263	279	324	369	416	450	476	508	542	3,902	**17,980**
State	142	199	210	222	236	253	278	296	318	341	2,495	**11,370**
Effects of Medicaid and Medicare Modernization Options on Spending (ref 2)												
Option 1: Coordinated care for all non-dual Medicaid beneficiaries	0	-2	-5	-9	-10	-12	-14	-15	-17	-18	-103	**-580**
Federal	0	-1	-3	-5	-6	-8	-9	-9	-10	-11	-63	***-350***
State	0	-1	-2	-4	-4	-5	-5	-6	-7	-7	-40	**-220**
Option 2: Expand use of coordinated care for dual eligibles												
Scenario one: enroll dual-eligibles in Medicaid managed care	0	-1	-3	-4	-6	-9	-11	-14	-17	-21	-87	**-700**
Federal	0	-1	-2	-2	-4	-5	-6	-8	-10	-12	-49	***-400***
State	0	-1	-1	-2	-3	-4	-5	-6	-7	-9	-37	**-300**
Scenario two: enroll dual-eligibles in integrated Medicare and Medicaid managed care plans												
Medicaid	0	-1	-3	-5	-7	-10	-13	-16	-20	-25	-101	**-820**
Federal	0	-1	-2	-3	-4	-6	-7	-9	-12	-14	-58	**-470**
State	0	-1	-1	-2	-3	-4	-6	-7	-9	-11	-44	**-350**
Medicare	0	-4	-9	-15	-16	-18	-19	-21	-23	-25	-149	**-800**
Federal Medicaid and Medicare	0	-5	-11	-18	-20	-23	-26	-30	-34	-39	-206	***-1,270***
Option 3: Provide seniors in traditional Medicare with comprehensive care management services	0	-7	-14	-23	-32	-43	-45	-47	-51	-56	-317	***-1,900***
Option 4: Provide information and incentives in Medicare to help seniors choose the best health care (alt to Option 3)	0	-1	-3	-4	-6	-8	-8	-9	-10	-11	-59	***-370***
Option 5: Information and incentive 'nudges' to support Medicare patients improve their own health (alt to Option 3)	0	-1	-1	-2	-2	-3	-4	-7	-10	-14	-46	***-450***

Notes:

1/ Estimates are based on CBO's August 2010 baseline projections and include the estimated impact of health care reform legislation on Medicare and Medicaid. Figures do not include Medicare payments to increase spending to physicians above payment levels under current law.

2/ Figures do not account for interactions between policies. One may add the effects of the managed care provisions for the non dual eligibles to either of the estimates for the dual-eligibles. The estimate for changing the Medicare FFS program into an ASO model include the effects of the two alternative polices. Those two policies may be added together. Effects on Medicare Part B premiums or the Part D clawback are not included in estimates. Figures may not sum due to rounding.

Option 1: Provide Coordinated Care for All Medicaid Beneficiaries (other than those also 'dually eligible' for Medicare)

Background. Cost growth in the traditional Medicaid program is partly driven by the underlying fragmentation of care delivery, itself reinforced by a fee-for-service (FFS) reimbursement mechanism. Traditional Medicaid's efforts to control spending simply by cutting back on provider reimbursements do nothing to ensure appropriate utilization, while exacerbating care access difficulties for vulnerable populations. The symptoms of this malfunctioning Medicaid FFS system therefore include well-documented gaps in needed preventive care, frequent visits to the emergency room, multiple and sometimes conflicting drug prescriptions, and over-reliance on 'revolving door' inpatient admissions for behavioral health problems.

Over the past twenty years, some states have been innovators in testing new models of care that improve access and health outcomes for low-income and high need populations, while helping to control health care cost growth. Health plans have partnered with states to enhance care coordination, raise the quality of care, and improve the stewardship of taxpayer funding. This has been achieved partly by using accessible provider networks, carefully targeted clinical programs, member outreach and health education, and other strategies to improve prevention and integrate care.

