

Potential Savings Associated with the Blue Cross and Blue Shield Association's

*Building Tomorrow's Healthcare System
The Pathway to High-Quality, Affordable Care in America*

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This letter provides estimates of the potential federal savings associated with the adoption of the recommendations offered in the Blue Cross and Blue Shield Association's (BCBSA) new proposal, *Building Tomorrow's Healthcare System, The Pathway to High-Quality, Affordable Care in America*. By implementing comprehensive and interconnected health policy recommendations to transform the way Medicare and Medicaid operate, as proposed by BCBSA, it is possible to save **\$319 billion** in federal healthcare spending over the next decade. The key to achieving such savings is to take a holistic approach that moves away from traditional fee-for-service-based payments and instead reimburses providers for delivering high quality, coordinated care that is appropriate for each individual. While modest savings can be achieved by individual recommendations, the potential for significant savings is greatest by implementing more comprehensive changes as proposed by BCBSA. Though the estimates focus on potential federal budget savings, the proposals outlined below would be most effective when adopted broadly in both the public and private sector. Presented below are separate estimates of the potential savings associated with either individual recommendations or recommended changes that are combined.

Recommendations

1. Accelerate and fast track the adoption of new, high-priority safety measures in the hospital value-based purchasing program.

Savings 2012-2021 = \$3 Billion

Section 3001 of the Affordable Care Act established a hospital value-based purchasing program that provides incentive payments to hospitals that meet certain performance standards during the year. The incentive payments start by creating a pool funded by 1 percent (in 2013) and increasing to 2 percent of base hospital diagnosis-related group (DRG) payments by 2017. Hospitals would receive a composite quality score with top ranking hospitals receiving the highest bonus. The proposal would accelerate the implementation of the current Section 3001 plan, as well as expanding the Hospital Quality Incentive Demonstration nationally. Based on a similar scoring estimate from the Congressional Budget Office, estimated ten year savings could total \$3.0 Billion.

2. Expand the bundled payment initiative and incorporate it into the Medicare program.

Savings 2012-2021 = \$21 Billion²

The Affordable Care Act included provisions that would pilot the use of hospital bundled payments. Hospitals would receive a single bundled payment from Medicare for each discharge that covers the inpatient admission as well as Medicare-covered services for the next 60 days. This proposal would accelerate the use of bundled payments by taking it from a pilot and incorporating it eventually to cover all Medicare inpatient discharges. Hospital bundled payments would cover 20 percent of all admissions in 2013 rising to 100 percent of all admissions by 2020. Savings associated with the proposal result from reductions in the use of post-acute care services.

3. Move toward national adoption of primary care medical homes combined with the use of bundled payments.

Savings 2012-2021 = \$125 Billion

Option 1. Enroll dual Medicare-Medicaid eligibles (“dual eligibles”) into health plans that incorporate evidence-based care coordination functions (as outlined in Section 3502 of the Affordable Care Act). States could also contract with health plans, community health teams, or other care entities to provide the same set of care coordination functions. Dual eligibles would have the ability to opt-out of care coordination. Randomized trials have shown the potential for saving at least 4 percent when adopting these evidence-based care coordination functions.³

Savings 2012-2021 = \$145 Billion gross savings and \$105 Billion net savings

(includes costs of creating the health and medical home teams).

Option 2. Make care coordination available to fee-for-service Medicare beneficiaries over the next three years.

Today, more than 9 million individuals are eligible for both Medicare and Medicaid—the dual eligibles. Dual eligibles are among the most expensive and chronically ill of all patients. Per capita spending among dual eligibles exceeds \$20,000 per year.⁴ Though they account for a small share of total enrollment, dual eligibles account for 36 percent of total Medicare spending and 39 percent of Medicaid spending. In 2011, the federal government—through Medicare and Medicaid—will spend over \$230 billion on dual eligibles. Using projections of Medicare and Medicaid spending from the Congressional Budget Office, federal spending on dual eligibles will total nearly \$3.7 trillion over the next decade.⁵ Yet, despite the potential for team-based care to improve quality and lower spending through improved care coordination and transitions

of care, few dual eligibles receive their care this way. Fewer than 2 percent of dual eligibles are enrolled in a coordinated care program that manages all Medicare and Medicaid covered benefits.⁶

There is also tremendous potential to improve quality and health outcomes at lower cost for those enrolled in the traditional fee-for-service Medicare program. Other than homebound patients (about 9 percent of all in the traditional Medicare program), there is no care coordination in traditional Medicare. About half of all Medicare patients are currently treated for 5 or more conditions. They see several physicians and typically fill 10 to 15 medications in a month. None of this care is coordinated, so, as a result, chronically ill patients have high rates of hospitalizations, readmissions, emergency room and outpatient clinic use.

One option for building care coordination into the program is to expand the use of medical homes and other forms of care coordination, such as those outlined in Section 3502 of the Affordable Care Act. These include the provision of transitional care, medication management and reconciliation, health coaching, close links with primary care providers and a care coordinator available 24/7 for the patient.

