



## **FINDING RESOURCES FOR HEALTH REFORM AND BENDING THE HEALTH CARE COST CURVE**

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**ABSTRACT:** President Obama has made health reform a top priority for the nation. In addition to the initial investments enacted in the American Recovery and Reinvestment Act, the president has included a \$634 billion health reform reserve fund in his 2010 budget as a downpayment on health reform, leaving the legislative details to Congress. Comprehensive reform will likely require an investment of \$1 trillion or more over the 2010–19 period to achieve coverage for all and implement critical system reforms. This report examines policy options that could slow growth in health spending, improve health outcomes, and provide additional revenues to finance comprehensive reform. It also illustrates how widely estimates of policy options can vary based on underlying assumptions. The rich menu of options presented here, along with impact estimates, should help policy leaders identify the resources required to make health coverage for all and improved health system performance a reality.

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## EXECUTIVE SUMMARY

In February 2009, President Obama sent his first budget to Congress. The budget outlined the new Administration's priorities for health reform:

- protecting families' financial health;
- ensuring that health coverage is affordable;
- aiming for universality in coverage;
- providing portability of coverage;
- guaranteeing consumer choice;
- investing in prevention and wellness;
- improving patient safety and the quality of care; and
- maintaining long-term fiscal sustainability.

Consistent with the president's belief that health reform should be financially sustainable, he included a \$634 billion reserve fund to advance reform over the next decade, 2010–19. The budget proposal builds on the \$150 billion investment included in the American Recovery and Reinvestment Act (ARRA, or economic stimulus package) enacted in February 2009.

In a departure from the past, the Administration has left the details of the health reform legislation to Congress, looking largely to the committees of jurisdiction to develop legislation consistent with its goals. The Administration has set an ambitious timeline—calling for action on legislation during its first year.

This report examines several policy options that could improve the value of the nation's investment in the health care delivery system and help finance federal support of coverage expansions. To illustrate the importance of the structure and details of the policy options, it presents a range of estimates from three different sources: 1) estimates prepared for The Commonwealth Fund by the Lewin Group and published in a recent report, [\*The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way\*](#) (the Path report); 2) estimates by the Office of Management and Budget (OMB) for the president's budget proposal and the economic stimulus bill; and 3) estimates by the Congressional Budget Office (CBO). The discussion and comparisons

focus on policy options that were examined by the three sources. All estimates consider the potential impact over 10 years, 2010–19.

The estimates of the potential impacts different policies would have indicate that there is potential for significant gains. As shown in this report, the available estimates differ primarily in terms of the scope of the policies and particular elements of the proposals.

As the health care reform debate unfolds, it will be important to keep in mind that there are various options for financing the necessary federal investment and stimulating change throughout the care system. The challenge will be building consensus to move forward and implement policies that have the potential to simultaneously address health care access, quality, and costs.

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### **Comparing the Budget Impact of Select Policy Options**

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#### *Changes to Medicare Advantage*

- OMB budget estimate: \$175 billion federal savings
- CBO estimate: \$157 billion federal savings for setting benchmark at local fee-for-service rates; \$158 billion federal savings for competitive bidding
- Path estimate: \$135 billion federal savings

#### *Achieving Lower Drug Costs in Public Programs*

- OMB budget estimate: \$29 billion federal savings
- CBO estimate: \$110 billion federal savings
- Path estimate: \$93 billion federal savings, \$62 billion total health system savings

#### *Bundle Payments for Hospitals to Include Post–Acute Care*

- OMB budget estimate: \$26 billion federal savings
- CBO estimate: \$19 billion federal savings
- Path estimate: \$123 billion federal savings, \$182 billion total health system savings

#### *Changes to Home Health Reimbursement*

- OMB budget estimate: \$37 billion federal savings
- CBO estimate: \$50 billion federal savings
- Path estimate: Not available

#### *Hospital Pay-for-Performance*

- OMB budget estimate: \$12 billion federal savings
- CBO estimate: \$3 billion federal savings
- Path estimate: \$43 billion federal savings, \$55 billion total health system savings

#### *Patient-Centered Medical Homes*

- OMB budget estimate: Not available
- CBO estimate: (\$6 billion federal budget)
- Path estimate: \$83 billion federal savings, \$144 billion total health system savings

*Primary Care Payment and Physician Payment Reform*

- OMB budget estimate: Not available
- CBO estimate: \$5 billion federal savings
- Path estimate: \$23 billion federal savings, \$56 billion total health system savings

*Health Information Technology*

- ARRA estimate: \$13 billion federal savings
- CBO estimate: \$4 billion federal savings through incentives, \$61 billion if HIT use were required as condition of participation in Medicare
- Path estimate: \$70 billion federal savings, \$180 billion total health system savings

*Comparative Effectiveness Research*

- ARRA estimate: Not available
- CBO estimate: (\$1 billion federal budget), \$8 billion total health system savings
- Path estimate: \$174 billion federal savings, \$480 billion total health system savings

*High-Cost Area Update*

- OMB Budget or ARRA: Not available
- CBO estimate: \$51 billion federal savings
- Path estimate: \$100 billion federal savings, \$177 billion total health system savings

*Select Population Health Options*

- ARRA estimate: Not available
  - CBO estimate: \$205 billion federal revenues (2009–18 period)
  - Path estimate: \$247 billion federal savings, \$583 billion total health system savings
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## **FINDING RESOURCES FOR HEALTH REFORM AND BENDING THE HEALTH CARE COST CURVE**

### **THE PRESIDENT'S HEALTH REFORM RESERVE FUND: A CRITICAL DOWNPAYMENT**

In February 2009, President Obama sent his first budget to Congress. The budget outlined the new Administration's priorities for health reform:

- protecting families' financial health;
- ensuring that health coverage is affordable;
- aiming for universality in coverage;
- providing portability of coverage;
- guaranteeing consumer choice;
- investing in prevention and wellness;
- improving patient safety and the quality of care; and
- maintaining long-term fiscal sustainability.

Consistent with the president's belief that health reform should be financially sustainable, he included a \$634 billion reserve fund to advance reform over the next decade, 2010–19. The proposed reserve fund includes a roughly equal mix of increased revenues (\$318 billion) and reductions in federal spending (\$316 billion) through payment reforms.<sup>1</sup> The budget proposal builds on the \$150 billion investment included in the American Recovery and Reinvestment Act (ARRA, or economic stimulus package) enacted in February 2009. Specifically, ARRA included \$19.2 billion for health information technology and \$1.1 billion to support generating better information for patients and clinicians on the comparative effectiveness of different medical treatments. While the reserve fund would make a substantial commitment to health reform, both the proposed revenues and reductions in spending are controversial and face an uphill battle in Congress. Even if it wins support from Congress, the reserve fund would fall short of what would be required to achieve health insurance for all and to make critical health system reforms. A variety of estimates indicate that this type of comprehensive reform would require more than \$1 trillion over the next decade.<sup>2</sup>

In a departure from the past, the Administration has left the details of the health reform legislation to Congress, looking largely to the committees of jurisdiction to develop legislation consistent with its goals. The Administration has set an ambitious

timeline—calling for action on legislation during its first year. Congressional leaders have responded by holding a series of roundtables, hearings, and meetings with key stakeholders in an effort to prepare legislation that could be ready for floor action by the summer of 2009.

In both the House and Senate, the committees of jurisdiction have taken unprecedented steps to coordinate their efforts. The Senate Finance Committee and the Health, Education, Labor, and Pensions Committee have committed to working in tandem on health reform legislation; in the House, the three committees of jurisdiction (Ways and Means, Energy and Commerce, and Education and Labor) have committed publicly to producing similar health reform legislation. The budget resolution adopted by Congress in April 2009 largely included the principles laid out in the president’s budget and a deficit-neutral reserve fund for health reform, although the amount of the reserve fund was unspecified. Under the budget resolution, the committees of jurisdiction were instructed to identify ways to finance their reform proposals, prompting congressional leaders to reach agreement not only on substantive policy proposals and legislative changes but also on how to pay for comprehensive reform.

#### **Developing the Budget Resolution**

In most years, the president submits to Congress a detailed budget request for the coming federal fiscal year (beginning October 1) on or before the first Monday in February. This detailed request has three main roles: to convey to Congress what the president recommends for overall fiscal policy, including levels of tax revenue and public spending; to lay out the president’s priorities for federal programs; and to signal to Congress what spending and tax policy changes the president recommends. The president’s budget request must include a discretionary spending request each year, and may also include changes to entitlement programs and the tax code.

