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Public Programs: Critical Building Blocks in Health Reform

Karen Davis
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The Commonwealth Fund
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Senate Finance Committee Retreat
June 16, 2008

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U.S. Health System: What's Working, What's Not?

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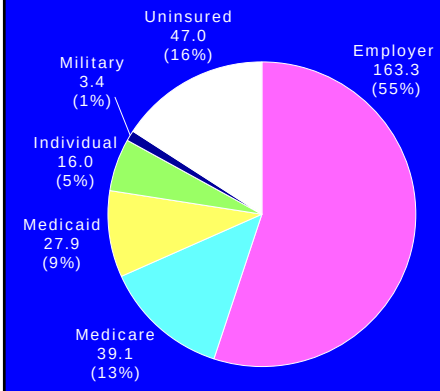
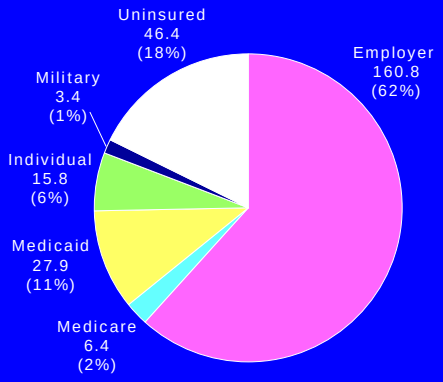
Health Insurance Coverage

Numbers in millions, 2006





Total population = 296.7

Under-65 population = 260.7

Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007).
Data: Analysis of the Current Population Survey, March 2007, by Bisundev Mahato of Columbia University.

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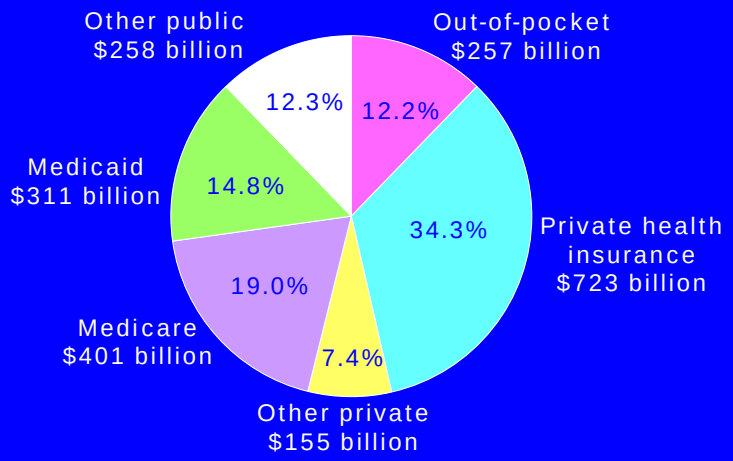
Total National Health Expenditures, $2.11 Trillion – 16% of GDP



Note: Data were rounded to the nearest tenth of a percent because rounding to the nearest percent does not reflect the significant difference in spending between Medicaid and Medicare.
Data source: A. Catlin et al., "National Health Spending In 2006: A Year of Change For Prescription Drugs," *Health Affairs,* Jan./Feb. 2008 27, no. 1: 14-29.

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Employer Health Insurance: Preferred by Many Working Americans

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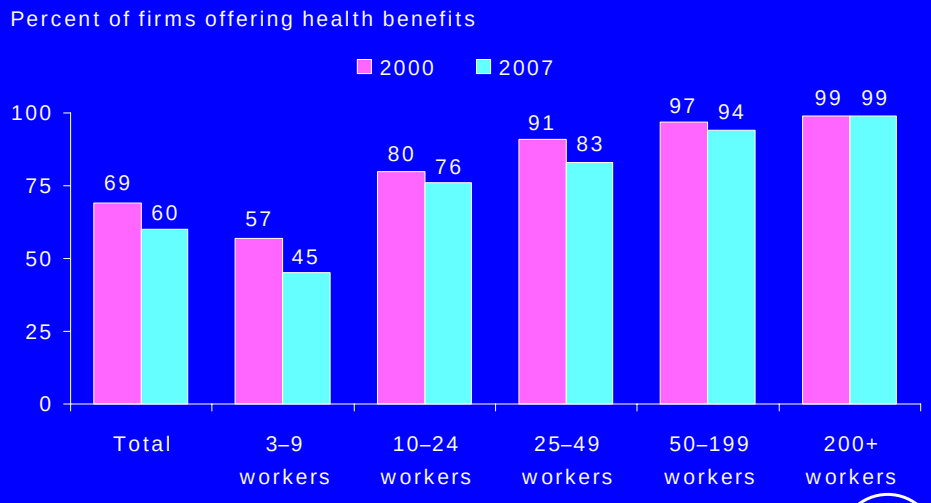
6

Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms



Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007). Data: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.

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Employees in Large Firms Are Most Likely to Have Two or More Health Plan Choices

Percent of adults ages 19-64 insured all year with ESI*

*ESI = employer-sponsored insurance.
Based on adults 19-64 who were who were insured all year through their own employer.
Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006.

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Percent of People with ESI* Who Say That Employers Do a Good Job Selecting Quality Insurance Plans to Offer Their Workers

Percent

*ESI = employer-sponsored insurance. FPL = federal poverty level.
Note: Based on respondents age 19-64 who were covered all year by their own employer's insurance.
Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006.

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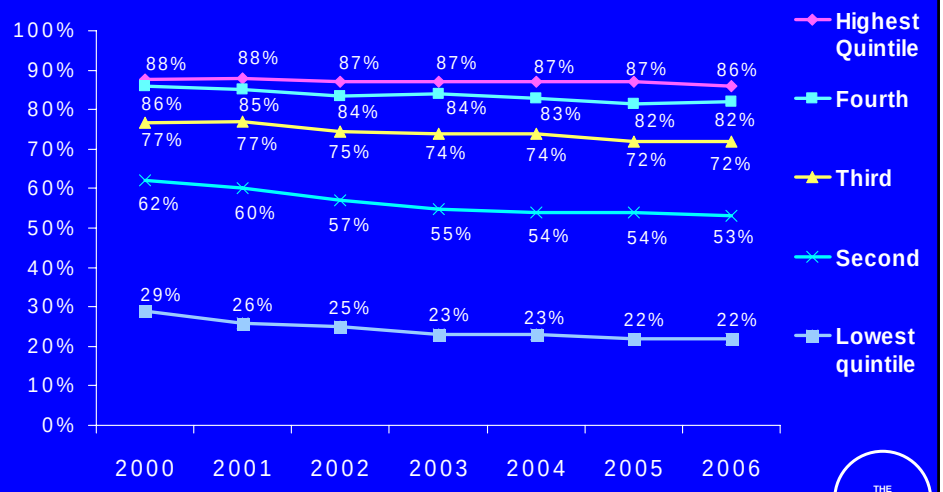
Employer-Provided Health Insurance, by Income Quintile, 2000–2006

Percent of population under age 65 with health benefits from employer



Source: E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

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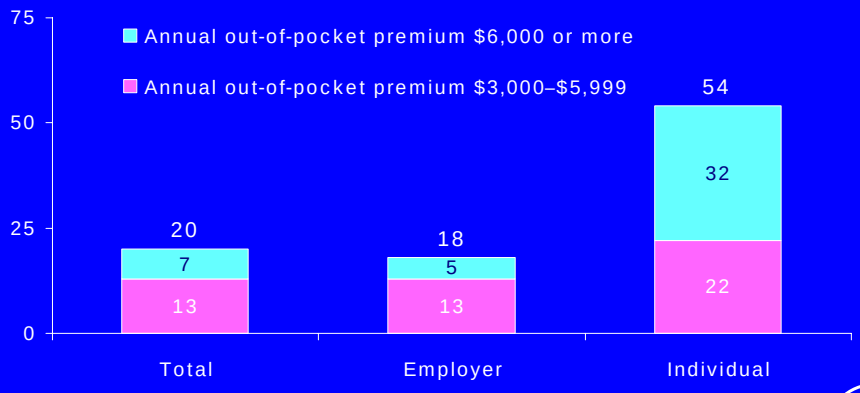
10

Risk Pooling and Employer Premium Contributions Lower the Cost of Health Benefits for Adults with Employer Coverage Relative to Those with Individual Market Coverage

Percent of adults ages 19–64 insured all year with private insurance



Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006.

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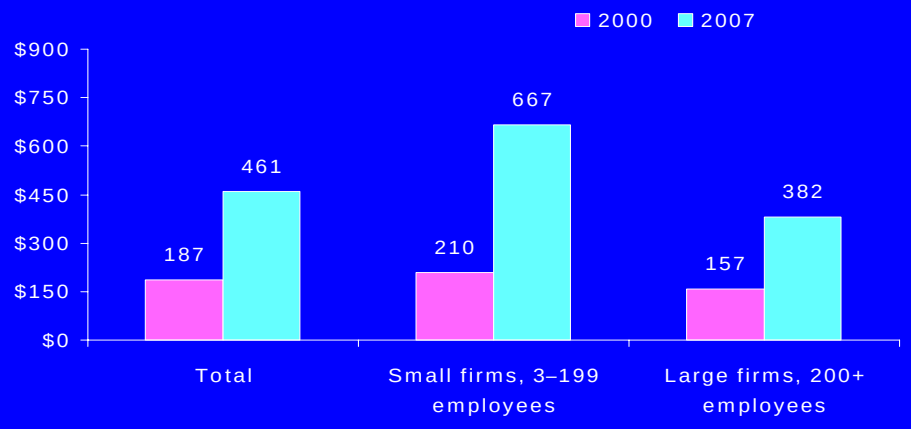
Deductibles Rise Sharply, Especially in Small Firms, Over 2000–2007

Mean deductible for single coverage (PPO, in-network)



PPO = preferred provider organization. PPOs covered 57 percent of workers enrolled in an employer-sponsored health insurance plan in 2007.
Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.

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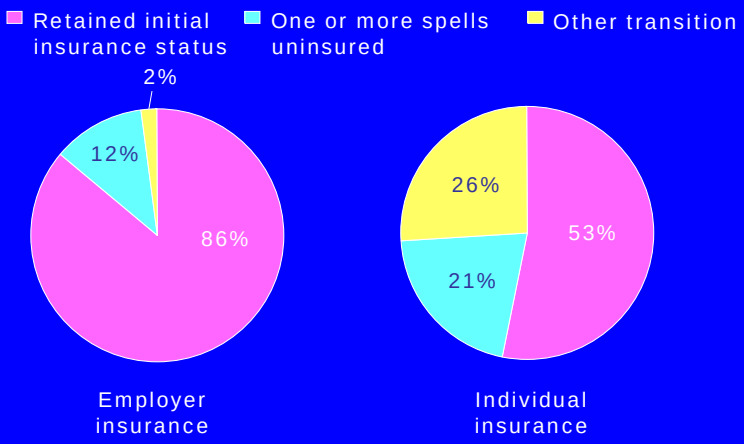
12

People With Employer Insurance Have More Stable Coverage Than Those with Individual Market Insurance

Retention of initial insurance over a two-year period, 1998–2000



Source: K. Klein, S. A. Glied, and D. Ferry, Entrances and Exits: Health Insurance Churning, 1998–2000, The Commonwealth Fund, September 2005. Authors' analysis of the 1998–2000 Medical Expenditure Panel Survey.

