Issue Brief

Why Health Reform Will Bend the Cost Curve

David M. Cutler, Karen Davis, and Kristof Stremikis

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ABSTRACT: The health reform bills passed by the U.S. House of Representatives and under consideration in the Senate introduce a range of payment and delivery system changes designed to achieve a significant slowing of health care cost growth. Most assessments of health reform legislation have focused only on the federal budgetary impact. This study projects the effect of national reform on total national health expenditures and the insurance premiums that American families would likely pay. We estimate that the combination of provisions in the House and Senate bills would save $683 billion or more in national health spending over the 10-year period 2010–2019 and lower premiums by nearly $2,000 per family. Moreover, the annual growth rate in national health expenditures could be slowed from 6.4 percent to 6.0 percent.

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OVERVIEW

To judge the merit of health reform proposals, it is essential to understand the impact of the provisions on both the affordability of insurance coverage and overall health care spending. Most assessments of the current congressional health reform bills, however, have taken a federal budgetary perspective only. These include the estimates prepared by the Congressional Budget Office (CBO), which "scored" the federal budget impacts of the Affordable Health Care for America Act (H.R. 3962, the House bill)[1] and the Patient Protection and Affordable Care Act (the Senate bill),[2] finding in each case a modest deficit reduction in the first 10 years of implementation.

But the federal budget impact is not the same as the health system impact. Some of the federal funds would be used to reduce costs for people who already have health insurance coverage but struggle to afford it, while others would assist very small businesses with the cost of insurance premiums. To estimate health spending accurately, we need to separate out the costs into *new* health care

spending and transfers of *existing* spending from the private sector to the government. Furthermore, CBO assigned very little savings to system reform efforts, rendering its overall analysis incomplete.

The Office of the Actuary within the Centers for Medicare and Medicaid Services (CMS), meanwhile, estimated the health system impacts of H.R. 3962[3] and determined there would be a small increase in medical spending as a result of the reform. But, again, this analysis is limited, since it gives almost no weight to proposals for improving the information available to providers and modifying the financial incentives in the current system.

This study considers the Senate bill introduced by Senator Harry Reid on November 18, 2009, and the House bill passed on November 7, 2009, to project the impact of major health reform on national health expenditures and the insurance premiums that families would likely pay, accounting for the full range of impacts the legislation is likely to induce. As part of our analysis, we provide estimates of the effect of key provisions on health spending by government, employers, and households.

IMPACT OF REFORM ON NATIONAL HEALTH EXPENDITURES

Health care reform will affect national health expenditures through five major channels.

Impact of New Coverage

Extending health insurance coverage to essentially all Americans would increase medical spending, at least in the short run. (Some argue that increased coverage will lower spending over time by making it possible to pursue more-aggressive cost-containment policies without risking access to care for the uninsured, but in this analysis we do not consider such effects.[4]) From previous studies, data are available to estimate the magnitude of the increase in spending. Hadley and colleagues, for example, estimate that each uninsured individual who gains coverage will incur annually an additional $1,600 of medical care expenses—an increase of 70 percent.[5] The Congressional Budget

Office estimates that spending for uninsured individuals, if they become insured, would increase by 25 to 60 percent.[6] The actual increase will depend in part on the rates that are paid to health care providers for treating currently uninsured patients.

For our estimates, we increase the $1,600 figure over time with expected increases in medical costs. We then multiply the revised amounts by the number of newly insured resulting from the various legislative proposals to produce a total estimate. Fully phased in, incremental coverage costs about $75 billion per year to cover 60 percent of the uninsured, or 2 percent of total health care spending. This is comparable to the estimate of Davis and Schoen,[7] who project that covering all of the uninsured would add 3 percent to medical spending, and Schoen, Davis, and Collins, who found that covering all of the uninsured would add 2 percent to medical spending.[8] This methodology suggests that the Senate bill would lead to a 10-year cumulative medical spending increase of $402 billion over the period 2010–2019, and that the House bill would lead to a cost increase of $549 billion (reflecting the greater coverage under that bill). These estimates are shown in the first row of Exhibit 1.