After receiving the president’s budget request, Congress holds various hearings and develops its own budget resolution. Initially, the House and Senate work separately and the two Budget Committees draft their own resolutions. Once the House and Senate resolutions are passed in their respective chambers, a conference is held to resolve any differences and both chambers vote on the conference report. Unlike an ordinary bill, the budget is a concurrent resolution that does not go to the president for his signature or veto, only requires a majority to pass, and cannot be filibustered in the Senate. The budget resolution itself is not detailed like the president’s budget request, but establishes spending targets or limits for 19 broad spending areas through outlays and budget authority, and outlines total revenue collected for the next five years. Greater detail about the assumptions made in developing the budget (e.g., how a certain program may be cut or expanded) is specified in the report accompanying the final resolution.

#### **OPTIONS FOR FUNDING COMPREHENSIVE REFORM**

This report examines several policy options that could improve the value of the nation’s investment in the health care delivery system and help finance federal support of coverage expansions. To illustrate the importance of the structure and details of the

policy options, it presents a range of estimates from three different sources: 1) estimates prepared for The Commonwealth Fund by the Lewin Group (Lewin) and published in a recent report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (the Path report); 2) estimates by the Office of Management and Budget (OMB) for the president's budget proposal and the economic stimulus bill; and 3) estimates by the Congressional Budget Office (CBO).<sup>3</sup> The discussion and comparisons focus on policy options that were examined by the three sources. All estimates consider the potential impact over 10 years, 2010–19.<sup>4</sup>

All three sources focus on the potential savings compared with projected cost trends (i.e., bending the cost curve) if the policies were adopted by federally sponsored programs. In the Path report estimates, the policies would apply to a reformed health insurance market in which a new, federally sponsored public health insurance option would be available to the under-65 population through a national insurance exchange. As a result, savings estimates apply to the current Medicare or Medicaid programs as well as to populations enrolled in the new public insurance plan.

Estimates from the Administration's budget and economic stimulus legislation (ARRA), the Path report, and CBO indicate that early investments could yield significant reductions in total health care spending over time through gains in the quality and efficiency of care. The three sources provide a rich menu of policy options and approaches. Table 1 summarizes select policy options and the resulting estimates of potential federal savings or increases in revenues over a 10-year period, compared with the projected cost growth trend. Reforms estimated to increase federal spending or reduce revenue compared with the projected cost trend are noted in parentheses to indicate negative amounts.

Typically, federal budget proposals and CBO estimates focus only on the estimated effect on federal spending and do not estimate the potential impact on total national health expenditures (NHE). Because the policy options examined here seek to improve the health system for the nation and have direct impact on state revenues as well as on households and employers, the Path report looked at potential savings in terms of both federal and national health spending. As this report shows, federal reforms have the potential to produce substantial total health system savings for the nation—well beyond what is reflected in the estimated federal budget impact.

Table 1 groups similar reform proposals for ease of comparison. However, the estimated savings often vary significantly because of significant differences in elements of the proposals. The discussion below examines several policies in depth to highlight such differences and the assumptions that underlie the estimates. The comparisons

illustrate that the way policy options are structured greatly affects their estimated budgetary impact.<sup>5</sup> Although there are differences among the estimates, there are several common approaches being discussed to identifying funding for comprehensive health reform. Unless noted, estimates refer to potential federal savings over a 10-year period, 2010–19.

**Table 1. Potential Sources of Federal Savings and Revenue Compared with Projected Trends, Cumulative, 2010–2019**

	<b>OMB: Budget and ARRA</b>	<b>CBO</b>	<b>Path (Federal)</b>	<b>Path (Total Health System)*</b>
	<i>\$ Billions</i>	<i>\$ Billions</i>	<i>\$ Billions</i>	<i>\$ Billions</i>
<b>Savings</b>				
Revise Medicare Advantage Benchmarks	\$175	\$157 or \$158	\$135	—
Reduce Prescription Drug Costs	\$29	\$110	\$93	\$62
Payments for Hospital Episodes to Include Post–Acute Care	\$26	\$19	\$123	\$182
Modify the Home Health Update Factor	\$37	\$50	—	—
Hospital Pay-for-Performance	\$12	\$3	\$43	\$55
Patient-Centered Medical Homes	—	(\$6)	\$83	\$144
Primary Care Payment Reform	—	\$5	\$23	\$56
Health Information Technology Adoption	\$13	\$4 or \$61	\$70	\$180
Comparative Effectiveness Research and Use of Information	—	(\$1)	\$174	\$480
Modify High-Cost Area Update	—	\$51	\$100	\$177
<b>Select Population Health Options</b>				
Tobacco Excise Tax	—	\$95	\$79	\$215
Alcohol Excise Tax	—	\$60	\$47	—
Sugar-Sweetened Beverage Excise Tax and Obesity Abatement	—	\$50	\$121	\$321

Note: Savings are not additive and policies may have overlapping or synergistic effects.

\* If Lewin did not provide any estimate for a policy or only provided an estimate of impact to the federal budget, the Total Health System column is left blank.

## COMPARISON OF SELECT POLICY OPTIONS

### Changes to Medicare Advantage

- OMB budget estimate: \$175 billion federal savings
- CBO estimate: \$157 billion federal savings for setting benchmark at local fee-for-service rates; \$158 billion federal savings for competitive bidding
- Path estimate: \$135 billion federal savings

### *Current Policy*

The current method of setting benchmarks for payments to Medicare Advantage (MA) plans results in payments estimated to average 13 percent higher than costs would have

been under traditional Medicare fee-for-service (FFS) plans. In 2009, this translated into a projected \$11 billion in extra costs to the federal government, bringing the total extra payments to MA plans from 2004–09 up to nearly \$44 billion. Under the current method for determining payments, plans submit bids for covering Medicare beneficiaries based on their expected costs for providing coverage. The bid is then compared with benchmark rates for each county and national rates.

If a plan’s bid is below the benchmark, the plan receives a payment equal to the amount of the bid *plus* 75 percent of the difference between the bid and the benchmark. These additional funds must be returned to beneficiaries through additional services or premium reductions. If the plan’s bid is at or above the benchmark, the plan receives the benchmark amount. In many geographic areas, benchmarks are well above costs expected under traditional Medicare. By 2008, benchmarks in nearly a third of counties were on average 10 percent higher than local FFS spending. As a result, the current method of setting benchmarks and contracting with plans sends a price signal that encourages higher rather than lower costs.

#### **Budget Reconciliation**

The budget reconciliation process is a tool designed to reduce the deficit by forcing committees to produce spending cuts or raise tax revenue called for in the budget resolution (although it was used several times during the George W. Bush Administration to enact tax cuts). A reconciliation bill is a single piece of legislation that typically includes multiple provisions, all of which affect the federal budget. This type of legislation may not be filibustered in the Senate and only requires a majority vote to pass. If Congress decides to use this procedure, the budget resolution must include a reconciliation directive instructing a committee to produce legislation by a certain date that meets certain spending or tax targets.

All of these bills are packaged for a single floor vote with limited opportunity for amendment, differences between the House and Senate versions are resolved in conference, and the final conference report is considered in both chambers before going to the president for signature or veto. The Byrd rule constrains the reconciliation process so that, of the bundle of bills considered on the floor, any provision deemed extraneous to the purpose of amending entitlement or tax law is vulnerable to a point of order, thereby stripping that provision from the bill unless at least 60 senators vote to waive the rule. The Byrd rule also prohibits any entitlement increases or tax cuts that cost money beyond the five years covered by the reconciliation directive, unless these costs are fully offset by other provisions in the bill.

Independent of the budget process is the “Pay-As-You-Go” rule, or “PAYGO,” which requires that all entitlement increases or tax cuts be fully offset. For example, a House or Senate bill that increases Medicare spending would have to be paid for by cutting somewhere else in Medicare or another entitlement program, by raising revenues, or by a combination of the two. If no offsets are included in legislation, any senator may raise a point of order against the bill, which can be waived by the vote of 60 senators. In the House, any member can raise a point of order, and there is no mechanism to waive the rule—the bill is automatically defeated unless the leadership-appointed Rules Committee decided in advance to waive PAYGO as part of a broader measure setting the terms of debate on the bill.

### *OMB Option*

The Administration's budget includes a provision that would establish competitive bidding for MA that would determine payment levels based on an average of bids submitted rather than current benchmarks. The budget proposal estimates that allowing the market to set limits would reduce Medicare outlays by \$175 billion over the 2010–19 period as well as reduce Part B premiums for beneficiaries.

### *CBO Option*

The first CBO option would modify the payment mechanism to establish a benchmark. This option would set the benchmark in each county to equal the projected local per capita spending for traditional FFS spending, beginning in 2011. CBO estimated that this would yield \$157 billion over the 2010–19 period.