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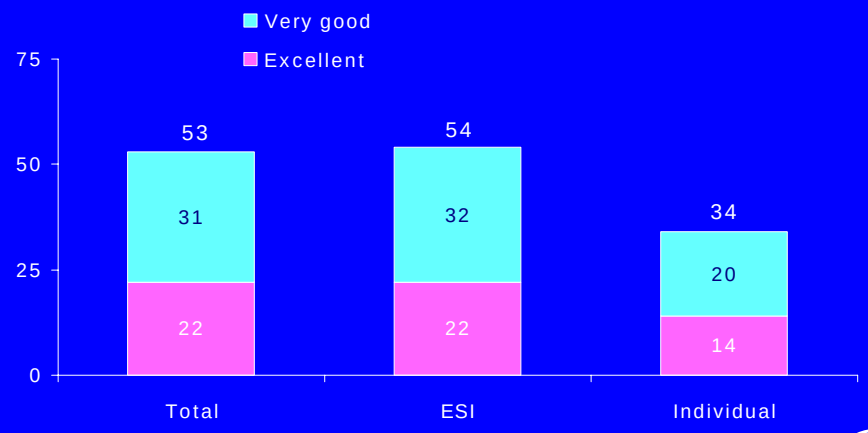
13

Adults With Employer Coverage Give Their Health Plans Higher Ratings Than Those in the Individual Market

Percent of adults ages 19–64 insured all year with private insurance



Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006.

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Medicare: Working for Elderly and Disabled Americans

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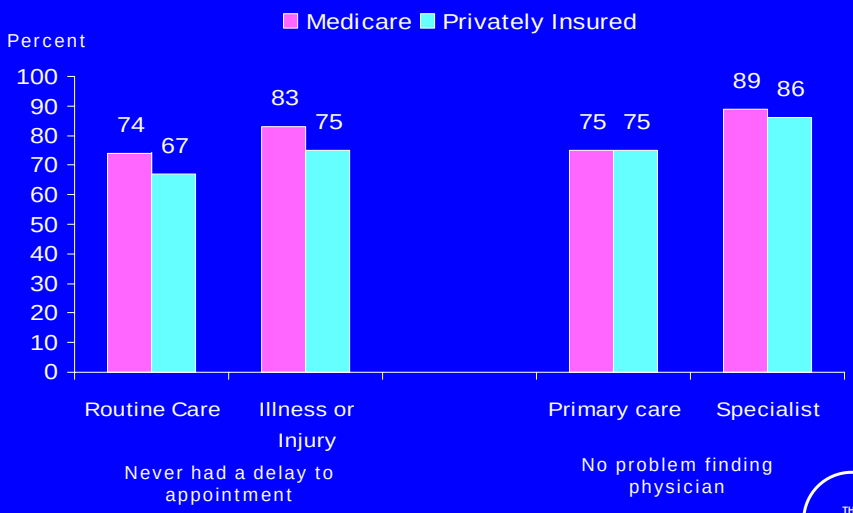
Access to Physicians for Medicare Beneficiaries and Privately Insured People, 2005



Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.

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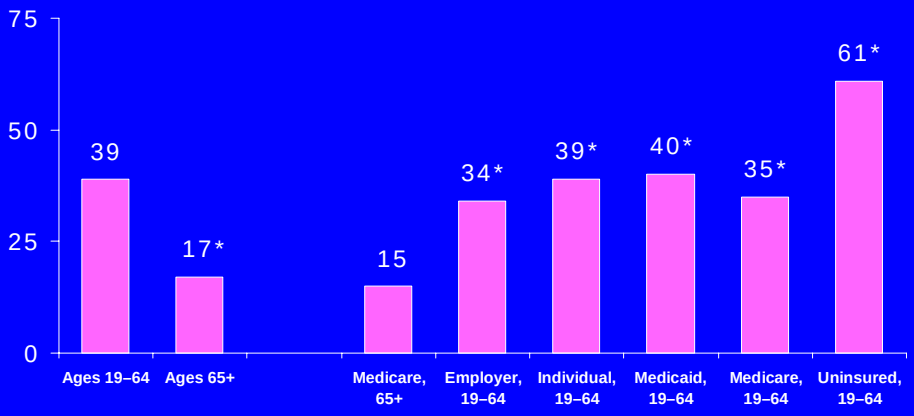
Access Problems Because of Cost

Percent of adults who had any of four access problems[1] in past year due to cost



Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.

[1]Did not fill a prescription; did not see a specialist when needed; skipped medical test, treatment, or follow-up; did not see doctor when sick.

* Significant difference at $p \leq .01$ or better; referent categories are "ages 19–64" and "Medicare 65+".

Source: K. Davis and S.R. Collins, "Medicare at Forty," *Health Care Financing Review,* Winter 2005–2006 27(2):53–62.

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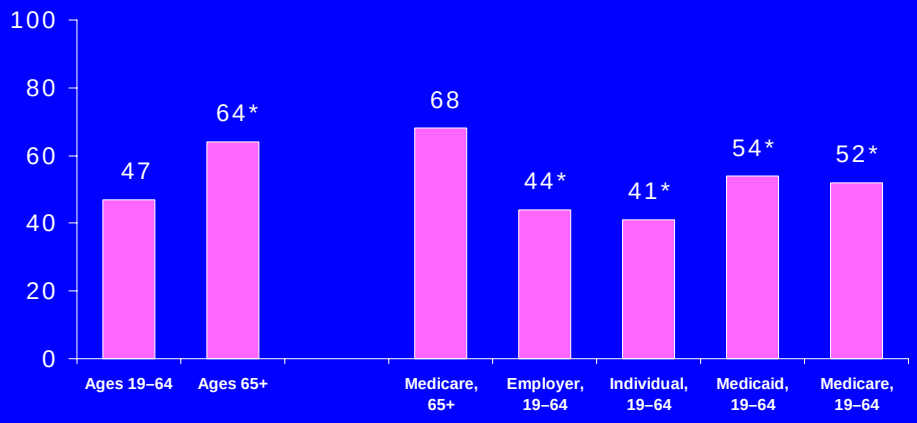
Rating of Current Insurance

Percent of adults who rated their current insurance as "excellent" or "very good"



Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.
* Significant difference at p≤.01 or better; referent categories are "ages 19–64" and "Medicare 65+".
Source: K. Davis and S.R. Collins, "Medicare at Forty," *Health Care Financing Review*, Winter 2005-2006 27(2):53-62.

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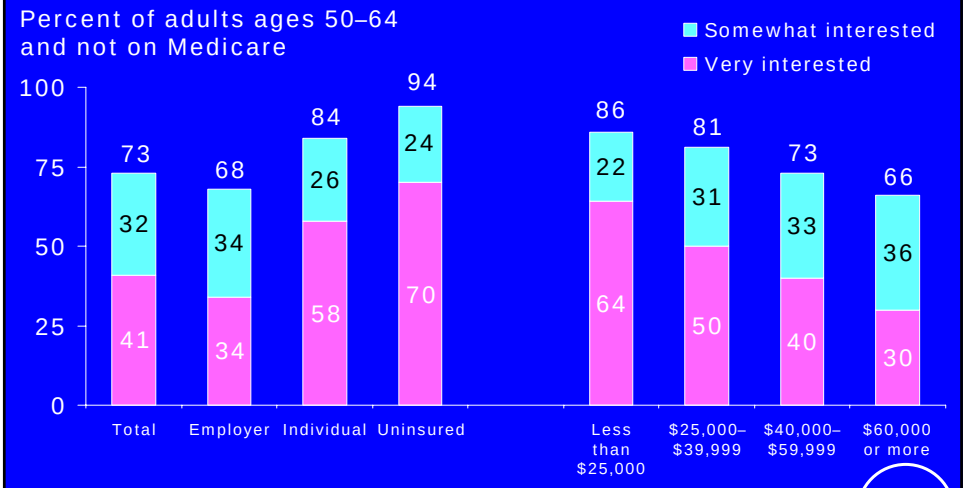
Percent of Adults Ages 50–64 Who Are Very/Somewhat Interested in Receiving Medicare Before Age 65, by Insurance Status and Income

Percent of adults ages 50–64 and not on Medicare



Source: S. R. Collins, et al., *Will You Still Need Me? The Health and Financial Security of Older Americans: Findings from The Commonwealth Fund Survey of Older Adults*, Commonwealth Fund, June 2005.

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Medicaid/SCHIP:
Working for Most at Risk Americans

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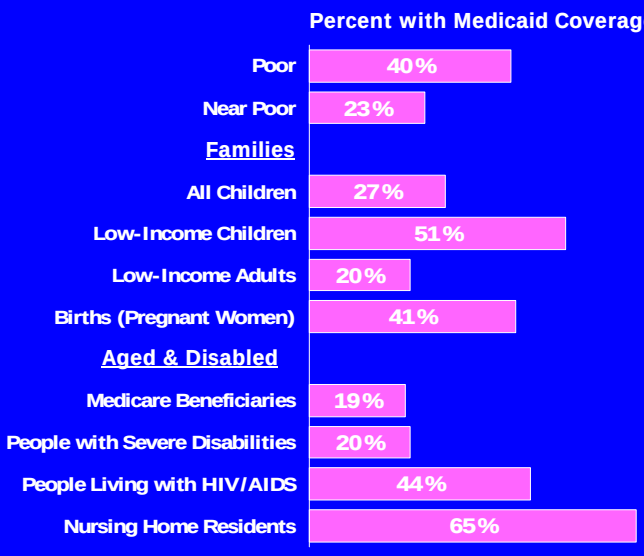
Medicaid's Role for Selected Populations



Note: "Poor" is defined as living below the federal poverty level, which was $17,600 for a family of 3 in 2008.
SOURCE: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, and Urban Institute estimates; Birth data: NGA, MCH Update.

