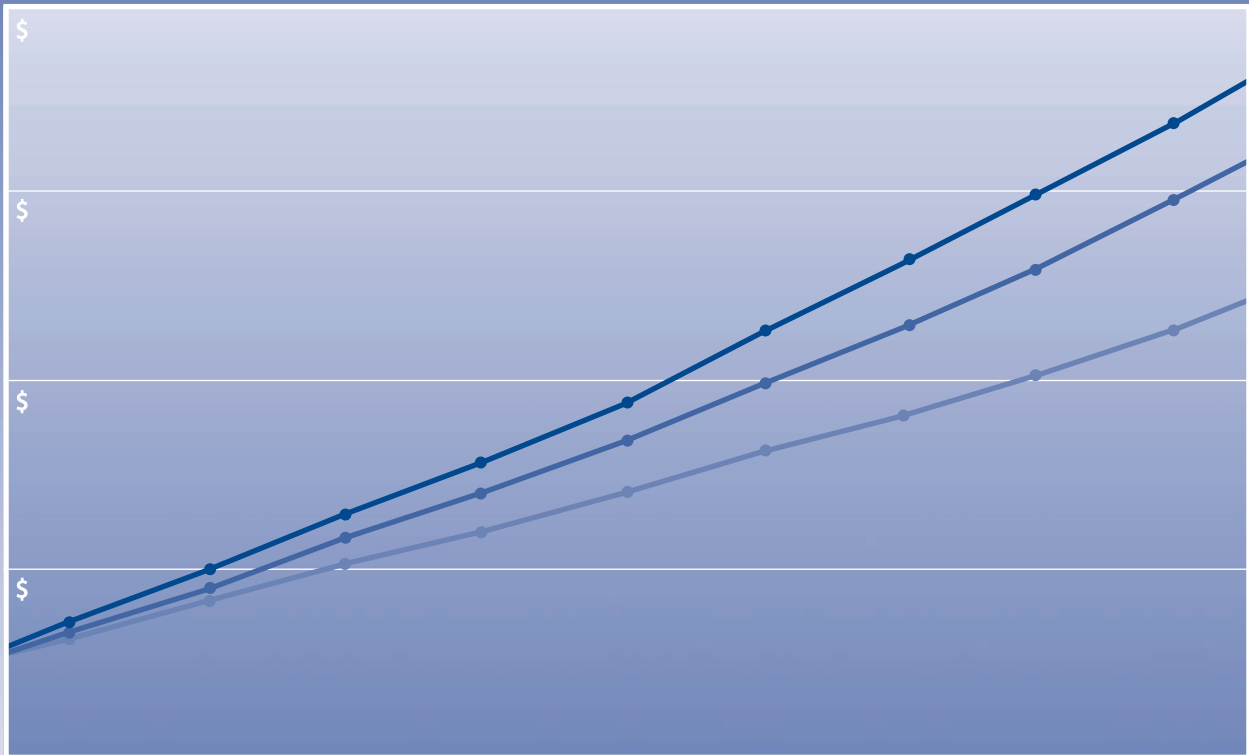


BENDING THE CURVE

Options for Achieving Savings
and Improving Value in U.S. Health Spending



THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM
DECEMBER 2007



THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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BENDING THE CURVE: OPTIONS FOR ACHIEVING SAVINGS AND IMPROVING VALUE IN U.S. HEALTH SPENDING

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ABSTRACT: U.S. health spending is projected to increase from 16 percent of GDP in 2006 to 20 percent in 2016—from \$2 trillion to \$4 trillion. Meanwhile, the number of uninsured Americans continues to rise. In this report prepared for The Commonwealth Fund Commission on a High Performance Health System, the authors examine 15 federal policy options that have the potential to lower health spending relative to projected trends. They include policies that would: produce and use better information for health care decision-making, promote health and enhance disease prevention, align financial incentives with quality and efficiency, and correct price signals in health care markets. Combining policies would capture the synergistic benefits of individual changes. If implemented along with universal health insurance, a combination of selected options could save \$1.5 trillion in national health expenditures over 10 years, while also improving value in terms of access, quality, and health care outcomes.

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PREFACE

High and rising health care expenditures and the growing number of people who are uninsured are putting the health and economic security of the nation at risk. Despite health expenditures far above those of any other country, quality of care in the United States is highly variable, access is inequitable and declining, and there is widespread evidence of inefficiency in both the delivery and financing of health care. To spur and inform debate and stimulate action to achieve savings, while at the same time improving health care access, quality, and outcomes, The Commonwealth Fund Commission on a High Performance Health System presents the report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*.

The report is unique in two ways: 1) it focuses on *total national* health care expenditures, and 2) it presents estimates of the effects of policy options that are intended to moderate future cost growth in a manner that would yield higher value for the nation's investment in health care. These options are not presented as the recommendations of the Commission, but they represent an array of initiatives that have been proposed and discussed in the context of improving health system performance.

The analysis indicates that it should be possible for the nation to reduce projected spending trends while also improving value. Combining selected options in the context of reform to ensure affordable private or public health insurance coverage for all could yield \$1.5 trillion in national health expenditure savings over 10 years, while achieving universal coverage and improved quality. Building consensus on the best ways to control health spending growth and achieve a high performance health system—and successfully implementing those changes—will require leadership and collaboration among all stakeholder groups in the public and private sectors.

The Commission has sponsored this report to inform its development of future recommendations, as well as to stimulate broader discussion of how to “bend the curve”—that is, reduce the projected trend in health spending that threatens to engulf both the federal budget and the nation's economy. With cost pressures mounting and coverage eroding, both the economic and human consequences of failing to act are significant, and will become more so in the future.

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The policy options were drawn from a range of ideas often discussed as possible initiatives at the national level to moderate U.S. cost growth and improve performance. Each represents a possible approach. Neither the Commission on a High Performance Health System nor its individual members necessarily endorse or support all of the individual options discussed in the report; the set of options are presented solely to stimulate debate.

We thank members of The Commonwealth Fund Commission on a High Performance Health System for their review and critical comments. We particularly thank the Commission Achieving Savings Options Workgroup, chaired by Glenn Hackbarth, J.D., and workgroup members, Maureen Bisognano, Executive Vice President and Chief Operating Officer, Institute for Healthcare Improvement; Michael Chernew, Ph.D., Professor, Department of Health Care Policy, Harvard Medical School; Patricia A. Gabow, M.D., CEO and Medical Director, Denver Health and Hospital Authority; Robert Galvin, M.D., Director, Global Healthcare, General Electric; and Sandra Shewry, Director, California Department of Health Services.

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EXECUTIVE SUMMARY

Health spending in the United States is projected to increase from 16 percent of gross domestic product (GDP) in 2006 to 20 percent in 2016—from \$2 trillion to \$4 trillion in 10 years. At the same time, the number of people who are uninsured is rising sharply, including a growing proportion of middle-income families. While rising costs are putting all sectors of the economy at risk, the nation lacks a concrete, realistic plan for adopting a different approach that could achieve savings and improve value.

To inform national discussions and spur progress toward such a plan, The Commonwealth Fund Commission on a High Performance Health System sponsored this report, which examines 15 federal policy options and their potential for lowering health spending over the next 10 years, relative to projected trends.

These options are not presented as the recommendations of the Commission, but they represent a range of approaches that have been proposed to address the various factors that contribute to high and rising costs and represent sources of inefficiency in the current health care delivery and financing systems. The report focuses on federal policies for three reasons: the federal government accounts for the largest portion of health spending; changes at the federal level would probably have the broadest immediate effects on national health spending; and federal policies, particularly those adopted by Medicare, frequently serve as a model for policies adopted at the state and local levels and by the private sector. Nonetheless, many of the policy options could be applied by states and private payers as well. Indeed, collaborative efforts across public and private sectors will be essential for achieving higher performance and greater value.

The report's findings illustrate that it would be possible to reduce national expenditures over the next decade while simultaneously improving access, quality, and population health. Achieving significant savings, however, will require a combination of policies that span strategic areas amenable to policy action at the federal level. These include policies that:

- Produce and use better information 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.

By applying these policies collectively, the nation would be able to capture the synergistic benefits of specific changes that, if implemented individually, would yield more modest reductions in projected spending trends. Further, policies aimed at achieving savings while also improving quality would be even more effective in improving overall health system performance if they were combined with a policy to extend affordable health insurance coverage to everyone in the United States. On a foundation of universal coverage, payment and other policies could apply to a larger share of the population. Well-designed insurance also has the potential to lower administrative costs while ensuring access—both improve value. Combining selected options with affordable health insurance for all could yield \$1.5 trillion in national health expenditure savings over 10 years, and enable a more integrated, systemic approach to health care delivery and financing.

Modeling the future impact of complex policy changes is inherently challenging and risky. The technical challenges include the uncertainty of estimating dynamic effects over time. Further, the estimates assume effective design and implementation, and therefore do not reflect the difficulty of achieving agreement on what changes are necessary, designing the often complex policies necessary to achieve those changes, or making the organizational adjustments required to implement them successfully.

What is certain is that the stakes are very high if we continue on our current path of escalating costs and eroding coverage.

Options and Results

This report contains analyses of a set of 15 federal policy options that could ease health care cost pressures while at the same time either enhancing or maintaining access, quality, efficiency, equity, and the health system's capacity to innovate and improve. These options include federal policies targeted to produce and use better information, promote health and prevent disease, align incentives with quality and efficiency, and correct price signals in the health care market. The Commonwealth Fund contracted with the Lewin Group* to estimate the potential effects of each option, with a focus on total national health expenditures and the distribution of expenditures across payers—the federal government, state and local governments, private employers, and households. The estimates include effects on incremental and cumulative spending over a 10-year period, from 2008 to 2017. A summary of the options modeled in this report, their objectives, and the estimated effects on spending are described below.

* The Lewin Group is one of the leading health care and human services consulting firms in the United States, with more than 35 years of experience serving organizations in the public, nonprofit, and private sectors.

Producing and Using Better Information

These options are intended to address information barriers that contribute to the inefficiency of our health system and undermine care outcomes. The transparent availability of information and the incentives and ability to use it are critical prerequisites for effective, safe, coordinated care and the development of policies that encourage such care.

- **Promoting Health Information Technology.** Accelerate provider adoption of health information technology (HIT) with the capacity for decision support and to share patient health information across sites of care, financed by an assessment of 1 percent on insurance premiums and Medicare outlays. After initial investment costs, estimated net health system savings could reach \$88 billion over 10 years as HIT capacity is improved. Net savings would accrue by year 10 to all except private payers, which would realize cumulative savings in following years.
- **Center for Medical Effectiveness and Health Care Decision-Making.** Invest in the knowledge needed to improve decision-making and incorporate information about the relative clinical and cost-effectiveness of alternative treatment options into insurance benefit design. By generating the information and creating payment and cost-sharing incentives for providers and consumers to use it, this policy option could result in estimated health system savings of \$368 billion over 10 years, shared by all payers.
- **Patient Shared Decision-Making.** Help patients decide between alternative treatment options by requiring providers to educate Medicare beneficiaries about alternatives through use of patient decision aids (such as videos and other materials). This option could save an estimated \$9 billion over 10 years, primarily for the Medicare program. System savings would be greater if this policy were extended to Medicaid and private insurance.

Promoting Health and Disease Prevention

These options focus on the substantial costs to the health system of the care and complications of chronic diseases, such as diabetes or heart disease. They seek to lower the incidence of disease through public health initiatives and improved care.

- **Public Health: Reducing Tobacco Use.** Increase federal taxes on tobacco products by \$2 per pack for cigarettes, with revenues going toward support of national and state tobacco control programs. If revenues were invested in effective programs, this option could yield \$191 billion in health system savings over 10 years, shared by all payers. State savings would be largely offset by reduced state tobacco tax revenue, as consumption of tobacco products fell.

- **Public Health: Reducing Obesity.** Establish a new nominal tax on sugar-sweetened soft drinks of 1 cent per 12-ounce drink to finance national and state obesity prevention programs. If successful in reducing rates of increases in obesity and associated costs, the option could yield an estimated \$283 billion in savings over 10 years, shared by all payers.
- **Positive Incentives for Health.** This option would use federal funds and incentives to encourage the federal government, state governments, and private employers to create positive incentives for individuals to engage in wellness programs and healthy behavior, and to cover preventive services. Such a focus on high value benefit designs could save an estimated \$19 billion over 10 years, with a net investment by the federal government of \$2 billion.

Aligning Incentives with Quality and Efficiency

These policy options are intended to address the misalignment of incentives in our fee-for-service payment system and the private insurance market. The options modeled include:

- **Hospital Pay-for-Performance.** Establish a Medicare pay-for-performance program for all hospitals similar to the current Centers for Medicare and Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration. This option could result in health system savings of \$34 billion over 10 years, with the major share accruing to the federal government through reduced Medicare payments, primarily from decreased hospital readmissions. If all payers adopted similar policies, estimated savings would be greater.
- **Episode-of-Care Payment.** Transform the current Medicare fee-for-service payment system to fixed prospective payments per episode of care (based on the current distribution of cumulative fee-for-service costs per episode). This policy would change Medicare payment methods to reward and encourage more efficient, coordinated care. When applied to hospital and ambulatory care, this could generate estimated net health system savings of \$229 billion over 10 years. Other payers could avoid cost-shifting by emulating this payment approach.
- **Strengthening Primary Care and Care Coordination.** Change reimbursement to primary care physician practices to support enhanced primary care services, such as care coordination, care management, and easy access to appropriate care. Under this option, Medicare fee-for-service beneficiaries would be enrolled in “medical homes” that have this enhanced capacity. Mandatory enrollment could result in net health system savings of \$194 billion over 10 years, with savings accruing to all payers. Estimated savings would be larger if this approach were adopted by all payers.

- **Limit Federal Tax Exemptions for Premium Contributions.** To provide incentives to enroll in high-value health insurance plans, cap the tax-deductibility of employer-sponsored insurance premiums. The option could reduce national spending by an estimated \$131 billion over 10 years, with savings in federal tax expenditures exceeding that amount. However, to avoid putting sicker, older, and low- or modest-income families at increased health and financial risk, and to avoid potentially undermining current employer-sponsored pooled-risk group coverage, this change would have to be combined with universal coverage and changes in insurance market rules.

Correcting Price Signals in the Health Care Market

These options seek to address the tendencies of the current pricing mechanisms to send the wrong signals to participants in the market. These include signals for higher rather than lower costs and pricing mechanisms that support inefficient care and wide variation in costs without corresponding differences in quality and outcomes across geographic areas.

- **Reset Benchmark Rates for Medicare Advantage Plans.** Modify the current Medicare Advantage payment methodology by setting the benchmark rate for plans in each county at a level equal to the county's projected per capita spending under traditional Medicare. The current mechanism for setting the benchmark rates, which results in payments to plans that are higher than what costs would have been in traditional Medicare, sends a price signal through the market that encourages higher rather than lower costs among those plans. By recalibrating benchmark rates, this option could result in an estimated health system savings of \$50 billion over 10 years and reduce federal spending by \$124 billion over the decade. However, spending by Medicare beneficiaries would increase by \$74 billion, in the form of additional private premiums for those individuals who replace the additional benefits available under the current Medicare Advantage payment rates, as well as extra payments required for those who enroll in plans with bids that exceed the benchmark rate.
- **Competitive Bidding.** Establish competitive bidding among Medicare plans and traditional Medicare. This option would replace the current administered pricing mechanism in Medicare Advantage with a system that would determine prices through increased competition on the basis of quality and efficiency. The option could result in estimated health system savings of \$104 billion over 10 years and substantial reductions in federal spending over the same period. Spending by Medicare beneficiaries would increase by \$178 billion, as they may choose to stay in more expensive plans (or remain in traditional Medicare where it is more

expensive than the available alternatives), or may choose to pay to restore extra benefits they currently receive under Medicare Advantage. This option would have to be designed carefully to avoid drawing healthier beneficiaries away from Medicare and putting elderly and disabled beneficiaries, as well as those with modest incomes, at risk.

