Published in final edited form as:

Forum Health Econ Policy. 2013 January ; 16(1): 123–136. doi:10.1515/fhep-2012-0002.

Integrating Patient Incentives with Episode-Based Payment

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Abstract

To rein in cost, payers are exploring bundled payment, which aggregates fees for a range of services into a single prospective payment. While under bundled payment providers would have incentives to reduce cost, they might also withhold more expensive care that patients prefer.

We explore how bundled payment could be aligned with a benefit design that would encourage patients' consideration of cost without jeopardizing access to the most expensive treatments. Least-costly-alternative approaches allow patient choice but might deter patients from choosing more expensive care by exposing them to potentially large out-of-pocket payments. A novel "shared-savings supplement" would reward patients for choosing the least costly alternative with a supplemental cash disbursement and thus allow them to share in any cost savings. This cash incentive for the least-costly-alternative allows a reduction of the out-of-pocket payment for the expensive alternative. Thus, patients would still have the option of the more expensive therapy while facing only a modest out-of-pocket cost. Such benefit modifications could be aligned with bundled payment by splitting the responsibility for the incremental cost of more expensive care between patients and their providers.

I. Introduction

As is widely recognized, efforts to ensure Medicare's long-term sustainability must address its rapidly growing cost. Current strategies to control spending growth generally focus on changes in provider payment including lowering the fee-for-service (FFS) payment rates and moving away from FFS to bundled payment.

A central issue is how to integrate patient incentives into different provider payment systems. For example, in many clinical situations there are acceptable clinical alternatives with very different economic consequences. Under traditional FFS payment, Medicare captures most of the savings when patients opt for less expensive treatment options. In bundled-payment systems, providers capture the savings, often shared with Medicare. In this paper we explore a mechanism for patients who choose less costly treatment to share in those savings immediately.

The basic dilemma is how to incorporate patient incentives that allow for patient-centric care without exacerbating disparities to intolerable levels and while recognizing issues of imperfect information and shortcomings of competition inherent in health care markets. A strategy that relies solely on physicians to control spending will be challenging, given that for many conditions a patient's preferences, genetic predisposition, and compliance behavior may play an important role in treatment choice and effectiveness. Moreover, many physicians feel poorly equipped^{1,2} and are often reluctant³ to consider cost and to discuss it with their patients; those who do may find themselves suspected of trying to cut costs rather than improve patient health. Thus, we believe some role for patient incentives will be valuable going forward.

Our attention to patient incentives complements ongoing attention to the redesign of Medicare and private benefit packages. Increased cost-sharing, often proposed to increase patients' cost-consciousness, would reduce the insurance value of coverage. On the other hand, means-tested subsidies, which would reduce or eliminate entirely the deductibles and premiums for low-income beneficiaries but would phase out with rising income, would reduce the incentive to work.⁴

Instead, we build on recent work by the Medicare Payment Advisory Commission (MedPAC) examining least-costly-alternative payment systems⁵ and on the requirement stipulated in the Affordable Care Act that the National Association of Insurance Commissioners explore a redesign of "Medigap" supplemental insurance policies.⁶

Sharing savings with providers

We illustrate our model of shared savings by considering first an episode-based payment for cancer care, which would replace current fee-for-service reimbursement schedules for chemotherapy drugs and services with a lump sum payment similar to Medicare's prospective payment for hospital-based services.⁷

In a specific example outlined by Bach and colleagues, the episode-based payment would cover "the most costly components of care: anticancer drugs; supportive-care drugs ...; and their attendant administration" during a single month of care or the full course of treatment. Patients and their oncologists would select the treatment from a list of chemotherapy regimens recommended by the National Comprehensive Cancer Network or other compendia approved by the Centers for Medicare and Medicaid Services (CMS). For metastatic non-small-cell lung cancer, the authors estimate that "monthly costs to Medicare range from \$1,322 for a treatment combining paclitaxel and carboplatin, to \$7,092 for a regimen combining pemetrexed and carboplatin". If Medicare replaced its current fee-for-service reimbursement with "a hypothetical reimbursement rate of \$4,000 for a month of treatment, ... a physician selecting pemetrexed plus carboplatin would lose \$3,092 per month per patient" but "would earn an additional \$2,678 per month each time paclitaxel plus carboplatin was chosen." In this way, Medicare would share program savings with providers, which in turn would "make providers gravitate toward lower-cost regimens."