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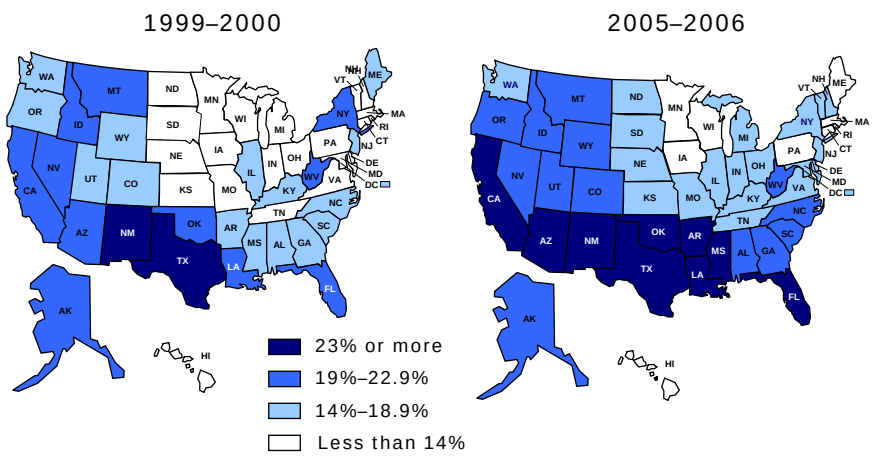
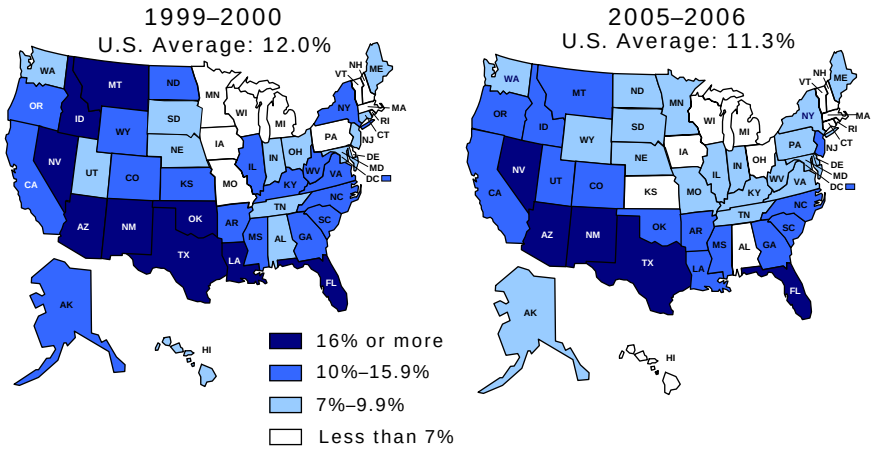
Uninsured Nonelderly Adult Rate Has Increased from 17.3 Percent to 20.0 Percent in Last Six Years



Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated Data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

22

Percentage of Uninsured Children Has Declined Since Implementation of SCHIP, but Gaps Remain



Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated Data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

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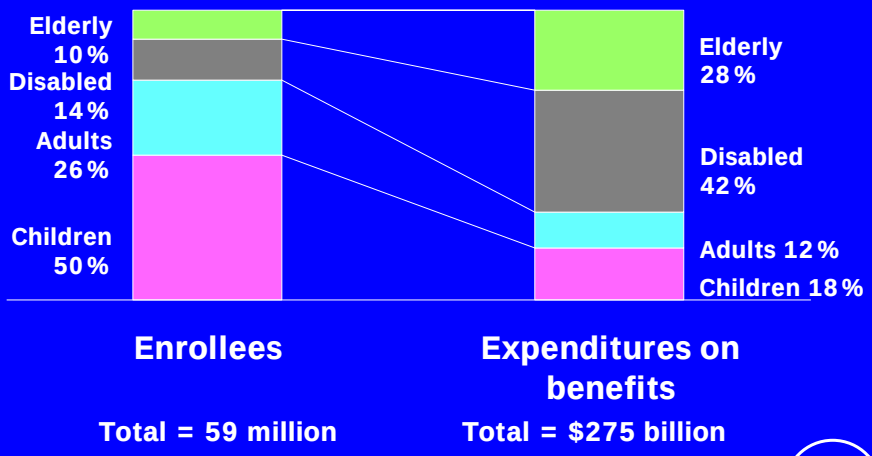
Medicaid Enrollees and Expenditures by Enrollment Group, 2005



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data.

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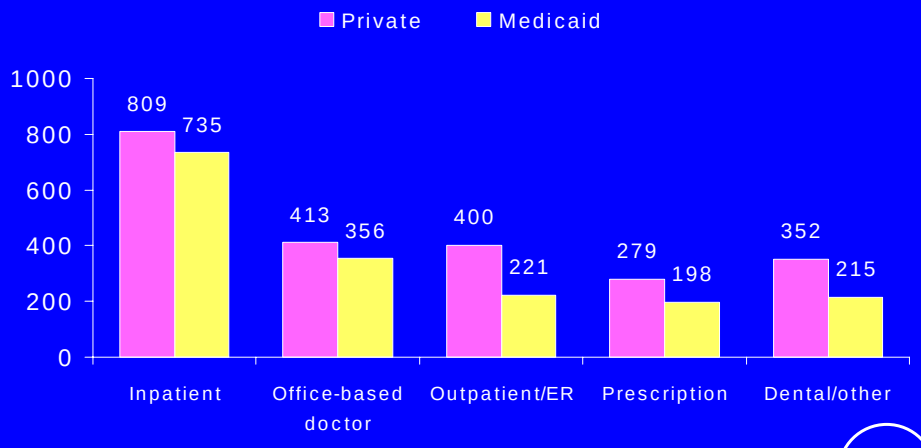
Medicaid's Spending on Health Services Is Lower Than That of Private Coverage

Expenditures ($) on health services for people without health limitations in private coverage and Medicaid



Source: Hadley J., Holahan J., Is health care spending higher under Medicaid or private insurance? *Inquiry*. 2003 Winter;40(4):323-42.

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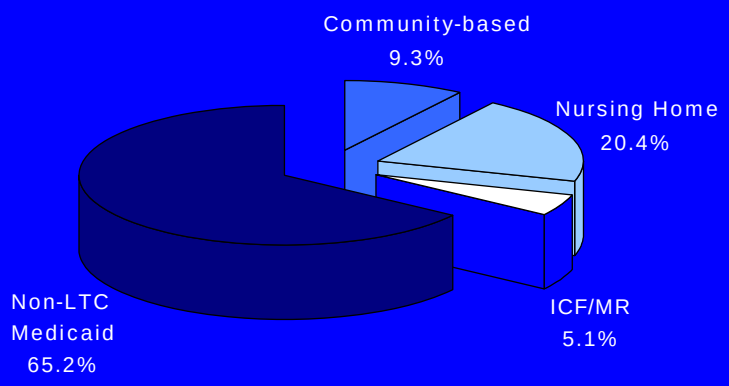
Thirty-five Percent of Medicaid Spending Goes to Long-Term Care



Note: ICF/MR = intermediate care facilities for the mentally retarded
Source: MEDSTAT HCBS

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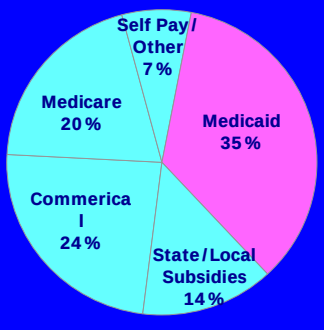
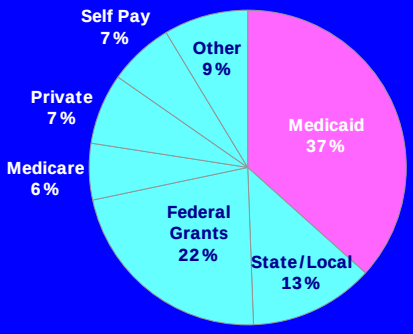
Medicaid Financing of Safety-Net Providers

Public Hospital Net Revenues by Payer, 2004



Total = $29 billion

Health Center Revenues by Payer, 2006



Total = $8.1 billion

SOURCE: Kaiser Commission on Medicaid and the Uninsured, based on *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, October 2006. KCMU Analysis of 2006 UDS Data from HRSA.

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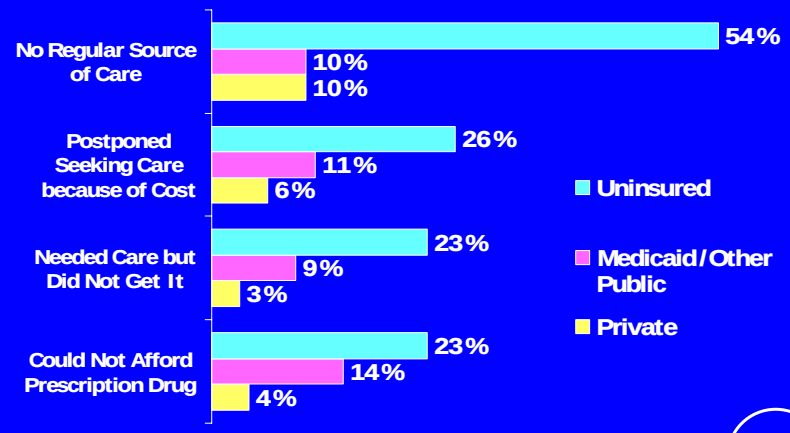
Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2006

Percent of adults (age 19 – 64) reporting in past 12 months:



NOTE: Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data.

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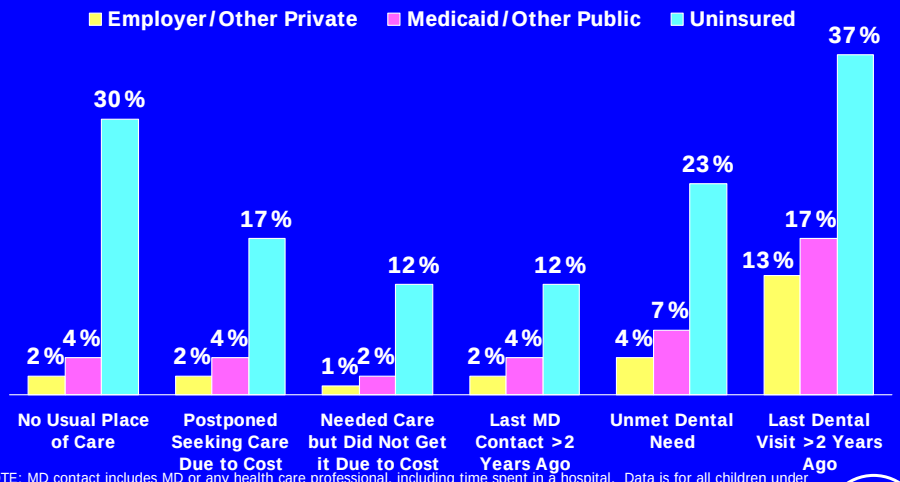
Children's Access to Care, by Health Insurance Status, 2006



NOTE: MD contact includes MD or any health care professional, including time spent in a hospital. Data is for all children under age 18, except for dental visit and unmet dental need, which are for children age 2-17. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All estimates are age-adjusted.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC. 2007. Summary of Health Statistics for U.S. Children: NHIS, 2006.

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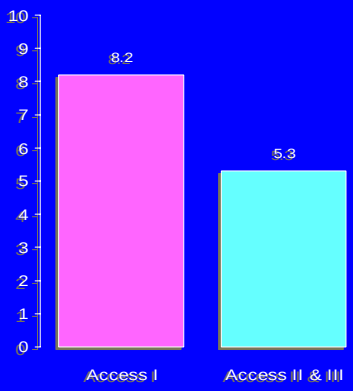
Community Care of North Carolina: Medicaid

Asthma Initiative: Pediatric Asthma Hospitalization rates

(April 2000 – December 2002)

In patient admission rate per 1000 member months



- 15 networks, 3500 MDs, >750,000 patients
- Receive $3.00 PM/PM from the State
- Hire care managers/medical management staff
- PCP also get $2.50 PMPM to serve as medical home and to participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost (FY2003) - $8.1 Million; Savings (per Mercer analysis) $60M compared to FY2002

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Source: L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007

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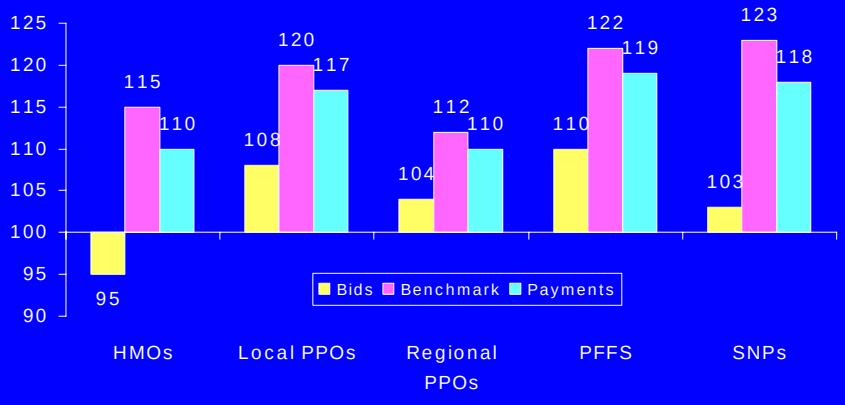
Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006

Percent of fee-for-service costs



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Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2007).