- **Negotiated Prescription Drug Prices.** Give the U.S. Secretary of Health and Human Services the authority to negotiate or set price limits for Medicare prescription drug plans for their enrollees. This option could result in a net savings of \$43 billion over 10 years, with a focus on dual eligibles and prescriptions within monopolized seller markets. Without provisions to prevent cost-shifting, all payers except the federal government could experience a net increase in spending. The potential impact of this option on innovation in the development of new effective drugs would have to be assessed.
- **All-Payer Provider Payment Methods and Rates.** Require all payers to adopt Medicare payment rates and methods for hospitals and physicians. This option would provide higher payments for Medicaid patients and reduce the pressure on the prices paid by private insurers to offset Medicaid and other shortfalls. It would also address the fragmented system under which providers must deal with numerous payment mechanisms and reporting rules. The option could result in net system savings of \$122 billion over 10 years, with the savings accruing to the private insurance industry. This estimate presumes the resolution of the payment cuts projected under the current sustainable growth rate mechanism for physician payments, and so does not reflect the projected cost of those changes. Moreover, to avoid undermining safety net providers, it would be necessary to redirect some of the savings to finance insurance expansion or uncompensated care pools.
- **Limit Payment Rate Updates in High-Cost Areas.** Reduce Medicare spending growth by basing annual hospital and physician payment updates on cost per beneficiary in relation to a national benchmark. This option would focus more cost control pressure on high-cost regions and avoid across-the-board adjustments that otherwise would apply equally to low- and high-cost geographic areas. Limiting payment growth in high-cost regions could save \$158 billion in health system spending over 10 years, with savings accruing to the federal government. Unless they followed Medicare's lead, other payers in the affected regions could see increased costs as a result of cost-shifting.

The estimated net effects of each of these options on national health spending, and on spending by payer group, are shown in exhibits ES-1 and ES-2, respectively.

Exhibit ES-1. Policy Options and Net Cumulative Impact on National Health Expenditures over One, Five, and 10 Years

	One-Year Impact on NHE (billions)	Cumulative Five-Year Impact on NHE (billions)	Cumulative 10-Year Impact on NHE (billions)
Producing and Using Better Information			
1. Promoting Health Information Technology	\$8	\$14	-\$88
2. Center for Medical Effectiveness and Health Care Decision-Making	-\$18	-\$125	-\$368
3. Patient Shared Decision-Making	-\$1	-\$4	-\$9
Promoting Health and Disease Prevention			
4. Public Health: Reducing Tobacco Use	-\$5	-\$64	-\$191
5. Public Health: Reducing Obesity	-\$3	-\$61	-\$283
6. Positive Incentives for Health	\$0	-\$5	-\$19
Aligning Incentives with Quality and Efficiency			
7. Hospital Pay-for-Performance	-\$2	-\$14	-\$34
8. Episode-of-Care Payment	-\$17	-\$96	-\$229
9. Strengthening Primary Care and Care Coordination	-\$5	-\$60	-\$194
10. Limit Federal Tax Exemptions for Premium Contributions	-\$10	-\$55	-\$131
Correcting Price Signals in the Health Care Market			
11. Reset Benchmark Rates for Medicare Advantage Plans	-\$3	-\$20	-\$50
12. Competitive Bidding	-\$7	-\$42	-\$104
13. Negotiated Prescription Drug Prices	-\$3	-\$16	-\$43
14. All-Payer Provider Payment Methods and Rates	\$2	-\$23	-\$122
15. Limit Payment Updates in High-Cost Areas	-\$4	-\$43	-\$158

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

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

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

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

† In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total.

Combining Individual Options with Affordable Coverage for All

In addition to the individual options described above, we modeled the effects of several of those options under a scenario intended to provide affordable health insurance coverage for all. The universal coverage scenario is based on a policy that would expand affordable coverage through a blend of private and public group health insurance. Similar to the savings options above, this scenario is presented as one of a range of potential approaches aimed at accomplishing this goal, rather than as the particular policy favored and recommended by the Commission. We refer to this scenario as the Insurance Connector approach.

The Insurance Connector approach builds on and connects current public and private group insurance through the creation of a new national entity that would offer a structured choice of private health plans as well as a Medicare option to individuals and small employers. Enrollment in some plan would be required. The availability of both publicly sponsored and private plans would help induce competition not only among private insurers, but also between private insurers and the public plan. This would put pressure on all plans to operate more effectively and efficiently. The expansion would achieve near-universal coverage.

With insurance changes alone, total health system costs would increase by an estimated \$15 billion in the first year and \$218 billion over 10 years, as a result of improved access for those who are currently uninsured or underinsured.[†] As modeled, this scenario would increase spending by private employers and the federal government, because of financing provisions to make coverage affordable. State and local governments and households would experience net reductions in spending.

To illustrate the potential of policies focused on better information, public health, improved incentives, and price signals in the context of universal coverage, we modeled the Insurance Connector approach together with the following options that were described above: Promoting Health Information Technology; Center for Medical Effectiveness and Health Care Decision-Making; Public Health: Reducing Tobacco Use; Public Health: Reducing Obesity; Episode-of-Care Payment; Strengthening Primary Care and Care Coordination; Competitive Bidding; and Negotiated Prescription Drug Prices.

In the context of universal coverage with a national insurance connector as described above, several of the Medicare-focused policies that are combined in this option

[†] This scenario offers the option of selecting Medicare. The modeling estimates that lower administrative costs and other features would partially offset costs of coverage expansion.

would apply to a larger number of people and therefore would have a larger estimated effect. Although not included in the modeling, in addition, the synergistic effects of implementing a combination of policies aimed at improving health system performance with universal coverage could be expected to lead to even greater savings. For example, the potential savings from electronic medical records (as well as the improvements in the quality and effectiveness of care) would be augmented if physicians also had expanded information on clinical effectiveness.

This combined approach could lower national health expenditures by 1 percent initially and 6 percent after a decade, compared with baseline projections. These annual savings add up to cumulative 10-year savings over the current system baseline of more than \$1.5 trillion, as shown in exhibits ES-3 and ES-4. As illustrated, the cumulative effect of the combination of options grows rapidly over time: the estimated reduction in national health expenditures in the first year is \$31 billion, while the reduction over 10 years is more than 50 times greater; similarly, the net costs to federal government diminish rapidly over time as savings offset federal costs of insurance expansion. Further, by the end of a decade, the net federal costs could be negligible if bundled with options that focus on improving both the effectiveness and efficiency of care.

Exhibit ES-3. Distribution of the Effect of Combination of Selected Individual Options with Insurance Connector Approach on Spending over One Year, Five Years, and 10 Years Across Payer Groups (in billions)

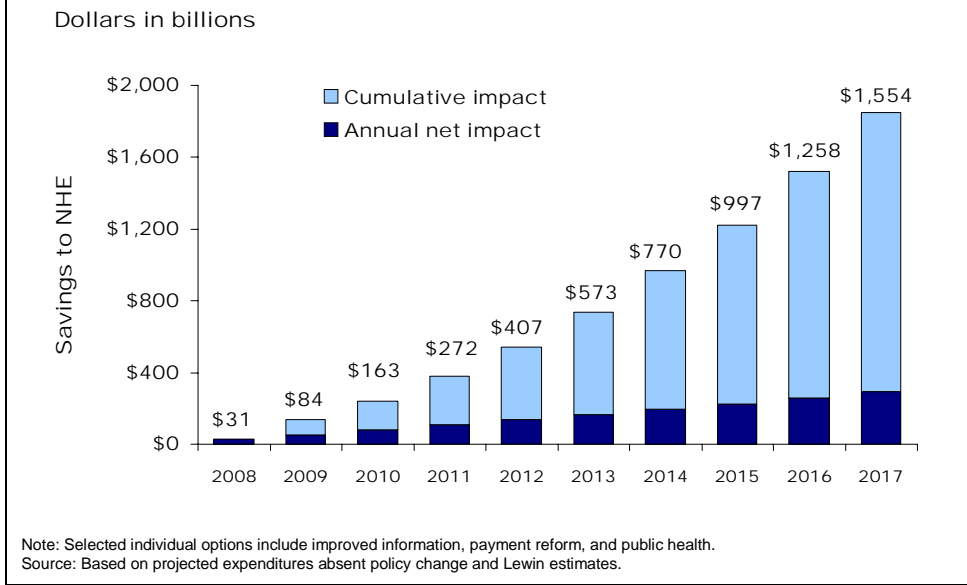
	Total NHE†	Federal Gov't	State/ Local Gov't	Private Payer	Households
Combining selected individual options with Insurance Connector approach††					
—after 1 year	-\$31	\$31	-\$14	\$24	-\$71
—after 5 years	-\$407	\$111	-\$119	\$87	-\$486
—after 10 years	-\$1,554	\$158	-\$380	\$72	-\$1,404

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

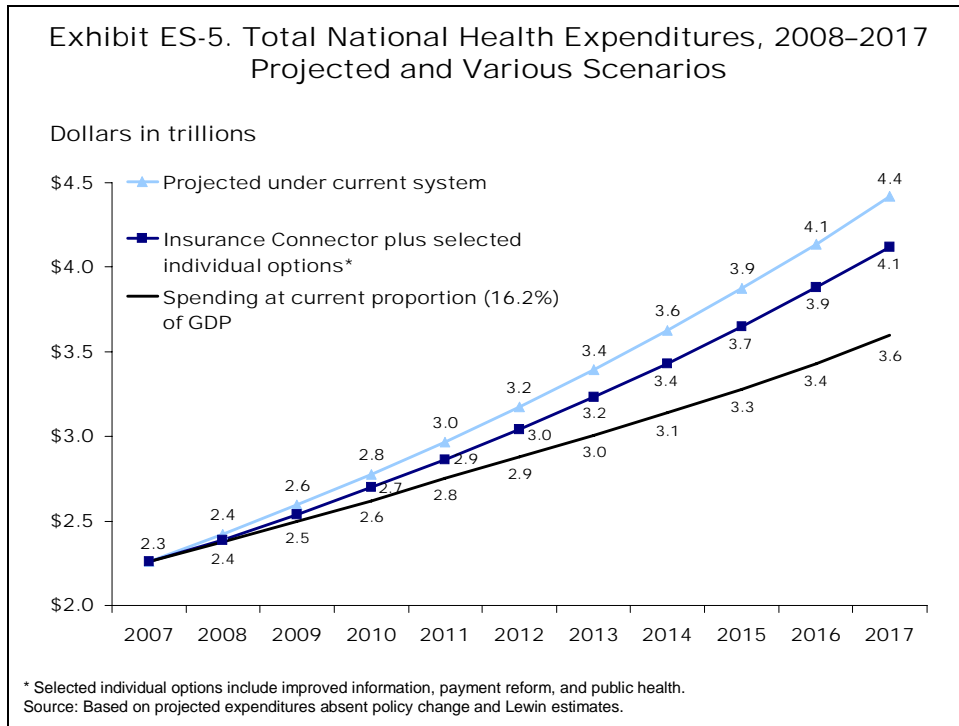
† In some cases, because of rounding, the sum of the payer group effect does not add up to the national health expenditures total.

†† Selected options include: Promoting Health Information Technology; Center for Medical Effectiveness and Health Care Decision-Making; Public Health: Reducing Tobacco Use; Public Health: Reducing Obesity; Episode-of-Care Payment; Strengthening Primary Care and Care Coordination; Competitive Bidding; and Negotiated Prescription Drug Prices.

Exhibit ES-4. Cumulative Impact on National Health Expenditures (NHE) of Insurance Connector Approach Plus Selected Individual Options



As shown in Exhibit ES-5, these estimated savings succeed in “bending the curve” to about halfway between the currently projected trend and the amount that would maintain the current proportion of GDP devoted to health spending. A policy of guaranteeing health insurance for all combined with selected savings options yields savings in national health expenditures of \$1.5 trillion over 10 years. This represents an extremely large amount of resources that could be available to address other societal needs or wants, either within the health system or elsewhere. Moreover, an environment in which affordable health care is available, markets operate with better information, and payment reform offers potential for even greater savings, can produce dynamic, synergistic gains over the longer term. The first-order estimates are thus likely conservative compared with the potential gain over time.



Toward a Higher-Value Health System: Cross-Cutting Themes and Conclusions

When one considers the results presented in this report, some key themes emerge:

- **Improvement is possible, and it is urgent to start now.** The consequences of continuing the status quo, with respect to both human and economic costs, are very significant. The numbers of the uninsured are up sharply and moving up the economic ladder as middle-income families lose coverage. Costs are squeezing households, businesses, and the public sector. The option estimates illustrate that cost savings are achievable in the context of a high performance health system. They also demonstrate that early enactment of even modest changes has the potential for substantial cumulative benefits over several years. On a base of more than \$2 trillion, even small percentage changes add up quickly.
- **Better information is a key to improved performance.** It is difficult to improve the health system without information on current performance at the national, local, and individual provider levels. Transparency of information on quality and price is essential to the effectiveness of a number of policies that aim to achieve higher performance. A valid, publicly available database on provider performance, appropriately adjusted for patient conditions, is critical for focusing providers on improving both quality and efficiency, enabling payers to construct rewards and other mechanisms that encourage such behavior, and providing patients with the information they need to make appropriate choices. Data on the

patterns and causes of variations in spending across geographic areas is essential for developing policies to narrow such variations and providing consistently effective and appropriate care, regardless of location.

- **Addressing total health system costs, not shifting costs among sources of financing, should be the focus of policy action.** Many of the policies proposed in the past have simply shifted costs from one payer source to another—between government and employers, or from payers to beneficiaries and patients. Narrow policies that cut governmental budget outlays by simply displacing those costs onto Medicare beneficiaries, or by paying substandard rates to providers under Medicaid, are stopgap measures that do not fundamentally address underlying health care cost trends.
- **There are no magic bullets that by themselves fully address rising costs and key sources of inefficiency.** Just as the steady increase in costs relative to incomes—which is projected to worsen over time—represents the cumulative effect of multiple and interacting factors, tackling cost levels and trends will require a coherent set of policies aimed at the misaligned incentives and structural flaws that plague our health system and produce the cost pressures we face. The design and effective implementation of policies matter. The solutions are not simple, and will require risk-taking and a willingness to invest, learn, and allow time for health systems and system capacity to improve through innovation.
- **A multifaceted approach that is combined with health insurance coverage for all can be designed to achieve substantial reductions in future spending growth.** When combined with universal coverage, a bundled approach focused on system performance should be able to reduce the growth of spending significantly over the next decade while maintaining and enhancing the value of our health care dollar. But we need to start now, with a strategic, coherent set of goals, policies, and incentives designed to address the underlying factors that add to costs without adding commensurate value.
- **Value means more than savings in national health expenditures.** Higher value includes improved performance on quality, equity, access, and healthy lives, in addition to savings. A policy proposal that generates a modest savings but achieves substantial improvement in access or health outcomes may be as valuable, or more so, than one that generates larger savings but makes minimal progress toward other health system goals. Options that extend health insurance to all, promote the public health, improve information and lead to more informed patient decisions, enhance quality and care coordination, and eliminate waste, duplication, and unnecessary care all contribute to value and performance.

- **Reaching consensus will require a focus on the potential gain for the nation.** The Commission has sought to identify options that are win-win—that is, that both achieve savings and contribute to improving key dimensions of health system performance. Yet, approaches that substantially reduce projected expenditures over time will by definition decrease revenues for some segments of the health care sector.
- **Achieving high performance will require that every stakeholder take part in finding solutions.** Across the individual options, the estimated distribution of savings or net new cost varies among major payers—the federal government, state and local governments, employers, and households. Achieving national health system savings may require a shift in payment sources and an increase in federal outlays. Doing so will also require that providers be willing to address payment inequities where providers that care for the uninsured and the poor receive lower compensation than those with privately insured patients. Narrow self-interest is a major barrier to changes that have the potential to benefit all.

Constructive approaches will also require political compromises, and a willingness to forsake ideological purity. As a nation, we will need to move beyond the point where everyone's second choice is the status quo.