Savings in Public Programs

Both the House and Senate health reform bills contain a number of changes to Medicare and Medicaid payments. Many of these are traditional payment changes—for example, reductions in the amount paid to Medicare Advantage managed care plans to a level comparable to the cost of covering beneficiaries under traditional Medicare, or smaller increases in Medicare inpatient payments to account for a likely increase in productivity. We take estimates of the impact of these changes on medical spending from CBO, noting that while this is a good place to begin, the CBO has in the past often misestimated, or failed to estimate, the behavioral consequences of such changes.[9]

We consider all such changes, with a few exceptions. First, we exempt the net savings associated with health care modernization (Section 1104 and Title III, subtitle A, of the Senate bill; Titles III

Exhibit 1. Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2019

	Senate	House
Affordable Coverage for All: Coverage Expansion and National Health Insurance Exchange		
• **New coverage utilization**	$402 billion	$549 billion
Payment and System Reforms		
• **Traditional savings**[1]	−$393	−$364
• **Reduced administrative costs**[2]	−$162	−$187
• **Health system modernization**[3]	−$530	−$530
Total Net Impact on National Health Expenditures, 2010–2019	**−$683 billion**	**−$532 billion**

Notes:
[1] CBO estimate of the effect on direct spending for non-coverage provisions net of modernization and CLASS;
[2] Authors' estimate of reduced administrative costs in addition to CBO estimate of $29 billion (Senate) and $34 billion (House) in administrative savings;
[3] Author's estimate of savings due to health system modernization.
Data: Authors' estimates; The Congressional Budget Office Preliminary Analysis of the Patient Protection and Affordable Care Act, Nov. 18, 2009, http://www.cbo.gov/doc.cfm?index=10731; The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

and IV and certain parts of Title I of the House bill), which we consider separately. We also omit the sections associated with coverage expansions, which are accounted for above. Finally, we omit savings from the Community Living Assistance Services and Supports (CLASS) Act, which are a collection of premiums in anticipation of future spending. CBO estimates that the net impact of the remaining proposals in the Senate bill is to reduce Medicare and Medicaid spending by $393 billion over the 2010–2019 period. The comparable value for the House bill is $364 billion. These estimates are depicted in the second row of Exhibit 1.

The reduction in Medicare and Medicaid spending is approximately on par with the increase in medical costs associated with covering the uninsured. The net impact of covering the uninsured and reducing traditional program payments (and other taxes from outside the health care system) would be an increase in spending of $9 billion over 2010–2019 in the Senate bill and an increase of $185 billion over the same period in the House bill. This roughly parallels the analysis from the Office of the Actuary, which estimated that national medical expenditures under H.R. 3962 would increase by $289 billion over 2010–2019. The difference of about $10 billion per year is very small on the scale of health expenditures (less than

1 percent per year) and indicates that this analysis matches that of the actuary when no other cost changes are considered.

Our analysis assumes that reduced Medicare and Medicaid payments are not offset by higher prices to private payers, and equivalently that greater coverage does not result in savings to existing payers because of reduced cost-shifting. This assumption is common to other estimators and is consistent with empirical research.[10]

Insurance Exchanges and the Public Option

Currently, nearly 13 percent of insurance premiums are accounted for by administrative costs.[11] These costs range from about 5 percent in large firms and firms that are self-insured to 30 percent for individuals. Higher costs for marketing, underwriting, churning, benefit complexity, and brokers' fees explain the bulk of the difference.

Both the House and Senate bills propose insurance exchanges that would group individuals and small firms into larger entities and thus drive down those administrative costs. A public option would contribute to this effort. In many areas of the country, there is little meaningful insurance competition. By providing such competition, the public option can drive down

profits and force insurers to streamline other compo-
nents of administration, including benefit design. The
House bill would offer a public health insurance plan
in the exchange, and the Senate bill would establish a
public option, with states being able to opt out at their
choosing. Each of these would reinforce the impact of
insurance exchanges.

The exchange could also minimize marketing
costs through more transparent posting of premiums,
facilitated enrollment (assistance with the applica-
tion process and screening for eligibility), and stron-
ger oversight of industry practices. The House bill
establishes additional insurance market regulations,
including repeal of the McCarran-Ferguson exemption
from antitrust laws, a requirement that plans devote 85
percent of premiums to medical care, and authority for
states to review and reject premium increases. These
can be expected to place downward pressure on admin-
istrative costs.

If all individuals and small firms received the
same premiums as large firms or self-insured firms do,
the costs of insurance administration would decline to
less than 10 percent. The Commonwealth Fund ana-
lyzed the experience of other countries and estimated
that administrative costs could fall to 8 percent or
lower under a robust exchange system.[12] We assume
more modest savings, such that administrative costs
fall to 10 percent of total premiums. We assume that
rate is constant over time, even though this implies
administrative costs increase along with national health
spending. We assume such savings begin in 2013 under
the House bill and 2014 under the Senate proposal, the
years the exchanges would become operational, and
are phased in over three years. The reduction in health
spending associated with reduced insurer administra-
tion is $191 billion to $221 billion over 2010–2019.

