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Issue Brief

The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings

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ABSTRACT: The presidential election has focused public attention on the need for health system reform—to ensure health insurance for all, to make health care more accessible and responsive to patients, and to slow the growth in health care cost. This issue brief sets forth a framework for expanding health coverage that offers Americans a choice of a product modeled on Medicare to those under age 65, made available through a national insurance connector. Coupled with reforms to Medicare provider payment, expansion of preventive health care, and improved information, such a strategy has the potential to achieve near-universal coverage and improve quality and access, while generating health system savings of \$1.6 trillion over 10 years.

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OVERVIEW

The 2008 presidential campaign has focused public attention on the need for health care system reform—to ensure that all Americans have health insurance, to make health care more accessible and responsive to patients, and to slow the rapid growth in health care costs. One strategy worthy of serious investigation, and one with the potential to create a transformative dynamic in the health insurance market, is to offer a new insurance product modeled on the Medicare program but made available to all people, both under and over age 65.

In this issue brief (and in the companion *Health Affairs* article, “Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance,”¹), we set forth a framework for health coverage reform featuring just such a product—Medicare Extra—that would be available, along with private insurance plans, through a national “insurance connector.” We then estimate the changes in insurance coverage, access to care, and costs that would be possible under a framework founded on the building blocks of private group insurance and a comprehensive publicly sponsored health plan.

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We estimate that Medicare Extra premiums would be more than 30 percent lower than premiums that are typically charged for employer-sponsored plans, especially those in the small-group market—a result of Medicare’s lower administrative costs and payment rates for providers. Overall, the “Building Blocks” framework could not only help ensure that affordable coverage is available to the uninsured, but it could also ensure improved coverage at lower costs for many employers, the self-employed, and insured individuals who are currently buying coverage on their own.

Simultaneously, coverage expansions could be linked to other health system reforms, including ones designed to give providers and patients the information they need to make appropriate health care decisions; revise methods for paying providers in order to encourage greater accountability for the care delivered; and spur preventive care use and health promotion. This analysis illustrates that such a strategy has the potential to achieve near-universal coverage, improve quality, and expand access—all while generating health system savings of \$1.6 trillion over 10 years. Broader system reforms, if combined with coverage expansion, would also achieve federal budget savings that largely offset the cost of achieving universal coverage by years 5 to 10.

HEALTH INSURANCE FOR ALL: THE BUILDING BLOCKS FRAMEWORK

The Building Blocks framework for expanding health insurance coverage has six core components:²

1. A structured choice of private plans and an enhanced Medicare-like plan (Medicare Extra) made available through a new national insurance connector; insurance would be available to all at community-rated premiums that would not vary with health risks. The same premium rating provisions would apply inside and outside the connector;
2. A requirement that all individuals obtain health insurance coverage, with automatic enrollment of uninsured tax-filers through the personal income tax system.
3. Financial responsibility shared between employers and employees, with a requirement that all firms cover their workers or else contribute 7 percent of workers’ earnings (up to \$1.25 per hour) to a pool to help finance coverage.
4. An expansion of Medicaid and the State Children’s Health Insurance Program (SCHIP) that would enable coverage of all low-income

Exhibit 1. “Medicare Extra” Benefits vs. Current Medicare Benefits

	Current Medicare benefits*	“Medicare Extra”
Deductible	Hospital: \$1,024/benefit period Physician: \$135/year Rx: \$275/year**	Hospital/Physician: \$250/year for individuals; \$500 for families Rx: \$0
Coinsurance	Physician: 20%	Physician: 10% Rx: 25% Preventive services: 0%
Ceiling on out-of-pocket	No ceiling	\$5,000 for individuals; \$7,000 for families
Insurance-related subsidies	Medicare Savings Programs Low-Income Subsidy	Ceiling of 5% of income for low-income beneficiary premiums or 10% if higher income

* See <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2488>.

** Under “standard” plan. In 2008, only about 10% of national prescription drug plans offer the defined standard benefit. More frequently, plans eliminate the deductible and use tiered, flat-dollar copayments (see <http://www.kff.org/medicare/upload/7762.pdf>).

