

**THE NEW CENTER**

**Policy Paper**



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# Medicare Payment Reform

**SHIFTING THE HEALTH CARE DEBATE FROM WHO PAYS TO HOW**

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## **ABOUT THE NEW CENTER**

*American politics is broken, with the far left and far right making it increasingly impossible to govern. This will not change until a viable center emerges that can create an agenda that appeals to the vast majority of the American people. This is the mission of The New Center, which aims to establish the intellectual basis for a viable political center in today's America.*

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# Executive Summary

## **NEW CENTER SOLUTION:**

# Shifting the Health Care Debate from Who Pays to How

According to a recent Medicare trustees report, the program will be unable to fully fund its services by 2026.<sup>1</sup> While Congress balks at bipartisan health care reform, funding dwindles for the benefits that nearly one in five Americans rely on. To keep Medicare solvent, Congress must address systemic inefficiencies in the way that Medicare pays for medicine and services.

Each side in Washington continues to debate *who* will pay for health care—assuming that shifting all Americans to public or private health insurance will slash health care costs. However, *how* America pays for health care is arguably even more important. The United States pays more than any other country in the world for almost every aspect of care.<sup>2</sup> America is the most expensive place in the world for hospital stays, ambulatory care, prescription drugs, delivery and C-section services, scanning and imaging, joint replacements, and multiple other services. Despite this, Americans have lower life expectancies, longer wait times for care, and lower access to medication than residents of similar high-income countries.<sup>3</sup> In short, America needs more economical health care, regardless of whether public insurers, private insurers, or individuals pay the bills.

The Centers for Medicare & Medicaid Services (CMS), the federal program that administers Medicare, is the largest single payer of health care costs in the United States, covering roughly 37% of all health spending.<sup>4</sup> This gives Medicare significant influence over marketplace standards and practices. Yet structural flaws in the design of Medicare continue to reward the volume of care delivered (tests, procedures) over the value of the care (keeping patients healthy)—which comes at a higher price tag.

### **The New Center believes that the following reforms could improve how Medicare pays for services and medications:**

- Accelerating the transition from volume-centered care to value-centered care by implementing more bundled payments
- Answering the end-of-life question by offering Medicare enrollees Advance Directives
- Curbing high spending by allowing Part D (prescription drug coverage) to negotiate drug prices
- Looking to other countries for pricing references for single-source drugs



# The Problem

# Historical and Current Trends

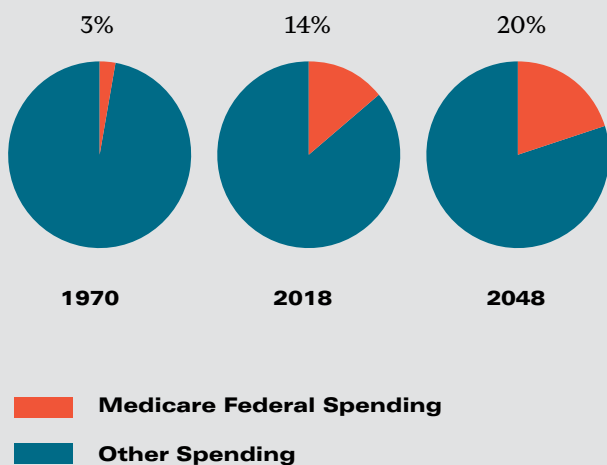
Current Medicare beneficiaries are “taking out” much more funding than they ever “paid in” to Medicare.<sup>5</sup> Unlike a 401(k) or similar retirement plan, the taxes a person pays for Medicare are not set aside for when they reach 65. Rather, the taxes that individuals contribute while working are used on current Medicare beneficiaries. The average Medicare beneficiary will get anywhere from \$2.40 to \$7.80 in benefits back from Medicare for every dollar they gave in taxes, as a consequence of longer lifespans and more costly medical treatments.<sup>6</sup> At this rate, Medicare will face budget deficits before current 57-year-old Americans can sign up.