However, states still pay for about two-thirds of Medicaid spending for their non-dual eligible populations (ie. for those beneficiaries who are not receiving both Medicaid and Medicare benefits) through uncoordinated and fragmented fee-for-service models. That is because while about half of the costs of coverage for children and low-income families is provided through coordinated care arrangements, only about a fifth of spending for (non-Medicare eligible) people with disabilities is funded in this way – and it is this spending that accounts for a large share of overall Medicaid costs. Furthermore, under the new PPACA legislation an estimated 16 million net new enrollees are set to join the program.

Option Description. Under this option states would enroll most of their fee-for-service Medicaid population in coordinated care programs. This would include non-dual eligible beneficiaries with disabilities and chronic conditions needing institutional long-term care services. Recognizing that states are able to decide whether to do so, the federal government could nevertheless adjust its share of the federal matching funds to take account of each state's savings opportunity.

Savings Estimate. This option builds on and extends the modeling contained in our recent working paper *Coverage for Consumers, Savings for States: Options for Modernizing Medicaid* (April 2010). In that document we estimated the potential savings relative to fee-for-service if all states transitioned their non-dual eligible FFS Medicaid populations to managed care. That would include the incremental PPACA Medicaid populations who would not otherwise have been enrolled in Medicaid managed care under each state's current practices. The working paper's analysis did not include savings from using managed long-term care for non-dual populations who require a nursing home level of care. Here we factor in those additional savings, and also extend the 10 year estimates to cover a 25 year period. (The next section of this working paper goes further by also estimating savings for dual eligible beneficiaries.)

Real-world experience drawn from states, evidence from meta-analysis of the published research, and UnitedHealth Group's own results as America's largest Medicaid health plan, suggest that Medicaid could save about 5% of fee-for-service costs by enrolling children and low-income families in managed care. Likewise, savings of around 8% could be feasible by transitioning enrollees with disabilities into managed care, because FFS coverage for this population is particularly fragmented and care needs are high.

Our analysis recognizes each state's different baseline starting point in the managed care 'adoption curve'; and makes downward adjustments in nearly all states' savings opportunities to reflect each state's rural/urban composition, as well as its share of Medicaid

enrollees currently in primary care case management programs.

Results. We estimate that if all states adopted a comprehensive managed care approach for their non-dual eligible Medicaid FFS enrollees there would be savings of about $103 billion over the 10-year period of 2011 through 2020. Of that amount $63 billion would accrue to the federal government. **Over 25 years, the total savings figure would grow to about $580 billion, of which the Federal share would be $350 billion.** The federal government could look at ways to incentivize state participation.

Option 2: Expand Use of Coordinated Care for Dual-Eligible Medicaid and Medicare Beneficiaries

Background. About 9 million people are dually-eligible for Medicare and Medicaid. This is typically a high need population, with multiple chronic health conditions requiring high-cost services and intensive support. For 2011, combined Medicare and Medicaid spending on the dual-eligibles could be about $330 billion. Of this total, we estimate that Medicare will spend about $180 billion (including prescription drugs), with Medicaid covering about $150 billion, mainly for institutional care. **Over the next 10 years, we estimate spending on dual eligible individuals could reach around $5 trillion.**

Two structural problems undermine the efficiency of this spending:

● first, the majority of spending for dual-eligible individuals – approaching 90% of it - occurs on a fee-for-service basis, for Medicare and Medicaid benefits. This leads to a lack of care coordination and misaligned incentives regarding appropriate care settings.

● second, funding responsibility for dual eligible care is split in a tangled web of responsibilities between Medicaid and Medicare. The result is siloed care, cost-shifting, reactive services, and duplication. Medicare serves as the primary payer for hospital and physician benefits, and operates a separate program providing prescription drugs. Medicaid is the primary payer for long-term care services, including institutional and home and community-based services, and also covers wrap-around benefits and beneficiary cost sharing. While Medicare pays for post-acute nursing home benefits, those benefits are limited in time and scope.