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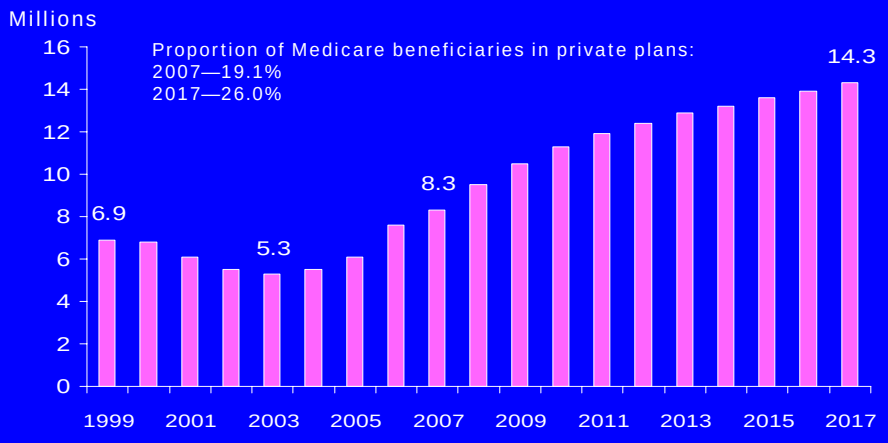
Total Medicare Private Health Plan Enrollment, Actual 1999-2007 and Projected 2008-2017



Note: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, cost contracts, demonstrations, HCPP, and PACE contracts.
Source: Actual through 2006—Mathematica Policy Research, Inc. "Tracking Medicare Health and Prescription Drug Plans Monthly Report." December 1999-2006. Projected 2007 through 2017—Congressional Budget Office, Fact Sheet for CBO's March 2007 Baseline: Medicare.

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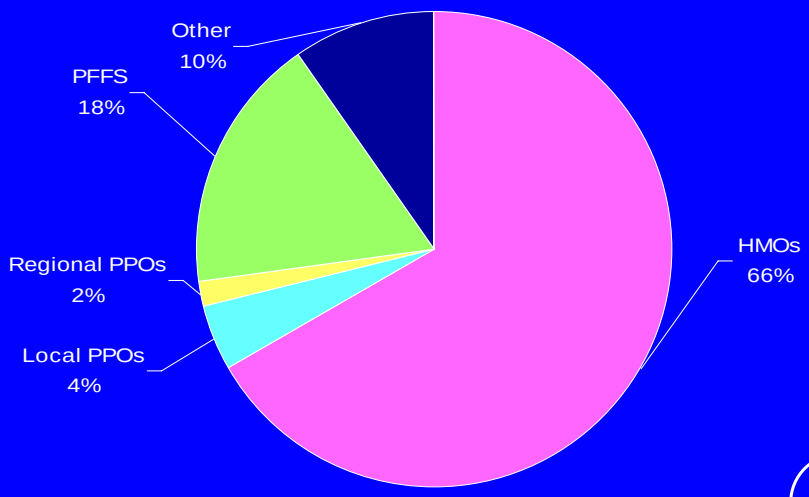
MA Enrollment by Type of Plan, April 2007



Source: Mathematica Policy Research. "Tracking Medicare Health and Prescription Drug Plans, Monthly Report for April 2007" accessed on Kaiser Family Foundation web site, May 31, 2007.

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Illustrative Array of Plan Designs Offered on National Basis, 2008

Plan	Deductible	Tier 1	Tier 2	Tier 3	Specialty Tier	Gap Coverage
Aetna Essentials	$275	$3	$39	$80	25%	None
Aetna Premier	$0	$4	$40	$70	33%	Generics
Humana Standard	$275	25%*	25%*	25%*	25%*	None
Humana Complete	$0	$4	$25	$54	25%	Preferred Generics
Medco Choice	$0	$6	$35	75%	33%	None
Sterling Rx Plus	$100	$0	$25	25%	25%	None
United/AARP Preferred	$0	$7	$30	$74.85	33%	None
United/AARP Saver	$275	$5	$20	$49.68	25%	None
Wellcare Signature	$0	$0	$45	$107	33%	None

Notes: * No tiers. 25% coinsurance only.
Some values are median amounts for plans that use different tiered cost-sharing arrangements across regions.
Source: J. Hoadley, *Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries,* The Commonwealth Fund, May 2008.

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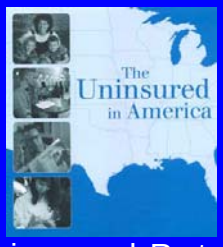
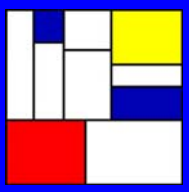
What Are the Problems?



Uninsured Rates

Costs of Care

Quality of Care Chasm



Administrative Complexity

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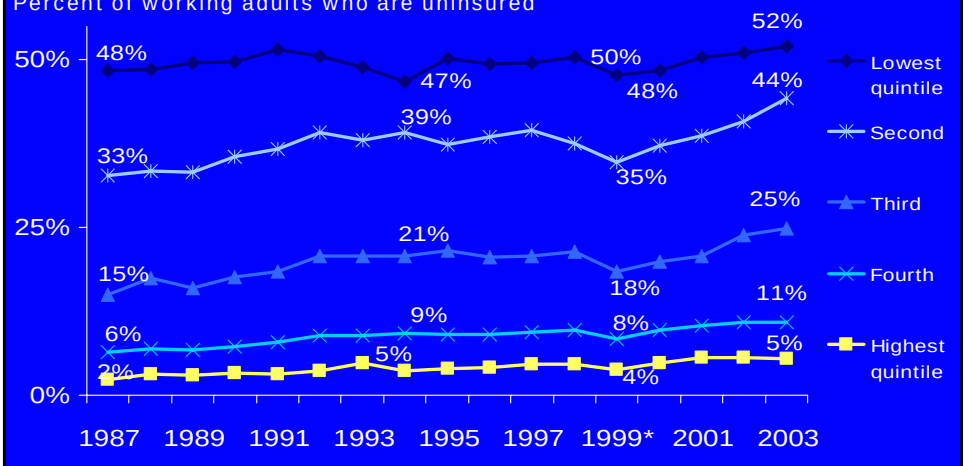
Uninsured Rates are Increasing Most for Working Middle Class Adults



*In 1999, CPS added a follow-up verification question for health coverage.
Source: Analysis of the March 1988–2004 Current Population Surveys by D. Ferry, Columbia University, for The Commonwealth Fund.

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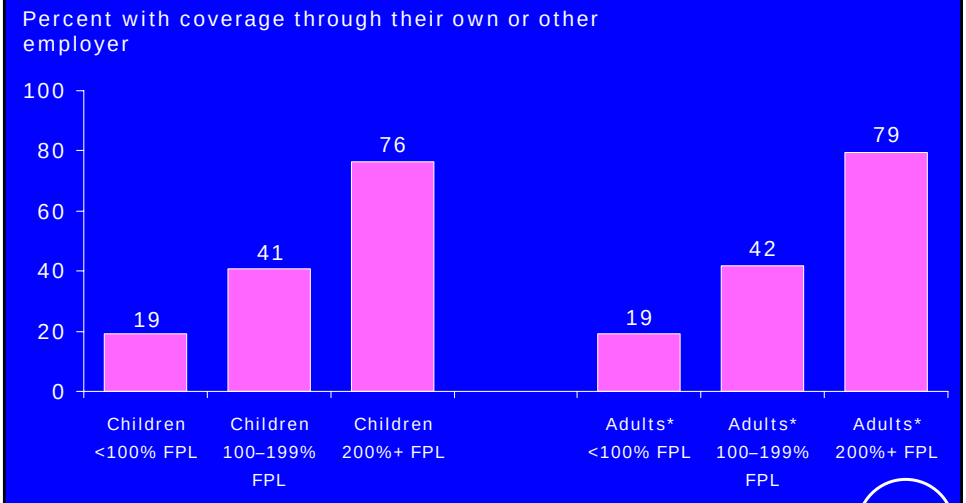
Percent of Children and Adults With Employer-Sponsored Coverage, by Poverty



FPL = federal poverty level.
*Adults age 19 and over; children are age 18 and under.
Source: Analysis by S. Glied and B. Mahato of Columbia University of the 2006 Current Population Survey.

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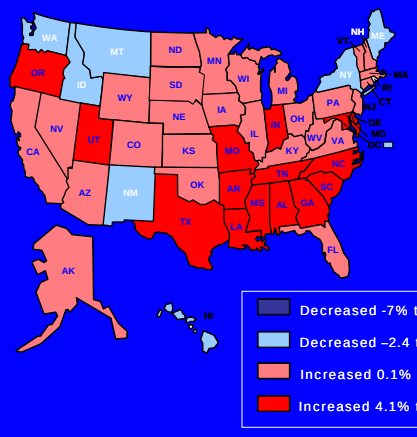
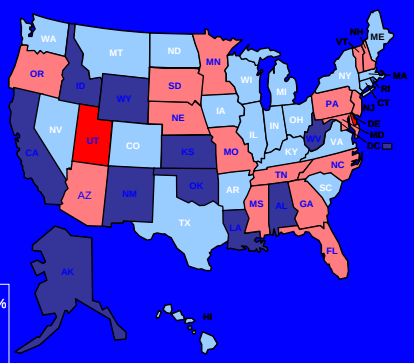
Health Insurance Coverage Getting Worse for Adults, Better for Children

Percent change between 1999-2000 and 2005-2006 in uninsured adults ages 18-64



Percent change between 1999-2000 and 2005-2006 in uninsured children under 18



Data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

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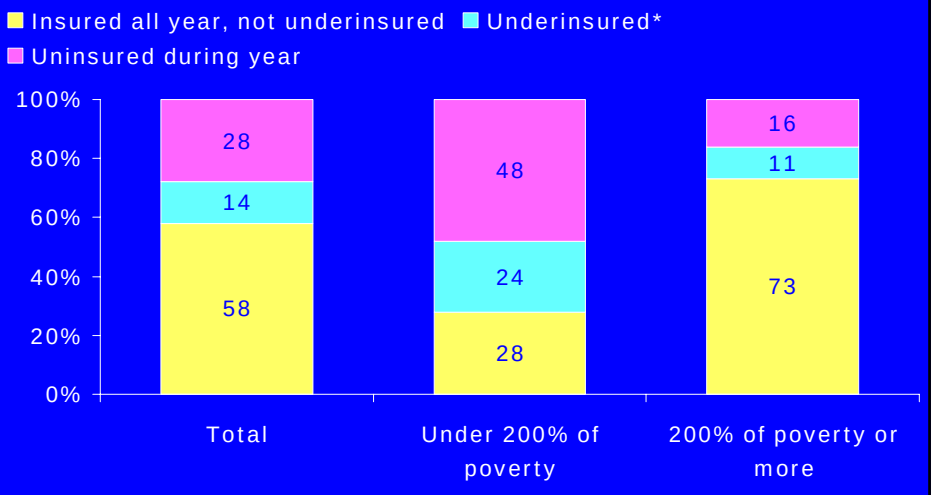
Adults Ages 19–64 Who Are Uninsured and Underinsured, By Poverty Status, 2007



*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of incomes if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: 2007 Commonwealth Fund Biennial Health Insurance Survey (Schoen et al. 2008).