A second CBO option would replace the existing MA payment mechanism with a system in which benchmarks would be determined solely by plans' bids, which reflect the per capita payment they would accept for providing benefits covered by Medicare. The benchmark for each county would be the average bid of the plans that served that county, with each bid weighted by its enrollment the previous year. Beneficiaries who enrolled in a plan with a bid below the county's benchmark would receive the full difference between the bid and the benchmark in the form of additional benefits or a rebate on their Part B premium. Beneficiaries who enrolled in a plan with a bid above the county's benchmark would pay the full difference between the benchmark and the bid in additional premiums. CBO estimated that this option would yield \$158 billion in savings over the 2010–19 period.

### *Path Option*

The Path option would recalibrate the benchmark rate to the FFS per capita costs, eliminating excess payment due to the differences between the existing benchmark rate and the FFS per capita costs. Lewin estimates that this change would yield a reduction in federal spending of \$135 billion over the 2010–19 period.

### *Comparison*

Although the policy options take different approaches, all three seek to recalibrate the method of reimbursing MA plans to promote more efficient care. The Path option and the first CBO option are very similar; both use county-based FFS per capita costs as a new benchmark. These options, in effect, would return to earlier payment policies that rewarded plans that could deliver high-quality care and costs below current Medicare fee-for-service levels. Unspecified differences in the assumptions (e.g., the estimated number

of Medicare Advantage enrollees, timing for phasing in a new benchmark) account for the slight difference in estimates of savings. Plans with bids well above average costs would be at a competitive disadvantage. The second CBO option and the option in the Administration's budget proposal would compare plan bids within geographic areas, promoting efficiency by allowing plans to bid based on their projected costs rather than using bids below the current benchmark to turn a profit.

#### **President Obama's First Budget Request**

A major indication of the Administration's commitment to achieving health reform was the inclusion of a \$634 billion health care reform reserve fund in the budget request released in February 2009. To ensure budget neutrality over the coming decade, 2010–19, the Administration proposed a two-part funding mechanism for this reserve fund: a reduction in the itemized deduction rate for families with incomes over \$250,000 per year, and realized savings of \$316 billion over 10 years from policy changes in the Medicare and Medicaid programs. These changes would deliver an estimated:

- \$177 billion from Medicare Advantage;
- \$37 billion from modifying the home health update;
- \$26 billion through incentives to reduce hospital readmissions;
- \$29 billion from prescription drug price reforms; and
- \$12 billion through hospital pay-for-performance rewards.

In total, the major health provisions specified in the budget save \$316 billion over 10 years and generate new revenues of \$318 billion from tax changes affecting high-income households. While the proposed reserve fund represents a substantial commitment to moving forward on reform, the revenue and savings proposed fall short of what would be required to achieve health insurance for all.

Although the Administration's request was silent on whether Congress should consider using reconciliation to pass a health reform bill, the final budget resolution passed by Congress did include such instructions. Congressional leaders have indicated that it is their preference to pass comprehensive health reform in a bipartisan manner but may resort to using the reconciliation tool if bipartisan negotiations are unsuccessful. In April 2009, Senator Arlen Specter of Pennsylvania switched from the Republican to the Democratic Party, giving the majority 59 votes in the Senate. As of June 2009, legal challenges to the Minnesota election results were still under way, but if Al Franken is ultimately seated as a senator for Minnesota, the Democrats will have a filibuster-proof majority and may not need to use the reconciliation process.

#### **Achieving Lower Drug Costs in Public Programs**

- OMB budget estimate: \$29 billion federal savings
- CBO estimate: \$110 billion federal savings
- Path estimate: \$93 billion federal savings, \$62 billion total health system savings

#### *Current Policy*

Prescription drug costs currently account for more than a fifth of total national health spending and have been increasing rapidly. International comparisons as well as experience within the United States indicate that there is potential to lower spending in public programs by using purchasing leverage, especially for unique, expensive

medications. The Veteran's Administration and other federal programs have mechanisms in place to achieve cost-effective acquisition of drugs. Medicaid uses manufacturer rebates and Medicare allows Part D plans and MA plans with prescription drug coverage to negotiate prices directly with manufacturers. A variety of policy options would seek further savings through the expansion of economies of scale and leverage of group purchasing through federal programs.

#### *OMB Option*

The Administration's budget proposes reducing Medicaid drug prices by increasing the Medicaid brand-name drug rebate from 15.1 percent to 22.1 percent of the average manufacturer price. The larger rebate would apply to new drugs and would be available to Medicaid managed care organizations as well as state Medicaid FFS programs. The budget proposal estimates this expansion of the rebate would yield \$20 billion in federal savings over the 2010–19 period. In addition, the Administration's budget proposes changing the regulations for approval of biologic drugs to establish a process for affordable follow-on biologics (i.e., a new version of an existing biopharmaceutical that uses the same mechanism of action and treats the same clinical indications as the original, though not truly “generic”) or generic drugs. This would save an estimated \$9 billion over the 10-year window.

#### *CBO Option*

The CBO option would create a Medicare drug rebate policy modeled on the existing Medicaid rebate for purchases of brand-name drugs by all Part D beneficiaries, requiring manufacturers of brand-name drugs to provide a rebate to the federal government equaling 15 percent of the average manufacturer price. This would produce estimated savings of \$110 billion over the 10-year period. Various congressional proposals have called for allowing the Secretary of Health and Human Services (HHS) to have broader negotiation authority. CBO did not include an estimate of costs or savings from allowing the Secretary to negotiate drug prices for Part D in its December 2008 report. However, CBO did analyze such a provision in legislation from the 110th Congress. Senate bill 3 (S. 3) would have revised the “noninterference clause” of the Medicare Modernization Act Part D legislation to allow the Secretary to negotiate prices or join negotiations between drug manufacturers, pharmacies, private drug plan (PDPs), or sponsors. The proposal would have restricted the Secretary from instituting a formulary or price structure for Part D drugs, and would have allowed PDPs to negotiate lower prices than those negotiated by the Secretary. CBO estimated that striking the non-interference provision as proposed would have had a negligible effect on federal spending, because it anticipated the Secretary would not have leverage to negotiate rates lower than those currently negotiated by PDPs.

### *Path Option*

The Path policy options would authorize the Secretary to set or negotiate the price of therapeutically unique, expensive drugs using prices paid internationally as the target range. Policies in the Path report also would focus on beneficiaries who are dually eligible for Medicare and Medicaid and have high rates of chronic disease, allowing the Secretary to establish a multi-payer purchasing collaborative open to all public payers and multi-employer private purchasing groups. For the dually eligible group, drug manufacturers would be required to give the full Medicaid rebate to current Part D and MA plans. Lewin estimates that this change would yield \$90 billion in federal government savings over the 2010–19 period and a \$57 billion net reduction in national health spending over the same period.

Giving the Secretary authority to negotiate lower prices for prescription drugs for federal programs, including Medicare, would focus on the average global price for single-source drugs for which there are no therapeutic alternatives—a category in which current Part D plans have been relatively unsuccessful in containing costs. Lewin estimates that such negotiations could yield \$3 billion in federal savings and a \$5 billion net reduction in national health spending over 10 years.

### *Comparison*

While all of these policy options target areas in which current U.S. prescription drug spending is high, they take different approaches to achieve savings. The Administration’s budget option would simply increase the Medicaid drug rebate, reducing the costs of drugs for Medicaid beneficiaries. In contrast, the Path policies would focus on prices paid for medications for the chronically ill and promote broad price negotiations. The CBO option would apply the current rebate to all brand-name drugs purchased through a PDP or Medicare Advantage Prescription Drug Plan, expanding the population to which the rebates would apply.

The policy option allowing the HHS Secretary to negotiate drug prices was not included in the Administration’s budget, though in recent years there have been numerous legislative attempts in Congress to give the Secretary this ability. Although the CBO estimates of a policy option weaker than the Path options assumed that the Secretary would not have sufficient leverage to obtain prices lower than what PDPs currently obtain, the Path policies focus on an area where PDPs have been unsuccessful in lowering prices—namely, non-competing single-source drugs—and allow the Secretary to use global prices at targets. Lewin assumed that despite drug manufacturers’ monopoly position with these drugs, they may be willing to agree to discounts to avoid

negative public opinion. In an April 2007 letter to Senator Ron Wyden (D-Ore.), CBO indicated that this type of limited negotiating by the Secretary could achieve lower prices but that the likely effect would be modest, a conclusion consistent with Lewin's estimate of prospective savings.