As residual claimants, some providers might stint on treatments, however, if a reduction in the cost of care also raised their net revenue. For their part, patients might find it difficult to

discern whether a provider's recommendation of cheaper treatment reflected his or her clinical judgment or the added financial incentive. In fact, a concern that providers were now balancing their patients' clinical needs against the payer's financial incentives might lead beneficiaries to insist on the most expensive treatments. Although the evidence to date does not allow for definitive conclusions, these behavioral responses might not only exacerbate the current bias toward high-priced regimens and but also impose financial risk on providers, who would now sustain a loss every time a patient chooses an expensive regimen.

Sharing savings with patients

While episode-based payment to providers would offer a financial incentive to steer patients to less costly treatment, the eventual treatment choice would continue to depend on the consent of beneficiaries. Yet, many existing supplemental coverage plans "protect beneficiaries from having to pay almost anything out of pocket"⁸ and thus insulate Medicare beneficiaries with such coverage from the true cost differentials across treatments. These beneficiaries would not necessarily share their providers' cost considerations. At the same time, for beneficiaries without supplemental coverage, who also tend to be poorer, the copayments required even for the least costly treatment currently add a sudden and potentially large financial burden to the diagnosis of a life-threatening condition such as cancer, for which few if any patients will want to delay care or forego it altogether. In the chemotherapy example, even choosing the least costly treatment – paclitaxel plus carboplatin at \$1,322 per month – would entail a 20-percent copayment of about \$264 per month, or about 15 percent of the median beneficiary's monthly income in 2010⁹ (Figure 1). In sum, the cost-sharing requirements under the current benefit design are likely ineffective for beneficiaries with policies that cover all deductibles and coinsurance payments under Parts A and B of Medicare ("first-dollar supplemental coverage"), such as the two most popular currently offered Medigap plans, which together accounted for 57 percent of Medigap enrollment in 2010.⁸ For beneficiaries without such supplemental coverage, however, the cost-sharing requirements impose substantial financial risk.

Balancing the insurance and incentive dimensions of benefit design

These considerations illustrate the tension between two important dimensions of the Medicare benefit: to minimize a beneficiary's risk of large unexpected out-of-pocket payments especially for treatment that costs more than the least costly alternative – the insurance dimension – while encouraging this beneficiary to consider less costly alternatives – the incentive dimension (Table 1). We contrast the current benefit design with two modifications: no copayment for the least costly alternative (LCA) only and a novel "shared-savings supplement" for choosing the least costly alternative. Both benefit modifications can be described by comparing the copayments they would require for the cheapest treatment option and for more expensive alternatives. For both modifications, we examine to what extent they would encourage beneficiaries with supplemental coverage to consider cost and to what extent they would offer beneficiaries without it protection against sudden out-of-pocket payments. We then discuss how these benefit modifications could serve to integrate patient incentives with episode-based payment proposals and how these changes to Medicare's current benefit design could be tested in a companion pilot program.

II. No Copayment for the Least Costly Alternative Only

Both modifications of the current benefit design are based on reference pricing policies, which presuppose groupings of “clinically comparable services”¹⁰, such as the chemotherapy options for metastatic non-small-cell lung cancer endorsed by the National Comprehensive Cancer Network. More generally, clinically comparable services would include those that “an independent panel charged with developing the standards [of care] ... deemed to be appropriate and effective, irrespective of their cost”.⁷

“[W]here comparable prescription drugs exist,” a typical least-costly-alternative (LCA) pricing strategy “covers the full cost of the lowest price option, but individuals opting for a higher cost option pay the full price difference.”⁵ (Figure 2) In contrast to the current Medicare benefit, this reference pricing strategy thus fully insures beneficiaries who opt for the least costly alternative, which is especially important for conditions that no patient will want to leave untreated regardless of cost. This reference pricing strategy also offers beneficiaries strong incentives to consider cost by exposing them to the full incremental cost of consuming more expensive care.

Muted incentives for beneficiaries with supplemental coverage

To the extent that currently available supplemental coverage plans agreed to assume the cost differential between the least costly alternative and the more expensive option chosen by the patient, an LCA benefit would likely encourage too few beneficiaries with such first-dollar supplemental coverage to choose less costly care because they would remain insulated from the true cost differentials across treatments. Thus, inasmuch as it raises the required copayments for more expensive options, rather than leading beneficiaries to migrate to lower-cost options, the only effect of implementing an LCA benefit may be to raise the premiums that beneficiaries pay for their supplemental Medigap plans.