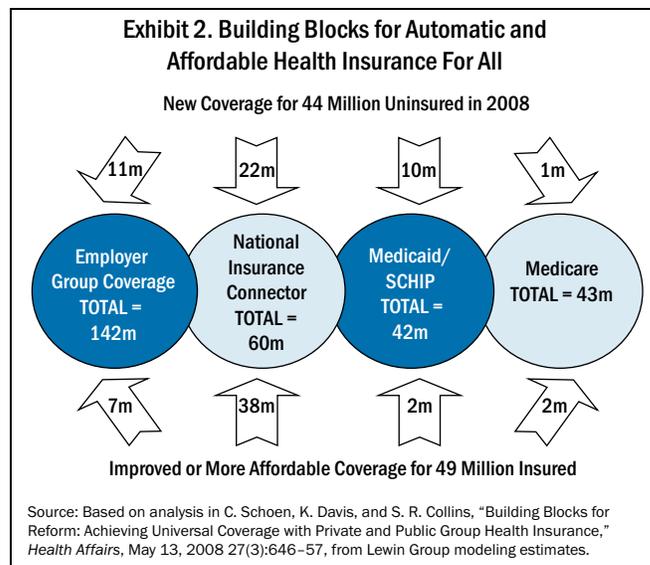
adults and children below 150 percent of the federal poverty level, with modest copayments for health care services, no premiums, and enhanced federal matching to cover additional costs to states.

5. Tax credits that offset any premium cost in excess of 5 percent of income for lower-income tax filers (15 percent-or-lower tax bracket) and 10 percent of income for higher-income tax filers (benchmarked to premium of the Medicare Extra plan).
6. Extension of improved Medicare Extra benefits (Exhibit 1) to current Medicare beneficiaries; elimination of the two-year waiting period for Medicare coverage for people with disabilities; the ability of older adults age 60 or older to “buy in” to Medicare; and the same financial protection on premiums as a percentage of income for Medicare beneficiaries as for nonelderly households.

Building Blocks represents an evolution of the authors’ 2003 proposal, “Creating Consensus,”³ which formed the core of the health reform proposals advanced by Senator John Kerry and other presidential candidates in 2004.⁴ That earlier proposal sought to achieve universal coverage in part by enabling everyone to enroll in one of the private health insurance plans participating in the Federal Employees Health Benefits Program. Building Blocks, too, is a private-public approach, but one in which a reorganized private insurance market works in tandem with a comprehensive Medicare plan option. Its key advantage is the role of Medicare Extra—a national, self-insured plan that provides nationwide access to all hospitals and physicians. This option, along with a choice of integrated health care delivery systems, would be available through the new national connector.

Building Blocks’ Impact on Insurance Coverage

Based on estimates by the Lewin Group, the Building Blocks framework would achieve near-universal coverage: 44 million of the 48 million people in the U.S. who are currently uninsured would have health insurance, or 99 percent of the total U.S. population (Exhibit 2). Tax-filers with income above 150 percent of the poverty level who do not verify insurance coverage when filing personal income tax returns would be automatically enrolled in Medicare Extra and assessed a premium based on their income—5 percent of income in households in the 15-percent-or-lower marginal tax bracket, and 10 percent of income for other households. Uninsured tax-filers with incomes below 150 percent of poverty would be automatically enrolled in Medicaid or SCHIP, with no premium assessed. Those remaining uninsured would largely be low-income non-tax-filers; these individuals could be retroactively enrolled in Medicaid or SCHIP when seeking health care.



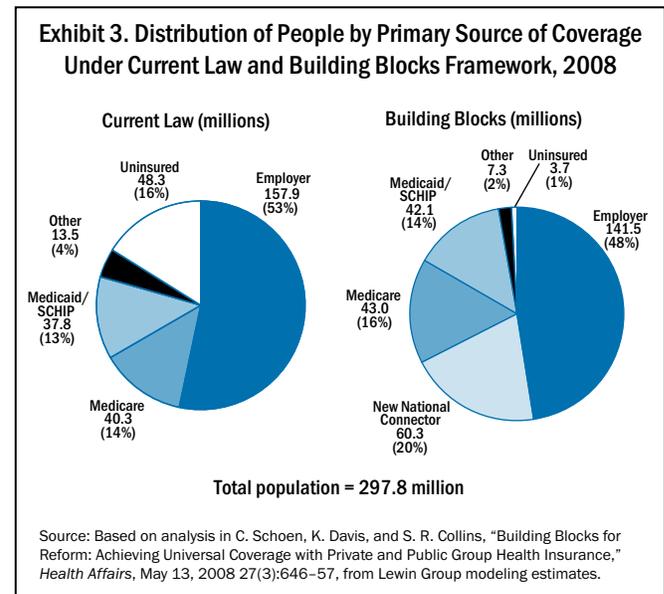
Based on the Lewin Group estimates, about half of those individuals gaining insurance coverage under the Building Blocks framework would obtain their coverage through the national insurance connector and