### **Bundle Payments for Hospitals to Include Post–Acute Care**

- OMB budget estimate: \$26 billion federal savings
- CBO estimate: \$19 billion federal savings
- Path estimate: \$123 billion federal savings, \$182 billion total health system savings

#### *Current Policy*

The Medicare FFS program currently pays hospitals fixed amounts for each hospital admission/discharge based on the diagnosis and risk adjustments. Paying a bundled rate for the inpatient hospital stay up to the time of discharge would create an incentive for hospitals to provide efficient care. However, such payments would not support or provide incentives for hospitals to help patients during their transitions home or to post–acute care settings; neither would they support or provide incentives for hospital to ensure that patients receive follow-up care. As a result, hospitals lack financial support or incentives to take measures to prevent complications that could lead to rehospitalizations. One way to align incentives, provide better care for vulnerable patients, and prevent readmissions would be to expand the scope of bundled payments to encompass acute hospital care and post–acute care and hold hospitals accountable for the costs of the initial hospitalization and readmissions. With estimates that as many as 75 percent of readmissions may be preventable, such policy options have the potential to improve patient care and lower health care costs.

#### *OMB Option*

The Administration's budget would bundle hospital payments for inpatient acute care and targeted post–acute care providers for the 30 days after hospitalization. Hospitals with high rates of readmission would be paid less if patients are readmitted within 30 days. The Administration expects reduced readmissions to save \$8 billion and increased efficiency in post–acute care to save \$18 billion over the 2010–19 period, totaling \$26 billion in savings.

#### *CBO Option*

The CBO option would expand the unit of payment for acute care provided in hospitals to include post–acute care provided in acute care hospitals and non-hospital settings, defined as any service initiated within 30 days of a patient's discharge from an acute care

inpatient hospital provided by specific types of post-acute care providers including skilled nursing facilities and home health care agencies. Hospitals would receive a single bundled payment from Medicare for these services, regardless of whether a particular patient received post-acute care. Medicare would no longer make separate payments for post-acute care services following an acute care inpatient stay. This policy would likely reduce the cost of post-acute care services for Medicare beneficiaries through reductions in the volume or intensity of post-acute care or through hospitals' contracting with more efficient providers. The policy seeks to improve patient outcomes through greater coordination of post-discharge and post-acute care. Hospitals would retain 20 percent of the anticipated savings and the remainder would be recaptured through adjustments in Medicare's annual update factors. This would yield an estimated \$19 billion in reduced mandatory spending.

#### *Path Option*

The Path option follows a similar approach to the CBO policy option to expand the current hospital bundle to cover the costs of readmissions and post-acute care. For all inpatient prospective payment system hospitals and their associated integrated care networks, Medicare would bundle payments encompassing inpatient care, inpatient physician services while hospitalized, readmission care, and post-acute care services provided up to 30 days after the discharge date, including skilled nursing facility and home health care. The policy would be staged: expanding first to readmission care, then post-acute care, and finally to inpatient physician services. The initial payment amounts would be calculated as a percentage of the current mean payments for each component of the bundle, yielding 15 percent savings for readmissions, 10 percent savings for post-acute care, and 5 percent savings for inpatient physician and emergency department care. In future years, the update factor would be reduced each year to account for improved integration of care. The update would be reduced by 0.5 percentage point in 2010-12, 0.75 percentage point in 2013-15, and 1.0 percentage point starting in 2016 as greater efficiency is achieved over time. Lewin estimates that this policy would yield \$123 billion in federal savings and \$182 billion in total health system savings.

#### *Comparison*

The differences among the three estimates of savings stem from the scope of and approach to bundling and from policies related to payment updates. The CBO estimate assumes the expanded bundled payment rate would be updated with the current update factors, less the savings adjustment, while the Lewin estimate includes annual decreases to the update factors. Without this reduction, Lewin estimates that bundling would yield \$74 billion in federal savings. In addition, the Path option would be applied to the

Medicare program and a new public health insurance plan option offered through a national insurance exchange to the under-65 population. In contrast, the Administration's budget option and the CBO option would only apply to Medicare. Of the net \$182 billion saved through this option, Lewin estimates \$115 billion would come from Medicare savings. The CBO option would set the expanded bundled payment rate at the current average cost across all post-acute care settings for treating patients in that Medicare severity diagnosis-related group, whereas the Path option sets the expanded bundled payment rate lower than what Medicare currently pays on average. The CBO option would apply to one-third of post-acute care admissions beginning in 2013 and to all admissions beginning in 2015. In contrast, the Path option would apply to all admissions beginning in 2010. The policy proposal in the Administration's budget would target reductions in the costs of post-acute care as well as readmission rates.

### **Changes to Home Health Reimbursement**

- OMB budget estimate: \$37 billion federal savings
- CBO estimate: \$50 billion federal savings
- Path estimate: Not available

#### *Current Policy*

Home health agencies currently receive a single, prospectively determined payment to cover all of a beneficiary's services for a 60-day period. This single amount is determined by a national base payment rate adjusted to account for differences in patients' medical conditions and functional status ("case mix") and for geographic variation in the prices of inputs such as wages. The base payment is updated annually based on the projected increase in the home health market basket index, which reflects increases in the prices of inputs. Among freestanding home health agencies, the excess of Medicare's payments over and above providers' costs totaled 15 percent of Medicare payments in 2006.

#### *OMB Option*

The Administration's budget option would adjust home health payments to align with costs. The budget does not specify the mechanisms to achieve this alignment and the corresponding \$37 billion in savings, but it is likely that the estimate is based on the recommendations of the Medicare Payment Advisory Commission (MedPAC) from its March 2009 Report to the Congress. MedPAC made three recommendations: eliminate the market basket index update to reduce 2010 payment rates by 5.5 percent from 2009 levels; re-base rates for home health care services in 2011 to reflect the average cost of providing care; and assess payment measures that protect the quality and efficiency of care. The recommended changes seek to address excess payments in light of the

MedPAC analysis that home health payments have been more than adequate in recent years. The first recommendation is estimated to save between \$5 billion and \$10 billion over the 2010–14 period, with additional unspecified savings stemming from the 2011 payment re-base. The third recommendation yields no estimated costs or savings.

#### *CBO Option*

The CBO option would eliminate the market basket index update. This component of the update increased by 0.25 percent in 2008, but the proportion of Medicare payments in excess of providers' costs remained at 11 percent. Payments would continue to be adjusted for geographic variation and case mix. CBO estimates that eliminating the market-basket-index component of the update would yield \$12 billion over five years and \$50 billion over the 2010–19 period.

#### *Path Option*

The Path policies did not include specific changes to home health reimbursement.

#### *Comparison*

The CBO option is similar to the first MedPAC option, but the MedPAC option resets the base rate in 2011 based on the average costs of providing care. The Administration's budget does not specify the mechanisms it used to achieve the \$37 billion estimate of savings from realigning home health payments with costs, but it is likely that the provisions considered were similar to the MedPAC recommendations and CBO option.

### **Hospital Pay-for-Performance**

- OMB budget estimate: \$12 billion federal savings
- CBO estimate: \$3 billion federal savings
- Path estimate: \$43 billion federal savings, \$55 billion total health system savings

#### *Current Policy*

Pay-for-performance initiatives focused on hospitals have sought to reward and support providers to improve the quality of care and achieve better outcomes. Incentives are designed to drive improvement as well as achieve benchmark performance levels. These initiatives can achieve savings through the reduced cost of higher-quality care and through decreased payments or payment updates for hospitals that do not achieve benchmark performance levels. The magnitude of savings achieved is linked to the magnitude of these reductions. The CMS/Premier Hospital Quality Incentive Demonstration (Premier) began in 2003 and aims to promote quality improvement in acute care hospitals by expanding the public quality reporting system and providing financial incentives to

improve. The program now applies to five conditions: acute myocardial infarction, isolated coronary artery bypass graft, heart failure, community-acquired pneumonia, and hip and knee replacement surgery. A participating hospital receives a 1 percent or 2 percent bonus for performing at or above the 80th or 90th percentile, respectively, for a condition; similarly, a hospital receives a 1 percent or 2 percent penalty for performing at or below the 20th or 10th percentile, respectively, in the previous two years.

#### *OMB Option*

The Administration's budget would link a portion of Medicare payments for acute inpatient hospital services to hospitals' performance on certain quality measures. This is estimated to save more than \$12 billion over the 2010–19 period.

#### *CBO Option*

The CBO option would expand the Premier demonstration to all acute care hospitals. All hospitals would receive reduced Medicare payments for the five conditions based on the estimates of productivity growth, and top-performing hospitals would be eligible to receive bonus payments between 0.75 and 1.50 percent. Beyond the initial universal reduction in payment for the five conditions, no additional payment reductions would be made for hospitals that provided lower-quality care once the initial payment reduction was made. CBO estimated that this would reduce federal outlays by \$3 billion over the 2010–19 period.

