

## IAH Fits CBO Savings Analysis

Finance Committee member, Senator Menendez has cosponsored the Independence at Home Act (S. 1131, H.R. 2560) bringing the number of Senate sponsors to 11 including two members of the Finance Committee and four members of the HELP Committee.

The attached CBO letter of July 25 sets forth the following features that CBO believes are necessary for achieving savings in health reform proposals:

1. Moving away from a fee-for-service system toward one that pays providers for value;
2. Bonuses based on performance or penalties for substandard care;
3. Providing stronger incentives for both providers and patients to control costs;
4. Higher cost-sharing requirements or tighter management of benefits; and
5. Facilitating good decision making on the part of providers and patients by equipping them with more information about the effectiveness of different treatments and the quality of care delivered by different providers.

CBO states that the Administration's Independent Medicare Advisory Council Act forwarded to Congress on July 17 is unlikely to generate significant savings because the composition of the Council is unclear, it is not required to mandate any savings, and the first year of potential savings is not until 2016. CBO recommended that greater savings could be achieved if (a) "explicit and feasible quantitative goals for reducing outlays" could be prescribed, (b) an "explicit fall-back mechanism" were included in case cost reduction goals were not met, and (c) authority were included for "broad changes in coverage, benefit design and payment and delivery systems."

**The Independence at Home Act includes all of CBO's recommendations, and can be implemented within a year.** The Independence at Home Act

- A) Moves away from fee-for-service reimbursement and pays only for prescribed results;
- B) Only allows Independence at Home Organizations to be paid for chronic care coordination services if they achieve (i) minimum savings

of 5% annually, (ii) improved outcomes, and (iii) patient/caregiver satisfaction;

C) Provides stronger incentives for both providers and patients to control costs by allowing providers to share in the savings they achieve (beyond 5%) and for beneficiaries who receive care in their homes rather than an ER, hospital, or physician's office to have their copayments waived for physician house calls;

D) Provides for 80% of savings beyond 5% to be paid to the IAH Organization and permits tighter management of benefits through an electronic exchange of information; and

E) Facilitates good decisionmaking by providers and beneficiaries by equipping them with more information about the effectiveness of IAH programs and the quality of care provided by IAH organizations.

The IAH Act also provides "explicit and feasible quantitative goals for reducing outlays" by prescribing the minimum percentage of savings to be achieved each year, an "explicit fall back mechanism" in the form of mandated budget neutrality in the event cost reductions goals are not met, and broad change in the benefit payment and health delivery system. Under the Independence at Home Act, providers and practitioners no longer have an incentive to avoid the highest cost chronically ill beneficiaries, but rather, for the first time in the history of the Medicare program, they have an incentive to identify those beneficiaries and develop methods to reduce their costs while improving their outcomes and preserving their independence. The IAH Act is also not dependent upon a yet-to-be-determined council to make recommendations, but rather relies on providers and physicians to develop innovative ways to achieve the IAH minimum performance standards.

In addition, the Independence at Home Act incorporates the approaches recommended by CBO in its "High-Cost Medicare Beneficiaries" report (May 2005) for achieving "large savings" in Medicare.

In short, the Independence at Home Act implements CBO's recommendations for savings in the distant future, but makes those savings more certain and achievable immediately.



July 25, 2009

Honorable Steny H. Hoyer  
Majority Leader  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Leader:

As you requested, the Congressional Budget Office (CBO) has analyzed some possible approaches for giving the President broad authority to make changes in the Medicare program. Under those approaches, any changes the President decided to implement would be based on recommendations from an advisory council and subject to Congressional disapproval.

Expanding the authority of the President to effect change in the Medicare program might lead to significant long-term savings in federal spending on health care. The available evidence implies that a substantial share of spending on health care contributes little, if anything, to the overall health of the nation. Therefore, experts generally agree that changes in government policy have the potential to significantly reduce health care spending—for the nation as a whole and for the federal government in particular—without harming people’s health. However, achieving large reductions in projected spending would require fundamental changes in the financing and delivery of health care.