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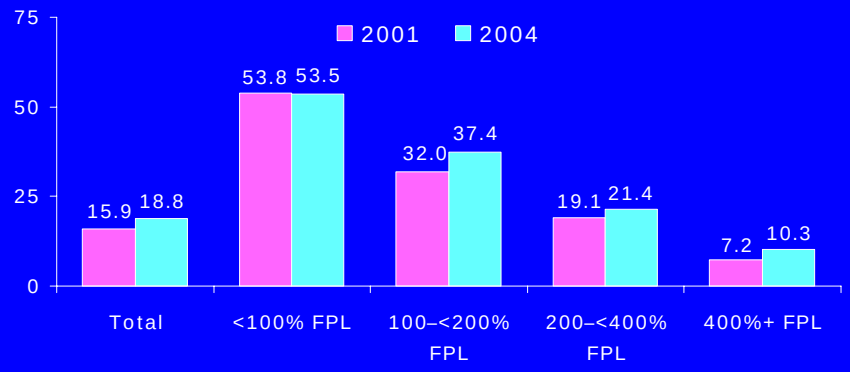
Percent of Privately Insured Non-Elderly Adults with High Out-of-Pocket Burdens by Income, 2001–2004

39

Percent of nonelderly adults with private insurance (group and non-group) who spend >10% of disposable household income on out-of-pocket premiums and expenditures on health care services



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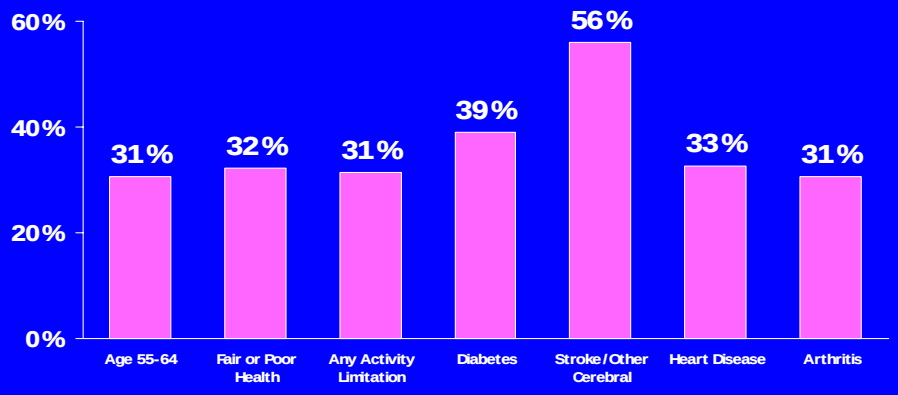
Source: Jessica S. Banthin, Peter Cunningham, and Didem M. Bernard, "Financial Burden Of Health Care, 2001–2004," *Health Affairs*, January/February 2008; 27(1): 188–195.

Groups at High Risk of Having High Financial Burden for Health Care, 2003

40



NOTE: High Financial Burden defined as families spending more than 10% of their after-tax income on health care, including premiums and out-of-pocket health costs.
SOURCE: Kaiser Family Foundation, based on Banthin, JS and DM Bernard. "Changes in Financial Burdens for Health Care," *JAMA* 296(22), December 2006.

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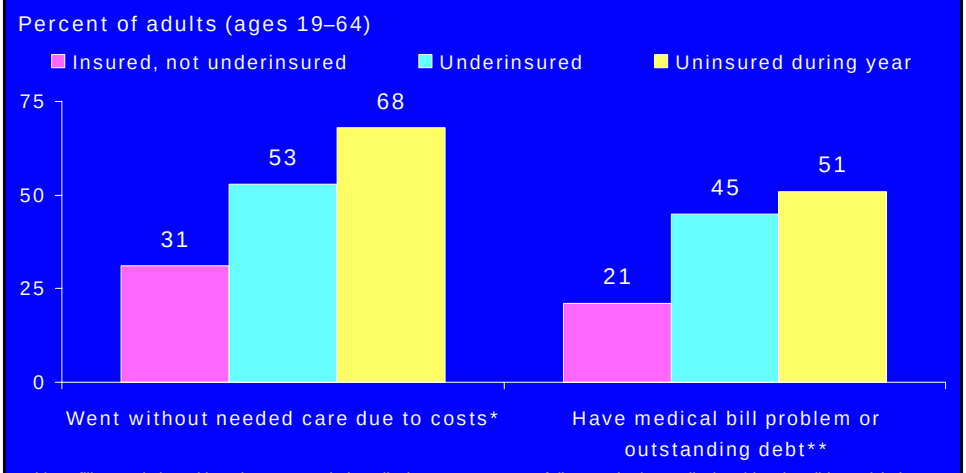
Underinsured and Uninsured Adults at High Risk of Going Without Needed Care and Financial Stress

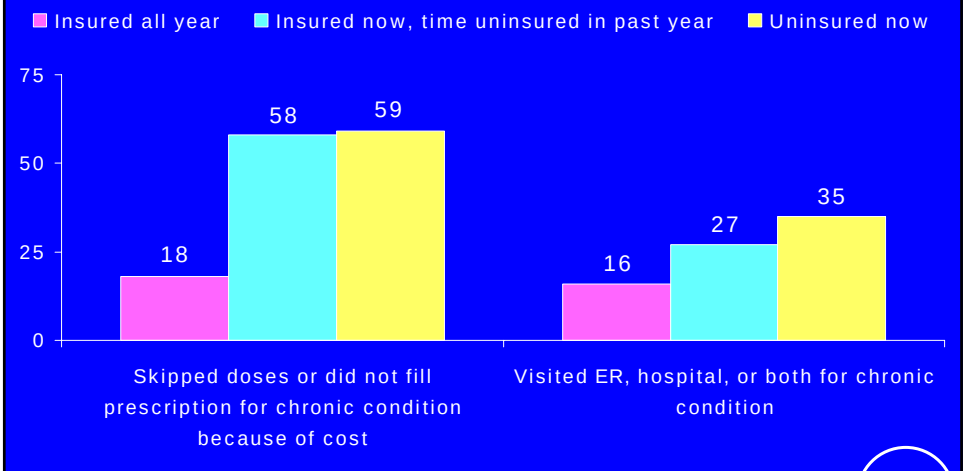


*Did not fill prescription; skipped recommended medical test, treatment, or follow-up, had a medical problem but did not visit doctor; or did not get needed specialist care because of costs. **Had problems paying medical bills; changed way of life to pay medical bills; or contacted by a collection agency for inability to pay medical bills.

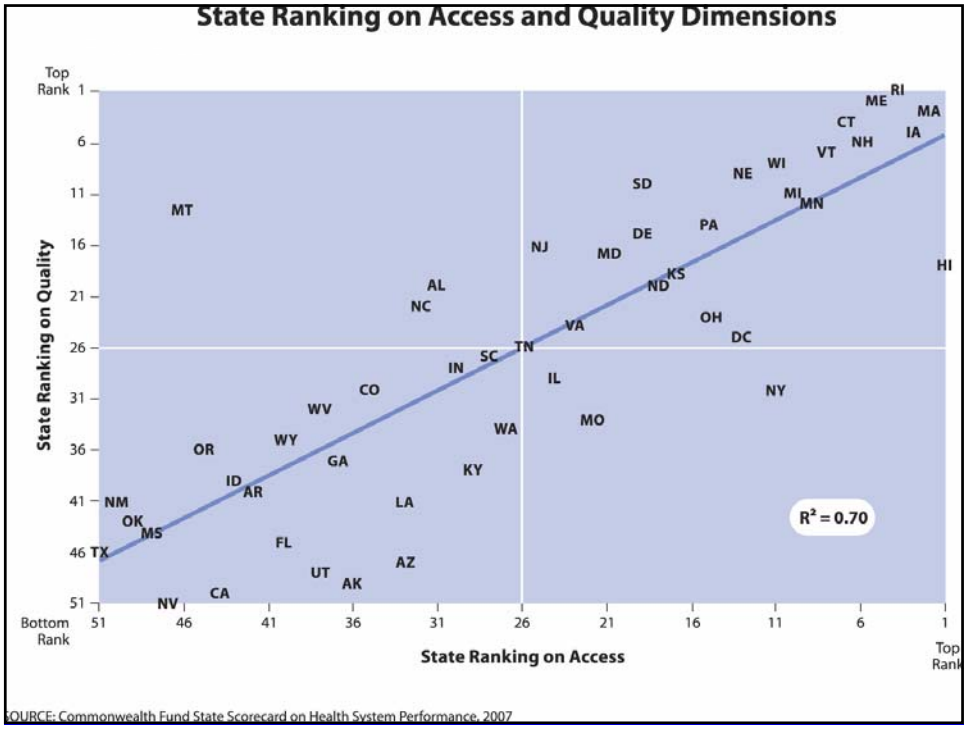
Source: C. Schoen et al., Insured But Not Protected: How Many Adults Were Underinsured in 2007 and What Are The Trends?", *Health Affairs* Web Exclusive, June 10, 2008. Data: 2007 Commonwealth Fund Biennial Health Insurance Survey

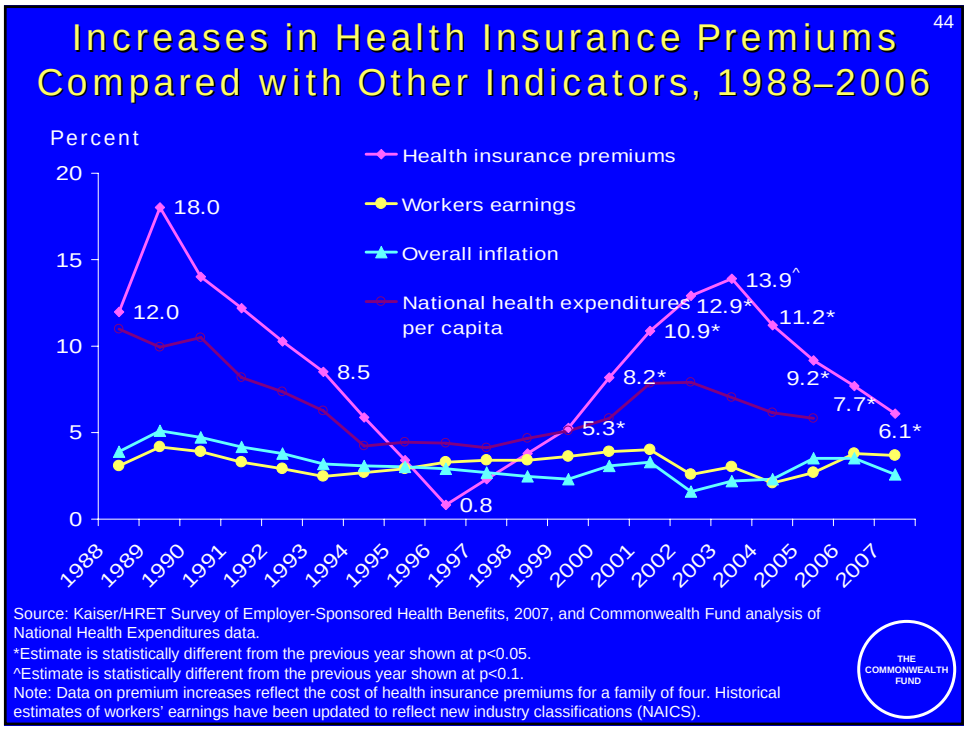
42

Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions



*Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund, Apr. 2006).