CBO estimates some reduction in premiums
from exchanges, but not as large: between 1 and 4
percent for small groups, and no savings for large
groups, for an average of about 0.4 percent.[13] Applying
such estimates yields 10-year savings of $29 billion to
$34 billion. We assume additional savings above this
amount, totaling $162 billion under the Senate proposal

and $187 under the House bill over 2010–2019 (see
third line of Exhibit 1).

Health System Modernization

Both the House and Senate bills include numerous pro-
visions to change the information available to patients
and providers and the incentives facing medical care
providers, and thus make medical care more efficient.
The Commonwealth Fund has recently summarized
these provisions.[14] Within the Medicare and Medicaid
programs, these include:

- Payment innovations, including higher reim-
  bursement for preventive care services and
  patient-centered primary care, bundled pay-
  ment for acute and post-acute medical ser-
  vices, shared savings or capitation payments
  for accountable provider groups that assume
  responsibility for the continuum of a patient's
  care, and pay-for-performance incentives for
  Medicare providers;

- Negotiation of pharmaceutical prices (in the
  House bill);

- Increased funding for comparative effectiveness
  research;

- Profiling medical care providers on the basis of
  cost and quality, making that data available to
  consumers and insurance plans, and providing
  financial incentives for relatively low-quality,
  high-cost providers to improve their care;

- Increased emphasis on wellness and prevention;

- Mechanisms to streamline demonstration and
  pilot projects in Medicare and the rapid expan-
  sion of successful models across the program;

- An ongoing Medicare commission to recom-
  mend structural changes to Medicare and put
  such recommendations on fast-track consider-
  ation in Congress (in the Senate bill); and an
  Institute of Medicine study of geographic varia-
  tion in health care spending, and authority for
  the Secretary of Health and Human Services

(HHS) to rapidly implement recommendations to address such variations (in the House bill); and

- An excise tax on high-cost insurance plans (in the Senate bill).

In addition, the House bill gives the HHS secretary authority to use innovative payment methods in a public health insurance option as well, including bundled-payment systems and value-based insurance design, to further the impact of these reforms.
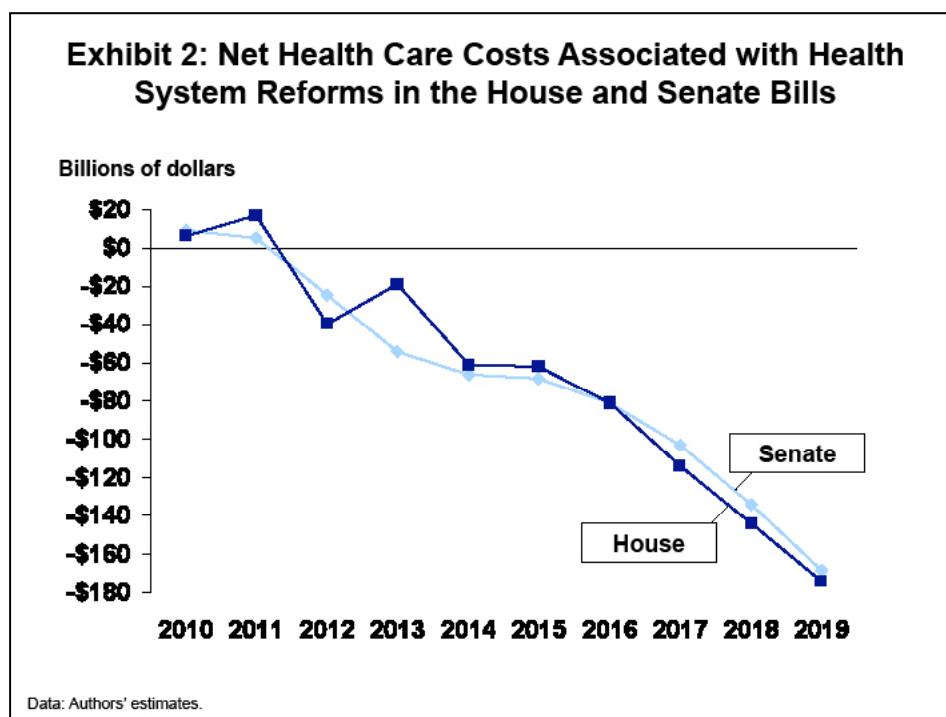
The exact amount that would be saved from these provisions collectively is uncertain. Partly as a result of this uncertainty, CBO and the Office of the Actuary assume only minor savings. For example, CBO estimates that the major parts of the bill including these provisions would cost $10 billion over the 2010–2019 period, and the Office of the Actuary assumes savings of only $2 billion.