Medicare makes up one of the largest shares of the federal budget, accounting for 15% of federal spending. This share will continue to grow, projected to rise to 20% of federal spending by 2048.<sup>7</sup>

Almost every aspect of health care is growing exponentially more expensive for Americans, creating funding problems for Medicare and other insurers.

In 1970, the average American would expect to spend just \$601 out of pocket for health care every year, adjusted for inflation. In 2017, the average American spent \$1,124 out of pocket for health care.<sup>8</sup> Another measure of spending trends is the share of the economy devoted to health care. In 1970, the U.S. spent around 7% of gross domestic product (GDP) on health-related costs. In 2017, that figure had risen to 17.9% of GDP.<sup>9</sup>

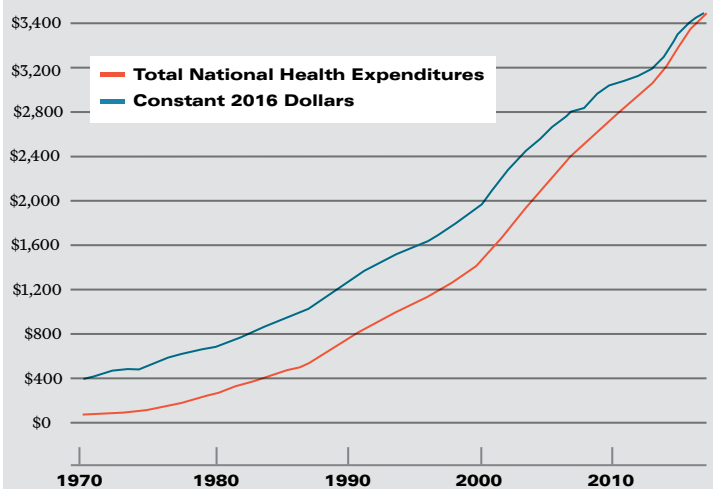
## Medicare Represents a Growing Share of the Federal Budget



Note: Pies represent total spending.

Source: Office of Management and Budget, Budget of the United States Government, Fiscal Year 2020, March 2019; and Congressional Budget Office, The 2018 Long-Term Budget Outlook, June 2018 Compiled by PGPF<sup>10</sup>

## Total National Health Expenditures US \$ Billions, 1970-2017



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data<sup>11</sup>



# The Context



# U.S. Health Outcomes Don't Reflect Costs



**According to the Kaiser Family Foundation, the U.S. pays more than any other country for health care across multiple measures:<sup>12</sup>**

- The United States spends \$10,739 on average per person on health care, roughly double the average cost of \$5,280 per person in comparable countries.
- The prices charged by drug manufacturers to wholesalers and distributors in the United States are 1.8 times higher than in other countries for top-selling drugs.
- Despite Americans spending far fewer days in hospitals than comparable countries (6.1 days vs. 10.2 days, respectively), the average cost of a hospital stay is \$18,000, almost three times the average of the 36 countries in the Organization for Economic Co-operation and Development (OECD) average of \$6,200. The OECD is comprised of 36 high-income member countries.
- In 2019, the United States spent nearly 18% of GDP on health care—80% more than other comparable developed countries.
- This problem isn't going away. Health spending is projected to grow 0.8% faster than GDP annually over the 2018-27 period.

## **HOW ARE WE DEFINING "COMPARABLE COUNTRIES"?**

The Peterson Center on Healthcare and the Kaiser Family Foundation defines "comparable countries" as Switzerland, the United Kingdom, Germany, Sweden, Austria, the Netherlands, France, Canada, Belgium, Australia, and Japan. These countries were chosen for being "similarly large and wealthy (based on GDP and GDP per capita)."<sup>14</sup>