State Ranking on Access and Quality Dimensions
Top Rank
Bottom Rank
State Ranking on Quality
State Ranking on Access
1
6
11
16
21
26
31
36
41
46
51
MT
NM
OK
MS
TX
OR
ID
AR
WY
CO
WV
GA
FL
UT
AK
NV
CA
AZ
LA
KY
WA
IN
SC
TN
AL
NC
VA
NJ
MD
DE
SD
ND
KS
NE
WI
MI
MN
PA
OH
DC
IL
MO
NY
HI
RI
ME
MA
CT
NH
IA
VT
$R^2 = 0.70$
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007


44
Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2006
Percent
Health insurance premiums
Workers earnings
Overall inflation
National health expenditures per capita
20
15
10
5
0
18.0
12.0
8.5
0.8
5.3*
8.2*
10.9*
12.9*
13.9^
11.2*
9.2*
7.7*
6.1*
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007, and Commonwealth Fund analysis of National Health Expenditures data.
*Estimate is statistically different from the previous year shown at p<0.05.
^Estimate is statistically different from the previous year shown at p<0.1.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).
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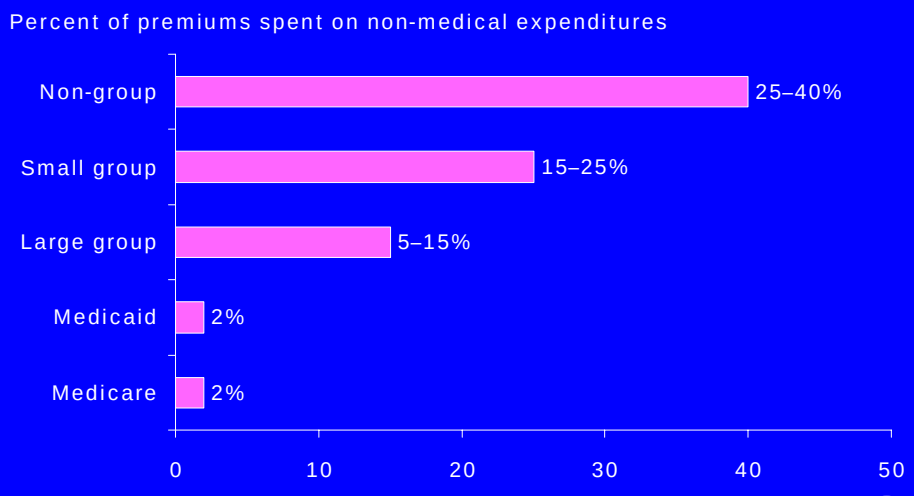
Only Two Percent of Premiums in Medicare and Medicaid Are Spent on Non-Medical Expenditures



Source: K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M. A. Hall, The geography of health insurance regulation, *Health Affairs*, March/April 2000; 19(2): 173–184;

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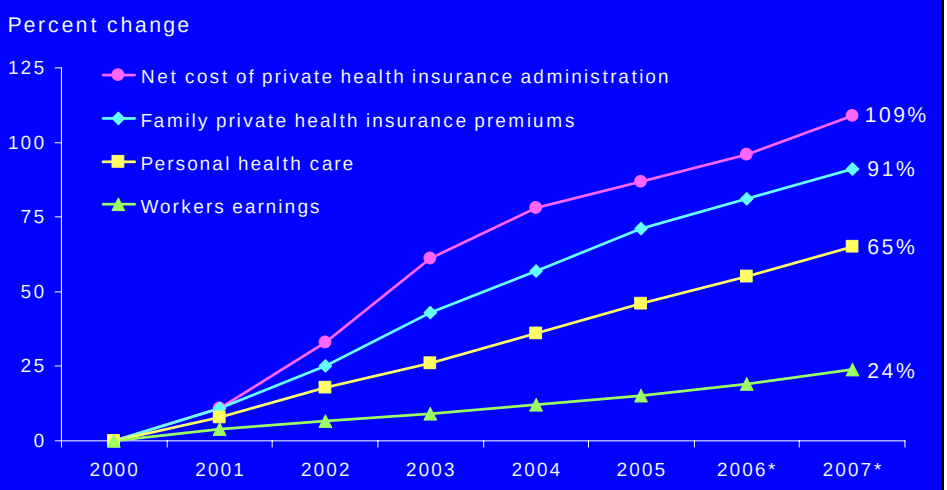
Cumulative Changes in Annual National Health Expenditures And Other Indicators, 2000–2007



Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four/the average premium increase is weighted by covered workers. * 2006 and 2007 private insurance administration and personal health care spending growth rates are projections.

Sources: A. Catlin, C. Cowan, S. Heffler et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):143–53; J. A. Poisal, C. Truffer, S. Smith et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs* Web Exclusive (Feb. 21, 2007):w242–w253; Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2007* (Washington, D.C.: KFF/HRET).

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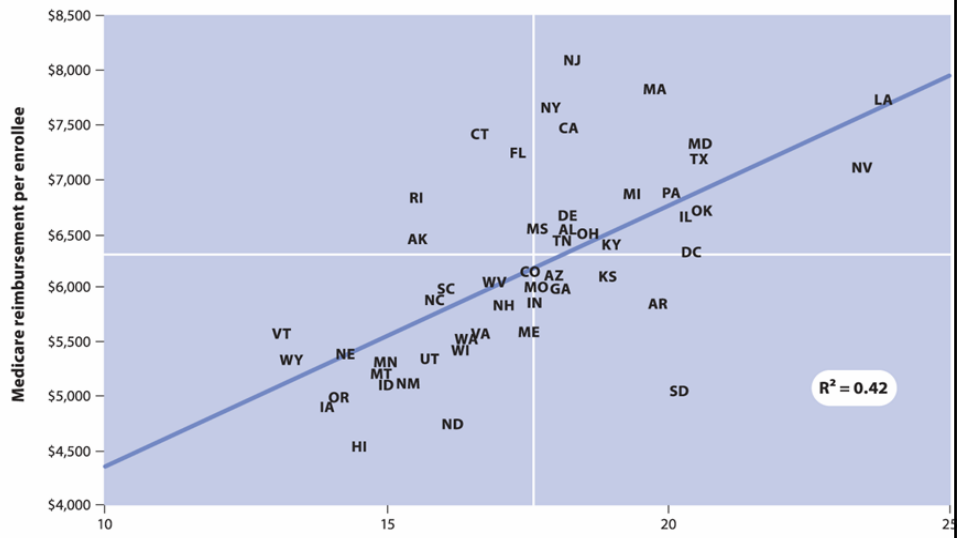
AVOIDABLE HOSPITAL USE AND COSTS

Medicare Reimbursement and 30-Day Readmissions by State, 2003



DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

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Lessons from International Experience

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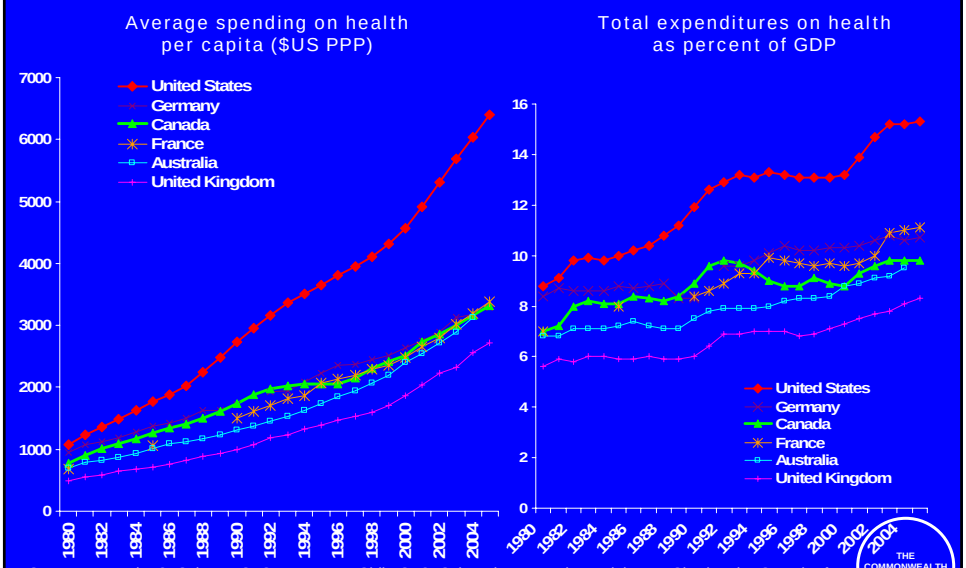
International Comparison of Spending on Health, 1980–2005



Source: K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007, updated with 2007 OECD data

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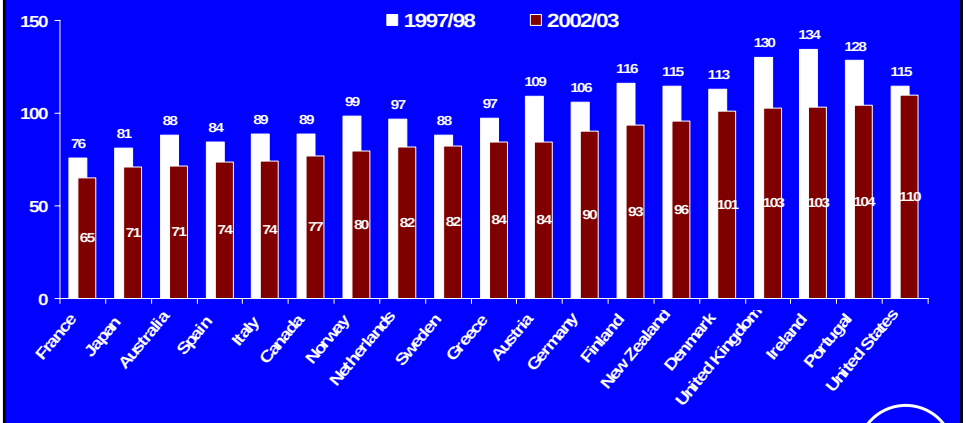
LONG, HEALTHY & PRODUCTIVE LIVES