The opportunity to better coordinate care for dual eligible individuals is therefore substantial. At present, under 10% of Medicaid spending for dual eligible beneficiaries is for those enrolled in Medicaid long-term care programs that combine acute, behavioral, nursing home, and home and community-based services. And only about 15% of Medicare spending on dual eligible individuals is for people enrolled in Medicare health plans, particularly Special Needs Plans (SNPs) designed for dual eligibles. Furthermore, these managed care approaches are typically not integrated across Medicaid and Medicare. So Medicaid managed care enrollees often receive their Medicare benefits on a fee-for-service basis, which leaves the Medicaid program at risk for costs associated with the lack of coordination of care in the Medicare program. Similarly dual-eligible people in Medicare managed care most often have their long-term care benefits paid by Medicaid on a fee-for-service basis.

Reform in this area will have to overcome a number of current barriers, including:

● Medicaid law currently constrains states in enrolling dual-eligible people in managed long-term care programs, absent specific state waivers of federal law - and even then, they can do so only for Medicaid benefits. Despite the opportunities for savings and improved care, states have been slow to pursue this approach for a range of reasons, including waiver process complexity, support for voluntary programs, and local contracting complexities.

● although some states have taken steps toward greater integration of Medicare and Medicaid benefits by contracting with SNPs, states cannot require dual-eligibles to enroll in Medicare managed care - which limits the opportunity to coordinate care and generate savings. It also requires states to maintain multiple systems to support people who voluntarily enroll and those who do not.

● different rules governing managed care plans in both programs (e.g. outreach, quality, and benefit design) serve as barriers to integration.

● the federal government can play a role in allowing waivers that facilitate integration of financing and benefits (such as in Minnesota, Wisconsin and Massachusetts), but today cannot require that Medicare beneficiaries enroll in managed care plans. New legal authority recently granted to CMS for testing of innovative delivery models may spur greater integration.

Option Description. We estimate the savings under two illustrative scenarios.

In the more limited *first scenario*, states would

fully deploy managed care models to better coordinate care and integrate *Medicaid* benefits for the dual-eligible population. Under that approach, all states would be required to enroll their dual-eligible enrollees in health plans that integrate Medicaid acute, home and community-based services, nursing home care, and behavioral health services with Medicare benefits, and followed best practices taken by other states such as Arizona, Texas, Florida and Tennessee.

The *second scenario* builds on the first one. In this scenario, all dual-eligible individuals would be required to choose a health plan providing their *combined Medicare and Medicaid benefits*. This would achieve full integration of benefits and would coordinate the complex care needs of the dual eligible population across two payment systems. This kind of integrated model would ensure seamless and holistic integration of Medicare and Medicaid benefits and reduce incentives to shift costs between the two programs. Using data from across the two funding streams would also allow better targeting of preventive and 'anticipatory' care to help keep people well, and support them in their own homes. Under this model, the health plan could receive two payment streams which they would then blend into a holistic sum – one from the federal government (Medicare) and one from the states (Medicaid). Alternatively, the federal government could provide funding directly to the states for the dual-eligible populations, which would then be topped up by states' current funding contribution. Medicare and Medicaid rules regarding quality, benefit design, marketing and enrollment would need to be better aligned. A variant of scenario two would be to allow passive enrollment of dual eligible beneficiaries into integrated Medicare /Medicaid health plans with the option of opting out.

Basis of Savings Estimate. Managed long-term care programs encourage the early detection and ongoing management of chronic and co-morbid conditions with a focus on maintaining the individual's highest level of functioning in the least restrictive setting. In our recent working paper, *Coverage for Consumers, Savings for States: Options for Modernizing Medicaid*, we describe how active state programs have reduced or delayed admissions to nursing homes through better care management, resulting in cost savings of 8%-10% as compared to fee-for-service.

Full integration of Medicaid and Medicare benefits could lower costs through more rational care delivery and reduction of unnecessary hospitalizations and nursing home admissions. Based on work by the Lewin Group, we estimate a savings potential of about 8% in overall dual spending relative to fee-for-service. An important element of those savings would be a reduction in avoidable and inappropriate inpatient hospitalizations. Because of the greater management of the Medicare portion of spending, savings would also increase for the wrap-around Medicaid benefits.