Considerable consensus exists among experts about the types of changes that are likely to make the health sector more efficient: moving away from a fee-for-service system toward one that pays providers for value, perhaps through fixed payments per patient, bonuses based on performance, or penalties for substandard care; providing stronger incentives for both providers and patients to control costs, through higher cost-sharing requirements or tighter management of benefits; and facilitating good decisionmaking on the part of providers and patients by equipping them with more information about the effectiveness of different treatments and the quality of care delivered by different providers. Those changes in the flow of money and information would spur and facilitate other changes in the organization and delivery of health care.

To ensure that *current* legislation puts the federal budget on a more sustainable path will probably require creating a framework for federal health care spending

that imposes ongoing pressure to increase efficiency over time—particularly, but not exclusively, in the case of providers. Such pressure could be imposed in several ways, including reducing Medicare’s payment updates automatically to take into account expected productivity gains; reducing Medicare payments in areas of the country with higher spending; giving an official in the executive branch broad discretion to change Medicare to produce savings (especially if there was also an across-the-board reduction in payments to providers if savings are not achieved in other ways); and limiting the growth of Medicare’s implicit subsidy of premiums. (CBO discussed a number of such approaches in a June 16 letter to Senators Conrad and Gregg.)

This letter focuses on proposals to give the President broad authority to make changes in the Medicare program, subject to Congressional disapproval. Such proposals could enhance the prospects for additional long-term cost control, but they would also entail shifting some power from the Congress to the executive branch.

In particular, CBO reviewed draft legislation transmitted to the Congress by the Administration on July 17, 2009, titled the Independent Medicare Advisory Council Act of 2009. CBO estimates that enacting the proposal, as drafted, would yield savings of \$2 billion over the 2010–2019 period (with all of the savings realized in fiscal years 2016 through 2019) if the proposal was added to H.R. 3200, the America’s Affordable Health Choices Act of 2009, as introduced in the House of Representatives. This estimate represents the expected value of the 10-year savings from the proposal: In CBO’s judgment, the probability is high that no savings would be realized, for reasons discussed below, but there is also a chance that substantial savings might be realized. Looking beyond the 10-year budget window, CBO expects that this proposal would generate larger but still modest savings on the same probabilistic basis.

This letter describes the considerations that underlie CBO’s estimate and identifies ways in which such proposals could be structured to garner significantly more savings—especially in the years beyond 2019. In particular, if legislation were to provide an independent advisory council with broad authority, establish ambitious but feasible savings targets, and create a clear fall-back mechanism for instituting across-the-board reductions in net Medicare outlays, CBO believes such a council would identify steps that could eventually achieve annual savings equivalent to several percent of total spending on Medicare. Achieving such savings, in addition to those estimated to result from the provisions in H.R. 3200 that govern Medicare’s payment rates, would probably require significant changes in the program’s coverage, benefit design, and payment and delivery systems—and a council with the clear mandate, independence, and resources to propose such changes.

### **The Proposed Independent Medicare Advisory Council**

The Administration's proposal calls for an Independent Medicare Advisory Council (IMAC) consisting of five members who are either physicians or have specialized expertise in medicine or health care policy. Those individuals would be appointed by the President and subject to confirmation by the Senate.

Beginning with fiscal year 2015, IMAC would be charged with making annual recommendations to the President for changing federal payments for various services covered by Medicare. Under the Administration's proposal, each annual package of recommendations would have to be designed so that implementation would not be expected to increase aggregate Medicare spending over the subsequent 10-year period, as compared with expected spending in the absence of those proposed changes. Determination of the effect of the council's recommendations on net Medicare spending would be made by the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS). In addition, the council could make recommendations for reform of the Medicare delivery system (but those recommendations would not have to be provided annually).