Other estimates, however, suggest that an aggressive approach to health care modernization could result in significantly greater cost reductions. Beeuwkes-Buntin and Cutler estimate that significant health care reform could reduce cost increases by 1.5 percentage points annually, or more than $700

billion in the 10-year window.[15] These savings would come from two primary sources. First, administrative expenses incurred by provider groups would decline as electronic medical records and incentives to use them appropriately are widely disseminated. The potential for administrative savings have been stressed by both provider groups and insurers,[16] and are distinct from the reduction in insurance administration noted above. Second, reform would lead to fewer and less-costly acute care episodes. Preventing certain recurrent illnesses by coordinating care better and rationalizing what is done when a person becomes sick, bundling payments, paying more for quality care, and sharing savings with accountable provider organizations are all areas of potentially substantial savings.

Similarly, Hussey, Eibner, Ridgely, and McGlynn estimate that savings of more than 10 percent are possible, largely from payment reforms like bundled-payment systems. Realizing these savings over a decade would imply cost reductions of nearly 1.5 percentage points annually.[17]

The Senate bill includes a Medicare commission to help control costs, while the House bill grants the HHS secretary authority to negotiate pharmaceutical prices and apply innovative payment methods broadly in Medicare and a public health insurance plan. The

Exhibit 2: Net Health Care Costs Associated with Health System Reforms in the House and Senate Bills

Data: Authors' estimates.

combination of provisions in the House and Senate bills would achieve substantial savings in total health spending. A Commonwealth Fund report indicates that similar provisions would slow the annual growth in national health expenditures from 6.5 percent to 5.6 percent over the period 2010–2020.[18] Thus, cost reductions on the order of 1.0 percentage points are realistic. To be conservative, we consider cost savings of a smaller amount: a reduction of 0.75 percentage points annually. We assume such savings are first realized in 2012, to allow time for payment changes to be designed and implemented.

The public and private savings from health system modernization are $530 billion over the 10 years (see fourth line of Exhibit 1). These savings are smaller in the early years but increase over time.

Taking account of these different factors, on net the Senate bill should reduce health care spending by $683 billion over 2010–2019, and the House bill should reduce health spending by $532 billion. The smaller reduction in the House bill reflects the increase in coverage over the Senate bill, especially in the early years of reform. Exhibit 2 shows the changes by year, highlighting the difference associated with earlier and greater coverage.

We find that the annual rate of growth in national health expenditures falls from 6.4 percent, absent reform, to 6.0 percent under the Senate proposal (Exhibit 3). When the current projection is corrected to reflect underutilization of services by the uninsured, the Senate reform package lowers the annual rate of growth from 6.6 percent to 6.0 percent, a reduction of 0.6 percentage points per year. Similar results are projected under the House bill.

The savings we estimate are comparable to the CBO and Office of the Actuary reports, with the exception that we also include reasonable impacts of system modernization incentives and efforts to streamline sales of insurance.