#### *Path Option*

The Path option would expand the Premier demonstration to all acute care hospitals and modify the financial incentives to provide a bonus to hospitals above the 75th percentile and eliminate the payment penalty for hospitals in the bottom two deciles. Lewin estimates that this would yield \$32 billion in savings to Medicare over the 2010–19 period. In addition, the performance incentives would be extended to other conditions at the rate of 5 percent per year. Funding for the bonuses would be derived by reducing the total hospital payment to all hospitals by the total projected bonus payments. Lewin estimates that this option would increase the savings to \$43 billion in federal government savings and result in \$55 billion net reduction in national health spending over the 2010–19 period.

#### *Comparison*

Although the Administration's budget does not specify the assumptions used to reach the \$12 billion estimate, it is likely that the Administration's budget extends the Premier demonstration to other acute care hospitals but does not modify the financial incentives or expand the program to include other conditions. The lower CBO estimate likely

reflects the exclusion of the low-quality financial penalties currently included in the Premier demonstration. The Path pay-for-performance option results in greater savings than the other estimates because it would expand the program to include additional conditions and would apply to Medicare as well as the new public health insurance plan—thus affecting a larger patient base and a larger share of total hospital spending.

### **Patient-Centered Medical Homes**

- OMB budget estimate: Not available
- CBO estimate: (\$6 billion federal budget)
- Path estimate: \$83 billion federal savings, \$144 billion total health system savings

#### *Current Policy*

More than half of people with chronic illnesses receive care from three or more physicians, with little communication or coordination among these providers. This fragmented care can result in duplicate tests, conflicting medical advice, and prescriptions for contraindicated medications. The patient-centered medical home is an approach to primary care organized around the relationship between the patient and the personal clinician. First championed by the American Academy of Pediatrics, the medical home is broadly defined as primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.” Rather than being a place, a medical home is a way of delivering care that includes five principles: a personal physician; whole-person orientation; safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology); enhanced access to care; and payment that recognizes the added value of a patient-centered medical home.

Focusing on coordinated, patient-centered care could improve health outcomes and reduce health spending. Related policy options would support a team approach to providing medical care and hold practices accountable for providing meaningful access to care, effectively managing chronic conditions, and ensuring that care is coordinated.

#### *OMB Option*

The Administration’s budget did not specifically address medical homes.

#### *CBO Option*

The CBO option provides that Medicare beneficiaries with at least two chronic conditions could designate a qualified physician as their medical home. Physicians, group practices, or clinics could qualify as medical homes by documenting that they have the systems and infrastructure in place to provide coordinated and timely, high-quality care. Those

providers who qualify as medical homes would receive a per-beneficiary monthly payment, compensating them for the additional time and other costs associated with managing more comprehensive care. This option is expected to cost \$6 billion over the 2010–19 period. Medical homes have the potential to improve the health and health care of enrolled beneficiaries, in some cases reducing spending by eliminating duplicated services and increasing the quality and efficiency of care. They may increase spending for patients who had not been receiving all recommended care.

### *Path Option*

The Path option would include a new per-patient payment to support increased access to primary care services, case management services for patients with complex conditions, and a team approach to care. This enhanced payment would be in addition to the traditional FFS payments that primary care providers currently receive. Participating providers would be required to demonstrate that their practice has capacity to provide enhanced, patient-centered care, with an emphasis on their ability to offer accessible, appropriate, and coordinated care for patients with chronic conditions and comorbidities. The option has three elements: the new per-patient medical home payment, incentives for patients, and incentives for providers. Patients, providers, and the federal government would equally share in the savings in total health spending for enrolled groups.

Providers who elect to participate would have the option of two alternative payment structures: a mixed capitation and FFS option through which certified practices receive a per-person per-month fee in addition to all FFS payments; or a primary care medical home option through which certified practices receive a risk-adjusted, global, per-person, per-month fee to cover all primary care services. Providers would be eligible to receive their share of savings through year-end bonuses based on performance, as judged by measures of clinical quality and patient experience. For example, a provider might be evaluated by the proportion of patients who are up-to-date with recommended preventive services and the percentage of patients with chronic conditions whose conditions are adequately controlled.

All Medicare beneficiaries and enrollees in the public plan option for the under-65 population would be eligible for the program, and Medicaid beneficiaries with chronic illnesses would be required to enroll in managed care or a primary care case management (PCCM) program. Positive incentives through lower premiums or reduced cost-sharing would encourage patients to designate a primary care practice that meets the certification requirements of a medical home. Including all three elements, Lewin estimates this option would yield \$83 billion in federal savings and \$144 billion in total health system savings between 2010 and 2019.

### *Comparison*

The CBO estimate does not acknowledge any potential savings from the medical home model and includes only the cost of the medical home payment and administration of the program. In contrast, the Lewin estimate projects savings from the medical home based on evidence from Medicaid PCCM programs, primary care in private managed care plans, medical home programs in private FFS plans, and medical home programs in integrated delivery systems. The CBO option applies only to Medicare beneficiaries and does not include Medicaid beneficiaries or any individuals who would enroll in Path's public plan option.

In addition, the per-member per-month fee varied. The CBO estimate began at \$34 per month in 2010, with annual adjustments relative to the Medicare physician fee schedule, whereas the Lewin estimate for the mixed capitation and FFS option fee would average around \$8 per month. The Lewin estimates for the global fee were not specified but would be set at the expected risk-adjusted average payment for primary care services, taking into account geographic differences in the prices of practice inputs.

### **Primary Care Payment and Physician Payment Reform**

- OMB budget estimate: Not available
- CBO estimate: \$5 billion federal savings
- Path estimate: \$23 billion federal savings, \$56 billion total health system savings

### *Current Policy*

In Medicare's fee-for-service (FFS) program, physicians who treat Medicare beneficiaries are paid separately for each service they provide. Currently, cognitive services and primary care services are relatively undervalued compared with procedures and specialty care. Moreover, annual updates aimed at slowing spending due to higher volume for procedures have held down annual updates for primary care physicians and generalists, despite the fact that these are not the services that are driving the higher volume of procedures. As a result, specialists' incomes have grown rapidly compared with those of primary care providers. Despite our projected growing need for primary care providers to serve an aging population, the market signal of lower pay and long hours has resulted in fewer graduates of medical school choosing primary care careers over specialties each year. Increasing reimbursement for primary care could provide better support for primary care, with an emphasis on prevention and taking time to manage patients with chronic conditions. Over time, improved payment policies such as increased reimbursement could increase the number of primary care providers entering the workforce.

### *OMB Option*

The Administration's budget did not specify changes to be made to the physician payment system, but indicates that the system needs to be reformed to give physicians incentives to improve the quality and efficiency of care. The budget describes policies that would enable physicians to form voluntary groups that coordinate care for Medicare beneficiaries and receive performance-based payments for the coordinated care, but it does not estimate a cost or savings from such policies.

### *CBO Option*

Under the policy option examined by the CBO, each Medicare FFS beneficiary would be assigned to a primary care physician (PCP) who would be reimbursed by a partial-capitation system. PCPs would receive three-fourths of their Medicare payments on a per-service basis and approximately one-fourth of their payments through risk-adjusted capitation; in addition, bonuses or penalties would result based on the total expenditures incurred by each PCP's panel of assigned beneficiaries. This is expected to facilitate PCPs' coordination of care and to reduce the volume and intensity of services provided to these beneficiaries, thereby increasing the cost-effectiveness of treatment under Medicare FFS. This policy would address some of the disparity between primary and specialty care reimbursement, largely by providing an incentive to provide primary care through a practice similar to a medical home. CBO estimates this would save the federal government \$5 billion during the 10-year window.

### *Path Option*

The Path option would revise the Medicare physician fee schedule to increase payment for primary care services by raising the relative value units by 5 percent for primary care services provided by "primary care focused" practitioners. This adjustment would be budget neutral in the first year through reductions in payments for all other services in proportion to the amount increased for the primary care services (an estimated 0.5 percent reduction). The Path option also would separate updates for primary care from more specialized care and procedures. The policy would apply preferential updates to payments for primary care (e.g., generalist, cognitive care) and slow the growth of payments for specialized care and procedures. Lewin estimates that the impact of modifying the fee schedule would increase payments for primary care by \$8 billion over 10 years, while simultaneously reducing payments for other specialized services by \$25 billion, resulting in a net Medicare savings of \$17 billion over the 2010–19 period. The changes in value could, over time, influence the proportion of physicians going into primary care. Through the extension of these payment policies to the new public health insurance option for the under-65 population, this policy could yield \$23 billion in federal government savings and \$56 billion in total health system savings over the 2010–19 period.