Mortality Amenable to Health Care



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, *Health Affairs*, January/February 2008, 27(1):58–71

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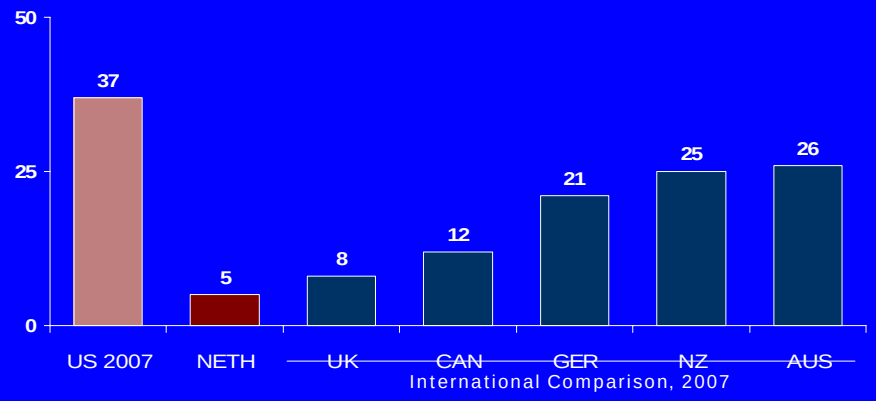
ACCESS: UNIVERSAL PARTICIPATION

Access Problems Because of Costs, 2007

Percent of adults who had any of three access problems* in past year because of costs



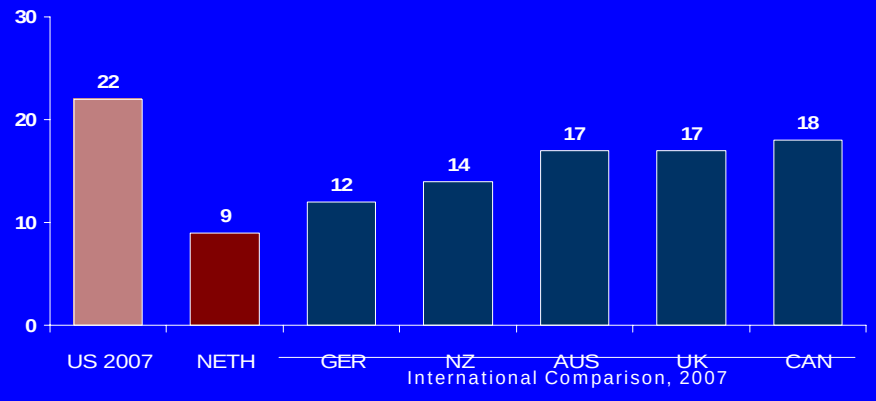
* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
AUS=Australia; CAN=Canada; GER=Germany; NET=Netherlands; NZ=New Zealand; UK=United Kingdom; US=United States.
Data: 2007 Commonwealth Fund International Health Policy Surveys.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

EFFICIENCY

Test Results or Medical Record Not Available at Time of Appointment, Among Sicker Adults, 2007

Percent reporting test results/records not available at time of appointment in past two years



AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom; US=United States.
Data: 2007 Commonwealth Fund International Health Policy Surveys.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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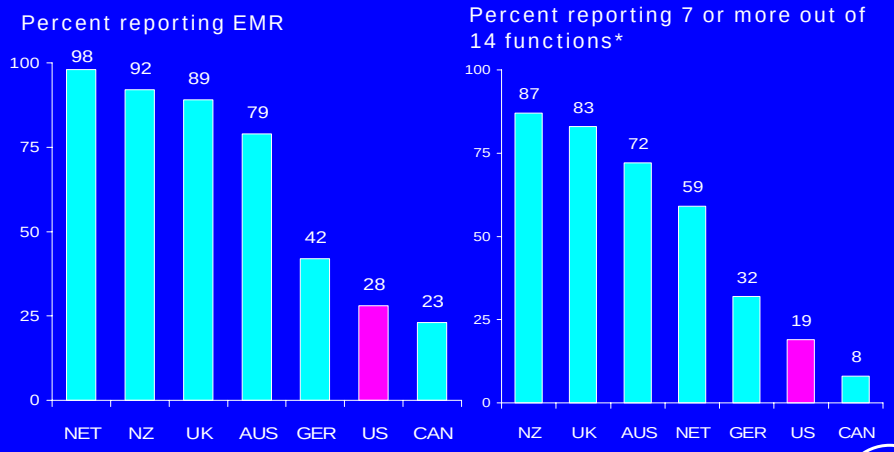
Where is the U.S. on IT? Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Have Advanced IT Capacity



*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians in Seven Nations: Australia, Canada, Germany, Netherlands, New Zealand, UK, and US.

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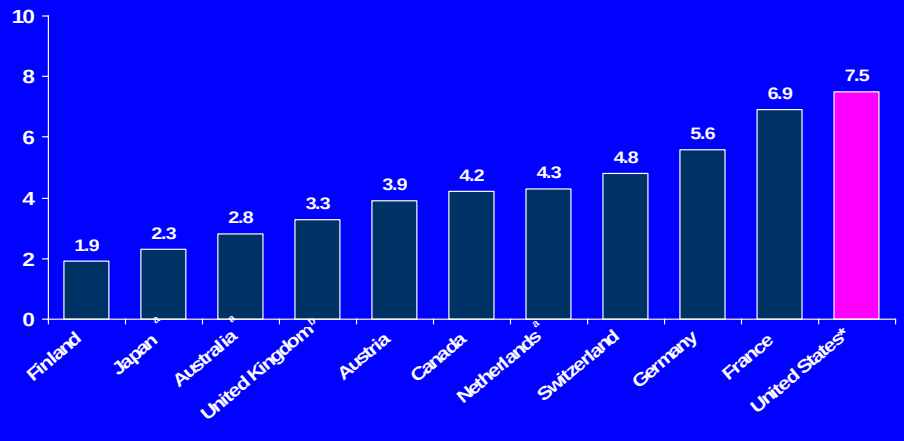
Percentage of National Health Expenditures Spent on Insurance Administration, 2005

Net costs of health insurance administration as percent of national health expenditures



[a] 2004 [b] 2001

* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

Data: OECD Health Data 2007, Version 10/2007.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, forthcoming July 2008

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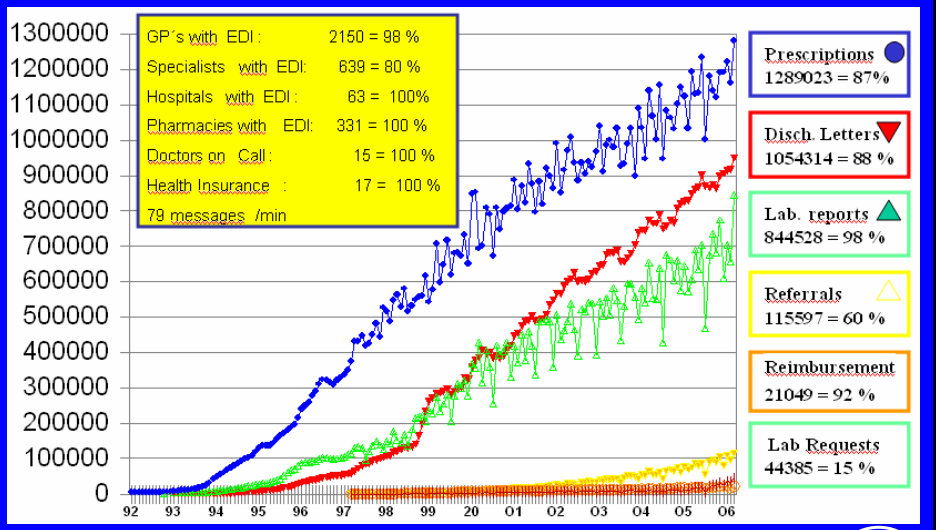
MedCom – The Danish Health Data Network



Source: I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

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Health Reform: All Private, All Public, or Mixed Private-Public?

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What are the Options for Health Insurance Reform?

Principles for Reform	Tax Incentives and Individual Insurance Markets	Mixed Private-Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum Standard Benefit Floor	–	+	+
Premium/Deductible/ Out-of-Pocket Costs Affordable Relative to Income	–	+	+
Easy, Seamless Enrollment	0	+	++
Choice	+	+	+
Pool Health Care Risks Broadly	–	+	++
Minimize Dislocation, Ability to Keep Current Coverage	+	++	–
Administratively Simple	–	+	++
Work to Improve Health Care Quality and Efficiency	0	+	+

0 = Minimal or no change from current system; – = Worse than current system; + = Better than current system; ++ = Much better than current system
Source: S.R. Collins, et al., *A Roadmap to Health Insurance for All: Principles for Reform*, Commission on a High Performance Health System, The Commonwealth Fund, October 2007.

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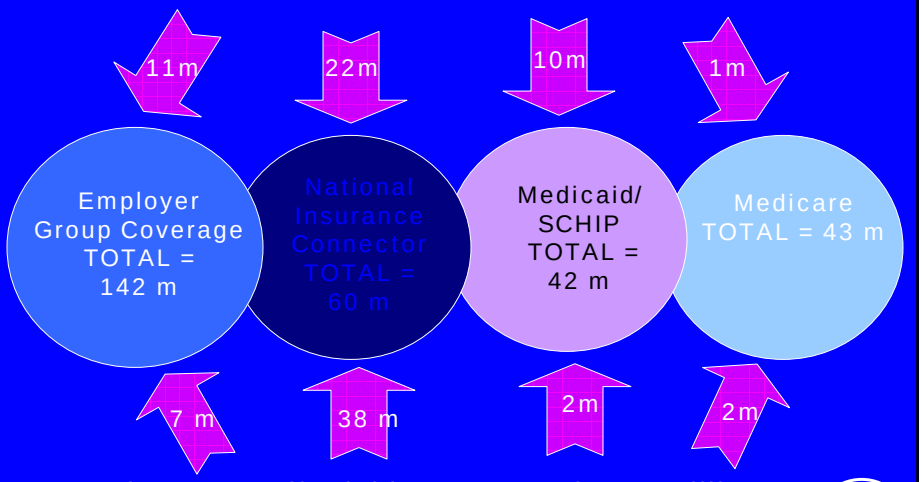
Building Blocks for Automatic and Affordable Health Insurance For All

New Coverage for 44 Million Uninsured in 2008



Improved or More Affordable Coverage for 49 Million Insured

Source: Based on analysis in C. Schoen, K. Davis, and S.R. Collins, "Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance," Health Affairs 27, no. 3 (2008): 646-657 from Lewin Group modeling estimates.