IMPACT ON THE FEDERAL BUDGET

The Congressional Budget Office estimated that the reform bills passed by the House and under consideration in the Senate would reduce the federal deficit by $130 billion to $138 billion over the 10 years, 2010–2019. Our estimates of the federal deficit impact differ from CBO's in two ways. First, we include savings to Medicare and Medicaid resulting from health system modernization. In addition, reductions in employer spending for health insurance lead to increases in
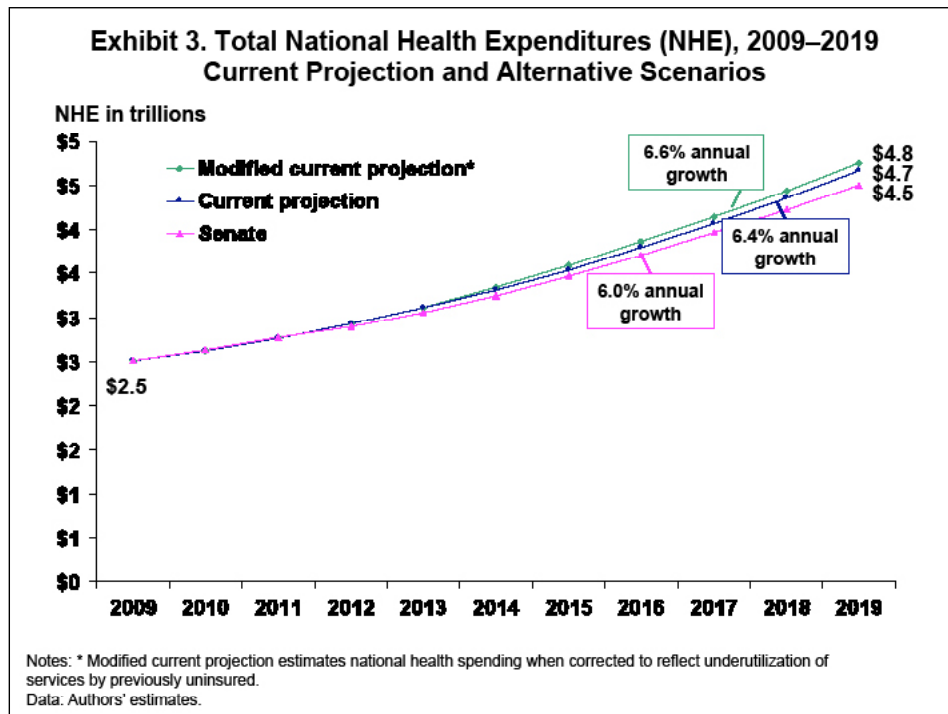

Exhibit 3. Total National Health Expenditures (NHE), 2009–2019 Current Projection and Alternative Scenarios

Notes: * Modified current projection estimates national health spending when corrected to reflect underutilization of services by previously uninsured.
Data: Authors' estimates.

Exhibit 4. Net Impact of Reforms on Federal Budget, 2010–2019 (in billions)

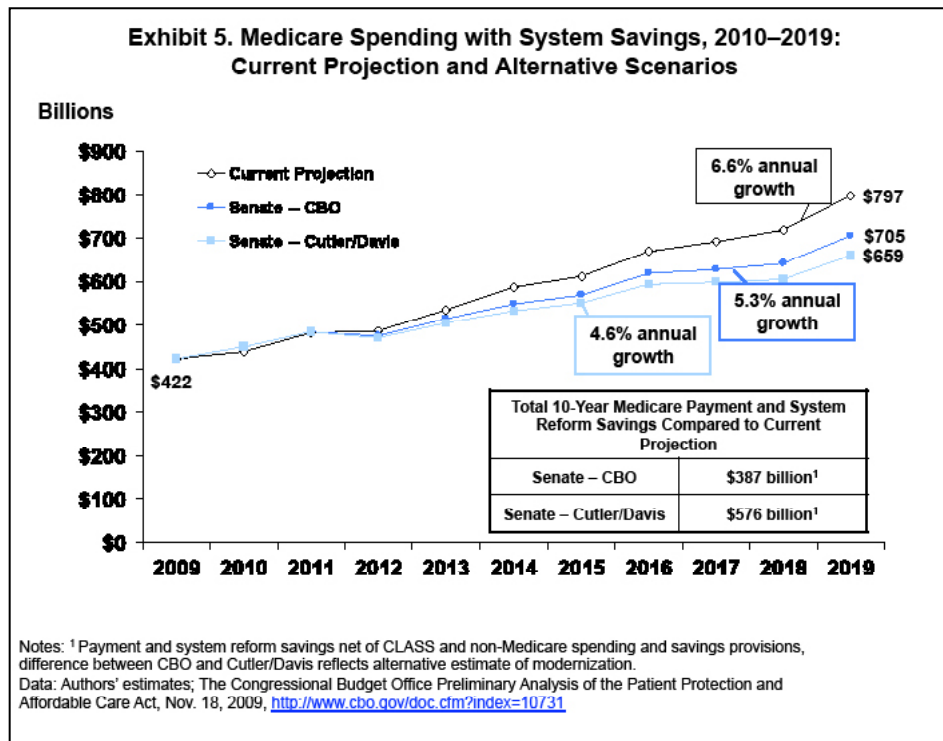|	Senate		House	
	CBO	Cutler/Davis	CBO	Cutler/Davis
Federal Cost of Coverage Expansion	$748 billion	$748 billion	$891 billion	$891 billion
Federal Savings from Payment and System Reforms[1]	–$491	–$680	–$456	–$681
Federal Tax Revenue	–$387	–$387	–$574	–$574
Additional Tax Revenue from Private Sector Savings[2]		–$90		–$95
Federal Budget Cost, 2010-2019	–$130 billion	–$409 billion	–$138 billion	–$459 billion