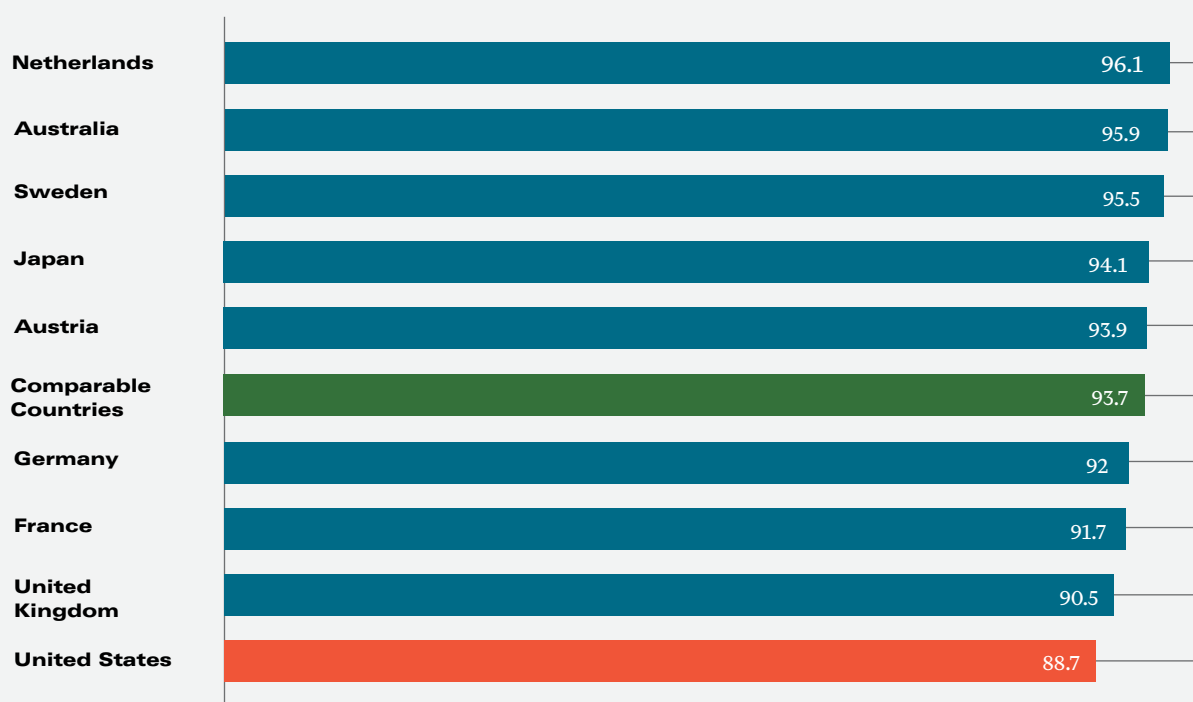
## Despite high spending, American health outcomes across key measures lag behind multiple other developed countries:<sup>13</sup>

- The U.S. has higher rates of medical, medication, and lab errors than comparable countries.
- The U.S. has longer wait times to see doctors and nurses than the comparable country average.
- The U.S. has an alarmingly high rate of maternal mortality due to childbirth complications—four times the average of comparable countries.
- The U.S. is ranked last among 11 comparable countries for rates of amenable mortality—death considered preventable by timely and effective care.



### Healthcare Quality and Access (HAQ) Index Rating, 2016

Note: The HAQ Index is based on amenable mortality and is scaled from 0 to 100: lower scores indicate high mortality rates for causes amenable to health care, while higher scores indicate lower mortality rates.



Source: Kaiser Family Foundation analysis of data from: "Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016" The Lancet, 23 May 2018.<sup>15</sup>



# Payment Systems Encourage High Spending

Medicare is unavoidably expensive compared to covering the general population because seniors typically need more frequent, costly, and intense care than younger groups. However, there are still many ways in which Medicare unnecessarily compounds costs.