- **Leadership is critical.** Building consensus will require leadership and public/private collaboration, and a coherent set of goals, policies, incentives, and tools. Options will work better if public and private policies align toward a common aim of achieving a high performance health system. Consensus will also require a whole-system view: aiming for improved cost trends while improving population health and achieving continuous improvement over time.

The range of options considered in this report illustrates strategic approaches that could, in combination, ease cost pressures and create a path toward a higher performing, high-value health system. The goal of the analysis is to spark discussion and development of constructive national policies that could reduce costs and enable a more efficient, effective, and equitable health system.

With cost pressures mounting and coverage eroding, the stakes are high. As a nation, we will all gain if we focus on improving the value we obtain for the \$2 trillion we are now spending on health care—a sum that will continue to consume a greater and greater share of our nation's economic resources, without yielding proportional gains to society, if we fail to act.

BENDING THE CURVE: OPTIONS FOR ACHIEVING SAVINGS AND IMPROVING VALUE IN U.S. HEALTH SPENDING

INTRODUCTION

The U.S. health system is not producing high value commensurate with our national investment. Per capita spending in the U.S. is twice as high as in any other country; spending is 50 percent higher than in the next-highest country as a percentage of national income; and the gap is widening, as U.S. expenditure growth outpaces other nations'.¹ This high spending, however, does not translate into superior health outcomes. Across an array of dimensions, including access, quality, equity, and efficiency, we fall far short of achievable benchmarks.²

Although advances in medical science and health care technology have yielded gains in the quality of life and healthy life expectancy, more-expensive care does not necessarily translate into higher-quality care. Within the U.S., we have broad evidence of excess costs, inefficient and poorly coordinated care, and variable quality. The fact that the highest-cost areas within the U.S. tend to have levels of quality and health outcomes that are similar to or worse than those in the lowest-cost areas indicates that reduced spending does not necessarily undermine quality. Moreover, various policies, if properly implemented, could improve quality while reducing spending.³ Comparisons across countries also support these conclusions.⁴

The analysis presented in this report seeks to illustrate a range of federal policy options that could begin to be implemented now to generate savings. Using a framework that emphasizes achieving better access, quality, equity, efficiency, and health outcomes for the U.S. population, we identified areas for potential federal policy action and analyzed a range of policy options for their potential to generate savings over a 10-year period. On behalf of the Commission, The Commonwealth Fund contracted with the Lewin Group[‡] to estimate the potential impacts of such options and their distribution across the major groups of payers for health care.

These options are not presented as recommendations of the Commission. Rather they represent a range of approaches that have been proposed to address the factors contributing to high and rising costs and inefficiency within the current health care delivery and financing systems. This report focuses on federal policies, since changes at the

[‡] The Lewin Group is one of the leading health care and human services consulting firms in the United States, with more than 35 years of experience serving organizations in the public, nonprofit, and private sectors.

federal level are likely to have the broadest immediate effects on national health spending. Yet, many of these options could be applied by states and private payers as well. In fact, collaborative efforts across will likely be essential to achieve higher performance and greater value.

As background for the analysis, the report first discusses national expenditure growth and its implications, and the need for improved value. This discussion also highlights factors contributing to high and rising costs that are potentially amenable to policy action without adverse effects on access, quality, equity, or health outcomes.

Within this context, we present a framework for moving toward a more financially sustainable health system, examining each of 15 options for the potential to achieve savings and improve value. The analysis throughout focuses on the potential effect of these options on projected total national expenditures over 10 years, and also the distribution of those effects across the major groups that pay for health care (the federal government as well as state and local governments, businesses, and households). An example also is presented of the potential effect of combining multiple options in the context of affordable health care for all. The concluding section of the report summarizes the findings and discusses their implications.

THE RAPID GROWTH OF HEALTH SPENDING AND ITS IMPLICATIONS

National health spending has risen rapidly over the past two decades, exceeding average national household income and economic growth. As illustrated in Exhibit 1, the most recent projections indicate that total expenditures will double over the next decade to \$4 trillion, increasing from 16 percent to almost 20 percent of gross domestic product (GDP).⁵ Those projections put all sectors of the economy at risk—including federal and state budgets, businesses, and households. With the financing of total expenditures now roughly evenly split between private and public sources, rising costs are expected to be borne equally by the two sectors.

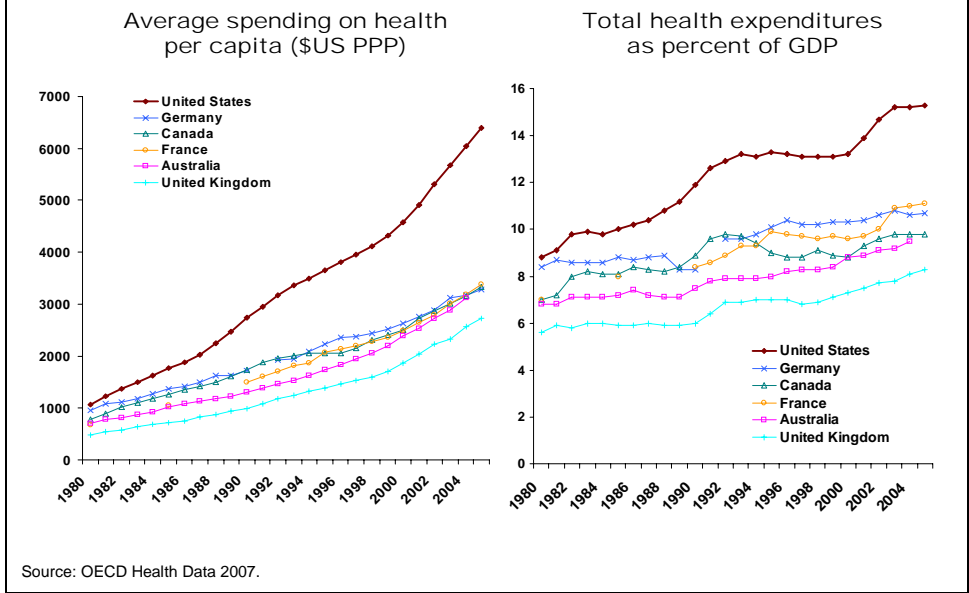
Exhibit 1. Projected National Health Expenditures (NHE) by Payer Source, 2005–2016

Total	2005	Projected	
		2011	2016
NHE (in billions)	\$1,987.7	\$2,966.4	\$4,136.9
NHE as percent of GDP	16.0%	17.5%	19.6%
Payer Source			
Private	\$1,085.0	\$1,566.1	\$2,123.3
Consumer Payments*	943.8	1,347.0	1,811.9
Other Private Funds	141.2	219.1	311.4
Public	902.7	1,400.3	2,013.6
Federal	643.7	1,027.4	1,486.5
State and Local	259.0	372.9	527.1

* Consumer payments include out-of-pocket payments and private health insurance.
Source: J. A. Poisal, C. Truffer, S. Smith et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs* Web Exclusive (Feb. 21, 2007):w242–w253.

As of 2005, U.S. health spending had already reached \$2 trillion, or 16 percent of GDP.^{6,7} Although other high-income nations also face upward pressures on national health spending as a result of aging populations and advances in medical science, the U.S. stands alone in having both the most spending per person and rapid rates of growth over the past two decades.⁸ As shown in Exhibit 2, the U.S. spends almost twice as much on health care per person as any other country, and a far greater share of GDP.

Exhibit 2. International Comparison of Health Spending, 1980–2005

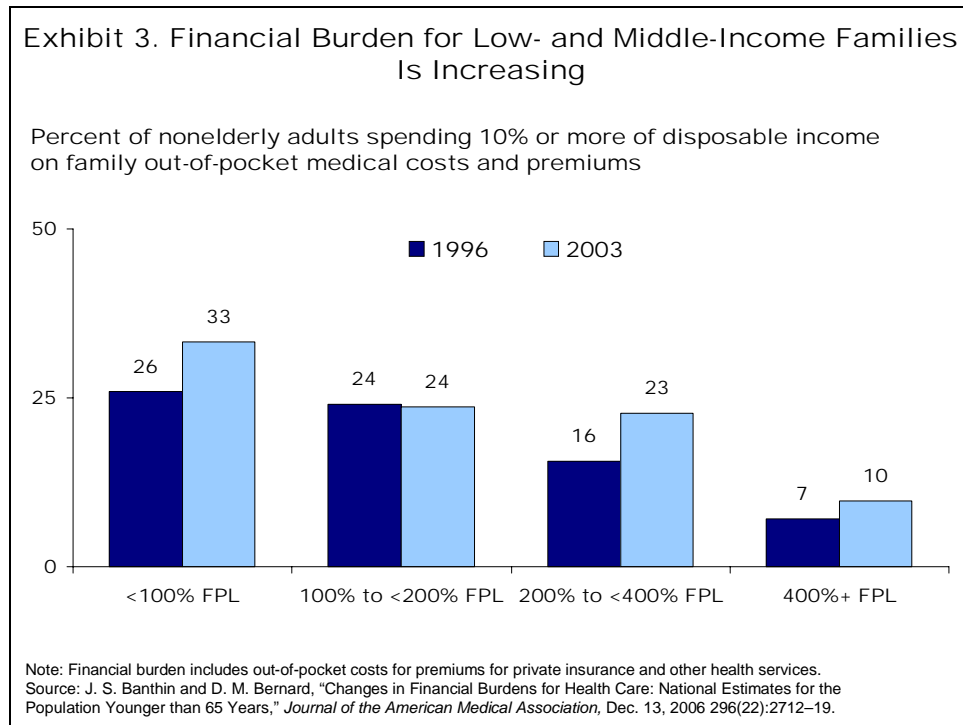


The high and rising cost of health benefits puts economic pressure on businesses and undermines the standard of living of their workforces, and puts future generations of retirees at risk as health costs erode pensions and retirement savings. High premiums and out-of-pocket health care costs, in fact, are among the American public’s top health care concerns.⁹ With further growth expected in public and private insurance costs, government, employers, and individuals will be forced to make difficult budget choices absent policies to moderate those costs.

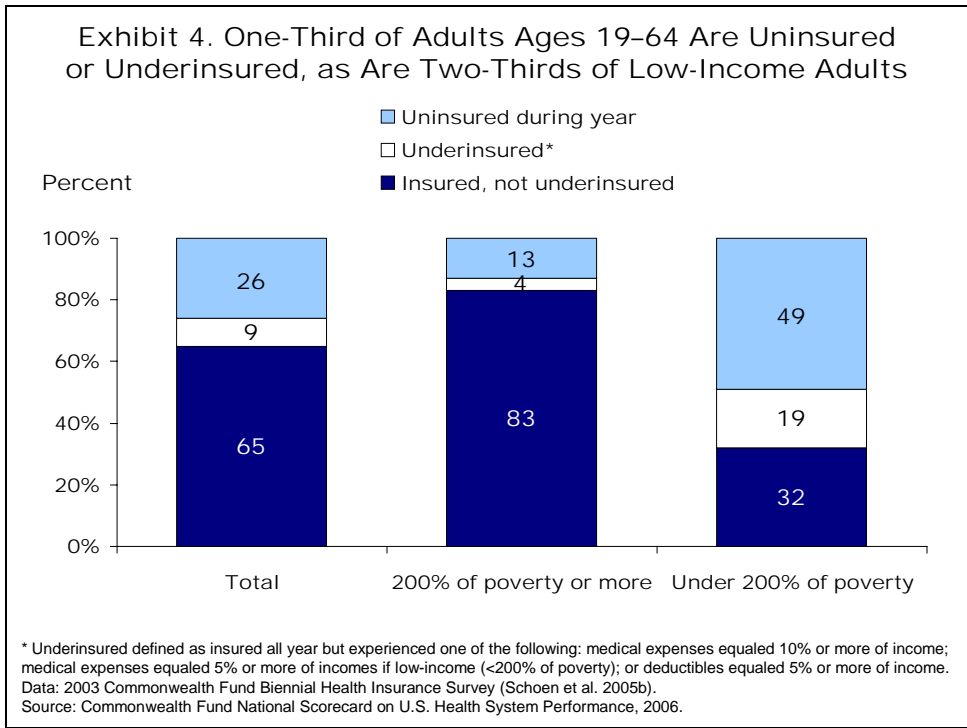
Rising health expenditures have outpaced wages and incomes. While workers’ earnings, adjusted for inflation, have been flat over the past 20 years—and have even declined for those with middle or lower incomes—health insurance premiums have soared, except during a brief respite in the late 1990s. Since 2000, the average family premium for employer-based health insurance has grown 81 percent, while median family income has increased by only 11 percent.¹⁰

Although the burden of higher health care costs is heaviest on those with low and modest incomes, costs have been increasing relative to income for those further up the economic ladder. As Exhibit 3 indicates, about one-third of nonelderly adults with incomes below the federal poverty level in 2003 spent at least 10 percent of their disposable incomes on out-of-pocket medical costs and insurance premiums, a steep increase since 1996, and the proportions among those in the middle and upper income

ranges also rose. Moreover, the difference between the lowest and highest income groups increased over that period.¹¹



As a result of cost pressures, employer-based health insurance, which has been the predominant source of coverage, has shown signs of deteriorating. Between 2000 and 2005, the proportion of workers receiving employer-provided health insurance declined from 74.2 percent to 70.5 percent—with the largest decreases among middle- and lower-wage workers.¹² The number of uninsured Americans has increased steadily from 2000 to 2006, to 47 million, with projections indicating further increases through the middle of the next decade.^{13,14} Moreover, an estimated 16 million nonelderly adults with health insurance in 2003 lacked adequate protection against high out-of-pocket costs, despite having coverage all year; this problem was particularly acute among low-income adults, as shown in Exhibit 4.¹⁵

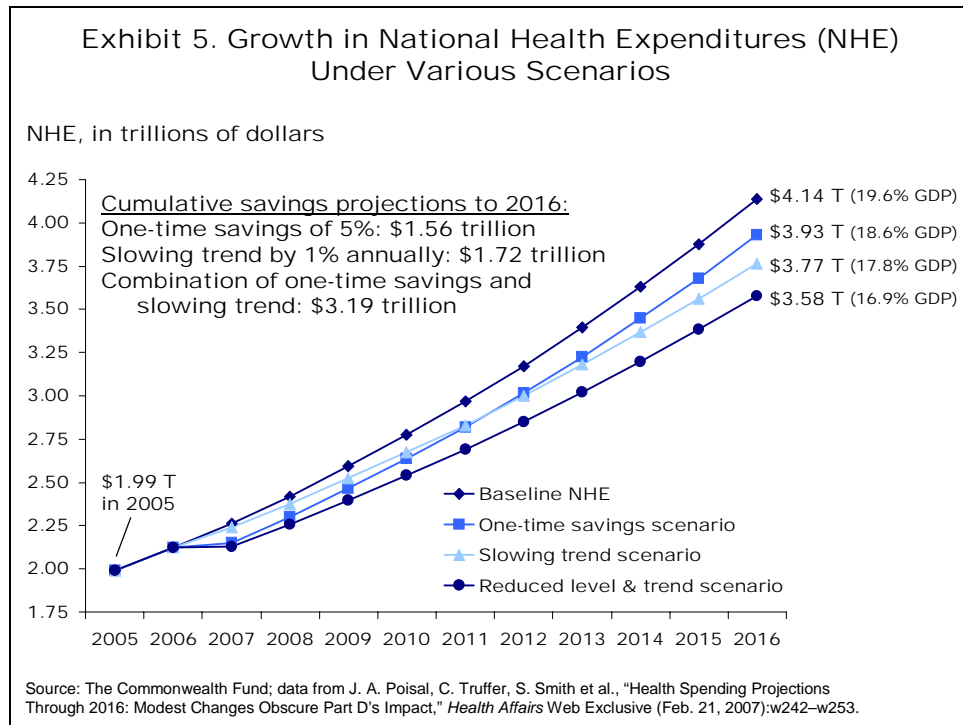


Similarly, the federal government and state governments are under pressure from increasing health care costs. Medicare, as the largest single purchaser of health care in the U.S.—directly accounting for 17.2 percent of total health spending in 2005—is vulnerable to the same increases faced by other payers, employers, and individuals. Moreover, Medicare faces a sharp increase in enrollment, as the baby-boom generation is about to retire—by 2025, there will be 71.3 million Medicare beneficiaries, an increase of 67 percent over the number in 2005.^{16,17}

Like Medicare, Medicaid is subject to the spending pressures that prevail throughout the health system. In addition, Medicaid’s role as a safety net for those with low incomes makes it particularly vulnerable to general economic downturns. Enrollment and costs increase during times when state and local governments face stressful fiscal conditions and deficits due to loss of tax revenues.