### *Comparison*

The Path option would apply to Medicare and those enrolled in the new public health insurance option, spanning a larger population than envisioned by CBO. The Lewin estimate of the impact of the Path option on Medicare alone projects \$17 billion in savings over the 2010–19 period, compared with the \$56 billion net savings when the public health insurance option is included. The CBO and Path options differ in their approach to specialized care and procedures. The CBO option would not change payment for these services but would reward or penalize the PCP for lower- or higher-than-average expenditures; it would reduce payment to other providers through the gatekeeping functions of the PCP and by decreasing utilization of specialized care and procedures. In contrast, the Path option would decrease payment for specialized care and services to maintain budget neutrality. The Lewin estimate includes a projected initial increase in utilization of specialized care and procedures that partially offsets the payment reduction.

### **Health Information Technology**

- ARRA estimate: \$13 billion federal savings
- CBO estimate: \$4 billion federal savings through incentives, \$61 billion if HIT use were required as condition of participation in Medicare
- Path estimate: \$70 billion federal savings, \$180 billion total health system savings

### *Current Policy*

Health information technology (HIT) has the potential to produce savings and improve the effectiveness and safety of medical care by increasing the efficiency with which care is delivered, reducing duplicative or unnecessary care, and lowering the incidence of medical errors. HIT also can improve patient safety through identification of contraindicated prescriptions or procedures. Built-in clinical decision tools enable providers to use the most up-to-date information when considering treatment options. Currently, the pace of adoption and use of HIT has been slow. All of the policy options discussed seek to accelerate the spread, effective use, and availability of essential information across sites of care.

### *Stimulus Legislation (ARRA) provision*

ARRA includes the Health Information Technology for Economic and Clinical Health (HITECH) Act, which encourages the adoption of interoperable electronic health records and the development of a national health information network. The legislation appropriates \$20 billion to provide financial incentives to use HIT, to fund grants that invest in HIT infrastructure, and to support technical assistance for HIT development,

adoption, and use. Financial incentives include Medicare payments to encourage doctors and hospitals to adopt and use interoperable HIT through bonuses; later, penalties such as reduced payment updates would be levied for non-use of HIT.

In an evaluation of HITECH prior to its inclusion in ARRA, CBO estimated that such an investment would save Medicare and Medicaid \$13 billion over the 2010–19 period and result in adoption rates of 70 percent for hospitals and 90 percent for physicians, compared with the projected adoption rates of 45 and 65 percent, respectively, without such public investment and incentives.

#### *CBO Option*

In its December 2008 report, CBO evaluated two options for achieving savings through HIT: creating incentives in Medicare for HIT adoption and requiring the use of HIT as a condition of Medicare participation. The first option would create a bonus-penalty system for use of qualifying HIT systems. Physicians who use a qualifying system would receive a 2 percent bonus on top of regular office visit fees during the first five years following implementation. Physicians who do not use a qualifying system would be assessed a 5 percent penalty during the second five years following implementation. This bonus-penalty option achieves an estimated \$4 billion in savings over the 10 years following implementation and would result in greater adoption of HIT than either bonuses or penalties alone. The second option would require that physicians and hospitals adopt and use a qualifying HIT system as a condition of participation in Medicare, beginning in 2015. This requirement would lead to nearly universal adoption of electronic health record systems by physicians and hospitals. CBO estimates such rapid spread would reduce administrative overhead, unnecessary utilization of services, and adverse events. Without any other changes in federal law, this option would achieve \$23 billion in savings. If policies adjusted payment rate updates for hospitals to reflect the reduced administrative costs, this option could achieve \$61 billion in savings over 10 years.

#### *Path Option*

The Path options focused on establishing health information network capacity as well as promoting the spread and effective use of HIT by physicians and hospitals. The policy would require electronic reporting of key health outcomes to qualify for payment updates starting in 2015. To provide funding to support development of network capacity and assistance for safety net providers and small practices, the policy would levy a 1 percent assessment on private insurance premiums and allocate funds equivalent to 1 percent of Medicare expenditures. These funds also would be available to assist small practices, safety-net providers, and rural areas in implementing effective HIT. The policy focused on ensuring capacity to exchange information across sites of care. The benefits of such

capacity would accrue to all providers and patients. As a public good, such capacity is unlikely to develop without direct support and standards for exchange. The funds raised through the assessments would target development of information networks as well as adoption of HIT within practices. The policy assumed funding would be available starting in 2010.

By 2015, five years after support begins, all physicians and hospitals would be required to report electronically on key health outcomes or data elements in order to receive full payment updates from Medicare, Medicaid, and the new public health insurance plan offered through the national insurance exchange. This option is estimated to increase use of HIT to 96 percent and to achieve a net savings of \$64 billion through reduced medical errors, administrative costs, and laboratory tests as well as through greater workforce productivity. The investment in HIT could increase such capacity from an estimated 5 percent in 2010 to 90 percent by 2017. This expanded capacity would enable more integrated care and information exchange throughout the health care delivery system. With the acceleration of development, adoption, and use of information exchange and HIT networks, the investment would result in an additional national savings of \$117 billion over the decade. In total, the public investment and HIT policies could reduce national spending by \$180 billion over 10 years compared with projected trends, \$70 billion of which accrue to the federal government. The federal savings are net of the initial investment.

### *Comparison*

The Path option to provide federal support for providers to implement HIT is similar to HITECH in terms of the provisions for increasing adoption of HIT within practices, with a similar estimated adoption rate among physicians. The estimates differ primarily in their approach to development of network capacity and inclusion of strong incentives for physicians and hospitals to report key data electronically. However, the Path option requires reporting of key health outcome data electronically and would thus stimulate use of systems as well as the development of national data exchange capacity. All physicians and hospitals would be required to report such data electronically in order to receive payment updates. The Path policy also would provide substantial funding and support for establishment of national, state, or regional information network capacity. This capacity could support more integrated care and provide a platform for rapid dissemination of the latest clinical information, including medication alerts, to providers. CBO estimates focus on the potential savings to the federal budget. The Path estimates illustrate the potential for national health system savings from accelerating adoption and use of HIT that has the capacity to integrate care across settings and support effective information exchange.

## **Comparative Effectiveness Research**

- ARRA estimate: Not available
- CBO estimate: (\$1 billion federal budget), \$8 billion total health system savings
- Path estimate: \$174 billion federal savings, \$480 billion total health system savings

### *Current Policy*

As medical science evolves, better information on the effectiveness and comparative effectiveness of available treatment options, medications, and devices is essential to support decision-making by providers and patients, as well as by payers. Better evidence is important both for existing treatment alternatives and for new treatments and technology. There is wide variation in practice patterns across the country and within regions, with no apparent relationship between higher costs and better health outcomes. The wide variation plus uncertainty about the relative benefits of alternative choices indicate that better information to inform decisions and effective use of information could reduce spending without sacrificing quality. Moreover, studies provide widespread evidence of inappropriate or unsafe care as well as failure to provide recommended care. Thus, an objective source of clinical information about what is likely to work well for particular patients would improve the quality of care.

Approaches that synthesize information about treatments and outcomes also would help inform patients about their care options. Investment in generating better information for health care decision-making, combined with incentives to encourage more effective use of available information, could reduce unnecessary care, increase the provision of appropriate care, and improve the management of chronic conditions. Information about the relative costs of similarly effective care options could further inform decisions—and potentially control costs over time while improving health care quality and outcomes.

### *ARRA Provision*

ARRA provides \$1.1 billion to invest in comparative effectiveness research. Of this amount, \$700 million would support the Agency for Healthcare Research and Quality (AHRQ) for comparative effectiveness research, including \$400 million for the National Institutes of Health (NIH). An additional \$400 million is allocated to the HHS Secretary to conduct, support, or synthesize comparative effectiveness research and to encourage the development and use of infrastructure and systems to generate or obtain outcomes data. The provision also establishes an interagency advisory panel to help coordinate and support comparative effectiveness research. The panel must report to the president and Congress annually but may not mandate coverage, reimbursement, or other policies for

payers, and the panel's recommendations may not be construed as mandates or clinical guidelines for payment, coverage, or treatment. The budget did not provide an estimate of potential savings from this investment.

#### *CBO Option*

Under the CBO option, the federal government would fund research on the comparative effectiveness of alternative medical treatments over the next decade. Funding would begin at \$100 million in 2010, grow to \$400 million in 2014, and remain at that level through 2019. This would generate improved evidence-based information to inform medical practice. CBO estimates that the investment would result in a \$1 billion increase in federal spending, although it would yield \$8 billion in reduced national health expenditures.