The President would have to approve or disapprove the council's recommendations as a package. If the President approved a set of recommendations, implementation would commence no sooner than 30 days after that approval unless the Congress enacted a joint resolution to disapprove the package of recommendations. (It would generally take far longer than 30 days to fully implement the council's recommendations.) Under the proposed legislation, the first potential reductions in spending would not go into effect until fiscal year 2016.

### **Estimated Savings**

The estimated savings of \$2 billion over the 2016–2019 period reflect CBO's assessment of the likely scope of the proposals that the council would make and the probability that its recommendations would be implemented by the President. (The possibility that the Congress might enact future legislation to disapprove those recommendations is not relevant to CBO's estimate of the savings that would arise from enacting the IMAC proposal into law; instead, the impact of legislation disapproving the recommendations would be reflected in CBO's cost estimate for that subsequent legislation. See the section "Budgetary Treatment" below.) Under H.R. 3200, as introduced, payment rates for nearly all Medicare services would grow more slowly than anticipated inflation. Thus, CBO considers it unlikely that IMAC would recommend substantial additional savings (relative to savings already expected under H.R. 3200) through *further* reductions in Medicare payment rates. In addition, several specific features of the legislation in its current form would reduce the likelihood that the council would recommend reductions in payment rates or reforms in the delivery system for Medicare services that would yield much greater budgetary savings:

- The proposed legislation states that IMAC’s recommendations cannot generate increased Medicare expenditures, but it does not explicitly direct the council to reduce such expenditures nor does it establish any target for such reductions.
- As proposed, the composition of the council could be weighted toward medical providers who might not be inclined to recommend cuts in payments to providers or significant changes to the delivery system.
- Some types of fundamental program changes would probably require study and experimentation before they could be implemented, and it is not clear what resources the council would have to develop recommendations involving such changes. Under the proposal, IMAC might have limited access to the resources of CMS and its Office of the Actuary for directing the study of reform ideas that could offer some promise of significant budgetary savings.
- Significant changes in the way payments to providers are made and in the incentives facing beneficiaries would probably be necessary to obtain substantial savings. Outside influence on the council and the President, however, might make it politically difficult to recommend and implement reforms that could be viewed as undesirable by interested parties. Medical providers, beneficiaries, and Members of Congress would probably exert considerable pressure on both IMAC and the President to balance recommendations for savings against beneficiaries’ concerns about the costs and availability of medical services and the interests of those receiving Medicare payments for delivering services.
- Finally, the first year of potential savings under the proposal is 2016. The five-year start-up period (and one-year lag in implementation) called for by the draft legislation would give the council some time to study reform proposals. However, concrete new evidence upon which to base some kinds of large-scale reforms might not be available for some time thereafter.

As noted earlier, the estimated savings of \$2 billion over the latter half of the 2010–2019 period represent a probabilistic assessment of a range of possible outcomes. On the one hand, savings might not be realized at all because the proposal specifies a process without specific goals for savings or a “fall-back” plan for ensuring spending reductions if the combination of annual IMAC recommendations and Presidential approval does not produce hoped-for savings. (A fall-back plan might, for example, specify certain automatic reductions in payment rates and increases in beneficiaries’ premiums or copayments if the process did not otherwise produce a certain amount of projected savings.) On the other hand, there is a small chance, in CBO’s judgment, that the council would

propose and the President would approve significant changes to Medicare that would reap substantial savings.

Expected savings from the IMAC proposal would grow after 2019, but many of the above points would still apply, reducing the likelihood of attaining large annual savings. The considerable uncertainty about the amount of savings that might occur within the first 10-year projection period would compound in future decades. Although it is possible that savings would grow significantly after 2019, CBO concludes that the probability of this outcome is low for the proposal as drafted, particularly because there is no fall-back mechanism to ensure some minimum level of spending cuts beyond those already included in H.R. 3200.

### **Budgetary Treatment**

Under this proposal, once the President had approved a set of recommendations, CBO would assume that, in the absence of Congressional action, the Administration would implement those recommendations. Upon that approval, CBO would modify the baseline used for scoring legislation to reflect that assumption. Consequently, for Congressional scorekeeping purposes, a resolution to disapprove those recommendations would be charged with the cost of canceling any expected Medicare savings from a set of IMAC recommendations that had been approved by the President.