Medicare, Medicaid, and the State Children’s Health Insurance Program combined accounted for 19 percent of total federal outlays in 2004. That share is expected to increase to 30 percent of federal outlays, with federal spending on Medicare and Medicaid increasing from \$625 billion to \$1.270 trillion, over the next decade.¹⁸ Similarly, Medicaid represented 17 percent of state general fund expenditures in 2003—second only to elementary and secondary education as a portion of state budgets—with projected increases squeezing out other essential state spending areas.¹⁹

If we fail to act, with a coherent set of policies to alleviate cost pressures, the price will be high. Conversely, with costs projected to continue to increase, if we succeed in reversing or reducing that trend over time, the potential for savings is significant. As shown in Exhibit 5, a policy option that had the effect of achieving a onetime reduction in the level of health care spending by 5 percent in 2007—without changing the projected growth rate—would achieve cumulative savings over a 10-year period of \$1.56 trillion. A policy option that did not affect the level of spending in 2007, but reduced the projected growth rate in health care spending by 1 percent each year, would yield cumulative savings of \$1.72 trillion over the same period. In combination, a onetime reduction of 5 percent in the level of spending plus a 1 percent decrease in the projected rate of increase would produce a substantial long-term yield of \$3.19 trillion, and leave us at 16.9 percent of GDP spent on national health expenditures by 2016—only a slight increase from today’s percentage—compared with 19.6 percent if nothing were done. Given the current U.S. spending trajectory, even modest changes in projected future increases would amount to a startling amount of estimated savings.



ACHIEVING SAVINGS THROUGH IMPROVED SYSTEM PERFORMANCE

As our health system continues to offer the potential to extend and enhance the quality of our lives, there will be continued pressure to increase spending, testing the limits of our resources. The challenge for the nation is to ensure that we use our resources in ways that yield the highest possible value.²⁰ Although there may be debate about how to allocate our resources among alternative priorities, it is clear that we need to change the way our health system is organized and financed. There is ample evidence that many of the factors that drive up spending do not yield corresponding improvements in health system performance and value.^{21,22}

It should be kept in mind that, although health spending has been increasing steadily and seemingly inexorably, both the \$600 billion increase over the past five years and the \$2 trillion increase projected over the next 10 years reflect the cumulative effect of many factors.²³ Consequently, we cannot expect to eliminate the pressures caused by the rapid growth of health spending through some grand policy panacea, but rather through a combination of distinct strategic policy changes that together can achieve cumulative savings that could amount to substantial reductions from the level of spending that is currently projected.

Achieving incremental and cumulative savings will require a focus on factors that contribute to excess costs without yielding value, and on long-term trends that are amenable to improvements in health policy, as described in a prior Commission report.²⁴ To address these factors, the Commission has developed a framework of four strategic areas for policy intervention to achieve a more financially sustainable health system:

- producing and using better information
- promoting health and disease prevention
- aligning incentives with quality and efficiency
- correcting price signals in the health care market.

Under each of these headings, we offer in this report a set of specific policy options that have the potential to improve value and achieve savings relative to projected spending levels.

In addition to these four targeted areas, extending affordable health insurance to all has the potential to achieve administrative savings and to enable a more integrated, whole-system approach that also ensures access and financial security. Policies would also be more

effective if combined to foster more dynamic, systemic change, and applied to a larger share of the population. To illustrate the potential to achieve savings and improve value of multiple strategic initiatives in the context of universal coverage, we analyzed the effect of combining several of targeted options in a scenario that expands insurance to all with a mix of private and public-group insurance.

The purpose of these analyses is to stimulate and inform the development of policies that will ease the cost pressures faced by the health system and yield greater value for the health care dollar, along the dimensions identified by the Commission in its previous reports: long, healthy lives; universal access; quality; equity; efficiency; and system innovation with the capacity to improve. With the nation at risk of enormous human and economic costs if we continue on the current path of escalating costs and eroding coverage, new policy directions are critical to the future health and economic security of the nation.

The sections below first briefly discuss the intended effect for each set of strategies. There follows a more detailed discussion of the specific policy options. For each option, we include estimates of the effects on total system spending and the distribution of those effects among the federal government, state and local governments, private employers, and households over one-, five-, and 10-year periods, as provided by the Lewin Group.²⁵

Producing and Using Better Information

Information barriers contribute substantially to the inefficiency of our health care system. In order for our providers to deliver the most effective and efficient care, they require information gathered from patient encounters—both with them and with the other providers seen by their patients—as well as the most up-to-date clinical decision support. Because of its volume, complexity, and geographic dispersion, this information can be effectively shared only with the widespread adoption of interoperable health information technology, which is the goal of the option, *Promoting Health Information Technology* ([see page 16](#)). As discussed below, health information technology, if implemented effectively and used appropriately, is a prerequisite “tool” for supporting systemic efforts to improve and coordinate care, and thus has value beyond its direct effect of lowering health care costs in the long run.

In addition to information for improving efficiency, providers (and payers) need data to guide their clinical decisions. This must include comparative effectiveness information, to support decisions that result in the most effective and efficient treatment for each patient. This type of information would be generated by a *Center for Medical*

Effectiveness and Health Care Decision-Making ([see page 19](#)). In addition to assisting the provider at the point of care, this information would be useful to payers for coverage and payment determinations and patients in encouraging more informed participation in the health care process.

From the perspective of patients, it is important that they be knowledgeable and engaged in health care decisions, especially when invasive surgical procedures are proposed that may have less radical or nonsurgical alternatives. This issue is addressed by the option, *Patient Shared Decision-Making* ([see page 22](#)).

Promoting Health and Disease Prevention

The treatment of chronic illnesses such as diabetes and heart disease, and their complications, places a large burden on our health system. The Centers for Disease Control and Prevention estimate that the medical costs for people with chronic disease account for more than 75 percent of total health care expenditures.²⁶ Among the chronically ill, a disproportionate amount of cost is incurred by sicker patients with multiple chronic diseases. In the Medicare fee-for-service population, the costliest 15 percent of beneficiaries account for 75 percent of total spending.²⁷

The prevention and management of these conditions is dependent not only on what occurs within our health system, but also on environmental factors outside the health system—such as where we work and go to school. Active public health strategies aimed at *Reducing Tobacco Use* ([see page 25](#)) and *Reducing Obesity* ([see page 27](#)) can lessen the burden of such diseases and result in substantial savings to the health system. Another lever for changing patient behavior is the development of “value based” health benefit designs that encourage healthy behaviors and disease management, which is the goal of the option, *Positive Incentives for Health* ([see page 29](#)).

Aligning Incentives with Quality and Efficiency

Our current health system, which relies predominantly on fee-for-service payment, rewards overutilization and inefficiency. The fundamental incentives for providers must be changed in order to build a health system that is both sustainable and effective. A symptom of the current misalignment of incentives is the wide variation in cost and quality across the U.S.: In 2003, Medicare outlays per beneficiary ranged from \$4,530 in Hawaii to \$8,080 in New Jersey.²⁸ Yet studies find no systematic relationship between higher spending and higher-quality care or longer lives for Medicare beneficiaries. On some measures, in fact, more spending appears to be associated with somewhat lower quality.²⁹ Two options are presented in this report that seek to better align Medicare

payment with quality and efficiency: *Hospital Pay-for-Performance* ([see page 32](#)) and *Episode-of-Care Payment* ([see page 36](#)). Although each focuses on Medicare, both approaches could also be adopted by states and private payers.

Our current health system also rewards specialty care over primary care, despite compelling evidence that regions with a higher prevalence of primary care deliver both higher-quality and lower-cost care.³⁰ The option focused on *Strengthening Primary Care and Care Coordination* ([see page 39](#)) seeks to correct this imbalance and reward high-value primary care.

The misalignment of incentives in current provider reimbursement is evidenced in the private insurance market as well, where tax laws offer limited incentives to choose more efficient health plans. This shortcoming is addressed in an option to *Limit Federal Tax Exemptions for Premium Contributions* ([see page 41](#)).

Correcting Price Signals in the Health Care Market

The current U.S. health system has given rise to certain pricing inefficiencies that could be addressed by correcting price signals in health care markets. Currently, private Medicare Advantage plans are paid at rates that exceed the anticipated costs of their enrollees by an average of 12 percent.³¹ The signal sent by these rates fails to encourage the level of efficiency of which those plans are thought to be capable. A policy that would *Reset Benchmark Rates for Medicare Advantage Plans* ([see page 44](#)) has been proposed to send a more appropriate price signal. In addition, *Competitive Bidding* ([see page 48](#)) among plans would make all plans compete on, and be accountable for, their quality and efficiency.

U.S. pharmaceutical outlays have increased faster than spending on other health care services, and are the focus of another option, *Negotiated Prescription Drug Prices* ([see page 51](#)). In the late 1990s, pharmaceutical spending increased at an annual rate of 15.9 percent.³² Even with slower annual growth in the 2000–2005 period (10.7%), pharmaceutical spending is growing at a faster rate than spending on hospital services (8.0%), physician services (7.9%), and nursing home and home health care (6.1%).

Provider payment rates, although rising at a slower rate than pharmaceutical spending and health plan administrative costs, are still rising faster than inflation and represent yet another opportunity for greater efficiency. Two options for addressing provider payment would establish *All-Payer Provider Payment Methods and Rates* ([see page 54](#)) and *Limit Payment Updates in High-Cost Areas* ([see page 58](#)). The former option would address price

differentials across insurance sectors, while the latter option would focus efforts on constraining spending growth in high-cost geographic areas.

Combining Individual Options with Affordable Coverage for All

In addition to the individual options described above, we modeled the impact of several of those options under a scenario intended to provide affordable coverage for all. To provide an insurance context for this estimate, we selected an example of a policy proposal intended to expand coverage through a blend of private and public group health insurance. Similar to individual options focused on savings, this scenario is presented as one of a range of proposals aimed at accomplishing its intended objective, rather than as the particular way favored and recommended by the Commission. We refer to this scenario as the Insurance Connector approach ([see page 65](#)).

The Insurance Connector approach builds on and links to current public and private insurance through the creation of a new national entity that offers to individuals lacking group coverage and small employers a structured choice of private health plans as well as a Medicare option. Enrollment in some plan would be required. By offering a choice of both publicly sponsored and private plans, this approach seeks to induce more effective competition not only among private insurers, but between private insurers with the public plan, and vice-versa. This puts pressure on all plans to operate more effectively and efficiently.

To illustrate the potential of policies focused on better information, public health, improved incentives, and correcting price signals in the context of universal coverage, we modeled the Insurance Connector approach together with a subset of the options from the different strategic areas described. The options combined with coverage included: Promoting Health Information Technology; Center for Medical Effectiveness and Health Care Decision-Making; Public Health: Reducing Tobacco Use and Public Health: Reducing Obesity; Episode-of-Care Payment; Strengthening Primary Care and Care Coordination; Competitive Bidding; and Negotiated Prescription Drug Prices.

POLICY OPTIONS: DESCRIPTION, ESTIMATES, AND DISCUSSION

The sections that follow describe policy options analyzed in the report, present estimates of the potential effects, and discuss issues and consequences related to the policy change. For each option, we provide estimates of the effect on total system spending and the underlying net changes in spending by the federal government, state and local governments, private employers, and households over a 10-year period, as provided by the Lewin Group.³³

In a \$2 trillion health sector that is expected to grow to over \$4 trillion in the next decade, the analysis illustrates that even small incremental changes in total national expenditures add up to significant cumulative effects. Exhibits 6 and 7 summarize the cumulative results for all 15 options. The option sections provide detailed annual tables.

The Challenge of Modeling the Future

These estimates must be approached with caution, since they depend on the specifics of the proposals as modeled, how rapidly and how well they could be implemented, and the behavioral responses of key stakeholders. Given the limitations of modeling possible future interactions, the estimates tend to focus on first-round effects, rather than the potential dynamic gains from implementing individual policies or the synergies possible from combinations of policies. Because each policy is modeled in isolation, the potential gains to be had from a multifaceted approach to achieving more effective and efficient care are not addressed.

The estimates draw on existing evidence regarding likely responses to policy changes relative to national projections of spending absent policy change. Where the effectiveness of a policy is particularly uncertain, the estimates use specific assumptions of the policy's potential effectiveness. These assumptions represent reasonable professional judgments of the likely consequences of pursuing each option.

Modeling the future with complex policy changes is inherently challenging and risky. The technical challenges include the uncertainty of estimating dynamic effects over time. Just as important, the estimates assume effective design and implementation, and therefore do not reflect the difficulty of achieving agreement, designing complex policy changes or the organizational adjustments required to implement them successfully.

Yet, envisioning potential new policy directions is critical to the future health and economic security of the nation. The stakes are very high with enormous human and economic costs if we continue on the current path of escalating costs and eroding

coverage. Consequently, the Commission sponsored the options analyses to illustrate that it should be possible to achieve savings and improve value and to stimulate broader discussion and consensus regarding how to move the health care system on a path toward a high-value, high performance health care system.

Exhibit 6. Policy Options and Net Cumulative Impact on National Health Expenditures over One, Five, and 10 Years

	One-Year Impact on NHE (billions)	Cumulative Five-Year Impact on NHE (billions)	Cumulative 10-Year Impact on NHE (billions)
Producing and Using Better Information			
1. Promoting Health Information Technology	\$8	\$14	-\$88
2. Center for Medical Effectiveness and Health Care Decision-Making	-\$18	-\$125	-\$368
3. Patient Shared Decision-Making	-\$1	-\$4	-\$9
Promoting Health and Disease Prevention			
4. Public Health: Reducing Tobacco Use	-\$5	-\$64	-\$191
5. Public Health: Reducing Obesity	-\$3	-\$61	-\$283
6. Positive Incentives for Health	\$0	-\$5	-\$19
Aligning Incentives with Quality and Efficiency			
7. Hospital Pay-for-Performance	-\$2	-\$14	-\$34
8. Episode-of-Care Payment	-\$17	-\$96	-\$229
9. Strengthening Primary Care and Care Coordination	-\$5	-\$60	-\$194
10. Limit Federal Tax Exemptions for Premium Contributions	-\$10	-\$55	-\$131
Correcting Price Signals in the Health Care Market			
11. Reset Benchmark Rates for Medicare Advantage Plans	-\$3	-\$20	-\$50
12. Competitive Bidding	-\$7	-\$42	-\$104
13. Negotiated Prescription Drug Prices	-\$3	-\$16	-\$43
14. All-Payer Provider Payment Methods and Rates	\$2	-\$23	-\$122
15. Limit Payment Updates in High-Cost Areas	-\$4	-\$43	-\$158

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

Exhibit 7. Policy Options and Distribution of 10-Year Impact on Spending Across Payer Groups (in billions)

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

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

† In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total.