In fact, as the Medicare program would now only assume the cost of the least costly alternative regardless of the patient’s treatment choice, Medigap premiums would now more closely reflect the cost of the incremental utilization that the first-dollar coverage inherent in these plans induces and thus shift this cost from the Medicare program to current Medigap enrollees. The prospect of higher Medigap premiums in turn might deter some beneficiaries from purchasing supplemental coverage, while pressure to limit premium increases might encourage Medigap plans to institute cost-control incentives on their own.

Erosion of insurance for beneficiaries without supplemental coverage

To restore beneficiaries’ consideration of cost when choosing among clinically equivalent treatment options, Medicare could prohibit supplemental coverage in this case. As a result, beneficiaries without supplemental coverage who preferred more costly options would now be exposed to the risk of greater out-of-pocket payments than under the current Medicare benefit. An LCA benefit might encourage such beneficiaries to switch to the least costly alternative if they found the monthly out-of-pocket payments to cover the full price differential prohibitively high.¹¹

In practice, even if treatment options in a given group were determined to be equally effective clinically, beneficiaries might strongly prefer a more costly option on account of its possible side effects or non-clinical treatment attributes, perhaps joined by their physicians if they assumed a fraction of the incremental cost under a bundled-payment arrangement. For example, while “no specific treatment for localized prostate cancer has been proven to be superior to another,”¹² the initial management strategies for localized prostate cancer currently covered by Medicare vary substantially in the risk of pain, inflammation, incontinence, and impotence as well as the time commitments and tolerance for anesthesia required of patients. Once patients’ preferences are factored in, it can be shown that a shared-savings supplement is optimal in maximizing welfare.¹³

III. A Shared-Savings Supplement for the Least Costly Alternative

As noted, even a seemingly manageable coinsurance rate of 20% may result in large out-of-pocket payments when beneficiaries choose expensive care options. To protect beneficiaries without supplemental coverage better against this risk, coinsurance rates could be reduced further. This reduction in coinsurance rates need not reduce beneficiaries’ incentives to consider cost if program administrators replace the zero copayment requirement for the least costly alternative with a cash disbursement – effectively a *negative* copayment. Thus, instead of *charging* beneficiaries a copayment of \$264 for paclitaxel plus carboplatin, Medicare could offer to *pay* them, for example, \$264 per month. This negative copayment for the lower cost treatment would allow the absolute copayment for the higher cost treatment to be reduced without compromising the incremental copayment for the higher cost treatment relative to the lower cost treatment (Figure 3). Such a “shared-savings supplement” would enable Medicare to share with beneficiaries the program savings that resulted from choosing less costly treatment.

Compatibility with supplemental coverage

As they do now, many beneficiaries with supplemental coverage who chose an expensive treatment would not pay the required copayment out-of-pocket. But Medicare could bypass the supplemental insurer and send a cash payment directly to those beneficiaries who chose the least costly alternative. In contrast to Medigap reform proposals that would eliminate first-dollar coverage in supplemental coverage plans⁸, shared-savings supplements for the least costly alternative would succeed in restoring beneficiaries’ exposure to (a fraction of) the true cost differentials between treatments *without raising their out-of-pocket payments*. To the extent that shared-savings supplements led beneficiaries to switch to the least costly alternative, it would allow issuers of supplemental coverage to reduce their premiums and thus make Medigap plans more affordable than they are under the current Medicare co-payment structure or would be if Medicare fully covered only the least costly alternative.

Beneficiaries with supplemental coverage could now be confident that they could choose any generally accepted treatment without making any out-of-pocket payments.

Strengthened incentives to consider cost without eroding insurance

Foundational work in the health economics literature^{13,14,15,16,17,18} suggests that shared-savings supplements for the least costly alternatives would help align the incentives of beneficiaries with the imperative of the Medicare program to reduce the overuse of more costly, yet no more effective treatment, and at the same time protect patients against the fear of being denied or priced out of access to their preferred treatment option. Specifically, by increasing exposure to the true cost differentials across treatments even for beneficiaries who carried first-dollar supplemental coverage, shared-savings supplements would reduce beneficiaries' tendency to "consume more of the insured service than they would if they faced the full price"¹⁹ (moral hazard).

Potential program savings

Under shared-savings supplements, Medicare would now pay more for beneficiaries who would have chosen the least costly alternative even without the supplement and it would continue to pay as much for beneficiaries choosing more expensive treatment options. Medicare might pay less, however, for beneficiaries who would have chosen expensive treatment but now switched to the least costly alternative. Shared-savings supplements would thus have the greatest potential to reduce program costs for conditions such as prostate cancer¹² whose generally accepted treatment options vary little in clinical effectiveness but widely in cost and whose most costly treatment options are chosen by a large share of patients. For these conditions, the number of beneficiaries who might switch to the least costly alternative and the program savings per switcher would be large.