Notes:
[1] Difference between CBO and Cutler-Davis reflect alternative estimate of modernization provisions;
[2] Increased tax revenue due to increased wages not already accounted for by CBO.
Data: Authors' estimates; The Congressional Budget Office Preliminary Analysis of the Patient Protection and Affordable Care Act, Nov. 18, 2009, http://www.cbo.gov/doc.cfm?index=10731; The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

wage and salary payments, which are taxed by the federal government. While CBO accounted for some of this effect in recent estimates, further reductions in employer spending for health insurance due to modernization and lower administrative costs can be expected. We assume that 90 percent of private health insurance savings are passed on to employees through increased wages, which are taxed at an average marginal rate of 28 percent.

The net effect is a federal deficit reduction of between $409 billion and $459 billion (Exhibit 4). The net effect is made up of several factors. As outlined above, the federal cost of coverage expansion is projected at $748 billion under the Senate bill and $891 under the House bill. Savings from payment and system reform provisions are projected to generate between $680 billion and $681 billion—substantially more than is estimated by CBO, owing to the reasonable estimates of health system modernization provisions. Our federal tax revenue projection mirrors that of CBO, though we also add in the additional revenue from employer savings and increased wages from modernization and lower administrative costs—projected to raise $90 billion to $95 billion over the 10-year, 2010–2019 period.

Exhibit 5. Medicare Spending with System Savings, 2010–2019: Current Projection and Alternative Scenarios

Notes: [1] Payment and system reform savings net of CLASS and non-Medicare spending and savings provisions, difference between CBO and Cutler/Davis reflects alternative estimate of modernization.
Data: Authors' estimates; The Congressional Budget Office Preliminary Analysis of the Patient Protection and Affordable Care Act, Nov. 18, 2009, http://www.cbo.gov/doc.cfm?index=10731

IMPACT ON MEDICARE

Medicare expenditures are currently projected to grow by 6.6 percent annually from 2010 to 2019 (Exhibit 5). The Senate bill's payment and system reform savings estimated by CBO total $387 billion when CLASS and non-Medicare provisions are removed. Applying these net Medicare savings bends the Medicare spending curve and reduces the projected annual growth rate to 5.3 percent. When additional savings from health system modernization are accounted for, the annual growth rate is reduced to 4.6 percent and total 10-year savings reach $576 billion. Similar results are projected under the House health reform bill.

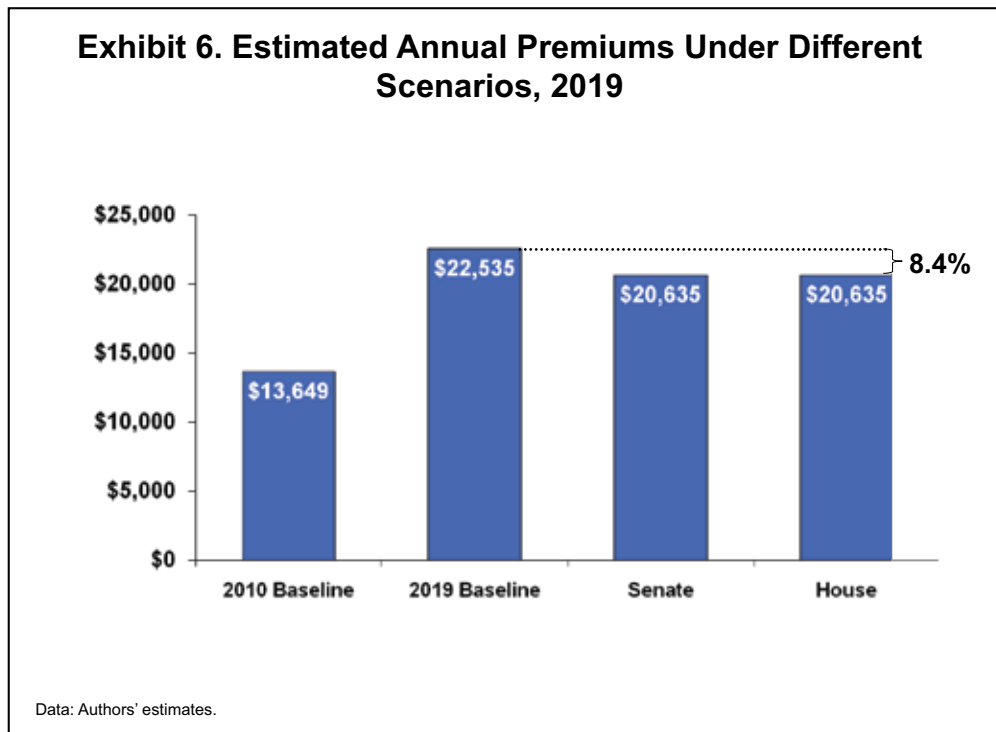## IMPACT ON PREMIUMS FOR PRIVATE COVERAGE