the new insurance products it makes available (Exhibit 2). The other half would be equally split between enrollment in employer plans and enrollment in Medicaid or SCHIP. The requirement that employers cover employees or contribute to coverage would induce some employers to offer coverage. Premium assistance based on income also would make it possible for more low-wage workers to take up their employer's offer of health coverage. In most states, healthy, working low-income adults with incomes up to 150 percent of the poverty level would for the first time be eligible for state low-income programs. And by automatically enrolling tax-filers with incomes below 150 percent of poverty in Medicaid or SCHIP, the number of uninsured low-income adults would drop and the proportion of eligible individuals who participate would increase.

For the 49 million people with insurance who change their health coverage, their coverage would improve or their premiums would be lower (Exhibit 2). Small businesses (under 100 employees) in particular would likely respond to the possibility of improved, lower-cost coverage by buying coverage through the national insurance connector instead of buying it directly themselves. An estimated 32 million insured people covered by employers would switch and now receive coverage through the connector. Enrollment directly through employer plans would also increase, if modestly, since some individuals now covered by Medicaid or SCHIP would switch to employer coverage, as would some who are now covered by individual insurance plans.

Altogether, total employer-based coverage—sponsored either directly by employer health plans or financed by employers through the connector—would increase from 158 million people to 184 million, up from 53 percent to 63 percent of the population (Exhibit 3). The change in coverage reflects decisions made by employers or, in some cases, by individuals, to switch to better health coverage—rather than a requirement that people change their current coverage. Some health insurance bills introduced by members of Congress would require everyone to drop employer

coverage and be covered under Medicare or a single-payer public program; others would abolish employer-based insurance and require everyone to obtain coverage on their own through the individual insurance market or a regional insurance connector.⁵ Given that many Americans are satisfied with their current coverage, offering choices is likely to garner greater support than requiring radical changes in existing insurance.⁶



An estimated 60 million Americans would be covered through the national insurance connector, including those individuals whose employers purchase insurance through the connector (Exhibit 3). Approximately two-thirds, or 40 million people, would obtain coverage through the Medicare Extra fee-for-service plan, and the remaining 20 million people would be in private plans. Combined with the modest increases in Medicare enrollment that would be gained by eliminating the two-year waiting period for disabled adults and by providing a buy-in option for adults ages 60 to 64, Medicare fee-for-service enrollment would increase from about 35 million to approximately 75 million.

The attraction of Medicare Extra comes from its lower premiums compared with private plan offerings. For individuals under age 60, premiums are estimated to be \$259 per month for single premiums and \$702 per month for families in 2008.⁷ By contrast,

employer premiums for a single individual were \$373 a month in 2007, and for a family were \$12,106 a year, or over \$1,000 a month.⁸

Premiums for Medicare Extra for individuals under age 60 represent significant savings—more than 30 percent below average employer premiums. If the differential persists over time, it might be expected that more switching would occur. Moreover, larger employers are likely to seek extension of the Medicare Extra option to their choices as well, leading to still further growth in enrollment. This could lead to a transformation of the private insurance market, as private insurers endeavor to “meet the competition” by lowering overhead, adopting a tougher stance in provider payment negotiations, and adopting innovative practices in pursuit of higher value or lower premiums.

For those ages 60 to 64 who are buying into Medicare, monthly premiums are estimated to be \$532 per month—again much lower than policies available to older adults on the individual insurance market (if they are available at all, given many insurers’ exclusions for preexisting health conditions or risks). As a result of eliminating the two-year waiting period for the disabled and implementing the new option to buy in, an additional one million uninsured older or disabled adults under age 65 would enroll in Medicare, and two million insured older or disabled adults would switch to Medicare coverage (Exhibit 2).