PROMOTING HEALTH INFORMATION TECHNOLOGY

\$ billions	Annual Net Impact										Cumulative Net Impact		
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		2008–2012	2008–2017
National Health Expenditure	8.0	5.7	2.8	-0.1	-2.8	-9.9	-16.4	-20.9	-25.4	-28.8		13.6	-87.8
Federal Government	2.3	1.4	0.3	-0.7	-1.8	-4.5	-7.0	-8.8	-10.7	-11.9		1.5	-41.4
State and Local Government	0.4	0.1	-0.3	-0.7	-1.1	-2.1	-3.0	-3.7	-4.3	-4.4		-1.7	-19.3
Private Employers	5.9	5.1	4.1	3.1	2.2	-0.3	-2.6	-4.2	-5.6	-7.7		20.5	0.2
Households	-0.6	-1.0	-1.4	-1.7	-2.1	-2.9	-3.7	-4.2	-4.7	-4.8		-6.8	-27.2

Background

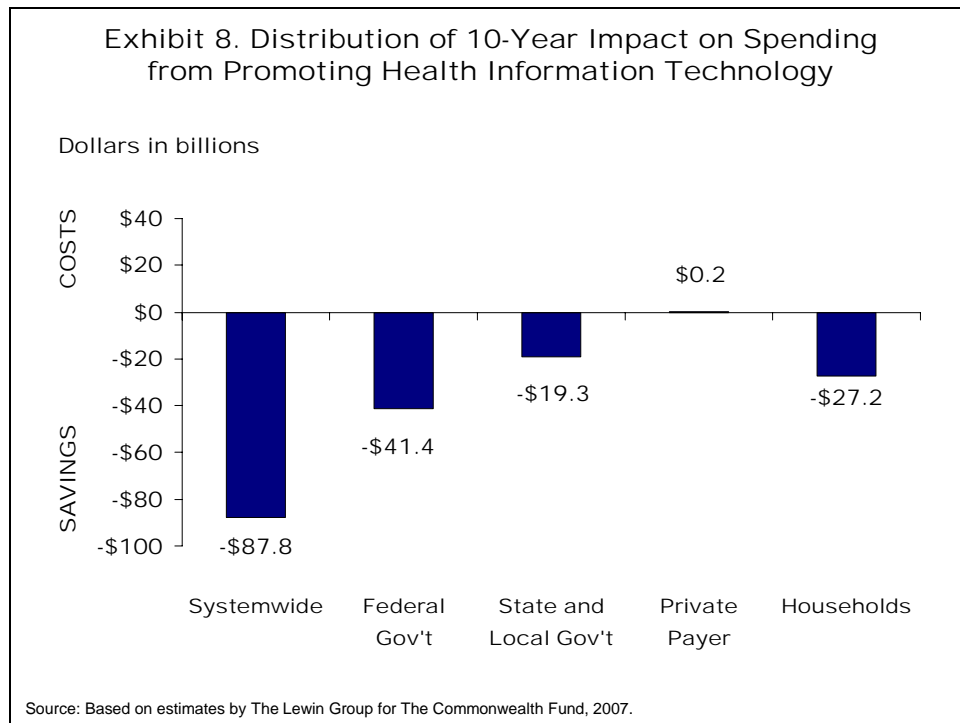
Health information technology (HIT) has the potential to improve overall health system performance and reduce overall costs.³⁴ Electronic medical records, when implemented along with process redesign efforts, can help physicians improve quality and reduce medical errors, while health information exchange can improve care coordination and reduce unnecessary tests. However, widespread adoption of health information technology has not occurred in the United States.³⁵ One of the barriers to adoption is that in the current environment, while it is the providers who purchase HIT, the primary economic benefits accrue more directly to the payers.³⁶

Policy Proposal

Under this policy, the federal government would levy a 1 percent tax on private insurance premiums and spend the equivalent of 1 percent of Medicare expenditures for HIT promotion activities. Those revenues would be divided between the Office of the National Coordinator for Health Information Technology (ONC) and the states. ONC would use the funds to strengthen federal efforts to promote HIT adoption, as well as to oversee federal matching programs for the states. The states would receive 3:1 federal matching funds to provide direct assistance (including capital assistance) to providers in the adoption of HIT technology, and 15:1 federal matching funds to promote the development of Health Information Exchange Networks (HIENs). Among providers receiving assistance, safety net and rural providers, as well as small practices, would be given high priority. Assistance programs would emphasize interoperability, clinical quality improvement functions, and performance measurement and reporting.

Estimated Effect

This policy option results in cumulative net increases in national health expenditures of \$13.6 billion over five years, but a 10-year cumulative net savings to national health expenditures of \$87.8 billion as the initial investment yields returns (Exhibit 8). Over 10 years, all payer groups experience net cumulative savings except for private payers. However, private payers realize a net annual gain beginning in year six (2013), and would have a net positive cumulative savings by year 11 (2018). In the analysis, the sources of savings from implementing provider HIT included reductions in rates of medical errors, more efficient use of diagnostic testing, more efficient drug utilization, and decreased provider costs (e.g., reduced transcription costs). Additional savings from the exchange of health information were due to better care coordination among multiple providers (reducing provider utilization) and better health outcomes through improved chronic-disease management.



Discussion

This policy option represents a long-term investment in our health system. The estimates represent the additional net change expected from new investment resources, on top of a base that is already growing. Although there are short-term investment costs, there are long-term savings, gains in the quality and efficiency of health care, and improved patient health outcomes. Widespread adoption of HIT and health information exchange would also be synergistic with other policy options described in this report. For instance, the ready

availability of comparative effectiveness information would make it possible to disseminate revised practice recommendations much sooner. Enhancements to HIT would also be important as a foundation for the performance measurement framework required by public reporting as well as payment reform efforts. Thus, HIT could be instrumental in improving transparency and comparative information for both outcomes and associated costs.

Relative to health information exchange, HIT adoption among individual providers is rising rapidly. Therefore, most spending under this option is on promoting health information exchange. This is a desirable consequence, as free-market mechanisms are unlikely to promote widespread adoption of health information exchange networks. Most existing and planned HIENs create a “public good,” and therefore have difficulty identifying a business case for their operations without external support.

The length of time it takes to achieve a positive return on investment for this option, especially for private payers, will likely make implementation very difficult. In addition, the success of this option depends on the adoption of national interoperability standards and the ability to address patient privacy concerns.

This policy option calls for a voluntary approach to promoting HIT adoption. An alternative approach would be to require providers, for instance, through Medicare’s conditions of participation, to implement electronic medical records (EMRs). A recent survey of health care opinion leaders supports such an approach.³⁷ If payer assistance is not provided, the effect would be to shift the costs of adopting EMRs to the providers. However, external assistance would still likely be required for promoting health information exchange.

**CENTER FOR MEDICAL EFFECTIVENESS
AND HEALTH CARE DECISION-MAKING**

\$ billions	Annual Net Impact										Cumulative Net Impact		
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		2008–2012	2008–2017
National Health Expenditure	-18.3	-21.2	-24.6	-28.3	-32.5	-37.0	-42.4	-47.9	-54.2	-61.2		-124.8	-367.5
Federal Government	-5.4	-6.3	-7.4	-8.5	-9.9	-11.4	-13.1	-15.0	-17.2	-19.4		-37.5	-113.6
State and Local Government	-2.5	-2.8	-3.3	-3.8	-4.3	-4.9	-5.7	-6.4	-7.3	-8.2		-16.6	-49.1
Private Employers	-5.0	-5.8	-6.7	-7.6	-8.7	-9.9	-11.3	-12.6	-14.2	-16.0		-33.7	-97.7
Households	-5.5	-6.3	-7.3	-8.4	-9.5	-10.8	-12.3	-13.8	-15.6	-17.6		-36.9	-107.1

Background

The rapid growth of health care spending in the U.S., combined with relatively poor performance, has led to calls for better decision-making and better evidence upon which to base it.³⁸ Research has indicated that the dissemination of information in the form of patient education and the promulgation of clinical guidelines can produce cost savings in the health care system. Fisher and colleagues showed that practice patterns associated with greater utilization and spending do not systematically result in better health outcomes, and that reducing that variation in practice patterns could cut Medicare spending by 30 percent.³⁹ O’Connor and colleagues suggest that the implementation of patient-shared decision-making, in which patients are educated on all the treatment options, can reduce unwarranted variations in the use of invasive procedures and improve patient satisfaction.⁴⁰ While Anderson and colleagues found that 83 percent of health care expenditure in the U.S. is associated with the treatment of the chronically ill, McGlynn and colleagues found that chronically ill patients receive only 56 percent of the recommended care for their conditions.⁴¹ A mechanism for providing better information upon which to base medical decisions, as well as incentives encouraging more effective use of currently available information, would reduce unnecessary care, increase effective care, and improve the management of chronic conditions—thereby leading to lower health care costs in the long run while maintaining or improving health care quality and outcomes.

Policy Option

This option seeks to establish a Center for Medical Effectiveness and Health Care Decision-Making as a public/private partnership to improve decision-making by health

care providers, payers, and consumers. The Center would identify the information required to make better medical decisions, collect that information where it exists, and generate that information where it does not. It would make the information available to providers and patients for clinical care decisions, and encourage payers to use that information for coverage, payment, and health care determinations.

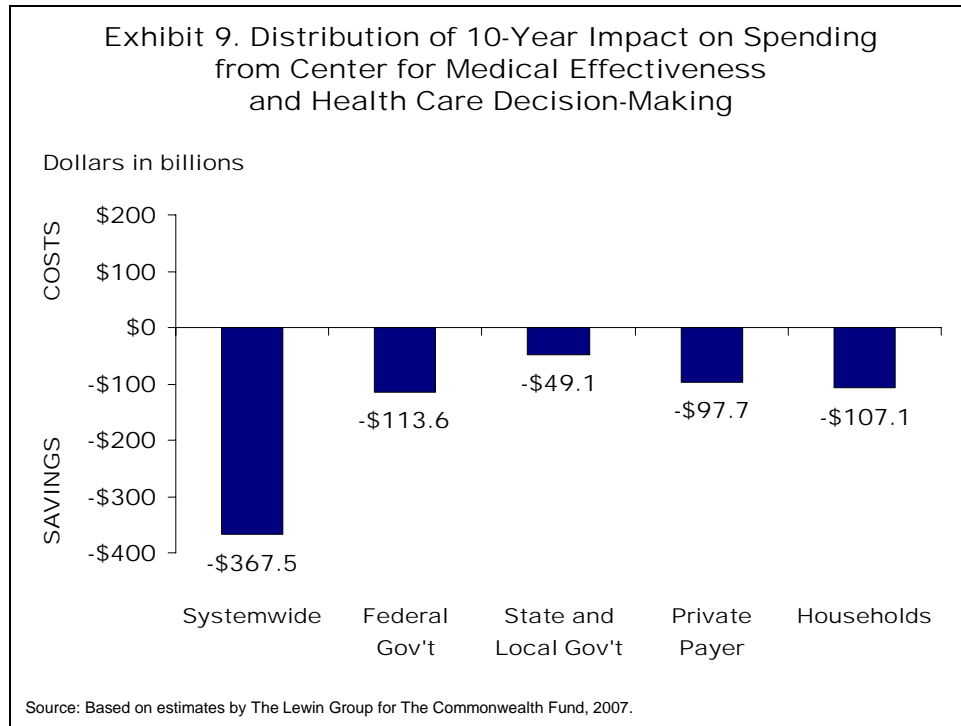
The Center would operate as a quasi-governmental entity possessing legal characteristics of both the public and the private sector, so that it could receive funding (and participation and support) from both; it would be funded by contributions equal to 0.05 percent of projected Medicare spending from the Medicare Hospital Insurance Trust Fund, 0.05 percent of projected federal Medicaid spending from general revenues, and an assessment of 0.05 percent of private insurance premiums. The funding available for the Center in 2008 would be \$0.8 billion, totaling \$4.4 billion over five years and \$10.5 billion over 10 years.

The Center would have a mandate to produce and publicize information that identifies and encourages the adoption of best practices and authority to establish certain incentives that are consistent with that objective. Specifically, under this option the Center would:

- Provide targeted funding for research intended to evaluate existing and new devices, drugs, procedures and other treatment regimens that it identified as most important for improving the overall appropriateness of health care and health care spending;
- Consistent with the findings produced by that research and other available information, require the use of patient decision aids in the evaluation of treatment options for selected procedures; and
- Require increased copays for treatment options that it found to be inconsistent with appropriate management of chronic illness.

Estimated Effect

Under this policy option, the projected net savings to national health expenditures would be \$18.3 billion in the first year, \$124.8 billion over five years, and \$367.5 billion over 10 years (Exhibit 9). The largest estimated net reductions would be to federal spending (\$113.6 billion over 10 years), household spending (\$107.1 billion over 10 years), and employers (\$97.7 billion over 10 years). Smaller savings would accrue to state and local governments (\$49.1 billion over 10 years).



Discussion

The savings estimated for this option are based on the use of the improved information produced by the Center to (1) increase screening and detection of certain conditions like hypertension and reduce invasive procedures like lower-back surgery, enhanced by the requirement to use patient decision aids, and (2) identify and apply more-appropriate treatment options for chronic conditions, enhanced by the requirement for higher cost-sharing for services inconsistent with appropriate treatment. The availability of better information and changes in clinical decision-making that result from the establishment of the Center may by themselves produce savings in the long run, but the estimates here consider only the effects of the incentives that the Center would be empowered to implement. Improved and expanded information on clinical effectiveness would also enhance the value of public reporting and transparency regarding treatment choices and costs.

As in other estimates presented in this volume, the distribution of savings across the various components of the health care system may be rebalanced by new policies. For example, the large savings in household insurance premiums would likely be shared in some way, so that they could benefit both insurance companies and their subscribers. Some of the savings from this mechanism might also be shared with the providers of health care, to provide additional encouragement for them to comply with the desired changes in practice and to offset some of the reduction in income that might result from the reduced utilization of some of the services that they otherwise would have provided.

PATIENT SHARED DECISION-MAKING

\$ billions	Annual Net Impact										Cumulative Net Impact		
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		2008–2012	2008–2017
National Health Expenditure	-0.7	-0.7	-0.8	-0.8	-0.9	-0.9	-1.0	-1.1	-1.1	-1.3		-3.8	-9.2
Federal Government	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-0.9	-1.1		-3.1	-7.5
State and Local Government	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		-0.1	-0.2
Private Employers	0.0	0.0	0.0	0.0	0.0	0.0	-0.2	-0.2	-0.3	0.0		-0.1	-0.4
Households	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2		-0.5	-1.2

Background

The *Dartmouth Atlas of Health Care* (www.dartmouthatlas.org) has consistently demonstrated unwarranted variation in the use of medical resources across the United States. One source of this variation is “preference-sensitive care”—services for which at least two valid alternative treatment strategies are available. In theory, the choice should be based on an informed patient’s preference; in practice, it appears to be determined largely by local medical opinion.⁴² Engaging patients in shared decision-making is one approach to better aligning treatment strategies with patient preferences, and that process can be facilitated with patient decision aids (PtDAs). A review of the effect of PtDAs suggests that they can increase the use of cost-effective medical interventions, and can reduce the utilization of certain invasive procedures that patients do not value over less-invasive treatments.⁴³

Policy Option

Under this policy, the Centers for Medicare and Medicaid Services (CMS) would require fee-for-service Medicare beneficiaries to utilize a PtDA prior to having certain high-cost, preference-sensitive procedures, and in other situations where PtDAs have been shown to increase the use of cost-effective medical interventions. Initially, the procedures and conditions selected for this process could include: coronary revascularization for angina; mastectomy for early breast cancer; lumbar spine surgery for low-back pain; prostatectomy for benign prostatic hypertrophy; medical stroke prevention therapy; treatment of hypertension; tube feeding in dementia patients; routine colorectal cancer screening; routine prostate cancer screening; treatment of menorrhagia; and use of mechanical ventilation for chronic obstructive pulmonary disease. Additional procedures and

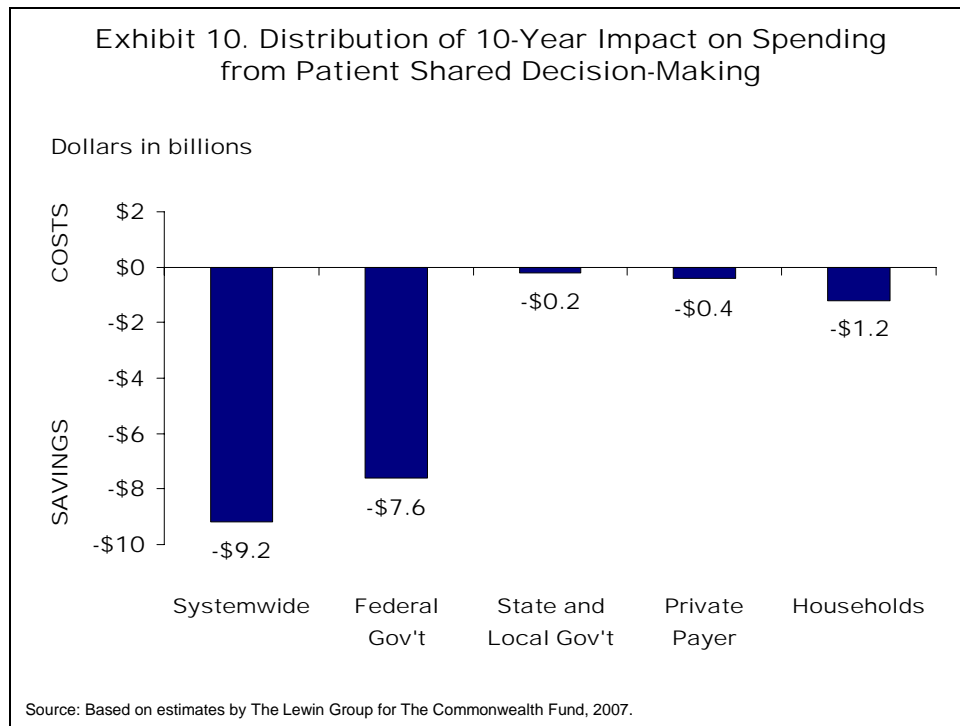
conditions would be added based on early program experience as well as emerging evidence regarding treatment alternatives to high-cost procedures.