Shared-savings supplements *at any level* would not hurt beneficiaries who continued to opt for more expensive treatment but it clearly would make better off all those who chose the least costly alternative, which was now paired with a cash payment. Therefore, administrators would be free to choose a supplement level that minimized program costs without being accused of rationing care.

Progressivity

Shared-savings supplements for the least costly treatment options would raise rather than reduce the discretionary incomes of poorer beneficiaries in particular, who are less likely to carry supplemental coverage²⁰ and who are already more likely to choose less or less costly treatment even without the prospect of a cash benefit²¹.

Poorer beneficiaries are also less likely to be screened for cancer, and a delayed diagnosis compromises many patients' prospects for survival. By removing the fear of comparatively large and recurring co-payments triggered by a cancer diagnosis, shared-savings supplements might encourage more low-income beneficiaries in particular to undergo screening for conditions that were eligible for a shared-savings supplement. This effect would have an ambiguous impact on total program expenditures depending on the number of new cases identified and the extent to which earlier identification changes the overall cost of treatment.

Implementation challenges

The appealing insurance and incentive properties of the proposed benefit modification as well as its potential program savings would have to be balanced against new challenges for patients and the program's integrity.

The program would have to ensure that patients were competent and free of outside pressure when they chose the least costly alternative. Opportunities for fraud could be minimized by restricting eligible conditions to those that are easy for program administrators to verify and by requiring a second confirmation, which for many conditions such as cancer are commonly sought already under the current benefit.

Even if not premeditated from the outset, some beneficiaries might come to regret foregoing more expensive treatment in favor of the least costly alternative plus the cash benefit. Limiting the duration of each episode and allowing beneficiaries to revise their earlier treatment choices periodically would reduce the incidence of regret and allay beneficiaries' fears of locking themselves out of new, preferred regimens.

IV. Integrating Patient Incentives with Episode-Based Payment

The introduction of new patient incentives such as no copayment or a shared-savings supplement for the least costly alternative would not preclude concurrent innovation in provider payment, including bundled payments.²² In fact, regardless of how the least costly alternative was covered, policy makers could adjust the coverage of more expensive options to balance the incentive and insurance dimensions of the Medicare benefit. For instance, instead of the full incremental cost of more expensive care, beneficiaries could be held responsible for only a fraction, as under the current benefit design. The remainder could be assumed either by the program or by the provider. As most beneficiaries carry supplemental coverage and therefore would remain partially insulated from the full cost differentials across treatment options, bundled payments for providers could play a complementary role in strengthening incentives for choosing low-cost care.

To estimate the potential savings from modifying the current Medicare benefit and to calibrate how the incremental cost of more expensive care should be shared among patients, providers, and the program, a pilot program could be set up as a companion trial to demonstration programs testing the episode-based payments. Ultimately, combining some version of episode-based payment with the sorts of patient incentives discussed here may be more desirable than exclusive reliance on an episode-based payment approach. By strengthening patient incentives, the provider incentives could be loosened to some extent to alleviate providers' risk (e.g., outlier payments or providing a partial payment for the additional costs of the more expensive option) without compromising the level of cost control achieved.

V. Making Medicare the Motor of Efficiency and Value in Health Care

Medicare currently lacks a legal basis to use cost-effectiveness criteria in its coverage decisions²³, and reforms of the program's benefit and its payment policies to encourage the use of cheaper, yet clinically comparable care have proven difficult to implement.

Episode-based payment for cancer care presents an innovative change away from the current fee-for-service reimbursement model that would expose providers to the full cost differential across treatment options. Using the example of chemotherapy for metastatic non-small-cell lung cancer, Bach and colleagues show how this payment reform could be pilot-tested immediately with the simple introduction of a new claim code.

Despite its appeal in principle, bundled payment for providers has so far only been tested for conditions other than cancer in pilot programs. Early experience suggests that significant implementation challenges remain, including the development and adoption of new claims codes and processing algorithms, the installation of quality-monitoring systems, and, crucially, the active engagement of frontline physicians.²⁴

Perhaps more important, while episode-based payment would encourage providers to steer patients towards less costly chemotherapy regimens, the eventual choice of treatment would continue to rely on the consent of the beneficiaries, who would have no greater incentive to choose less costly care because their Medicare benefit had not changed.