Results. The first scenario – full use of managed care for the dual eligibles in *Medicaid only* could lead to $87 billion in total federal and state savings over a 10-year period, with a ten-year phase-in that accounts for state ramp-up of home and community-based services infrastructure as a means of preventing future nursing home admissions. Of those savings, $49 billion could accrue to the federal government. **For Medicaid-only managed care for the dual eligible population, once fully implemented the savings relative to current law for the federal government could be about $400 billion through 2035.**

Under the second scenario, full integration of *Medicare and Medicaid* care for the dual eligible population would drive even larger savings. We estimate that $149 billion would accrue to the Medicare program and $101 billion to Medicaid over 10 years. Of that combined amount, $206 billion would accrue to the federal government and $44 billion to the states. We assume savings would phase-in over three years for Medicare and over a longer time frame for Medicaid, as described above. Better coordination for acute care benefits under Medicare managed care would also yield spillover savings in Medicaid above what states could generate through Medicaid managed care alone. **Once fully implemented, the savings for the federal government from a combined Medicare/Medicaid managed dual eligible program would be substantial – about $1.27 trillion through 2035.**

Option 3: Provide Seniors in Traditional Medicare with Value-Added Comprehensive Care Management Services

Background. Traditional FFS Medicare seeks to constrain cost growth mainly by the use of national unit price controls, and occasional adjustments to the scope of covered benefits. The ensuing structural weaknesses are well documented. Original Medicare's siloed approach to funding hospital, physician, drug and other elements of care undermines the holistic support that seniors need. Its inability to influence geographical and other variation in care patterns means ongoing waste and inefficiency. And a one-size-fits-all approach to managing costs through price controls can mean difficulties for seniors in finding a physician to treat them, and – according to hospitals – cost-shifting onto other population groups in the health care system.

For at least the past two decades or so, these weaknesses in traditional Medicare have been understood, but there has been something of a policy stand-off between those who nevertheless want to preserve the basic features of 1965-style Medicare, versus those who think the answer is to expand Medicare Advantage as a way of overcoming those structural design flaws.

Certainly the improved preventive services uptake and the savings that can be unleashed from coordinated care in Medicare Advantage have the potential to benefit both individual seniors and taxpayers. More than a quarter of seniors are now choosing to get their Medicare this way. However it is likely that for the foreseeable future many seniors will also remain in Original Medicare. The question therefore arises: what can be done to modernize traditional Medicare short of full risk transfer to health plans on the Medicare Advantage model?

Option Description. One possible answer to this 'stand-off' comes from observing the development path that many of the most sophisticated and creative large US employers have taken to modernizing how they manage their own employees' health benefits over recent years. Rather than using government price controls, they together with their health plan partners have evolved increasingly effective programs to manage health benefits, often on 'Administrative Services Only' basis. This means that while they technically self-insure, they contract-in the external expertise needed to help them manage the health care needs of their workforce. In addition to more traditional services such as claims processing, premium collection, and claims review, ASOs are increasingly offering other services to help employers control cost growth and improve the health of their workers. Those services include carefully credentialed networks of expert providers, health and wellness preventive programs, general medical management solutions, focused disease and case management models, payment fraud and integrity techniques, and the provision of actionable information and incentives for both providers and consumers, linked to the quality and appropriateness of care.

In similar vein, the TRICARE program, which provides health benefits and services to active duty and retired members of the armed services and their families, combines broad access with management of care operated in partnership with the Department of Defense and private contractors. TRICARE provides services through a community network of providers and the DoD direct care system, an approach that optimizes the use of efficient delivery systems. This approach also provides for performance-based incentives for the TRICARE private contractors through partial-risk arrangements.