#### *Path Option*

The Path reforms include the creation of a new Center for Comparative Effectiveness Research and Health Care Decision-Making (Center), which would synthesize and conduct research on the relative effectiveness of alternative therapies. The Center would be a public-private partnership, operating as an independent, quasi-governmental entity. To ensure budget independence and provide resources for operations, the policy provides for contributions equal to .05 percent of projected Medicare and Medicaid spending from the public sector and .05 percent assessment on private insurance premiums. The Center would be mandated to produce and disseminate comparative effectiveness information, guided by national priorities. The Center also would recommend incentives to inform public and private insurance payment and benefit design policies.

In addition, policies included in the Path approach would support the use of decision aids designed to inform patients of alternative treatment options, when appropriate. The policies would inform decisions made by Medicare, Medicaid, and the new public health insurance option regarding patient cost-sharing and relative pricing for alternative treatments, medications, and other clinical care. The estimates assume public and private insurance plans will incorporate such incentives into benefit designs and provide payments to promote effective and appropriate care. Payment and cost-sharing provisions would provide financial incentives to avoid high-cost options that are no more effective than lower-cost alternatives. Using the assumption that better information would be available and put to use, Lewin estimates national savings from 2010-19 to be a cumulative \$480 billion compared with projected trends, with \$174 billion in federal savings over the same period.

#### *Comparison*

The ARRA provisions make an initial investment in comparative effectiveness research but do not provide ongoing funding or an advisory capacity to inform public or private

health insurance policy decisions. Under the ARRA provisions, research remains decentralized, conducted separately by NIH, AHRQ, and the Secretary of HHS and evaluated by an advisory panel. The legislative language decouples the generation of information from payment policy.

Under the CBO option, comparative effectiveness research is funded entirely by the federal government, whereas Path's Center receives both public and private funding for research and dissemination—an estimated \$12 billion investment over 10 years. The CBO estimates rely on voluntary use of new information by patients and providers and do not assume a mechanism to translate evidence-based information into incentives for patients or providers to apply the information.

Under the Path option, research would be centralized in a new, independent entity, responsible for generating information and making recommendations for payment and cost-sharing policies. In addition, the policy would spread use of decision aids to inform patients of the risks and benefits of alternative treatment choices. Both policies would accelerate the use of comparative effectiveness information to improve the quality of care. In addition, both would reduce the delivery of care that is of little or no benefit as well as reduce the delivery of high-cost care when lower-cost alternatives exist. The incorporation of new information into payment and cost-sharing policies accounts for a great deal of the estimated savings from this option.

### **High-Cost Area Update**

- OMB Budget or ARRA: Not available
- CBO estimate: \$51 billion federal savings
- Path estimate: \$100 billion federal savings, \$177 billion total health system savings

### *Current Policy*

Medicare spending per enrollee varies widely across geographic areas. For example, Medicare spending per enrollee ranged from a high of \$14,359 in Miami, Fla., to a low of \$5,281 in Rapid City, S.D., in 2005. Analysis indicates that variations in practice patterns drive such differences in spending, rather than variations in the cost of living or health status. Moreover, lower-cost areas often have quality and outcomes that are at least as good as or better than in high-cost areas. Because Medicare prices per unit of service are predetermined and paid through fee-for-service payments, the program creates incentives to provide increasingly more services that drive up costs—especially in geographic areas with high ratios of specialized resources to population. High-cost regions of the country tend to have relatively few primary care providers and more expensive resources (e.g., hospitals, diagnostic facilities, and specialists) than lower-cost geographic regions.

### *ARRA and OMB Option*

Neither the Administration's budget request nor the economic stimulus package specifically addressed a high-cost area update modification.

### *CBO Option*

In the CBO option, payment rates in traditional Medicare FFS plans would be reduced for areas with relative spending of 10 percent or more above the national average. These high-cost areas would see a payment reduction equal to one-half the difference between their relative spending, compared with the national average and 110 percent of the national average. Payment reductions would be phased in over five years and capped at 20 percent, and would apply to all payments made on the basis of a fee schedule (e.g., payments to physicians, hospitals, and post-acute care providers). CBO estimates that this would yield \$51 billion in savings to the federal government over the 2010–19 period and would reduce beneficiaries' out-of-pocket costs by an unspecified amount.

### *Path Option*

To encourage more prudent use of resources in high-cost areas, payment updates for all providers each year would be based on total Medicare spending per beneficiary in each area relative to the national median, adjusted appropriately for costs beyond hospitals' control. The payment update in each area would be adjusted to reflect the percentage difference between Medicare spending per beneficiary in the region and the national median, with the full updates being applied for providers in low-cost areas (those with costs below 105 percent of the median), no updates for providers in areas with very high costs (those with costs at or above 125 percent of the median), and reduced updates (according to a sliding scale) for other areas with high costs (between 105 percent and 125 percent of the median). The update adjustments would be recalculated each year, based on the most recent data on Medicare spending per beneficiary, so that areas that improve their costs relative to the national median can increase their payment updates over time.

This payment policy would apply to traditional Medicare and the public health insurance plan offered through the national connector. Lewin estimates that this would yield \$100 billion in savings to the federal government over the 2010–19 period and \$177 billion in reduced national health expenditures over the same period.

### *Comparison*

The Path and CBO options use similar approaches to reduce the geographic variation in Medicare payments per beneficiary by reducing payment updates in high-cost areas.

However, the Path option is more stringent, reducing the update amount on a sliding scale for providers with costs between 105 and 125 percent of the median and eliminating updates for providers with costs at or above 125 percent of the median. The CBO option reduces the payment rate on a sliding scale for providers with costs above 110 percent of the national average but caps the reduction at 20 percent. Additionally, the Path option would apply not only to Medicare providers but also to providers participating in the public health insurance plan offered through the national connector. These differing approaches explain the varying estimates of savings to the federal government.

### **Select Population Health Options**

- ARRA estimate: Not available
- CBO estimate: \$205 billion federal revenues  
*Note: CBO estimate is for the 2009–18 period*
- Path estimate: \$247 billion federal savings, \$583 billion total health system savings

### *Current Policy*

More than a third of all illness is the result of poor diet, lack of exercise, and smoking. Population health initiatives such as tobacco, alcohol, and sugar-sweetened beverage taxes aim to lower the rate of chronic disease and preventable illness and increase tax revenue.

### *ARRA Option*

ARRA provides \$1 billion for a Prevention and Wellness Fund to be administered by the HHS Secretary, including \$300 million for the Centers for Disease Control and Prevention’s immunization program, \$650 million for evidence-based clinical and community-level prevention and wellness programs to address chronic disease, and \$50 million for state activities to reduce health care–associated infections. In addition, the Administration’s budget emphasizes the importance of prevention and wellness to improve population health as one component of comprehensive health reform, but does not specify any additional provisions beyond the funds allocated in ARRA.

### *CBO Option*

CBO considered three separate “sin” taxes to improve population health. The first option would increase the federal excise tax on cigarettes by one dollar per pack beginning in 2010. The increased revenue from the excise tax would be partially offset by reductions in payroll and income taxes. CBO projects that, for each 10 percent increase in the price of cigarettes, consumption will fall by 4 percent to 6 percent. The tobacco tax provision is estimated to yield \$95 billion in federal revenues over the 2009–18 period.

The second option CBO considered was to impose a federal excise tax of \$0.03 per 12 ounces of sugar-sweetened beverage (sugar drink), which would include a variety of beverages such as non-diet soft drinks, fruit cocktails, fruit drinks, flavored iced teas, and flavored milks. The tax would apply to beverages sweetened with sugar, high-fructose corn syrup, or similar sweeteners, but not to artificially sweetened soft drinks. Revenue from this excise tax would be \$50 billion over the 2009–18 period. This estimate reflects reductions in consumption and production of soft drinks as well as reduced income and payroll tax revenue that would stem from the excise tax. CBO acknowledges that this option would have a small but quantifiable effect on average body mass index and may reduce federal outlays for health care, but does not incorporate these effects into the estimate.

Similarly, CBO considered an increase on the federal excise tax on alcoholic beverages using the proof gallon as the measure. The tax rate would be raised to \$16.00 per proof gallon compared with the current \$13.50 per proof gallon for spirits, \$18.00 per barrel of beer, and \$1.07 per gallon of wine. The standardized, increased excise tax would increase revenues by \$60 billion over the 2009–18 period. CBO indicates that alcohol consumption creates costs for society that are not reflected in the pretax price of alcoholic beverages. Reducing these external costs would yield broad social benefits that would likely far outweigh the revenues derived from current alcohol excise taxes. However, CBO did not include an estimate of the financial ramifications of these potential social and health gains.