Providers who perform the selected procedures (e.g., lumbar spine surgery) or are accountable for the patient's care (e.g., managing hypertension) would assume primary responsibility for ensuring that patients utilize PtDAs by collecting a signed attestation by the patient that he/she has utilized a PtDA. Providers who fail to obtain such attestation will be subject to a 10 percent reduction in Medicare reimbursement for claims related to the identified procedures and conditions for that patient.

In order to support the delivery of patient decision aids, CMS would develop and maintain an interactive Web site of culturally sensitive and linguistically appropriate PtDAs for the selected conditions, and would also support regional nurse PtDA call centers for patients where the patient's care team (e.g., the patient's primary care practice) is not able to facilitate the PtDA use.

Estimated Effect

This policy option results in an estimated net savings to national health expenditures of \$3.8 billion over five years, and \$9.2 billion over 10 years (Exhibit 10). The savings are generated from both decreased utilization of expensive procedures (e.g., lumbar spine surgery) and increased use of cost-savings procedures, such as colorectal cancer screening. Since the savings are generated from changes in utilization, other payers, including households, who pay for care not covered by Medicare also experience savings.



Discussion

The estimated savings to national health expenditures are relatively modest, but the economic modeling was limited to treatment options for 11 conditions (chosen because of the available evidence of the impact on them of PtDAs) and applied only to Medicare beneficiaries. If Medicaid, private insurers, and other payers adopted this policy, its impact would be increased. It is anticipated that as more evidence is generated regarding cost-effective treatment options, more procedures and conditions would be added to the program. However, to the extent that patient-shared decision-making enhances the “match” between treatment preferences and treatments actually received, this policy option increases the value of health care expenditures even if no savings are generated. In addition, considered in the context of broader efforts to promote greater patient engagement in health care, this option has minimal, if any, negative effects on the patient. There is an additional burden on providers, who would have the responsibility of ensuring that patients utilize a PtDA prior to receiving the treatments, but this could likely be integrated into the current process of obtaining informed consent.

PUBLIC HEALTH: REDUCING TOBACCO USE

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-4.5	-10.2	-13.4	-16.6	-19.6	-22.0	-24.0	-25.5	-26.3	-28.4	-64.3	-190.5
Federal Government	-1.6	-3.7	-4.8	-5.9	-7.0	-7.9	-8.6	-9.1	-9.4	-10.2	-23.0	-68.2
State and Local Government	-0.8	-1.9	-2.5	-3.0	-3.6	-4.0	-4.4	-4.7	-4.8	-5.2	-11.8	-34.9
Private Employers	-0.9	-2.1	-2.7	-3.3	-4.0	-4.5	-4.8	-5.2	-5.3	-5.7	-13.0	-38.5
Households	-1.2	-2.7	-3.5	-4.2	-5.0	-5.6	-6.2	-6.5	-6.7	-7.3	-16.5	-48.9

Background

Cigarette smoking and other tobacco use is the biggest avoidable cause of disease and death in the United States. Not only is tobacco use associated with lung cancer and other respiratory illnesses, it also increases the risk of other cancers (oral cancers and pancreatic cancer, among others) as well as heart disease and stroke. The Centers for Disease Control and Prevention (CDC) has estimated that during the period 1997–2001, cigarette smoking was responsible for \$167 billion in annual health-related economic losses in the United States (\$75 billion in direct medical costs, and \$92 billion in lost productivity).⁴⁴

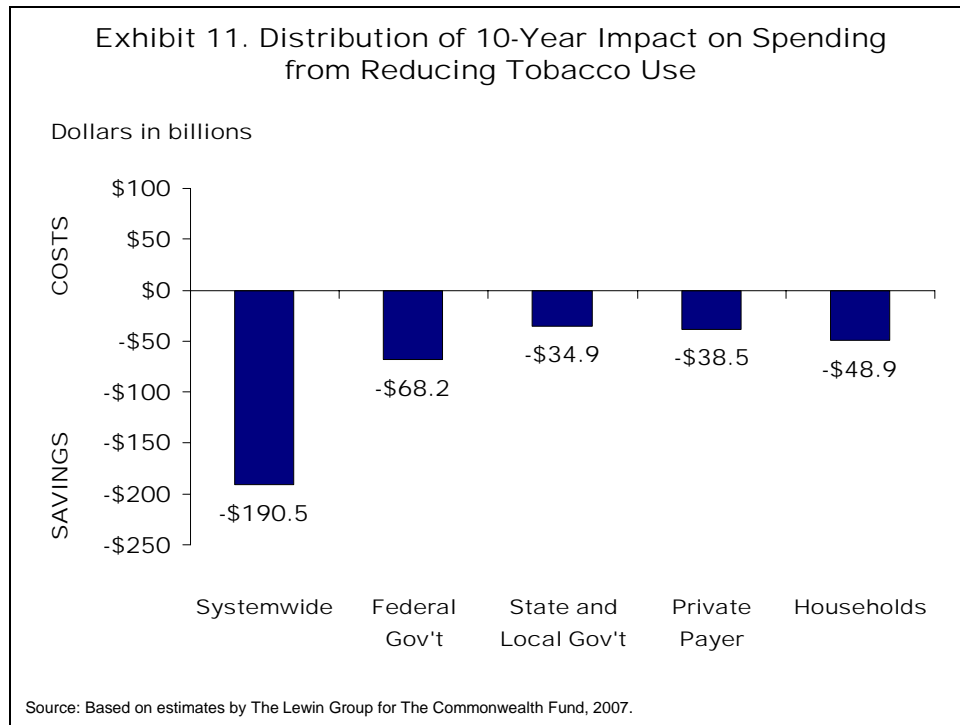
Policy Option

Under this policy, the federal government would increase the federal excise tax on cigarettes from \$.39 to \$2.39, with a proportional increase in the taxes on other tobacco products. Revenues from this increase would be used to strengthen the CDC’s national tobacco control programs, as well as to give block grants to states for their own control programs. States would be eligible for such grants only if they met minimum tobacco control requirements, such as enacting legislation that bans smoking in enclosed workplaces and public spaces.

Estimated Effect

The economic effect of reduced tobacco use is a net reduction in national health expenditures (NHE) of \$64.3 billion over 5 years and \$190.5 billion over 10 years (Exhibit 11). These result from a reduction in illnesses with tobacco use, though the savings decrease over time as the costs of age-related illnesses increase due to longer lives. Over 10 years, all

payers have a net savings. However, states' savings from reduced health care expenditures are partially offset by reduced revenues from state tobacco taxes.



Discussion

In addition to achieving savings, this policy option clearly increases the capacity of our health system to enable long, healthy, and productive lives. However, while the decrease in expenditures and improvement in population health represent an increase in overall health system efficiency, the policy would not directly improve individual provider efficiency. Also, although all payers would experience a net savings under this option, there would be a loss in state revenue from state cigarette taxes, estimated at \$32.2 billion over 10 years. But to the extent that these revenues had been used for state tobacco control programs, that loss would be more than offset by the federal block grants for those programs to states under this option. However, some of those state tax revenues are currently being used for other programs. During implementation of this policy, consideration should be given to the impact of lost funding on those programs and potential mitigation strategies (e.g., temporarily allowing the block grants to support such programs). In addition, it is important to note that the proposed tax is substantial and regressive, and will disproportionately affect low-income consumers.

PUBLIC HEALTH: REDUCING OBESITY

\$ billions	Annual Net Impact										Cumulative Net Impact		
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		2008–2012	2008–2017
National Health Expenditure	-3.4	-7.3	-11.7	-16.6	-22.2	-28.5	-35.6	-43.4	-52.1	-61.9		-61.1	-282.6
Federal Government	-1.2	-2.6	-4.2	-5.9	-8.0	-10.2	-12.7	-15.5	-18.7	-22.1		-21.9	-101.2
State and Local Government	-0.6	-1.3	-2.1	-3.0	-4.1	-5.2	-6.5	-8.0	-9.6	-11.3		-11.2	-51.8
Private Employers	-0.7	-1.5	-2.4	-3.4	-4.5	-5.8	-7.2	-8.8	-10.5	-12.5		-12.4	-57.2
Households	-0.9	-1.9	-3.0	-4.2	-5.7	-7.3	-9.1	-11.1	-13.3	-15.8		-15.6	-72.5

Background

Obesity is a significant risk factor for numerous illnesses such as high blood pressure, diabetes, and heart disease. Yet, data from the National Health and Nutrition Examination Survey showed that the prevalence of obesity among adults more than doubled from the 1970s to the 2000s.⁴⁵ The share of national health expenditures attributed to obesity has been estimated at 5.5 to over 9 percent.⁴⁶ Therefore, reductions in the prevalence of obesity should result in substantial savings to national health expenditures.

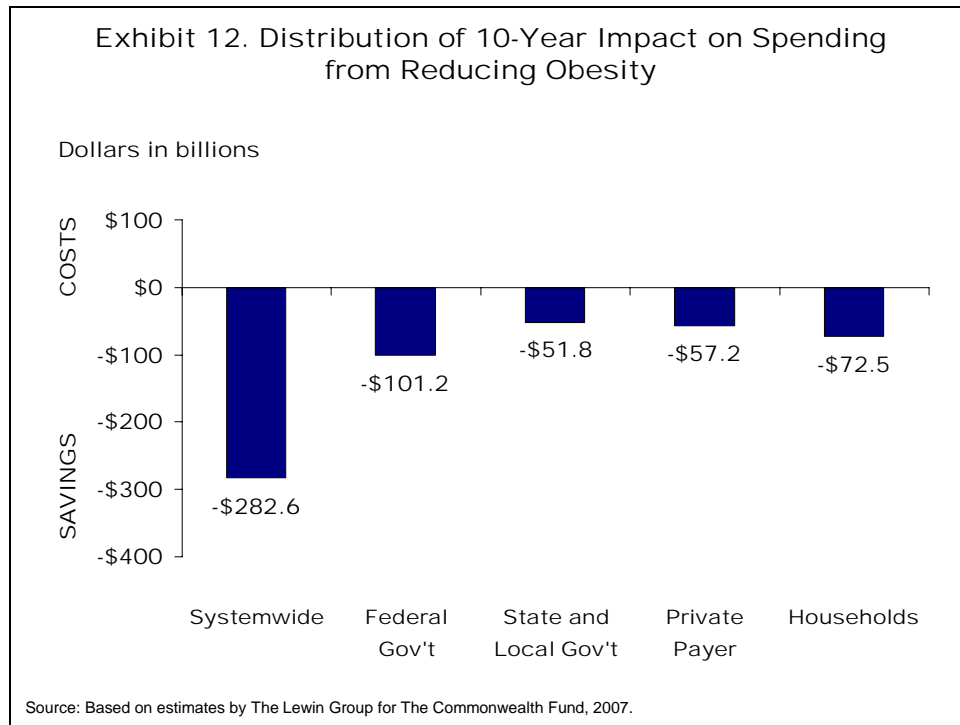
Policy Option

Under this policy, the federal government would establish a new federal tax on sugar-sweetened soft drinks at the retail level in the amount of \$.01 per 12 ounces. Revenues from that tax would be reinvested in block grants to states for obesity prevention programs. States would be eligible for such grants only if they met minimum obesity control requirements such as the enactment of legislation banning the use of trans fats in the preparation of food in restaurants; requiring restaurants that serve standardized food (e.g., at chain restaurants) to prominently display nutritional information; and requiring schools to ban the sale of sugar-sweetened soft drinks, enforce existing U.S. Department of Agriculture (USDA) regulations that prohibit serving school meals of minimal nutritional value, and serve meals consistent with USDA guidelines.

Estimated Effect

The economic effect of this policy is a net reduction in national health expenditures (NHE) of \$61.1 billion over five years and \$282.6 billion over 10 years (Exhibit 12). These savings accrue to all payer groups, and result from a reduction in illnesses associated with obesity, most notably cardiovascular disease and diabetes. Although consumers are

subjected to a new tax, it is offset by reductions in household insurance premiums and out-of-pocket health expenditures.



Discussion

In addition to achieving savings, this policy option increases the capacity of our health system to produce long, healthy, and productive lives. Although the decrease in expenditures and improvement in population health represent an increase in overall health system efficiency, the policy would not directly improve individual provider efficiency. And, while the new tax is regressive and disproportionately affects the lower-income population, the tax is not substantial and will likely not impose an economic hardship on consumers. It is important to note that the tax on sugar-sweetened soft drinks is just one example of a source of tax revenue for funding the proposed programs, and has been proposed by some states and professional societies. Alternatively, one could achieve a similar goal by assessing taxes on selected fast foods, candy, snacks, or other foods with minimal nutritional value.

These estimates are based on the assumption that the policy slows the rise in the prevalence of obesity; a more aggressive assumption, in which the obesity trend is actually reversed, would yield a cumulative savings to national health expenditures of over \$1.1 trillion over 10 years. Both of these estimates, however, rely on the assumption that decreasing obesity reduces health care costs (even if providers increase utilization of other services to partially offset the loss from obesity-related illnesses). This is extrapolated from cross-sectional studies, but is subject to debate by health policy experts.