To avoid this conflict and to alleviate providers' concerns of being viewed as balancing the books on the backs of beneficiaries, it seems natural to expose patients to the financial implications of their treatment choices. We describe and discuss two modifications of the current benefit design: no copayment for the least costly alternative only, which would deter beneficiaries without supplemental coverage from choosing more expensive care, and a novel "shared-savings supplement", which would encourage all beneficiaries to consider cost not by charging those who chose more costly care but by rewarding the choice of the least costly alternative. As highlighted in Table 1, the shared-savings supplement is the only one of these benefit design options that performs well on both criteria with or without the presence of supplemental coverage.

As a form of reference pricing, coverage of the least costly alternative offers conceptual simplicity and the greatest potential for program savings because of its strong incentives to opt for less costly care for beneficiaries without supplemental coverage. Yet, the determination that a more expensive treatment option was clinically comparable to a less costly alternative might prove contentious and politically too delicate to enforce. Moreover, for beneficiaries with first-dollar supplemental coverage, an LCA benefit would offer little incentive to choose less costly care. By contrast, a shared-savings supplement for the least costly alternative would increase beneficiaries' exposure to the cost differentials across treatments without penalizing them financially for choosing more expensive treatment. Therefore, such a benefit design might be more acceptable even for groupings of treatment options that vary in clinical characteristics. And as under an LCA benefit, beneficiaries without supplemental coverage would make no out-of-pocket payments when they chose the

least costly alternative. The resulting program savings might be smaller than under an LCA benefit, however, once the shared-savings supplement payments are factored in.

Although we discuss these benefit modifications in the specific context of a cancer pilot program, they could generalize to other conditions and care settings, in which patients must choose among alternatives that are clinically comparable but differ widely in cost, such as choosing between higher and lower cost specialists or hospitals. As one example, Accountable Care Organizations (ACOs) are premised on the shared savings concept²⁵, but like episode-based payment, it is only the payer and the providers who do all the sharing. Therefore, incentives to patients (and their consent to the lower-cost treatment) could again prove to be the Achilles Heel of the concept. Although rule-making on this issue is still evolving, conceivably ACOs could employ various standard value-based insurance design (V-BID) principles such as lower copayments for more effective care, but that would remain a limited way of incorporating patient incentives. Allowing patients to share in the savings via cash disbursements, not just reductions in co-insurance payments, may be a natural or even necessary step for the success of the ACO concept. For such an approach Medicare would have to authorize cash payments to beneficiaries, perhaps within designated “safe harbors” set up to improve quality of care and to further its existing shared-savings objectives. Expanding the pilot to that context, or simply encouraging ACOs to experiment with their own ideas of patient participation, could prove to be a valuable extension of the ideas presented here.

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Figure 1.

Under the current benefit design, beneficiaries pay a 20% copayment (red) regardless of their choice of regimen: \$264 per month for paclitaxel/carboplatin, \$1418 per month for pemetrexed/carboplatin. Medicare pays the remaining 80% (blue).

Source: Bach PB, Mirkin JN, Luke JJ (2011) and authors' calculations.

Figure 2.

Under a least-costly-alternative policy, Medicare would fully cover the least costly alternative paclitaxel/carboplatin (blue) but beneficiaries choosing the more expensive option pemetrexed/carboplatin would pay the full price differential of \$5,770 per month out-of-pocket (red).

Source: Bach PB, Mirkin JN, Luke JJ (2011) and authors' calculations.

Figure 3.

Under the proposed shared-savings policy, Medicare would pay beneficiaries \$264 per month when they chose the least costly alternative paclitaxel/carboplatin (green-blue). Beneficiaries choosing the more expensive option pemetrexed/carboplatin would pay a 20% copayment of \$1418 per month (red) and Medicare would assume the remainder (blue).

Source: Bach PB, Mirkin JN, Luke JJ (2011) and authors' calculations.

Table 1.

Incentive and Insurance Dimensions of Current and Proposed Benefit Designs.

		Insurance	
		low	high
Incentive	low		<ul style="list-style-type: none"> • Current benefit with Medigap • LCA with Medigap
	high	<ul style="list-style-type: none"> • Current benefit without Medigap • LCA without Medigap 	<ul style="list-style-type: none"> • Shared-savings supplement with / without Medigap

Notes:

Insurance: protection against out-of-pocket payments for treatment that costs more than the least costly alternative.

Incentive: difference in out-of-pocket payments between least costly alternative and more expensive treatment.

LCA: no copayment for least costly alternative only.

Medigap: supplemental coverage that covers all deductibles and coinsurance payments under Parts A and B of Medicare.