The Department of Health and Human Services could contract with a variety of organizations to perform these care coordination functions in the traditional Medicare program. Based on the staffing ratios of health teams in Vermont and North Carolina, developing the teams nationally would cost about \$40 billion over the next ten years. On the other hand, the new staffing would also create about 40,000 jobs. Costs associated with the teams would be salary and overhead. These could include health plans, home health agencies, and community health centers, among other groups. The key requirement would be to have the capacity to perform the range of care

coordination functions outlined in Section 3502 in well-connected care processes. Several randomized trials of transitional care, health coaching and other elements of care coordination show the potential of saving at least 4 percent with team-based care for “dual eligibles” and those enrolled in the traditional Medicare program.⁷

4. National Adoption of Evidenced-Based Lifestyle Change Programs including the Diabetes Prevention Program.

Savings 2012-2021 = \$7 Billion (\$27 Billion in lifetime savings)

Since 1987, the share of adults considered obese has doubled to 34 percent today. Though estimates vary, the doubling of obesity accounts for approximately 8 to 20 percent of the growth in healthcare spending. Rising rates of obesity account for much of the growth in chronic health care conditions such as diabetes, pulmonary disease, back problems, hypertension and co-morbid cases of depression. Obesity also adds substantially to the cost of Medicare and Medicaid. Obese adults spend 15 to 35 percent more on healthcare over their lifetime (starting at age 65) as compared to normal weight adults.⁸

One approach for generating federal savings is to scale and replicate the CDC diabetes prevention program (DPP). The DPP has been shown through repeated randomized trials to generate sustained weight loss (about 7 percent) among overweight, pre-diabetic adults. Taking the community-based version of the DPP national would cost about \$80 million and could be funded through the \$1 billion available next year in the Prevention and Public Health Trust Fund. Annual enrollment in similar programs total about \$240 to \$300 per member and would be federally subsidized for adults aged 60 and older who are pre-diabetic or have another

cardiovascular risk factor. Net savings associated with the DPP would be \$7 billion over the next decade and \$27 Billion over their lifetime.⁹

5. **Childhood obesity initiatives.**

Savings 2012-2021 = \$3 Billion

Rising rates of childhood obesity are a major public policy issue. Obesity among children increases chronic disease prevalence and healthcare spending for both private health plans and the Medicaid program. One option is to include a nationally-scalable model to deliver a childhood obesity prevention program to Medicaid and Children's Health Insurance Program (CHIP) recipients that may help reduce future healthcare spending related to chronic disease. The proposal relies on an evidence-based and cost-effective program that can treat the scale of obesity, as well as brainstorming a sustainable model of delivery that can reach medically-underserved young people. The objective of the proposal is to describe a scalable and sustainable model for delivering a particularly promising high-intensity, multi-component childhood obesity prevention and reduction program called the Mind, Exercise, Nutrition, Do It! (MEND) program. MEND is an evidence-based, community and family-centered program designed by an inter-disciplinary team of researchers in the United Kingdom that targets medically-underserved communities. The MEND program is based on a 10-week curriculum that includes two 2-hour after-school sessions per week, and includes an innovative, long-term weight maintenance strategy. Children and at least one parent or caregiver participate in a curriculum that includes nutrition education, physical activity and behavior modification. The program is delivered by non-specialist staff members that are trained to act as health coaches and motivators. This staffing model reduces costs and allows community members familiar with local dynamics and pressures to participate in the delivery of the program.

6. Establish prior authorization for imaging.

Savings = \$1 Billion¹⁰

Enact MedPAC’s June 2011 recommendation regarding prior authorization of advanced imaging services in Medicare for physicians who are outliers – those ordering more imaging services than their peers.

7. Medical Malpractice Reforms.

Savings = \$54 Billion¹¹

Establish nationwide curbs on medical malpractice tort recoveries including caps on non-economic and punitive damages, shortening the statute of limitations, changing the “collateral source” rule and eliminating joint and several liability.

NOTES

¹ Study prepared for the Blue Cross and Blue Shield Association's proposals outlined in their proposal, *Building Tomorrow's Healthcare System, The Pathway to High-Quality, Affordable Care in America*.

² These savings are similar in magnitude to those developed by the Congressional Budget Office, in Budget Options Volume 1, Health Care, December 2008, option 30.

³ Kenneth E. Thorpe, Building Evidence Based Models to Avert Disease and Reduce Health Care Spending, Emory University, July 2011

⁴ Accessed at <http://www.kff.org/medicaid/upload/4091-08.pdf>

⁵ March 2011 Medicare and Medicaid baseline from the Congressional Budget Office.

⁶ Available at http://www.medpac.gov/chapters/Jun11_Ch05.pdf

⁷ Kenneth E. Thorpe, BUILDING EVIDENCE-BASED INTERVENTIONS TO AVERT DISEASE AND REDUCE HEALTH CARE SPENDING, unpublished manuscript, August 2011, Emory University.

⁸ Zhou Yang and Amy Hall, The Financial Burden of Overweight and Obesity Among Elderly Americans: The Dynamics of Weight, Longevity, and Health Care Costs" Health Services Research, 2008 43(3): 849-68

⁹ Kenneth E. Thorpe and Zhou Yang, "Enrolling People with Prediabetes Ages 60-64 in a Proven Weight Loss Program Could Save Medicare \$7 Billion or More" Health Affairs 30 no. 9 (2011): 1673-1679

¹⁰ Based on Congressional Budget Office estimate, at <http://cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

¹¹ Based on the Congressional Budget Office estimate of the proposal at http://cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf, option 41 page 81.