Reducing insurer administration and modernizing the delivery of health care services will each result in reductions in private insurance premiums. Private premiums might be affected by other provisions as well. For example, health reform might change the generosity of the average benefits offered, thus raising or lowering premiums. In the current market, many people have coverage that is extremely limited, with deductibles totaling many thousands of dollars and classes of services that are excluded. Such people will face price increases under reform, although the quality of the coverage will be significantly improved and out-of-pocket expenses reduced. The Congressional Budget Office estimates that such changes will increase non-group premiums. For purposes of this analysis, we exclude changes in premiums associated with better coverage, since one would need to consider the impacts of the enhanced coverage and correspondingly lower out-of-pocket spending to gauge accurately the impact of the changes.

In addition, health reform might change the risk pool and thus affect the average cost of enrollees. Limiting age-based underwriting without providing offsetting subsidies to young adults would drive many within this population out of the insurance market. Close-to-universal coverage, in contrast, might bring more young people into the market, thus lowering premiums. Because of the issues associated with changes in out-of-pocket spending when people move in and out of coverage, we again omit this effect.

We estimate the impact of insurance exchanges and system reform on average premiums using a method analogous to the one proposed above. In particular, we consider how reductions in administrative loads and more-efficient care delivery will affect average market premiums. The basis for the premium estimates is the average employer premium in 2006, taken from the Medical Expenditure Panel Survey.[19] This premium is then trended forward using the projected growth of premiums under the different scenarios.

Exhibit 6 shows the premium estimates. Without reform, premiums are expected to increase from $13,649 in 2010 to $22,535 in 2019. Relative to this increase, premiums under reform increase only three-quarters as much. By 2019, family premiums are $1,900 lower. Adding reductions in out-of-pocket costs and lower taxes for Medicare and Medicaid would result in estimated savings for the typical family of over $2,500 that year. Again, these are conservative estimates. A recent analysis by the Business Roundtable prepared by Hewitt, for example, found that such legislative reforms could potentially reduce the trend line in employment-based health care spending by $3,000 per employee by 2019.[20]

Exhibit 6. Estimated Annual Premiums Under Different Scenarios, 2019

Data: Authors' estimates.

Explaining the Differences with Other Estimates

The estimated health system savings we present are larger than those forecast by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, which are similar to each other. The common assessments of CBO and the CMS Office of the Actuary are not surprising. Those groups rely largely on peer-reviewed studies utilizing carefully controlled comparison groups (either randomized trials or the natural equivalent) for their evidence. Within that genre, the dominant published themes are the inexorable nature of technology-led medical care cost increases, and the resulting need for unalterable demand or supply-side constraints to confront that trend. Although there is significant evidence in the literature that medical care providers are responsive to financial incentives,[21] there is not much evidence in the published literature on policy reforms short of severe constraints that save large amounts of money. And for every study that does show savings from baseline, there is another study that does not. Thus, the common assessment is that there is little efficacious that can be done.

There is, however, a less formal, but no less important, literature that sees the world very differently. Business scholars, including Michael Porter and Elizabeth Teisberg, and Clay Christenson, Jerome Grossman, and Jason Hwang, all note the enormous inefficiency in health care relative to other industries: excessive administrative spending, wasted time and money, and resources spent passing along costs, not reducing them.[22] They highlight the enormous potential for productivity improvement that reform can drive if it makes health care operate more like other industries.