Building Blocks’ Impact on Health Spending

One of the major barriers to enactment of universal health insurance coverage is the perception that it is extraordinarily costly. In fact, the estimated net effect on national health spending from implementing the Building Blocks framework is an increase of \$15 billion, a relatively small amount that works out to less than one percent of the \$2.4 trillion in estimated national health expenditures for 2008 (Exhibit 4).

The voluntary shift of a substantial number of people into Medicare Extra coverage achieves significant savings, including \$15.4 billion in lower administrative costs (after netting out the cost of establishing the insurance connector and administering income-

related subsidies) and \$22 billion in lower Medicare provider payment rates for individuals switching from private coverage (Exhibit 4). These savings would be even greater if the option of Medicare Extra were extended to all firms, not just those with fewer than 100 employees.

Exhibit 4. Changes in National Health Spending Under the Building Blocks Proposal in 2008 (in billions)

Total Change in Health Spending		\$15.3
Change in Health Services Expenditures		\$51.5
Change in utilization for newly insured	\$49.0	
Change in utilization due to improved coverage	\$2.5	
Provider Reimbursement Effects		(\$20.8)
Medicare rates for insurance connector	(\$22.1)	
Increased Medicaid rates to Medicare levels	\$32.3	
Provider assessment	(\$41.4)	
Payments for uncompensated care	\$15.4	
Eliminate federal Medicare and Medicaid DSH payments	(\$18.8)	
Increased cost-shifting	\$13.8	
Change in Administrative Costs		(\$15.4)
Insured administration	(\$17.7)	
Administration of subsidies	\$2.3	

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*, May 13, 2008 27(3):646–57, from Lewin Group modeling estimates.

An increase in the use of health services (\$52 billion) by newly insured, and more adequately insured, people is the primary source of greater health system spending. Indeed, a major goal of universal coverage is to reduce existing disparities in health care between the insured and uninsured, improve the receipt of preventive care, and make it more affordable to access services and medications for the control of chronic conditions.

Increasing Medicaid payment rates to the level of Medicare rates and reducing bad debts or discounts for the uninsured also have the effect of increasing outlays. These higher payments to providers are partially offset by an assessment on provider revenues (4% for hospitals, 2% for physicians) and elimination of current disproportionate share hospital payments that the government provides for care of the uninsured.

The Building Blocks framework would result in a reallocation of spending by federal and state governments, employers, and households. While the overall impact on health spending would be relatively minor, some sectors would gain while others would lose, depending on the specific design and the specific

sources of financing coverage. The most significant gainers, not surprisingly, would be uninsured and underinsured households who are relieved of the financial burdens of health care bills; estimated net savings for households in 2008 are \$76 billion (Exhibit 5).

State governments would also see benefits. For 2008, their outlays would drop by \$12 billion, as federal health insurance premium subsidies for low-wage workers replace some shared federal–state Medicaid outlays and yield some savings for state employee health insurance coverage. These savings, of course, could be redirected by reducing federal matching rates on Medicaid and making states budget-neutral, on average. However, given the variation in state Medicaid programs, some states would inevitably lose money under such a policy. Permitting certain states “fiscal windfalls,” and avoiding state “shortfalls,” likely increases the attractiveness of the proposal to states.

Employers that now provide coverage are estimated to save \$24 billion in 2008 under the proposal, as the cost of dependents is shared with other employers. On the other hand, employers that do not now cover employees would experience a cost increase of \$45 billion. More employers might experience savings if Medicare Extra were made available to larger firms.

Given these specific design choices, the federal government has a net cost of \$82 billion in 2008, stemming largely from the greater use of health services and reduced financial burdens on households. About half of this amount—\$43 billion—comes from improved coverage and financial protection for Medicare beneficiaries to provide them with coverage comparable to that of adults under age 65.⁹

Bending the Curve: Coupling Coverage with Health System Reform

If no other steps are taken to reform the way in which care is provided, these expenditures could be expected to grow with the rise in health care costs. The substantial costs to the federal budget estimated for 2008, and the inevitable growth in outlays for all payers over time, make it imperative that any proposal to expand coverage be coupled with significant measures to achieve health system savings.