#### *Path Option*

Path policies include three options targeting prevention and wellness: a tobacco tax, an alcohol tax, and an obesity abatement effort. The tobacco tax option would increase the federal cigarette tax by two dollars per pack, with taxes on other types of tobacco products increased in the same proportion. One percent of these revenues would be used to fund smoking cessation programs. Lewin estimates that smoking cessation induced by the increased tax could yield a significant reduction in national health spending above the increased revenues from the tax through improved population health; the initiative is estimated to achieve \$79 billion in federal government savings and \$215 billion in net national savings over the 2010–19 period.

The alcohol tax option would increase the federal excise tax on alcohol from \$0.05 per 12 ounces of beer to \$0.10 per 12 ounces of beer, with a similar proportional increase in the taxes on other alcohol products. A portion of revenues from this increase would be used to strengthen the Substance Abuse and Mental Health Services

Administration (SAMHSA) Center for Substance Abuse Prevention's national alcohol and illicit substance abuse prevention programs, as well as to give block grants to states for their own control programs. Lewin estimates that the increased excise taxes would yield \$47 billion in federal revenues over the 2010–19 period. Lewin noted that alcohol consumption leads to additional health expenditures and that a tax increase would likely lead to decreased consumption, but does not estimate the impact.

The obesity abatement effort in the Path options relies on a tax on sweetened soft drinks of \$0.01 per 12 ounces. The tax would discourage soft drink consumption and also fund state-run obesity abatement programs. Lewin estimated that this tax increase would result in declining sales of sweetened soft drinks at a rate of 0.58 percent per year, yielding \$10 billion in net federal revenues over the 2010–19 period. One percent of these revenues would be reinvested in block grants to states for qualifying obesity prevention programs. Lewin estimated the potential national savings if such initiatives were to achieve a 50 percent reduction in the growth of the share of national health expenditures attributable to obesity, cutting the rate of increase from 0.40 percent per year to 0.20 percent per year. This yields an estimated \$323 billion in decreased national health expenditures over the 2010–19 period. Overall, Lewin estimates that the Path option aimed at reducing rates of obesity and the associated levy on sugar drinks would yield \$121 billion in federal government savings and \$321 billion in total health system savings over the 2010–19 period. In addition to the increased revenue through new or increased taxes, these three provisions would improve the population's health and result in health system savings far beyond the revenue from the taxes alone.

### *Comparison*

The funding allocated in ARRA aims to improve population health and reduce health spending in the long term, but no estimate of these potential future savings is available. The CBO and Path options demonstrate that prevention and wellness measures can simultaneously raise revenue and improve population health. Although the CBO and Path options addressed the same behaviors (tobacco, alcohol, and sugar drink consumption), they used different tax rates and policy approaches (e.g., obesity abatement program vs. tax alone) and reached very different conclusions, although they both concluded that the select policy options would generate savings.

The main difference between the tobacco estimates is the level of tax increase: the CBO option estimates revenues from a one-dollar increase compared with the Path option's two-dollar increase for cigarettes and proportional increases on other tobacco products. A second major difference between the two is that the Lewin estimate includes

net savings in national health spending from reduction in health care utilization due to smoking cessation. While CBO acknowledges that smoking cessation is likely at the same levels used by Lewin, the CBO estimate does not estimate potential savings.

The most significant difference between the soft drink initiatives is the Lewin estimate of the potential if initiatives were to succeed in reducing the rate of increase in obesity. CBO estimates examine the increased federal revenue from taxes alone, while the Lewin estimate of the Path obesity abatement policy also estimates the potential reduction in spending from improved population health. The estimates also rely on different amounts of tax increase. Lewin's revenue estimate also may be lower due to a narrower tax; the CBO option applied to all beverages sweetened with sugar and the Path option applies only to soft drinks, excluding fruit drinks and other sugar-sweetened beverages.

The Path and CBO policies also differ in terms of the rate of alcohol tax. The CBO option estimates an increase in alcoholic beverage excise tax up to a standard \$16.00 per proof gallon across all types of alcohol (an average 92 percent increase in the alcohol excise tax), yielding \$60 billion in federal tax revenues over 10 years. By comparison, the Path option would double the alcoholic beverage excise tax for all types of alcohol, yielding \$47 billion in federal tax revenues over 10 years. CBO projects that the increase in alcohol excise tax would yield increasing revenues each year and Lewin projects relatively steady revenues each year after implementation.

## **CONCLUSION**

The proposed \$634 billion health care reserve fund is a historic step toward comprehensive health reform and more affordable, high-quality health care. The proposal signals the Administration's view of the importance of health reform and its willingness to invest in the U.S. health system to achieve meaningful change. In particular, the Administration's budget identifies innovative strategies to eliminate waste while improving the quality of care. However, additional policies will be needed to finance federal efforts to extend insurance coverage to everyone and achieve a high-quality health care system while slowing the growth in health care costs.

Changing the way public and private insurance programs pay for care has the potential to improve outcomes and patient experiences while at the same time providing strong incentives for more efficient care. Better information systems and population health initiatives could accelerate the pace of change, with benefits accruing broadly to families, businesses, and public and private insurance programs. The estimates of the

potential impacts of different policies indicate that there is potential for significant gains. As illustrated above, the available estimates differ primarily in terms of the scope of the policies and particular elements of the proposals.

As the health care reform debate unfolds, it will be important to keep in mind that there are various options for financing the necessary federal investment and stimulating change throughout the care system. The challenge will be building consensus to move forward and implement policies that have the potential to simultaneously address health care access, quality, and costs. Implementing the changes necessary to put the U.S. health system on a path to high performance will be difficult and require a significant upfront investment.

Yet, without bold initiatives, the nation faces a future in which millions more Americans are denied access to needed care and the health care system consumes a growing share of national income, without providing adequate value. The Obama Administration has begun to make changes by prioritizing health reform and identifying areas where greater efficiency is possible. Congress now has the challenge and opportunity to forge consensus to move forward. National economic recovery and the nation's health and productivity depend on an accessible, high-quality, and efficient health care system.

#### **Methodology Note on Path Estimates**

Modeling the recommendations of the Commonwealth Fund Commission on a High Performance Health System for health system reform required detailed specifications for each of the proposed policy approaches. The Path policy specifications were used for illustrative purposes. Recognizing that multiple policy variations are feasible for key policy reforms, the Commission endorsed the conceptual, strategic approaches rather than the specific policy parameters used to model potential effects. The main Path report provides further detail. The Lewin Group technical report, *The Path to a High Performance U.S. Health System: Technical Documentation*, is available online at [www.Lewin.com](http://www.Lewin.com). It details the data and parameters used to estimate the potential effects of particular policies over 2010–19.

## NOTES

<sup>1</sup> For details of the Administration's budget proposal, see sidebars.

<sup>2</sup> Ranges between \$1 trillion and \$1.7 trillion have been estimated by the Lewin Group, the Council of Economic Advisers, CBO, and others. See reference list for sources.

<sup>3</sup> For a description of the Path framework and policies, see The Commonwealth Fund Commission on a High Performance Health System, February 2009. The Lewin Group (Lewin) provided estimates of costs and savings for the Path options. A technical appendix details assumptions and policy specifications. The Congressional Budget Office (CBO) released a two-volume report on budget options for achieving federal savings in December 2008, with the first volume dedicated to health care. The Office of Management and Budget (OMB) estimated the impact of the provisions laid out in the President's FY2010 budget and in the ARRA stimulus legislation. See reference list for sources.

<sup>4</sup> All estimates of future spending include a degree of uncertainty, particularly those expressed as point estimates rather than a range. For more information about the evidence used to support assumptions and estimates, see CBO Budget Options, Volume 1, and Lewin technical appendix.

<sup>5</sup> See Appendix for technical notes on Lewin estimates.

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## **APPENDIX. TECHNICAL NOTES ON LEWIN GROUP ESTIMATES OF SAVINGS FROM PATH POLICY OPTIONS**

### **Expanded Population and Increased Federal Baseline Spending**

Many of the policies evaluated by the Lewin Group would apply to an expanded population through a public health insurance option for those under age 65. This expansion would give the proposed policies greater impact and produce increased savings. To account for the higher federal baseline spending due to the expanded population, Lewin estimated the increases to the baseline through subsidies, an expansion of Medicaid, and other investments. For more detail, see the Lewin technical appendix. Where possible, the description of the Lewin estimate distinguishes between federal savings through Medicare versus through a new public health insurance option for the under-65 population.

### **Wage Effects and Increased Productivity**

Lewin estimates that the comprehensive set of Path policies implemented together would save households over \$2.3 billion over the 2010–19 period. However, estimates of the impact of the Path policies do not adjust for wage effects (i.e., higher tax income due to households' increased income and decreased health spending) or for productivity effects from improved health or increased workforce participation.