Experiences of health care practitioners reach a similar conclusion. Physicians on the front line, including Guy Clifton, Arthur Garson, Atul Gawande, and Arnold Relman see waste, know it exists, and have a common view about why it exists—misaligned incentives being the major driver.[23] They present a story of care that could be better and cheaper, but operates in a system that discourages it. This story is echoed in journalistic accounts of health care.[24] A number of recent books show how the health care system fails patients, physicians, and society as a payer. In each case, the common theme is misaligned incentives, with the call for reforms that change the underlying incentives.

A number of case studies provide support for the potential of reform. The experience of Geisinger Health System, HealthPartners, Denver Health, and others all illustrate that health can be improved and costs lowered.[25] They also show the components that are most important for system improvement. These case studies are often in the published literature but lack the careful comparison groups that make the results compelling to the most skeptical reviewers. Thus, their results are not given as much emphasis as they otherwise might.

While evidence regarding appropriate evidence standards differs, the situation we analyze is one where there are essentially no clinical trials and where effects of large policy changes may differ substantially from effects of small trials. In such a situation, it is imperative to cast a wider net than traditional evidence standards. Our decision to be more inclusive in the use of evidence is the primary reason why our results differ from those of CBO and the CMS Office of the Actuary.

CONCLUSION

The bills passed by the House and under consideration in the Senate introduce a range of payment and delivery system changes likely to result in a significant slowing of health care cost growth. First, the bills call for the creation of health insurance exchanges that would offer a choice of plans—including a public plan—and the ability, for the first time, to truly compare plan premiums. In the House bill, an exchange would have authority to reject plans with excessive premiums and set caps on insurance profits and overhead of no more than 15 percent of the premium, providing savings to employers and workers that might reach 15 to 20 percent by 2019.

The bills also change how providers are paid and care is delivered, in ways that begin to reward value, not volume of services. Both the House and Senate bills would accelerate the testing, adoption, and spread of innovative payment methods to control growth in volume of services. The bills also include extensive provisions to report data on quality and cost and to enhance choice. Finally, the House bill calls for negotiated pharmaceutical prices, reduction of overpriced services, investment in primary and preventive care, and other changes that have the potential to yield substantial savings.

We estimate that the combination of provisions in the House and Senate bills would save $683 billion or more in national health spending over 2010–2019 and lower premiums by nearly $2,000 per family. The annual growth rate in national health expenditures could be slowed from 6.4 percent to 6.0 percent.

Congress has a historic opportunity to pass comprehensive health care reform legislation this legislative session and ensure that all families are able to get the care they need, as well as financial security and relief from rising premiums. Fortunately, the bills currently under consideration offer a significant first step toward bending the health care cost curve for the federal government and families and yield real economic benefits.

NOTES

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ABOUT THE AUTHORS

David Cutler, Ph.D., is the Otto Eckstein Professor of Applied Economics in the department of economics and Kennedy School of Government at Harvard University and recently completed a five-year term as associate dean of the Faculty of Arts and Sciences for Social Sciences. He served on the Council of Economic Advisers and the National Economic Council during the Clinton administration and was senior health care advisor to Barack Obama's presidential campaign. Professor Cutler also advised the presidential campaign of Bill Bradley. Among other affiliations, he has held positions with the National Institutes of Health and the National Academy of Sciences. Currently, Professor Cutler is a research associate at the National Bureau of Economic Research and a member of the Institute of Medicine. He is the author of *Your Money Or Your Life: Strong Medicine for America's Health Care System*, published by Oxford University Press. Cutler was recently named one of the 30 people who could have a powerful impact on health care by Modern Healthcare magazine and one of the 50 most influential men aged 45 and younger by Details magazine. He can be e-mailed at dcutler@fas.harvard.edu.

Karen Davis, Ph.D., is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences; and Health and the War on Poverty. She can be e-mailed at kd@cmwf.org.

Kristof Stremikis, M.P.P., is senior research associate for Commonwealth Fund President Karen Davis. Previously, he was a graduate student researcher in the School of Public Health at the University of California, Berkeley, where he evaluated various state, federal, and global health initiatives while providing economic and statistical support to faculty and postdoctoral fellows. He has also served as consultant in the director's office of the California Department of Healthcare Services, working on recommendations for a pay-for-performance system in the Medi-Cal program. Mr. Stremikis holds three undergraduate degrees in economics, political science, and history from the University of Wisconsin at Madison. He received a master of public policy degree from the Goldman School at the University of California, Berkeley, and is currently enrolled in the health policy and management program at Columbia University.