POSITIVE INCENTIVES FOR HEALTH

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-0.2	-0.6	-1.0	-1.5	-2.0	-2.2	-2.5	-2.7	-3.0	-3.2	-5.4	-19.0
Federal Government	0.6	0.5	0.4	0.3	0.2	0.1	0.1	0.1	0.0	0.0	1.9	2.2
State and Local Government	-0.6	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-4.4	-11.5
Private Employers	-0.1	-0.2	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-1.4	-4.5
Households	-0.1	-0.2	-0.3	-0.4	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-1.6	-5.2

Background

Personal behavior, such as smoking, diet, and physical activity, has a direct impact on not only morbidity and mortality, but also on healthcare costs. It is estimated that 25 percent of all health care costs are related to modifiable health risks.⁴⁷ Furthermore, there is evidence that health care costs can be controlled by promoting wellness and healthy behaviors to reduce overall health risk. At the patient level, a study by Edington and colleagues demonstrated that as an individual’s overall health risk decreases or increases, their medical claims costs decrease or increase accordingly.⁴⁸ For patients who already suffer from a chronic illness, participation in disease management programs has the potential to improve quality and reduce costs. In response to the potential for savings in these areas, both private employers and state agencies are exploring the use of financial incentives and “value-based” benefit designs to encourage employees to participate in wellness programs, engage in healthy behaviors and obtain essential preventive care.⁴⁹

Policy Option

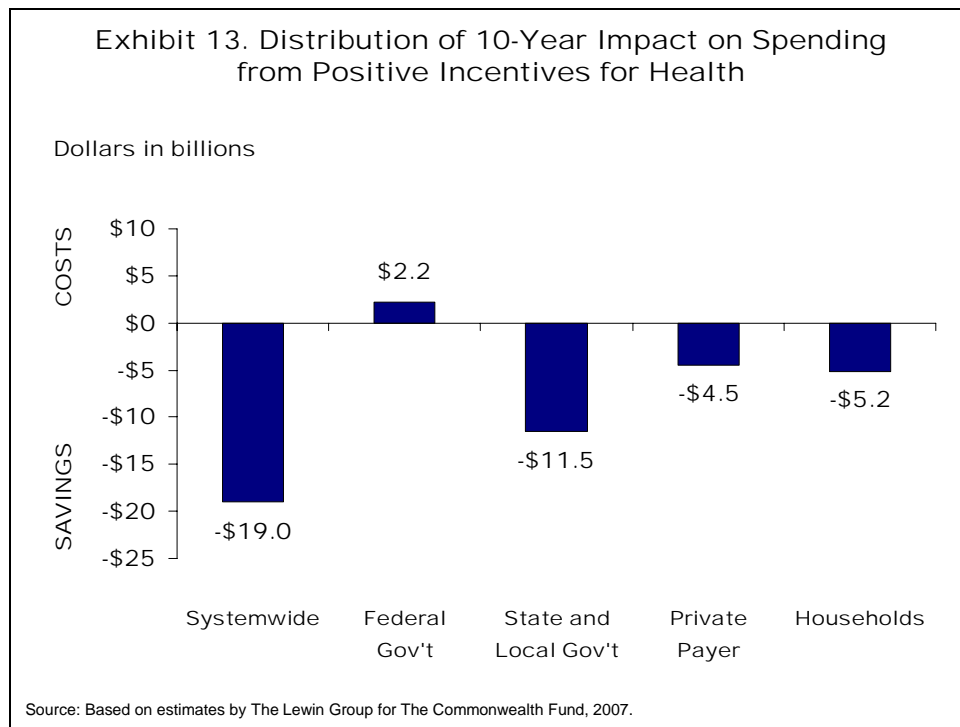
The goal of this option is to encourage state and private employers to design benefits that create positive incentives for wellness and healthy behavior. The proposal has four separate components:

- Provide a total of \$50 million in federal grants to states to promote insurance benefit designs that incentivize healthy behaviors and participation in disease management programs through state contracting requirements, directly in state-sponsored or state-subsidized plans, or through modification of insurance rating rules.

- Increase the federal share of the premium for plans in the Federal Employee Health Benefit (FEHB) program that incentivize healthy behaviors.
- Amend the tax code to allow employees to use Flexible Spending Accounts for specified programs to control weight and quit smoking.
- Amend the Health Insurance Portability and Accountability Act (HIPAA) to mandate that all insurance plans exempt preventive services recommended by the U.S. Preventive Services Task Force from deductibles.

Estimated Effect

Under this policy option, the projected net cumulative savings to national health expenditures are \$5.4 billion over five years, and \$19.0 billion over 10 years (Exhibit 13). Most of the savings are derived from increased disease management participation in state Medicaid programs, as well as increased utilization of preventive services for patients covered under all payers. There is a net cost to the federal government of \$1.9 billion over five years and \$2.2 billion over 10 years because of the increased costs of the FEHB program and the grants to states, but all other payers experience savings from changes in utilization and improved health outcomes.



Discussion

Although the savings to national health expenditures are relatively modest, this policy option would improve health outcomes, so the efficiency of the U.S. health care system

would be improved even if the net savings were zero. The assumptions used in the modeling credited less than \$1 billion in cumulative 10-year savings to decreases in obesity and smoking. If more aggressive benefit designs were used to address these two issues, more savings would be generated.

However, a drawback of designing insurance benefit programs that reward healthy behavior is the potential negative impact it would have on vulnerable populations. For instance, low-income populations are more likely to live in communities with less access to healthy foods and fewer opportunities to engage in active lifestyles, so penalizing this population for obesity may be less fruitful than investing in community infrastructure to facilitate healthy living.

HOSPITAL PAY-FOR-PERFORMANCE

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-2.4	-2.6	-2.8	-3.0	-3.2	-3.4	-3.7	-4.0	-4.3	-4.6	-14.0	-34.0
Federal Government	-1.9	-2.1	-2.3	-2.4	-2.6	-2.8	-3.0	-3.2	-3.5	-3.7	-11.3	-27.4
State and Local Government	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.8
Private Employers	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.7	-1.7
Households	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-0.6	-1.7	-4.1

Background

As the largest payer for health care, Medicare exerts substantial influence on the incentives for providers. The current fee-for-service system provides incentives for overutilization without regard to quality. Pay-for-performance (P4P) initiatives can align incentives with the provision of high-quality care. P4P initiatives typically begin with the identification of quality measures, which by itself can enhance quality by highlighting to the provider community the processes and outcomes that Medicare wants to encourage. The establishment of financial rewards for the accomplishment of these processes and outcomes can help improve quality in two additional ways: it can help to remove or at least counteract aspects of the current payment system that are inconsistent with quality improvement (such as the incentive to increase volume of services inherent in fee-for-service payment), and, more directly, it can reinforce actions that are consistent with high quality (such as the administration of aspirin to heart attack patients).

Policy Option

Under this policy option, the Centers for Medicare & Medicaid Services (CMS) will build on the experience of the CMS/Premier Hospital Quality Incentive Demonstration (HQID), under which more than 250 participating hospitals have been eligible to receive performance incentives since October 2003. This policy would expand the HQID pay-for-performance program to all acute-care hospitals that are paid under the Medicare prospective payment system (PPS) for inpatient hospital services and have a sufficient patient sample size for quality measurement. Funding for the bonuses paid under the program will be derived from reducing total base payments for all hospitals under PPS in

the coming payment year by an amount equal to the total projected bonus payments for discharges during that year.

Although the clinical conditions and specific measures for which incentives are provided may change over time, the initial clinical conditions will be the same as those included in the current HQID: acute myocardial infarction (AMI), isolated coronary artery bypass graft (CABG), heart failure (HF), community-acquired pneumonia (CAP), and hip and knee replacement surgery (Hip/Knee). The initial measures will be the measures for Year 4 of the HQID project.⁵⁰ Other performance criteria—such as measures from the hospital version of the Consumer Assessment of Health Providers and Systems (H-CAHPS) Survey, which gauges patient experiences in the hospital—may be added in the future.

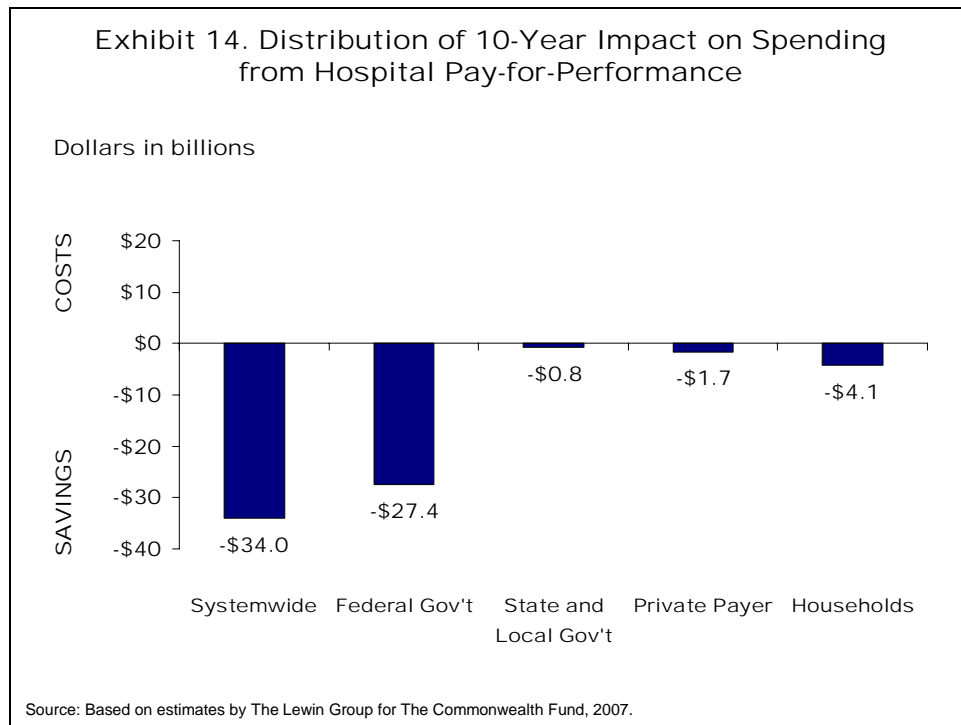
Bonus payments will be based on three types of performance (modeled after, but not identical to, those currently being used in the HQID):

- Top performance (relative threshold)—Hospitals that attain or exceed the 90th percentile composite quality score (CQS) for any clinical area will receive a 2 percent bonus on their Medicare payments for discharges in that clinical area (hospitals that exceed the 80th percentile will receive a 1 percent bonus).
- Absolute performance threshold—Hospitals that attain or exceed an absolute level of performance in any clinical area (as defined by the 75th percentile CQS among all eligible hospitals for the period two years prior to the payment year), regardless of the performance of other hospitals, will receive a 1 percent bonus on their Medicare payments for discharges in that clinical area.
- Performance improvement—Hospitals that attain or exceed the 80th percentile CQS improvement ratio (the ratio of the CQS for the payment year to the CQS for the period two years prior to the payment year) in any clinical area among all eligible hospitals will receive a 1 percent bonus on their Medicare payments for discharges in that clinical area, *if* they attained or exceeded the 50th percentile CQS among all eligible hospitals for the period two years prior to the payment year.

Hospitals that qualify for payment under more than one of the above bonus categories will receive all of the payments for which they qualify. Unlike the current HQID, there will be no potential decrease in Medicare payments for hospitals with poor performance.

Estimated Impact

This policy results in an estimated net savings to national health expenditures of \$14.0 billion over five years, and \$34.0 billion over 10 years (Exhibit 14). All payer groups experience net savings, but the major share of the savings accrue to the federal government through reductions in Medicare payments—predominately due to decreased readmissions for Medicare beneficiaries. Other payers that provide wraparound coverage to Medicare beneficiaries, and the beneficiaries themselves, also realize savings because of reduced hospital costs.



Discussion

This policy option reduces national health expenditures by improving the quality of hospital care. Although the bonus payments are made only by Medicare and the bulk of the savings are generated by a reduction in Medicare readmissions, the incentives provided through this policy apply to all hospital patients, because most of the measures are based on the total number of patients being treated for the target conditions at each hospital. If other payers adopt corresponding payment incentives, there is even greater potential for savings.

This option focuses on pay-for-performance for inpatient hospital services only, because that is the type of service (except, perhaps, for services provided by Medicare Advantage plans) for which Medicare has the most widely accepted measures of quality and the most experience in rewarding performance. Inpatient hospital services, however,

account for only 42 percent of all spending under traditional Medicare.⁵¹ Therefore, the potential for additional savings and quality improvement may exist when Medicare is ready to expand the pay-for-performance approach to all providers and services; CMS is currently developing measures and payment mechanisms to be incorporated into the expansion, but there is currently no experience upon which to base estimates of their effect.

Finally, it is also important to note that transparency of information on quality is essential for policies such as this one. The availability of a valid, publicly available database on provider performance enables payers to construct reward and other mechanisms to encourage the provision of high-quality care.

EPISODE-OF-CARE PAYMENT

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-17.4	-18.2	-19.1	-20.2	-21.5	-23.0	-24.5	-26.3	-28.3	-30.7	-96.4	-229.2
Federal Government	-28.7	-29.9	-31.4	-33.3	-35.4	-37.8	-40.4	-43.3	-46.6	-50.6	-158.7	-377.4
State and Local Government	1.4	1.5	1.5	1.6	1.7	1.8	2.0	2.1	2.3	2.5	7.7	18.3
Private Employers	6.8	7.1	7.5	8.0	8.5	9.0	9.6	10.3	11.1	12.1	37.9	90.1
Households	3.0	3.1	3.3	3.5	3.7	4.0	4.3	4.6	4.9	5.3	16.7	39.7

Background

The Medicare fee-for-service system rewards overutilization of resources, and does not incentivize efficient or coordinated care. A symptom of the current incentive misalignment is the wide variation in cost and quality across the U.S., as demonstrated by researchers at the *Dartmouth Atlas of Health Care* (www.dartmouthatlas.org). One alternative to fee-for-service that would reward efficiency and care coordination is bundled payment systems—for instance, making a single payment to cover the entire cost of the care (across providers and settings) of a patient during an episode of illness during a specified period.⁵²

Transitioning to episode-based payment and linking payment rates to performance benchmarks has the potential to reduce variation in performance and generate savings.

Policy Option

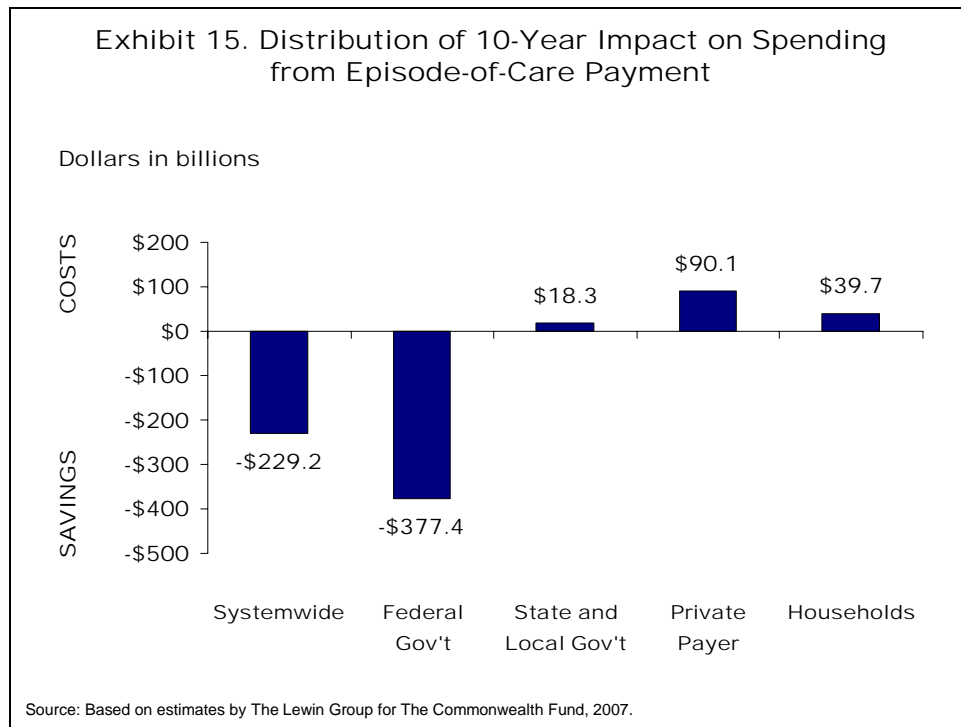
Under this policy option, Medicare fee-for-service would transition to a payment system based on bundled payments for episodes of care. For acute-care episodes that involve hospitalization (e.g., hip replacement, acute myocardial infarction, coronary artery bypass surgery), Medicare would prospectively pay a comprehensive bundled episode case rate by diagnosis-related group (DRG) that would cover all inpatient, physician, and related (e.g., home health) services traditionally covered under Medicare Parts A and B for care of the patient from the time of admission through a period post-hospitalization (in most cases, 90 days). Bundled case rates would also be developed for healthy and chronically ill beneficiaries in the ambulatory setting.