## FEE-FOR-SERVICE SYSTEM

Medicare Part A (hospital insurance) pays doctors, hospitals, and other providers on a “fee-for-service” basis. In a fee-for-service payment system, providers charge for every “service” they administer to a patient, such as seeing a nurse or having their temperature taken. The prices for these services are often inflated, making it unsurprising that hospital care accounts for 33% of U.S. national health expenditures.<sup>16</sup> News reports have cited some hospitals charging \$15 for a single Tylenol pill, \$20 per use for a blood pressure cuff, \$53 for a pair of non-sterile gloves, and \$6.25 for every time a nurse hands you a pill (called an “oral administration fee”).<sup>17</sup> People can enter an ER and leave with a three-digit bill—just for sitting in the waiting room and seeing a nurse.<sup>18</sup>

Fee-for-service encourages hospitals to issue as many tests and services as possible to maximize profits (and minimize liability), even if the services aren’t particularly necessary or beneficial to patient health.<sup>20</sup> Medicare and private insurers continue to use fee-for-service methods, with 90% of primary care practice revenues coming from fee-for-service methods.<sup>21</sup>

For years, health care reform advocates have been pushing for a payment approach that rewards the value of keeping patients healthy over the volume of medical services provided. Switching the entire population to a private or public plan—as many Democrats and Republicans have proposed over the years—won’t address the incentive for health care providers to reward volume over value. Rather, the problem of fee-for-service would follow patients regardless of their health plan. The challenge is defining “value” and crafting reforms that make care more affordable and effective.

**Relative Contributions to Total National Health Expenditures, 2017**



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data.<sup>19</sup>

## LIMITED PATIENT CONTROL FOR CARE

Medicare doesn't make it easy for elderly Americans to control their care. In a California survey, 70% of people said they would prefer to die at home, yet 68% of people do not die at home.<sup>22</sup> This example demonstrates the importance of an end-of-life plan for care. Only a third of Americans have an Advance Directive, which is a written plan for what kind of care someone would like to receive.<sup>23</sup> If an individual becomes incapacitated, they have little ability to determine their treatment. Medicare currently doesn't require beneficiaries to submit end-of-life care plans, and often isn't aware of individuals' preferences.

End-of-life treatment accounts for roughly 25% of Medicare spending, with costs that trickle down to beneficiaries and their families.<sup>24</sup> Yet the federal government doesn't provide a means of establishing care plans for beneficiaries when they sign up for Medicare. Rather, individuals must seek out legal documents from their states or health providers. The onus is on the individual, who must fill out the documents, have them officially witnessed, and send them out to several parties (such as doctors, lawyers, and advocates).



## OPAQUE AND EXPENSIVE PART D SPENDING

The Medicare Modernization Act of 2003 (MMA), the law that established Part D prescription drug benefits, includes a “noninterference” clause that stipulates that the government “may not interfere with the negotiations between drug manufacturers and pharmacies and Part D plan sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs.”<sup>25</sup>

This means that the government can have no direct role in negotiating or setting drug prices for Medicare Part D, unlike other federal programs. Medicaid, the Department of Veterans Affairs, and the Department of Defense are all capable of imposing price ceilings and mandatory rebates for brand-name drugs. These programs are incredibly cost-efficient—Medicaid's prices for the costliest drugs were 27% to 38% lower than Medicare's average prices for these drugs in 2010.<sup>26</sup> However, as the largest single payer in the health care industry, policy makers felt that Medicare negotiations would interfere with markets and discourage companies from investing in the research and development of new medicines.

To quell this concern, Medicare must go through “pharmacy benefit managers” (PBMs), third-party administrators of prescription drug



programs, to secure lower prices from pharmacies and drug manufacturers. These PBMs have incredible leverage for determining the final price of a drug, largely through drug “formularies.” Formularies are lists of drugs covered by insurance companies that divide prescription drugs into tiers, each with a different level of patient cost-sharing. Formularies provide insurance companies with substantial leverage in negotiations with manufacturers, as patients are much more likely to use drugs in the more affordable “preferred” category of medicine. Formularies are the main cost-control mechanism in Medicare Part D, as well as for most private insurance plans.<sup>27</sup>

So what’s the problem? If Medicare can negotiate indirectly through PBMs, the program presumably has the same leverage tools as private insurance and other federal programs. However, PBMs have competing incentives when crafting formularies. Because PBMs often receive rebates from manufacturers that are calculated as a percentage of the manufacturer’s drug price, PBMs receive a larger rebate for expensive drugs than they do for ones that provide the same value at a lower cost. This gives PBMs a reason to prefer higher-cost drugs over equally effective, lower-cost drugs.<sup>28</sup> As a result, drugs are more expensive to Medicare and its beneficiaries with copays.