This option would therefore transform Medicare by adopting an ASO model similar to large self-insured employers. Under this approach, all FFS beneficiaries would have their care managed by administrative services organizations. These organizations would effectively leverage networks, medical management tools and best practices on a more integrated, comprehensive basis. A robust care management program could lead to significant savings, improved care, and better clinical outcomes through network solutions and clinical advocacy. Application of clinical evidence-based care management tools with targeted preventive care and patient education tools additionally could reduce hospital admission rates.

There are various forms this new arrangement

could take. Medicare beneficiaries might choose between competing contractors. Or CMS might contract with a contractor for a defined geographical region, in effect being a much enhanced and value-adding Medicare Administrative Contractor (MAC) type program, going significantly beyond their traditional and passive core functions. Beyond claims processing, the contractors would operate clinical management programs, beneficiary and provider customer service, network management and development, and consumer engagement with decision support. Provider programs and rewards would help to align payments with high quality care. Enhanced payment integrity services would also help cost reduction. Opportunities for reduced cost sharing or direct rebates or benefits could provide consumers with incentives and decision-support tools to choose high-performing providers.

Payment rates might either continue to be set on an administered basis by CMS, or they could be set based on historic Medicare FFS rates per beneficiary trended forward for expected growth in seniors' health care costs. Partial-risk arrangements for performance or shared savings (per the proposed Accountable Care Organization model) could also be included under this approach in order to give contractors financial incentives to manage overall health care trend and quality for their assigned populations. These arrangements are also often used in the large employer ASO model and work to align incentives for the employer sponsor and the ASO provider.

Basis of Savings Estimate. Our own experience serving 70 million Americans, many of whom are employees of large national employers, shows the capacity of this model for reducing costs. In making this assessment, we have been able to contrast some of their care patterns and programs with those currently available to seniors, since we are also chosen by one-in-five seniors nationwide to help manage their Medicare benefits whether it be in Medicare Parts A&B, C or D.

These comparisons lead us to believe that high quality provider networks, thoughtful care coordination, and well targeted case and disease management and wellness programs all could play a greater part, alongside consumer information and incentives, treatment decision support, and use of value-based benefit designs.

Of course not all of those tools can be directly translated directly to Original Medicare, with its administered-prices, supplemental coverage, and other unique features. However, the main approaches can be, and we estimate that applying an ASO model to the Medicare program could result in substantial savings while improving the quality of care. On balance, it is possible that migration to this model could reduce non-institutional Medicare spending by about 8% to 10%, if it were fully effective in all areas of the country. (Our analysis excluded spending for Medicare beneficiaries in institutions.)

Results. With a 5-year phase in of such a model across the population, we estimate the Medicare program could save $317 billion over the coming decade. This would constitute a reduction of 6% off total Medicare spending under current law. **Over a 25-year time horizon, we estimate the federal government could save $1.9 trillion** on health care spending through adoption of this model in the Medicare FFS program. In developing this estimate, we assumed that the program would not be fully effective in all regions due to different provider market dynamics and accounted for a dampening effect on potential savings. If however the model were able to be implemented right across the country, savings of $2.5 trillion could in theory be realized over 25 years. Risk-based performance incentives could help to make the program more efficient and also lead to greater savings.

In the next two sections, we discuss the potential savings to Medicare by adopting voluntary incentive and information models to improve health, as freestanding (more 'diluted') alternatives to this option.

Option 4: Provide Information and Incentives in Medicare to Help Seniors Choose The Best Health Care

Background. Academic research has consistently demonstrated that the use of evidence-based care is variable, as are the resulting clinical outcomes. These variations are evident across geographies, within clinical specialties, and persist despite the availability of evidence-based standards covering many conditions and treatments.

Profiling these variations to identify high performing providers based on quality and resource use across episodes of care can both help health professionals continually improve the care they are able to offer, and inform the choices that patients make. New federal law means that in the future, hospitals and physicians will report on quality measures, which will be published on an HHS web site. In a few years, Medicare will begin reimbursing hospitals under a budget-neutral value-based purchasing model. This program will pay more to high performing hospitals, and less to hospitals that do poorly. And under the Medicare accountable care organization (ACO) or 'shared savings' model, quality providers that reduce aggregate spending compared to a benchmark would share in the cost reductions with taxpayers.