Over a 10-year period, the total impact on health system spending would be an increase of \$218 billion (Exhibit 5). This is modest relative to total health spending currently projected over that period (\$33 trillion).¹⁰ But the impact on individual sectors would be significant. The 10-year federal budget cost

Exhibit 5. Health Expenditure Impact of Building Blocks Without System Reforms by Sector, 2008–2017

\$ Billions	Annual Net Impact: Building Blocks Approach Without Savings Options*										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	15.3	16.5	17.7	19.0	20.5	22.1	23.8	25.5	27.5	29.7	89.0	217.6
Federal Government	81.7	90.4	100.1	110.6	122.3	135.8	150.1	166.1	184.4	204.6	505.1	1,346.1
State and Local Government	-11.5	-12.4	-13.3	-14.3	-15.4	-16.6	-17.9	-19.2	-20.7	-22.3	-66.9	-163.5
Private Employers	21.0	22.1	23.3	24.5	25.8	27.1	28.5	30.0	31.6	33.3	116.6	267.3
Households	-75.9	-83.7	-92.2	-101.7	-112.2	-124.3	-137.0	-151.4	-167.8	-185.9	-465.8	-1,232.2

* Selected 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.

would be \$1.3 trillion, while employers would pay an additional \$267 billion over and above current projected outlays. Households and state and local governments would experience significant 10-year savings of \$1.2 trillion and \$164 billion, respectively.

To offset these costs, it is important that coverage expansions be pursued simultaneously with comprehensive reforms to control costs and improve quality and access.¹¹ A recent report prepared for The Commonwealth Fund Commission on a High Performance Health System sets out a number of reform options that could be combined with the Building Blocks coverage expansion to achieve considerable savings.¹² With the assistance of the Lewin Group, the report analyzed the impact on national health expenditures of various reform options, including those designed to: ensure that the best-possible information is used for health care decision-making; promote health and enhance disease prevention efforts; align financial incentives with health quality and efficiency; and correct price signals in health care markets.

To illustrate the potential of a multifaceted approach, the report examined what might happen if the Building Blocks approach were combined with policies designed to achieve savings and enhance

value in health care. The options selected include the following:¹³

- promoting health information technology;
- establishing a Center for Medical Effectiveness and Health Care Decision-Making, and linking their recommendations to insurance benefit design;
- reducing tobacco use through public health measures;
- reducing obesity through public health measures;
- implementing a provider payment system based on episodes of care (for episodes involving acute hospitalizations only);
- strengthening primary care and care coordination;
- resetting benchmark rates for Medicare Advantage plans;
- allowing Medicare to negotiate prescription drug prices

The 10-year impact of combining the Building Blocks approach with these health system reforms is shown in Exhibit 6. The estimates illustrate the potential of multifaceted approaches for addressing projected cost increases. In the first year, net national savings are

Exhibit 6. Health Expenditure Impact of Building Blocks with System Reforms by Sector, 2008–2017