### **Options for Generating Greater Savings**

You requested that CBO identify ways in which the IMAC proposal or other similar proposals might be structured to garner significantly more savings. Features that would maximize the likelihood that a new council would recommend changes that would achieve greater reductions in spending for Medicare (and possibly other federal health care programs) include the following:

- Setting explicit and feasible quantitative goals for reducing outlays in the Medicare program.
- Providing clear authority for the council to recommend broad changes in coverage, benefit design, and payment and delivery systems.
- Incorporating an explicit fall-back mechanism (such as an across-the-board reduction in payments) if goals for cost reduction are not met.
- Requiring independent verification of the expected reduction in program spending from implementing the recommendations.
- Expanding the direction and authority of the council to include making recommendations for changes to Medicaid and other government health care programs, with specific goals set for each program.

- Expanding the council's mandate to include making recommendations for changes to the broader health care system. (Some such changes might be implemented through federal regulation, while others might require future legislation.)
- Ensuring that the composition of the council is heavily weighted toward medical and other health policy experts who will actively seek to improve the efficiency of the health care system.
- Ensuring the council's access to the resources necessary to develop and test ideas for cost reduction. These resources would include access to appropriate program data, the ability to tap technical expertise available through the Department of Health and Human Services (HHS), and explicit authority to coordinate such work with the Secretary of HHS.
- Providing mandatory funding to enhance the independence of the council.

An IMAC-type proposal that incorporated some or all of the features outlined above would generate larger expected savings over the next 10 years than the \$2 billion estimate for the proposal as initially drafted. However, the short time frame for action would still limit the likely savings.

Looking beyond 2019, a much stronger IMAC-type proposal could reap considerably more savings, depending on which specific features identified above were included and how those features were crafted in legislation. In particular, if the legislation were to provide IMAC with broad authority, establish ambitious but feasible savings targets, and create a clear fall-back mechanism for instituting across-the-board reductions in net Medicare outlays, CBO believes the council would identify steps that could eventually achieve annual savings equal to several percent of Medicare spending. In the absence of a fall-back mechanism, CBO expects that the probability that the President would approve recommended changes that would lead to such significant savings would be lower.

Several percent of annual Medicare spending would amount to tens of billions of dollars per year after 2019. By that point, H.R. 3200, as introduced, would already be on track to achieve tens of billions of dollars in Medicare savings each year, primarily as a result of provisions that would reduce payments to Medicare providers relative to those projected in the current-law baseline. (Total federal resources devoted to health care programs would increase under the introduced version of that bill, however, because of the provisions aimed at making health insurance available to more people.) Substantial additional savings from an IMAC-type proposal would probably require significant changes in coverage, benefit design, and payment and delivery systems aimed at reducing the quantity and intensity of services provided. Some of the savings that could be expected from such changes are probably already captured in CBO's assessment of the

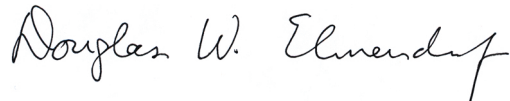
Honorable Steny H. Hoyer

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long-term savings that would result from provisions of H.R. 3200, but it is difficult to assess the extent of that overlap.

I hope this information is helpful to you. If you have further questions about CBO's analysis, we would be happy to address them. The CBO staff contacts are Holly Harvey and Tom Bradley, who can be reached at 202-226-2800 and 202-226-9010, respectively.

Sincerely,



Douglas W. Elmendorf  
Director

cc: Honorable John Boehner  
Minority Leader

Honorable Charles B. Rangel  
Chairman  
House Committee on Ways and Means

Honorable Dave Camp  
Ranking Member  
House Committee on Ways and Means

Honorable Henry A. Waxman  
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Honorable Joe Barton  
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