But there is, as yet, no program that specifically rewards Medicare beneficiaries for choosing high performing providers who may deliver care more efficiently. By contrast, 160 million+ people receiving employer-sponsored care are often able to share in some of the savings that come from so doing. These savings can be substantial, often around 20%, because of the quality and appropriateness of the care.

Option Description. This option would create incentives for participation in voluntary, tiered networks by Medicare beneficiaries, who could benefit from incentives such as lower cost sharing, rebates or benefit enhancements by choosing providers who scored well on clinically-led evidence-based quality and efficiency standards. States would also receive financial incentives and new authority to steer dual eligible consumers to those high quality provider networks. Providers would also have incentives to improve their performance.

These incentives could be deployed in FFS Medicare, with methodologies that could align across physicians' commercial and Medicare patients. Health plans could use their performance data and care management programs to create virtual network 'overlays' on fee-for-service Medicare. Participation in these programs would be entirely voluntary for seniors, who might however benefit from lower Part B premiums, lower cost sharing or rebates when they chose to use a premium-designated provider who scored better on quality and efficiency metrics. The bulk of the remaining savings would accrue directly to Medicare.

Alternatively, beneficiaries that access care through an ACO could be given incentives to choose quality providers. To the extent the program "shares" savings with physicians who perform well and lower costs, a portion of those savings could be given back to beneficiaries as an incentive for choosing high performing physicians. Rebates on a beneficiary's premium or a deposit into a patient account to be used for other medical care now or in the future could also help offset out of pocket costs.

Basis of Savings Estimate. Under this option, information is provided to seniors on quality and efficiency variations to influence their choices. An optional program is then introduced in which seniors who choose to use higher performing providers would benefit from financial incentives equivalent to about 10% of cost sharing amounts. Those incentives could also accrue through Part B premium reductions or rebates, especially for those with supplemental coverage. For the dual-eligible population, the policy would provide states with incentive payments and necessary authority to enroll the duals in high-quality networks.

Savings are based on the results of current UnitedHealth Group programs using our quality and efficiency measurement system coupled with a member incentive program that promotes the highest quality and most cost effective physicians. We adjusted our potential savings to account for Medicare's administered prices,

limits on the ability to steer based on unit price, together with adjustments for seniors' pattern of care usage. We made conservative assumptions about the uptake of these programs. Because the program is voluntary, we have modeled the potential effects of only a quarter of the non-dual Medicare FFS population shifting to higher performing providers initially. We assumed that there would be modest growth in participation over time.

As to the question about the capacity of 'high performing' providers to take on new patients, it is important to note that the incentives can produce results not just from movement of patients between providers, but also from the likely community-wide improvements in provider quality and efficiency as a behavioral response.

Results. This option could yield $59 billion in savings over a 10-year period, with a phase-in over five years. **Over 25 years, we estimate savings could reach $370 billion.** Stronger incentives with more gain sharing with seniors would produce more substantial savings, as well as likely stimulating stronger improvements in physician performance across the delivery system. These estimates do not include potential savings that could accrue to the Medicaid program as a result of dual-eligibles using higher quality providers.

Option 5: Provide Information and Incentive 'Nudges' to Support Medicare Patients Improve Their Own Health

Background. Despite advances in medical technologies that prolong life and cure disease, chronic conditions such as diabetes and cardiovascular disease contribute to substantial and growing health care costs. Social norms, changing living and work environments, and negative health behaviors all contribute to the growth in chronic conditions. By the time many people become Medicare-eligible, their conditions are already costly and advanced.

The complexity of the medical system for high cost treatments aggravates this problem. Patients with cancer or needing transplants, for example, are often required to make a variety of complex treatment decisions. They also have to contend with rigorous follow-up care protocols during treatment programs. Given the complexity of the illness, multiple opportunities exist for sub-optimal care. Patients may not be fully aware of the range of treatment options. They also may not fully understand home care requirements to prevent readmissions between treatments.