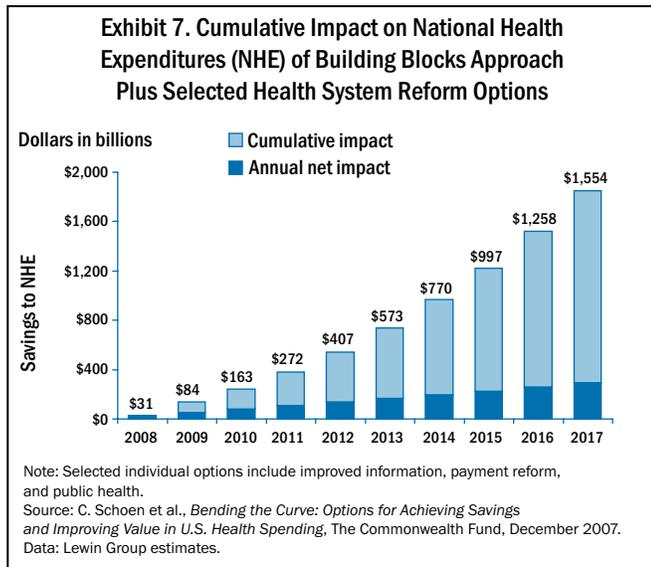
\$ Billions	Annual Net Impact: Building Blocks Approach Plus Savings Options*										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-\$30.8	-\$53.3	-\$79.2	-\$108.3	-\$135.7	-\$165.8	-\$196.6	-\$227.3	-\$261.0	-\$296.0	-\$407.3	-\$1,554.0
Federal Government	\$31.3	\$27.4	\$22.5	\$16.6	\$13.2	\$10.9	\$9.1	\$8.6	\$8.1	\$9.9	\$111.0	\$157.6
State and Local Government	-\$14.3	-\$18.6	-\$23.3	-\$28.6	-\$34.0	-\$39.9	-\$45.8	-\$51.8	-\$58.4	-\$65.1	-\$118.8	-\$379.8
Private Employers	\$23.5	\$20.6	\$17.5	\$14.1	\$10.9	\$6.3	\$1.6	-\$2.6	-\$7.1	-\$12.4	\$86.6	\$72.4
Households	-\$71.4	-\$82.8	-\$95.7	-\$110.3	-\$125.9	-\$143.3	-\$161.6	-\$181.5	-\$203.7	-\$228.1	-\$486.1	-\$1,404.3

* Selected 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.

estimated at \$31 billion, as savings more than offset the cost of the insurance expansion; by contrast, in the absence of system reforms there would be an expected net *increase* of \$15 billion. Over the 10-year period, multiple years of savings add up to a \$1.6 trillion cumulative difference in expenditures below projected trends. If Building Blocks is implemented without these additional health system reforms, there would be an increase of \$218 billion.

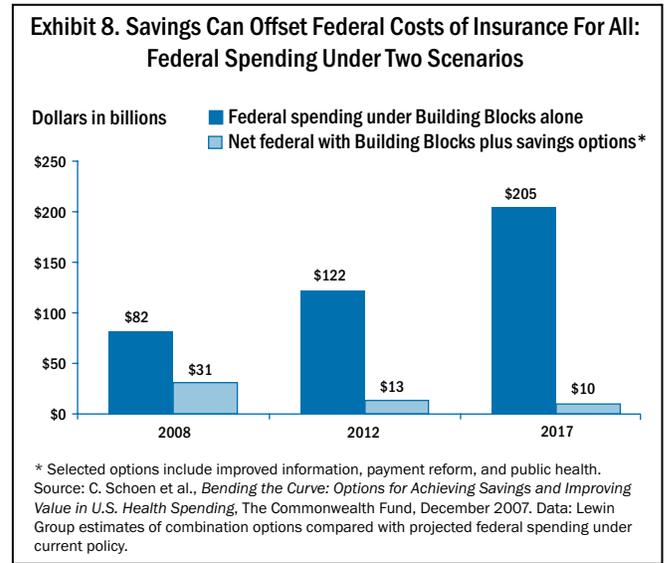
The substantial \$1.6 trillion reduction in national expenditures represents the cumulative effect of relatively small percentage changes in each year (Exhibit 7). The cumulative effect on expenditures of the combination of options grows rapidly year by year: the reduction estimated over 10 years is more than 50 times larger than that estimated in the first year.



Every sector that now pays for health care would ultimately benefit from the proposal. By the 10th year, households, employers, and state and local governments would be spending less on health care than they would otherwise spend, with reforms in place that improve the accessibility and quality of care (Exhibit 6).

The federal government would also ultimately benefit. While additional federal budget outlays would initially be required as an investment in an improved system providing better coverage and care, the Building Blocks framework, when combined with

other health system reforms, markedly cuts the federal budget cost of expanding coverage. In the first year, savings options could reduce net federal outlays to \$31 billion, compared with \$82 billion in the Building Blocks scenario alone. By 2014, the net federal costs could be negligible—a mere \$10 billion—if bundled with options that focus on improving both the effectiveness and efficiency of care (Exhibit 8).