Medicare has no ability to inspect the kickbacks PBMs receive from manufacturers. PBMs claim that Part D drug negotiations are a “trade secret”—meaning prices are not transparent, even to CMS. While this rebate may be entirely necessary for PBMs to operate, it’s impossible to know what is really transpiring in negotiations.

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## LIMITED PRICING REFERENCE FOR SINGLE-SOURCE DRUGS

One prominent headline in the drug-price debate has been the price gouging of the AIDS treatment Daraprim. A decades-old drug, Daraprim’s price skyrocketed from \$13.50 to \$750 a pill, a 5000% increase.<sup>29</sup> The price hike came after the drug’s manufacturer was bought by a hedge fund manager who moved to raise the drug’s price overnight. Similarly, drugmaker Mylan gained notoriety for steadily hiking the price of the EpiPen from around \$100 to over \$600.<sup>30</sup> Beyond sky high prices, these two medicines share one distinct commonality—near monopolies in the market.

Makers of brand-name medicines that are under patent and thus have no generic version, known as “single-source” drugs, have exploited their exclusivity to charge exorbitant prices. Because these drugs don’t face competition from other manufacturers, Medicare has little ability to assess the value of single-source drugs and biologics.<sup>31</sup> Single-source drugs are the largest expense to Medicare Part D, accounting for almost 72% of drug spending in 2017.<sup>32</sup> For these single-source drugs, the U.S. spends strikingly more than countries with similarly high incomes and large pharmaceutical markets. For the 79 most costly single-source drugs, U.S. prices were more than three times higher than prices in the U.K. and Japan.<sup>33</sup>

Without market competition, manufacturers have an incentive to introduce similarly effective, yet more expensive, versions of their patent-protected drugs, while also withdrawing their lower-cost predecessors. Because price negotiations are secret, Medicare has little ability to gauge the value and price of drugs, especially when they only have one vendor, as there are no other manufacturers to offer competing prices.