The way the current Medicare program is structured (defined benefit, fee-for-service) means beneficiaries do not have substantial incentives or information to improve their health status. As the elderly population grows and as chronic conditions become more prevalent, the lack of individual engagement in health care will continue to contribute to cost growth.

Option Description. Private and public sector employers, in partnership with their health plans, are developing and leveraging new incentive models to increase healthy behaviors, providing timely 'nudges' or prompts to help people make the healthy lifestyle choice that they say they want to. These include financial incentives such as premium or cost sharing reductions, rebates, or benefit enhancement for performance of certain activities or achievement of certain health goals based on credible external standards.

Information models include consumer treatment-decision support in advance of surgery or procedures where clinically appropriate alternatives (e.g., prostate or orthopedic surgery), and where individuals' preferences may differ.

In *activity-based incentive models*, beneficiaries receive rewards for performing certain health related activities such as completing a health risk assessment, attending a wellness seminar, getting preventive screening or following evidence-based care for certain chronic conditions (independent of the ultimate health outcome).

Results-based incentive models are more intensive, providing benefits for individuals meeting certain health improvement goals based on credible external standards (such as Body Mass Index, blood pressure, or LDL).

Basis of Savings Estimate. A combination of new incentive and information programs could provide substantial savings over the long run. Savings would come from improvements in health status, prevention of chronic conditions such as diabetes, avoidance of unnecessary hospitalizations, and more effective use of surgical procedures and treatments. Outcomes-based programs would yield greater savings than activity-based ones. We assumed that savings would take almost a decade to fully realize, with the recognition that interventions to spur behavior change and health improvement take time to implement effectively.

Costs of providing a range of health promotion programs would, we expect, offset about half of the savings, based on our experience in the commercial sector. We assumed that costs of the programs would phase-in more quickly than the savings as upfront investments would be required.

Our analysis was based on applying these new information and incentive programs to the non-institutionalized population, and includes Medicare spending for the dual-eligibles. We assumed that states would share in the incentives to generate dual-eligible participation, though our estimates do not include potential savings that likely would therefore also accrue to the Medicaid program.

Savings would depend on the number of and type of initiatives deployed in the Medicare population, the effectiveness of their implementation, and the willingness of beneficiaries to participate (which partly depends upon the size of the incentives). Because incentive-based programs would be new to the Medicare population and would represent a shift in the way they receive benefits, we only assumed that half of the eligible population ultimately responded to activity-based incentives and that one-third of the population responded to outcomes-based programs. For the dual eligibles, we assumed that the policy would require states to operate health promotion programs for that population to help stimulate their participation.

Results. Our estimated savings would be relatively small over the 10-year window as costs are phased-in, at around $46 billion. However measured **over a 25-year period, we estimate that about $450 billion could be saved**. That amounts to a reduction of about 2% of Medicare spending over the long run. That compares with a theoretically obtainable number of close to $900 billion in savings over 25 years if all beneficiaries participated and programs were fully effective.

About UnitedHealth Group

UnitedHealth Group serves 70 million Americans, funding and arranging health care on behalf of individuals, employers and government, in partnership with more than 5,000 hospitals and 650,000 physicians, nurses and other health professionals across the nation. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan – serving one in five seniors nationwide – and the largest Medicaid health plan, supporting underserved communities in 25 states and the District of Columbia.

About the UnitedHealth Center for Health Reform & Modernization

The Center serves as a focal point for work on health care modernization and national health reform. The Center assesses and develops innovative policies and practical solutions for the health care challenges facing the nation.

Drawing on UnitedHealth Group's internal expertise and extensive external partnerships, its work program falls into six priority areas:

- practical cost containment strategies to slow the growth of U.S. health care costs
- innovative approaches to universal coverage and health benefits, grounded in evidence-based care and consumer engagement
- reducing health disparities, particularly in underserved communities
- modernizing the care delivery system, including strengthening primary care
- payment reform strategies that better support physicians, hospitals and other providers in delivering high quality patient-centered care
- modernizing Medicare, including chronic disease management.

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