COMPARING BUILDING BLOCKS WITH THE 2008 PRESIDENTIAL CANDIDATES' PLANS

Health care reform has moved to the top of the national policy agenda in this presidential election year and continues to be a focal point of the candidates' campaigns. Many of the elements of Building Blocks and the health system reforms examined in this analysis can be found in the proposals of the remaining leading candidates (Figure 9).¹⁴ These include achieving near-universal coverage through a mixed private–public health insurance system, including a choice of a public plan like Medicare, a national insurance connector, income-related premium subsidies, the expansion of Medicaid and/or SCHIP, and required contributions from employers that do not cover their workers. The presidential candidates' proposals, however, would not improve benefits for current Medicare beneficiaries.

Exhibit 9. Features of Building Blocks + System Reform and Presidential Candidates’ Approaches to Health Care Reform

	Building Blocks/ System Reform	Clinton	McCain	Obama
Coverage Expansion				
Aims to cover everyone	X	X		X
Individual requirement to have insurance	X	X		Children only
Employer shared responsibility	X	X		X
Group insurance “connector”	X	X		X
Medicare/public plan option for < 65	X	X		X
Subsidies/tax credits for low- to moderate-income families	X	X	X	X
Regulation of insurance markets	X	X		X
Improves Medicare benefits for > 65 and buy-in for older adults	X			
Medicaid/SCHIP expansion	X	X		X
System Improvements				
Expanded use of Health IT	X	X	X	X
Medical effectiveness research	X	X	X	X
Pay providers for performance	X	X	X	X
Reduced Medicare Advantage payments	X	X		X
Negotiated Medicare Rx prices	X	X		X
Primary care and care coordination	X	X	X	X

Source: S. R. Collins and J. L. Kriss, *Envisioning the Future: The 2008 Presidential Candidates’ Health Reform Proposals*, The Commonwealth Fund, January 2008.

The details of the presidential candidates’ proposals have not been articulated, and no official public estimates of their impact on coverage or cost are available. In particular, details on income-related subsidies are critical to estimating federal budget cost. Also important are details on who is required to obtain coverage, how such a mandate would be enforced, and how enrollment would be administered—all these affect how many of the uninsured would gain coverage. With respect to health system reforms, many of the candidates are of like minds on many of the strategies explored in this issue brief, including expanding the use of health information technology, pursuing research on the most effective medical treatments, rewarding providers for higher performance, and pursuing patient-centered and better coordinated care.

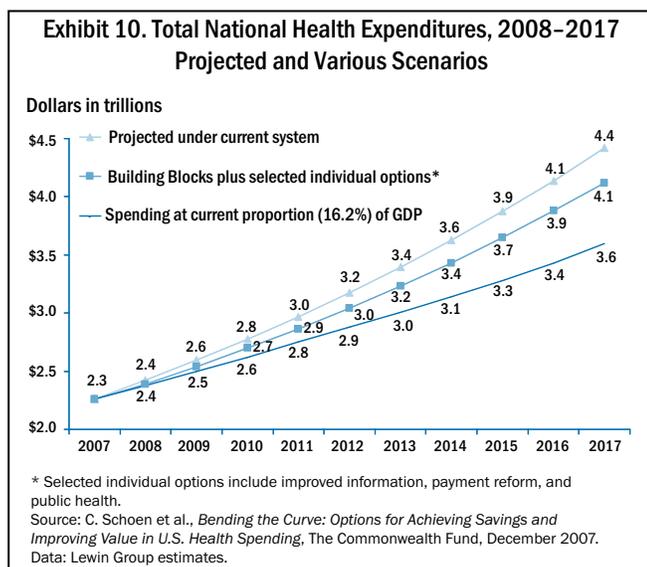
This issue brief has set out specific strategies on both insurance reform and health system reform

features, but they are not necessarily the way in which the candidates would design them. Consequently, the estimates provided here may not be representative of the impact of candidates’ proposals.

WITHIN REACH: A HIGHER-PERFORMING HEALTH SYSTEM

The estimates presented here should help dispel the conventional wisdom that universal coverage is beyond our means. Our analysis shows that it is possible to cover nearly everyone with affordable and comprehensive insurance, expand access to essential care, and improve informed decision-making by patients, clinicians, and payers—all while reducing spending on health care. Buying more effective, higher-value care has significant benefits for patients and will help move the U.S. health system toward higher performance.