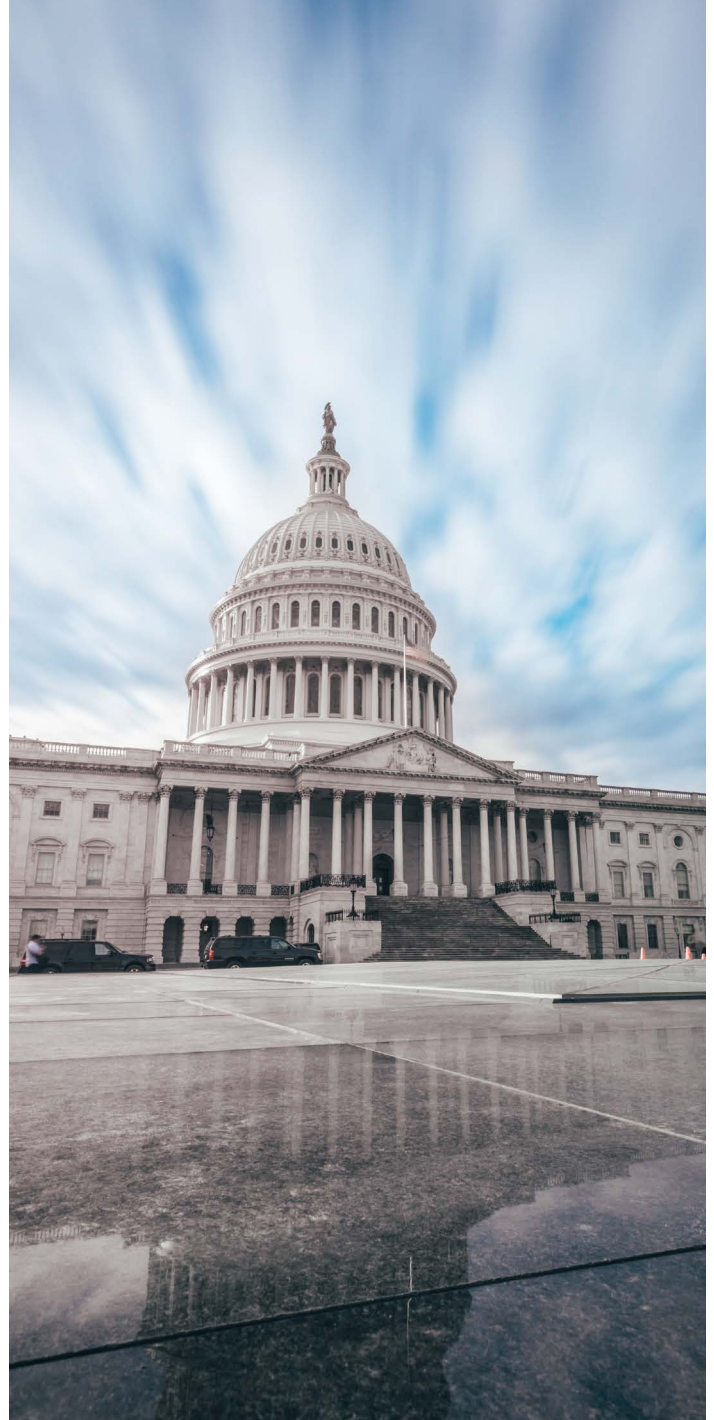


# Answers from the Right And Left

Democrats and Republicans have offered contrasting proposals to expand access to health care for seniors and reform Medicare's payment system. As of September 2019, 131 Democratic cosponsors from both chambers of Congress have signed onto the Medicare for All Act, which would offer a single government-run insurance provider and end private insurance. Conversely, the most recent 2016 Republican Party platform advocated for transitioning to a premium support model, where the government would help pay the premiums of private health care plans, gradually ending a public health insurance option.<sup>34</sup> Both sides assume that shifting all Americans to public or private health insurance will slash health care costs.

Despite health care ranking among voters' top three issues for years, Washington is far from forging a sustainable solution.<sup>35</sup>

Each side is so concerned with the deeply politicized question of *who* will pay for health care that they aren't addressing *how* anyone can afford to pay. There might be merit in both sides' proposals, but each is failing to address the egregious, pervasive cost of care.







# The Solutions





## 1. BUNDLED PAYMENTS

The Centers for Medicare & Medicaid Services can improve problems stemming from the fee-for-service system by switching to a “bundled payments” model. Medicare still mostly pays for the volume of care delivered rather than the value. Bundled payments—also called episode of care payments—pay for services in a lump sum, instead of for individual services. For example, providers would receive a set amount of money to provide all the care associated with treating a particular condition (i.e. a hip replacement, an asthma attack, a broken arm). This payment model reduces the incentive to order unnecessary tests and screenings, as providers will receive a set rate regardless of the volume of care. This payment model also reduces administrative complexity and costs to hospitals, as it requires less time-consuming coding for each individual service provided to patients.

Medicare’s limited initiatives for bundled payments have shown reduced costs and better patient outcomes with surgeries such as joint replacements and heart bypasses.<sup>36</sup> Tennessee’s Medicaid program saw a reduction of more than \$11.1 million in costs after the first year of implementing bundled payments—showing significant cost reductions for perinatal care, asthma exacerbations, and joint replacements.<sup>37</sup> UnitedHealthcare’s use of bundled payments reduced the cost of treating 810 cancer patients by \$33 million.<sup>38</sup> This approach has been a success for outpatient services as well, with the Pennsylvania Employees Benefit Trust’s program for joint replacements saving \$3,524 per outpatient.<sup>39</sup>

However, many of these successes are part of small-scale pilot programs. There are enough promising results from these programs to suggest that allowing Medicare to expand bundled payments (and making it the standard of care for treatments like joint replacements) could deliver major cost savings.