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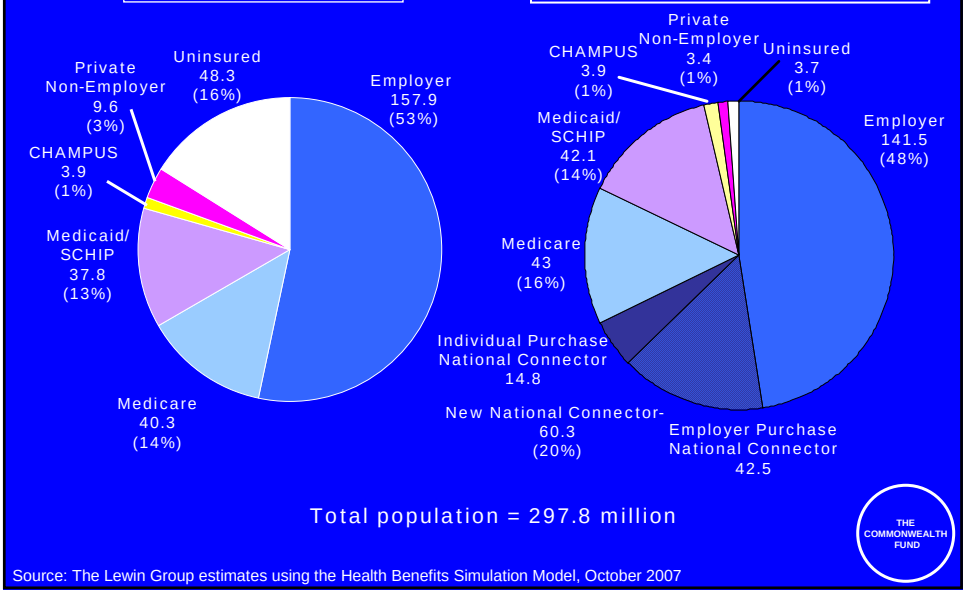
Building Blocks with Medicare Extra: Minimal Distribution in Coverage, 2008



Total population = 297.8 million

Source: The Lewin Group estimates using the Health Benefits Simulation Model, October 2007

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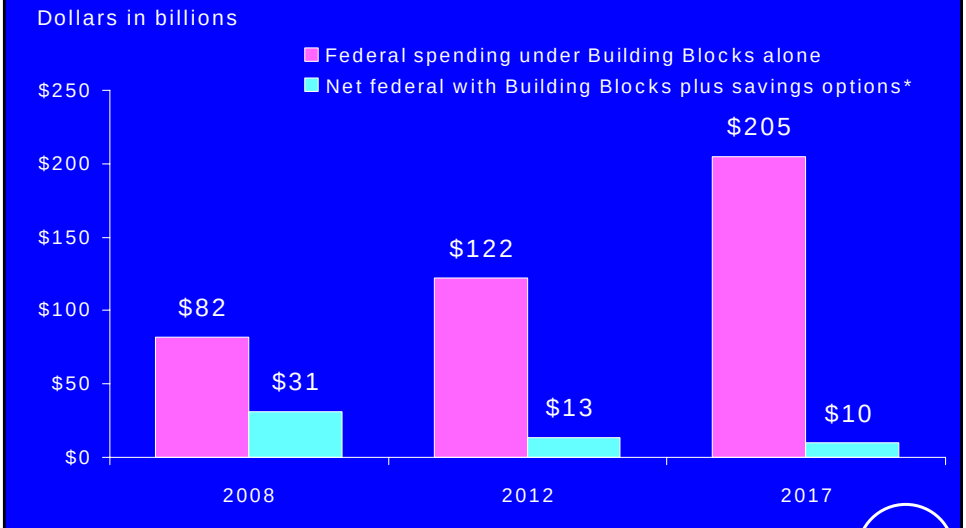
Savings Can Offset Federal Costs of Insurance For All: Federal Spending Under Two Scenarios



* Selected options include improved information, payment reform, and public health.
Data: Lewin Group estimates of combination options compared with projected federal spending under current policy..
Source: Schoen et al. Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, The Commonwealth Fund, December 2007.

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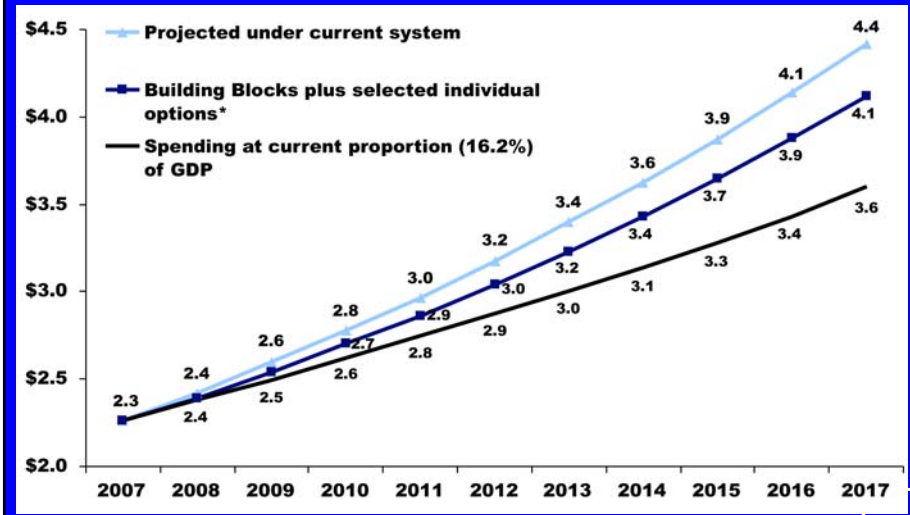
Total National Health Expenditures, 2008–2017 Projected and Various Scenarios

Dollars in trillions



* Selected individual options include improved information, payment reform, and public health.
Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending,* The Commonwealth Fund, December 2007. Data: Lewin Group estimates.

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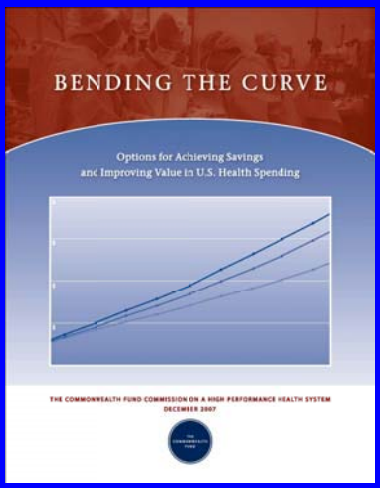
Options to Achieve Savings

- Producing and Using Better Information
- Promoting Health and Disease Prevention
- Aligning Incentives with Quality and Efficiency
- Correcting Price Signals in the Health Care Market



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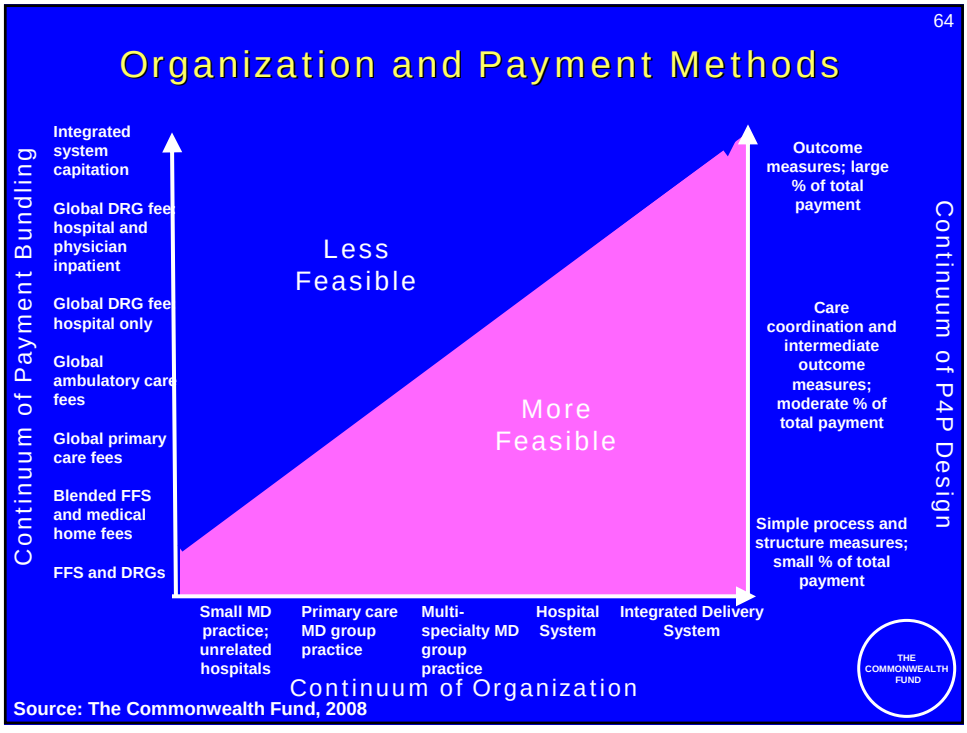
Source: *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2007.

ES-2. Policy Options and Distribution of 10-Year Impact on Spending Across Payer Groups (in billions)

	Total NHE†	Federal Gov't	State/ Local Gov't	Private Payer	Households
Producing and Using Better Information					
1. Promoting Health Information Technology	–$88	–$41	–$19	$0	–$27
2. Center for Medical Effectiveness and Health Care Decision-Making	–$368	–$114	–$49	–$98	–$107
3. Patient Shared Decision-Making	–$9	–$8	$0	$0	–$1
Promoting Health and Disease Prevention					
4. Public Health: Reducing Tobacco Use	–$191	–$68	–$35	–$39	–$49
5. Public Health: Reducing Obesity	–$283	–$101	–$52	–$57	–$73
6. Positive Incentives for Health	–$19	$2	–$12	–$4	–$5
Aligning Incentives with Quality and Efficiency					
7. Hospital Pay-for-Performance	–$34	–$27	–$1	–$2	–$4
8. Episode-of-Care Payment	–$229	–$377	$18	$90	$40
9. Strengthening Primary Care and Care Coordination	–$194	–$157	–$4	–$9	–$23
10. Limit Federal Tax Exemptions for Premium Contributions	–$131	–$186	–$19	–$55	$130
Correcting Price Signals in the Health Care Market					
11. Reset Benchmark Rates for Medicare Advantage Plans	–$50	–$124	$0	$0	$74
12. Competitive Bidding	–$104	–$283	$0	$0	$178
13. Negotiated Prescription Drug Prices	–$43	–$72	$4	$17	$8
14. All–Payer Provider Payment Methods and Rates	–$122	$0	$0	–$105	–$18
15. Limit Payment Updates in High-Cost Areas	–$158	–$260	$13	$62	$27

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
† In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total.



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Agenda for Change

- Offer Medicare Extra as a choice to small employers and individuals, eliminate two-year waiting period for disabled, and buy-in for older adults; financial protection for beneficiaries
- Expand Medicaid/SCHIP to all individuals under 150 percent of poverty
- Spread state innovations in quality and efficiency across Medicaid programs
- Offer Medicare global fee payment options to physician group practices, hospitals, and integrated care systems
- Level the playing field between Medicare “self-insured” coverage and Medicare Advantage
- Accountability for quality and care, transparency, rewards for results
- Health information technology and information exchange networks; personal health records for beneficiaries
- Comparative effectiveness
- National leadership and public-private collaboration

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Thank You!

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