Building Blocks, coupled with other health system reforms, would go a long way toward achieving needed changes in the health care system—universal coverage, better care, and lower health spending over time. Health spending is projected to be 19.8 percent of gross domestic product (GDP) by 2017 if current trends continue (Exhibit 10). Combined with the savings generated by additional system reforms, Building Blocks would “bend the curve” to 18.5 percent of GDP by 2017. Savings on this scale—\$1.6 trillion—represent significant resources that would be available to address other societal needs or goals, whether related to the health system or to others sectors of the economy.



Achieving needed changes in the way health care is delivered and paid for will be a challenge, even though the “savings” from these policy changes would derive primarily from reductions in the future growth, not the absolute amount, of health spending. Changing how spending is distributed means changing the flow of income to the many groups that currently depend on, and expect, future increases. The Building Blocks option relies on administrative cost savings and the application of Medicare payment rates to a larger share of the insured population. The health system savings options will require moving to a new set of incentives and market signals that require better quality and lower costs, and redistribute health care payments. The

public health initiatives will require policies to effect health behavior change. And enhancements to the health information system will require successful implementation and widescale adoption, which may necessitate substantial investments at the outset.

No single element of reform—no silver bullet—will be able to achieve the results described here. The framework explored in this paper is uniquely American: it leaves intact coverage for those who are insured; it does not abolish private insurance, as advocated by some who favor government solutions; and it does not abolish public programs like Medicaid and SCHIP, as advocated by some who favor private insurance markets.

The major innovation of our framework is that it builds on what is currently working—offering Medicare not just to the elderly and long-term disabled but also to individuals and small firms. It keeps market competition in place, but adds a new competitive dynamic. Private insurers, rather than competing to attract the healthiest patients, would need to add value, flexibility, and innovation to the products they offer. If carriers can offer better benefits or better premiums than Medicare, employers and individuals would stay with private insurance. If the Medicare Extra option demonstrated greater value and lower premiums than plans offered by private insurers, more employers and individuals would undoubtedly find such coverage more attractive. This proposal begins by offering this choice only to firms with up to 100 employees, but if it succeeds in this market niche, the case for extending it more broadly would be compelling.

But Medicare will need to change as well, and the challenge will be to see if it can handle the enrollment of a new population of young adults, families, and middle-aged workers. The additional system reform options will also pose challenges to Medicare, as they would fundamentally reform the way the program pays hospitals and physicians in order to reward primary care and strengthen care coordination, and allow prescription drug prices to be negotiated.

In the end, health reform will only work if hospitals, physicians, and other health care professionals

see in it the opportunity to provide all their patients with the best care possible. The reforms will help their uninsured patients afford their medications and recommended specialist care, and they will provide support to providers in the form of modern health information technology and information on the comparative effectiveness of alternative drugs or treatments. But reforms on this scale will mean a significant realignment of financial rewards—with rewards for delivering better care and better outcomes, rather than simply providing more services.

For patients, there are benefits to be gained through more secure and protective health insurance. The set of reforms we describe is intended to improve the accessibility of care, giving all patients a source of care—a medical home—that ensures they receive all

preventive and essential care and that assists them in navigating our complex health care system. But patients, too, have great responsibilities—to use the health system appropriately, to work in partnership with their physicians and nurses to manage their chronic conditions, and take responsibility for reducing their health risks.

The most encouraging message from the estimates presented here is that it is possible to aim for a high performance health system that simultaneously achieves better access, improved quality, and greater efficiency. Other nations have long since adopted many of the reforms we have set forth here. The U.S. can learn from their experience, as it can from states like Massachusetts and Vermont that have recently enacted reforms. Our future is up to us.

NOTES

- ¹ C. Schoen, K. Davis, and S. R. Collins, “Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance,” *Health Affairs*, May 13, 2008 27(3):646–57.
- ² Additional details are provided in the “Building Blocks” article in *Health Affairs*.
- ³ K. Davis and C. Schoen, “Creating Consensus on Coverage Choices,” *Health Affairs* Web Exclusive (Apr. 23, 2003):w3-199–w3-211.
- ⁴ S. R. Collins, K. Davis, and J. M. Lambrew, *Health Care Reform Returns to the National Agenda: 2004 Presidential Candidates’ Proposals* (New York: The Commonwealth Fund, updated Oct. 2004).
- ⁵ S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).
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