## 2. AN ANSWER TO THE END-OF-LIFE QUESTION

Medicare can provide patients with control over their treatment by requiring them to fill out an “Advance Directive” when they sign up for Medicare. An Advance Directive is a legal document stating an individual’s plan of care in the event that they become incapacitated. As it is, if an individual becomes unable to speak for themselves, they lose the ability to determine their care without documentation. Advance Directives are especially vital to patients who aren’t comfortable receiving aggressive end-stage treatments—such as painful, risky, and costly procedures like mechanical ventilation and blood transfusions.

Advance Directives can also play a role in curbing government and patient spending. Spending on Medicare beneficiaries in their last year of life accounts for about 25% of Medicare spending on beneficiaries age 65 or older—with some patients receiving treatments they might not be comfortable with.<sup>40</sup> Medicare patients without Advance Directives pay three times as much for hospitalization (an average of \$95,505) than those with Advanced Directives (an average of \$30,478).<sup>41</sup>

Cynics and critics have sometimes equated Advance Directives with “death panels” intent on killing off the elderly to save a buck.<sup>42</sup> However, that’s not the objective of this proposal. Advance Directives afford patients more choices, whatever those choices might be. While Advance Directives are cost-efficient, the primary purpose of an Advance Directive is to give patients and their families control over their care.



### 3. ALLOW PART D TO NEGOTIATE PRICES

Medicare spends \$129 billion annually on Part D prescription drugs.<sup>43</sup> Despite one-fifth of Medicare spending going towards prescription drugs, Part D is not afforded the same means to negotiate prices as Medicaid and the Department of Veteran's Affairs.<sup>44</sup> As a consequence, Medicare's brand-name drug costs are regularly more than 20% higher than other federal programs. Congress should come together on a solution to allow Medicare to negotiate the price it pays for Part D medications. In 2015, researchers from Carleton University and Public Citizen concluded that Part D could save up to \$16 billion per year with price negotiations.<sup>45</sup> This proposal enjoys wide bipartisan support with the general public, with 90% of Democrats and 80% of Republicans in support of letting Medicare negotiate prices.<sup>46</sup>

The challenge for Congress is to design a system for Medicare price negotiations that meaningfully brings down the cost of drugs, while still preserving the incentive for innovation that has made America the source of the most cutting-edge medical treatments in the world. Some Democrats have pushed for negotiations featuring "competitive licensing," meaning that if a manufacturer refused to offer a Medicare-specified price, the government could give the manufacturer's patent to another company. The licensed company would then be able to manufacture the drug at a more affordable rate.<sup>47</sup> Republicans have offered solutions aimed more at increasing pharmacy benefit manager transparency rather than direct negotiation, such as the Phair Pricing Act of 2019.<sup>48</sup> This bill would require PBMs to disclose the fees, price concessions, and incentive payments they negotiate to CMS. While this bill doesn't authorize CMS to directly negotiate, it does bring more transparency to the PBM negotiation process. Other proposals suggest that Medicare be able to favor certain drugs over others in formularies to yield significant savings. This encourages drugs with multiple manufacturers to compete for preferential treatment within formularies, without encouraging direct price setting that might disrupt markets.

There is limited research in Medicare negotiations, making it difficult to know which approach will meet the twin imperatives of preserving medical innovation and bringing down prices. But one way or another, the status quo—in which Medicare essentially pays whatever pharmaceutical companies tell them to pay—has to change.



### 4. IPI Model For Single-Source Drugs

Medicare can gain reference for single-source drug prices by looking to other countries, instead of solely within the American health care system. Single-source drug costs could be tied in some way to the "International Pricing Index"—an average of what economically similar countries pay.<sup>49</sup> Twenty nine high-income countries use the IPI Model to combat high prices for single-source drugs.<sup>50</sup> It is important to note, according to CMS, that the IPI Model is less useful for generic and multi-source drugs, as the U.S. already pays lower prices than other countries for these.<sup>51</sup>

Using international reference pricing to inform Medicare would foster price transparency, making it easier to identify which single-source drugs are financial outliers. However, CMS should consider legitimate concerns from health care professionals about the logistics of the IPI Model, such as securing accurate pricing data reporting and thwarting supply chain disruptions.<sup>52</sup>

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