The payment rates would be based on the 75th percentile of the Metropolitan Statistical Area (MSA) with the lowest severity-adjusted Medicare resource cost nationally.

The rate could be adjusted based on performance measures of clinical quality and patient experience.

Estimated Effect

The estimated result of this policy option is a net cumulative savings to national health spending of \$96.4 billion over five years and \$229.2 billion over 10 years (Exhibit 15). Savings are generated by reductions in Medicare payments to providers. As a result of the decrease, providers both increase utilization and shift costs to other payers, as illustrated below.



Discussion

The proposed payment system would effectively align payment with efficiency. The bundled payment provides a substantial incentive for cost reduction, as the provider is at risk for all costs associated with the patient. Quality incentives are necessary to ensure that cost reduction does not result in substandard care. However, there are numerous barriers to implementation. One of the greatest challenges is identifying an entity to which the episode case rates should be paid. In the long term, payments could be made to integrated delivery systems or hospital-physician organizations, but in the short term the payments may have to be disaggregated for each provider. Another challenge is to apply severity adjustment appropriately to reduce preferential patient selection by providers while also reducing their exposure to insurance risk.

The estimate of savings to national health expenditures assumes that payers other than Medicare do not alter their payment methodology. If Medicaid and private payers followed CMS leadership in episode-based payment, the potential savings to national health expenditures would be greater. The change in payment method would put pressure on providers in high-cost geographic areas to deliver care more efficiently.

STRENGTHENING PRIMARY CARE AND CARE COORDINATION

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-4.5	-6.6	-11.2	-16.5	-21.1	-22.7	-24.6	-26.5	-28.7	-31.0	-60.0	-193.5
Federal Government	-3.6	-5.4	-9.1	-13.4	-17.1	-18.4	-19.9	-21.5	-23.3	-25.2	-48.6	-156.9
State and Local Government	-0.1	-0.1	-0.2	-0.4	-0.5	-0.5	-0.5	-0.6	-0.6	-0.6	-1.3	-4.1
Private Employers	-0.2	-0.3	-0.5	-0.8	-1.0	-1.1	-1.2	-1.2	-1.3	-1.4	-2.8	-9.1
Households	-0.5	-0.8	-1.4	-2.0	-2.6	-2.8	-3.0	-3.2	-3.4	-3.7	-7.3	-23.4

Background

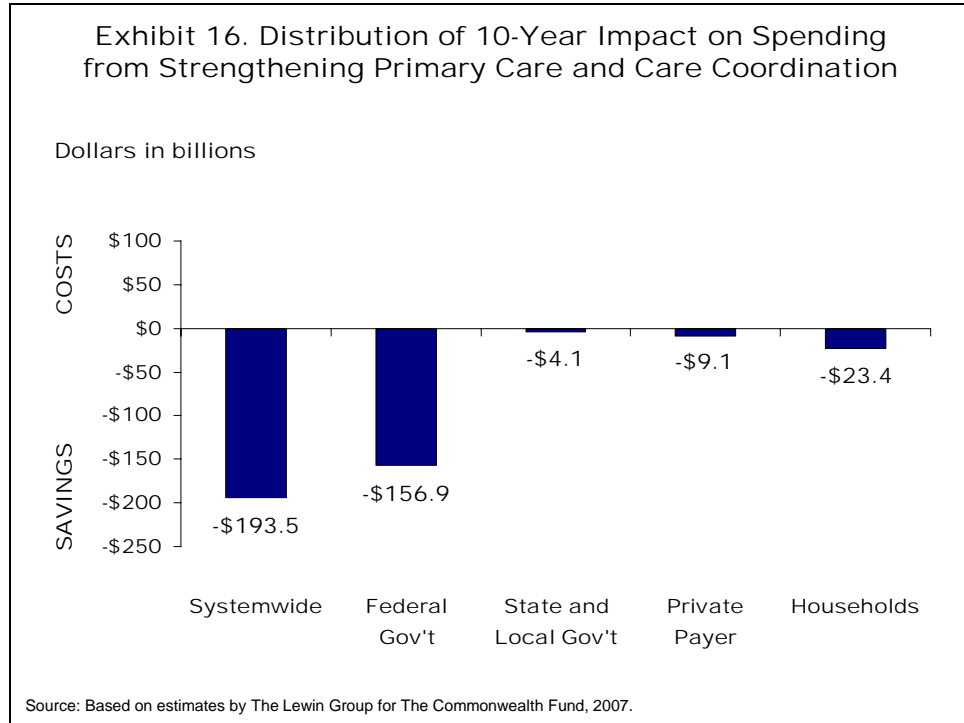
There is substantial evidence that in areas where there is a greater role for primary care physicians in the delivery of medical care, the health outcomes are better and overall costs are lower.⁵³ However, much of the services (e.g., care coordination, care management) and infrastructure (e.g., health information technology, advanced access) needed to deliver primary care effectively are reimbursed either inadequately or not at all in the current fee-for-service payment system. Some state Medicaid programs have successfully strengthened primary care, improved health outcomes, and reduced costs through Primary Care Case Management (PCCM) programs, which typically pay primary care physicians a per-member per-month fee for care management services in addition to usual fee-for-service payments.⁵⁴

Policy Option

Under this policy, beneficiaries in traditional fee-for-service Medicare would be required to enroll in a medical home for primary care. These medical homes would offer enhanced primary care services such as care management, care coordination, patient education and advanced access (e.g., 24-hour coverage). They would have an information technology infrastructure to support clinical care and would generally deliver care using multidisciplinary teams. The medical homes would be responsible for coordinating all care for the beneficiary and authorizing specialty referrals. Physician practices that were certified as Medical Homes would receive a per-member per-month fee in addition to all currently covered fee-for-service payments. There may be additional quality- and efficiency-based incentives that would modify the fee.

Estimated Effect

Under the policy option, the projected net cumulative savings to national health expenditures is \$60.0 billion over five years and \$193.5 billion over 10 years (Exhibit 16). Most of the savings are derived from a decrease in hospital and physician expenses as a result of higher-quality and more-efficient care delivered by medical homes. Since the savings are from changes in utilization, all payers providing wraparound coverage to Medicare beneficiaries accrue savings—including employer retiree plans and Medicaid.



Discussion

This policy option would have the benefit of both reducing expenditures and increasing health care quality and patient outcomes. It is a fundamental payment reform that is intended to strengthen and reward primary care. Two principal challenges to implementing this option are resistance from beneficiaries who would otherwise have less-restricted access to specialty care, and a shortage of primary care physicians to staff medical homes. If one modified the option to have voluntary beneficiary enrollment with modest financial incentives, the net cumulative savings to national health expenditures would be reduced to \$6.1 billion over five years and \$31.7 billion over 10 years. If state Medicaid agencies also participated, enrolling 75 percent of Medicaid beneficiaries would result in an additional \$16.8 billion in savings over five years, and \$55.5 billion over 10 years.

LIMIT FEDERAL TAX EXEMPTIONS FOR PREMIUM CONTRIBUTIONS

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-9.5	-10.2	-10.9	-11.6	-12.5	-13.3	-14.2	-15.2	-16.2	-17.3	-54.7	-131.1
Federal Government	-13.5	-14.5	-15.5	-16.5	-17.7	-18.9	-20.2	-21.6	-23.1	-24.6	-77.7	-186.2
State and Local Government	-1.4	-1.5	-1.6	-1.7	-1.8	-2.0	-2.1	-2.2	-2.4	-2.6	-8.1	-19.3
Private Employers	-4.0	-4.3	-4.6	-4.9	-5.2	-5.6	-6.0	-6.4	-6.8	-7.3	-23.0	-55.2
Households	9.4	10.1	10.8	11.5	12.3	13.2	14.1	15.1	16.1	17.2	54.1	129.7

Background

Employment-related group insurance is currently the primary source of coverage for the under-65 population, insuring two-thirds of working-age adults. Current federal tax laws promote and subsidize this coverage: employer-paid contributions for health insurance premiums are exempt from federal income taxes without regard to household annual income or the level of premium expenses.⁵⁵ The tax exemption has helped support the pooling of health risks and group health insurance. Yet, at the same time, the tax subsidy for premiums can at the margin undermine incentives to select higher-value, lower-cost health plans. Equity is also a concern. Since few low-wage workers have job-based benefits, the current federal tax benefits from the exemption accrue primarily to middle- and upper-income workers. Consequently, various analysts have suggested examining possible options that would amend current tax exemptions to improve the efficiency and equity of federal tax expenditures.

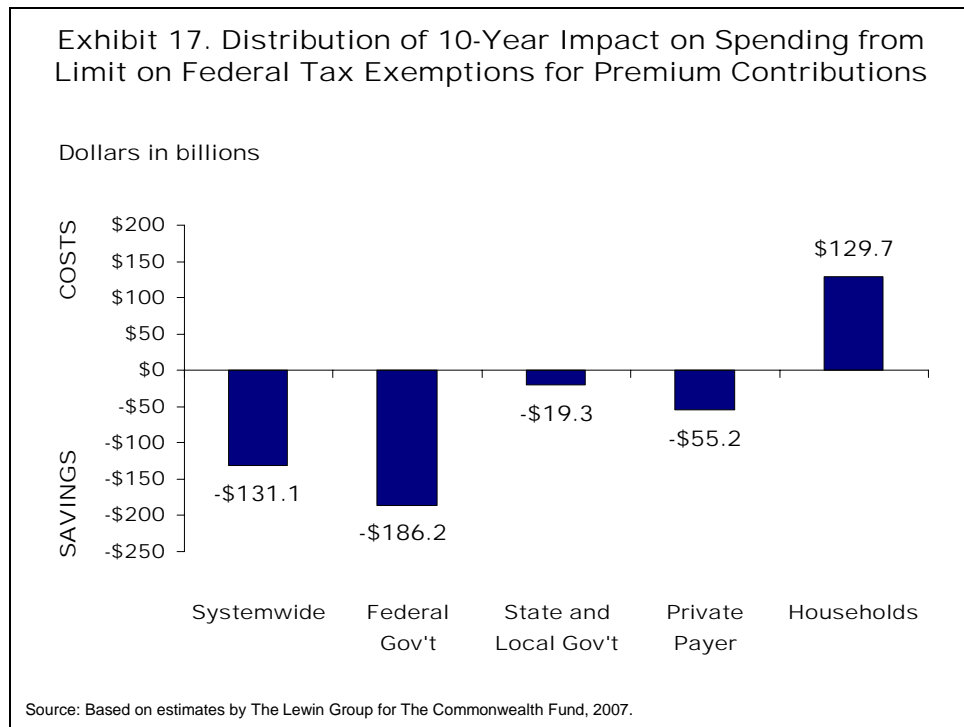
Policy Option

To provide tax incentives for enrolling in high-value health plans (high-quality and efficient care), this policy option would set a cap on the amount of premiums that would be fully deductible. Premiums in excess of the threshold would be subject to federal income taxes. The cap would be set to 110 percent of the median employer-based premium for single or family policies. To avoid penalizing groups with older workers or those who live in high-cost-of-living areas, the limits would be increased for groups with a higher-than-average proportion of workers age 50 or older and would be regionally adjusted for wage and cost-of-living variations. Increased federal income tax revenues resulting from the limit would be earmarked for reinvestment in the health system to help

offset federal health spending, including efforts to improve coverage for those with low or modest incomes, improve public health, and invest in areas with the potential to improve quality and achieve national savings.

Estimated Effect

The Lewin modeling estimates that currently 22.5 million workers, or about 30 percent of all covered workers, have premiums in excess of the tax cap (Exhibit 17). The simulation estimates that most of this group (15 million) would move to less-expensive plans, including a shift out of primarily fee-for-service insurance into more-integrated health plans, reducing total health care spending. As modeled, the policy change would result in an estimated net savings to national expenditures of \$55 billion over five years and \$131 billion over 10 years.⁵⁶ Employers would also save as a result of lower premium payments. Households remaining in plans with premiums above the tax-deduction cap would pay federal income taxes on the excess amounting to an estimated \$130 billion in federal tax revenues over 10 years, including income and Social Security taxes.



Discussion

Limiting the current federal exemption on health insurance premiums would provide incentives to enroll in plans that are less expensive. To the extent that this fosters the development of lower-cost health plans because of greater efficiencies in the delivery of

high-value care (e.g., through better organization of care delivery), the health system will move toward higher performance.

However, there could be unintended consequences, especially if this option were to be implemented in health insurance markets that remained unchanged. In many regions of the country, there are limited options for high-value, integrated care systems. For employers and employees to avoid the premium tax-deduction cap, there would likely be a shift to higher-deductible/cost-sharing/limited-benefit plans. This shift would disproportionately affect low- and moderate-income families, as they are more price-sensitive to exemption limits. Disparities in access to medical care would therefore increase, and would need to be addressed if this policy option were adopted.

One other important issue to consider is that in current private insurance markets, particularly individual insurance and small-group markets, variations in premiums are in large part driven by age and health risks, rather than reflecting underlying efficiency or value. Absent broad pooling of health risks and full community rating, a tax-deduction cap seeking to promote equity and value would need to make adjustments for age, health, and cost of living, or require all states to institute market rules that require community rating. It would otherwise disproportionately affect older, sicker individuals and small firms residing in high-cost regions of the country. A further risk is that this approach could undermine employer group-risk pools. And, finally, the complexity of addressing these concerns through the tax system could lead employers, and especially small employers, to decide to drop coverage altogether. To avoid putting older, sicker, or lower-income patients at risk or undermining current employer group (pool risk) coverage, this change could be combined with universal coverage and changes in insurance market rules.

RESET BENCHMARK RATES FOR MEDICARE ADVANTAGE PLANS

\$ billions	Annual Net Impact										Cumulative Net Impact		
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		2008–2012	2008–2017
National Health Expenditure	-3.0	-3.5	-3.9	-4.3	-4.8	-5.2	-5.6	-6.0	-6.4	-6.9		-19.5	-49.6
Federal Government	-7.5	-8.8	-9.8	-10.9	-11.9	-12.9	-13.9	-15.0	-16.1	-17.3		-48.9	-124.0
State and Local Government	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0
Private Employers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0
Households	4.5	5.3	5.9	6.5	7.1	7.7	8.3	9.0	9.6	10.4		29.3	74.4

Background

Medicare beneficiaries have for the past 35 years had the option of enrolling in private plans to provide their health care benefits, in expectation that private plans would be able to provide more-coordinated care, be more flexible in responding to the needs of their enrollees, operate more efficiently, and provide examples of improvements that could be made to traditional Medicare. Currently, however, payments to private plans for enrollees under the Medicare Advantage (MA) program are estimated to be an average of 12 percent higher than costs that would have been expected under traditional Medicare in 2006.⁵⁷ As a result, the current mechanism for setting the benchmark rates, which result in payments that are substantially higher than anticipated costs under traditional Medicare, sends a price signal through the market that encourages higher rather than lower costs among private plans.

Originally, payments to Medicare private plans in each county under the Medicare risk program were set at 95 percent of the county’s Adjusted Average Per Capita Cost (AAPCC) in traditional Medicare. Beginning in 1998, the Balanced Budget Act of 1997 (BBA) and subsequent legislation altered the mechanism for setting private plan payment rates and expanded the types of plans that could participate in Medicare. Since 2006, the payment rate for MA plans has been determined by the relationship between the bid submitted by the plan and the benchmark rate for the county, which is the highest of several amounts that are based on the old AAPCC rate trended forward, the nationwide average of the old AAPCC rates trended forward, minimum rates that apply to rural and small urban areas, respectively, and rates based on recent per capita costs under traditional Medicare. If the plan’s bid is below the benchmark, the plan receives a payment equal to

its bid plus a “rebate” equal to 75 percent of the difference between the benchmark and its bid. The plan is required to use the rebate amount to provide additional benefits, or reductions in premiums or cost-sharing. If the plan’s bid is above the benchmark, beneficiaries wishing to enroll in the plan have to pay a premium equal to the difference between the plan’s bid and the benchmark.

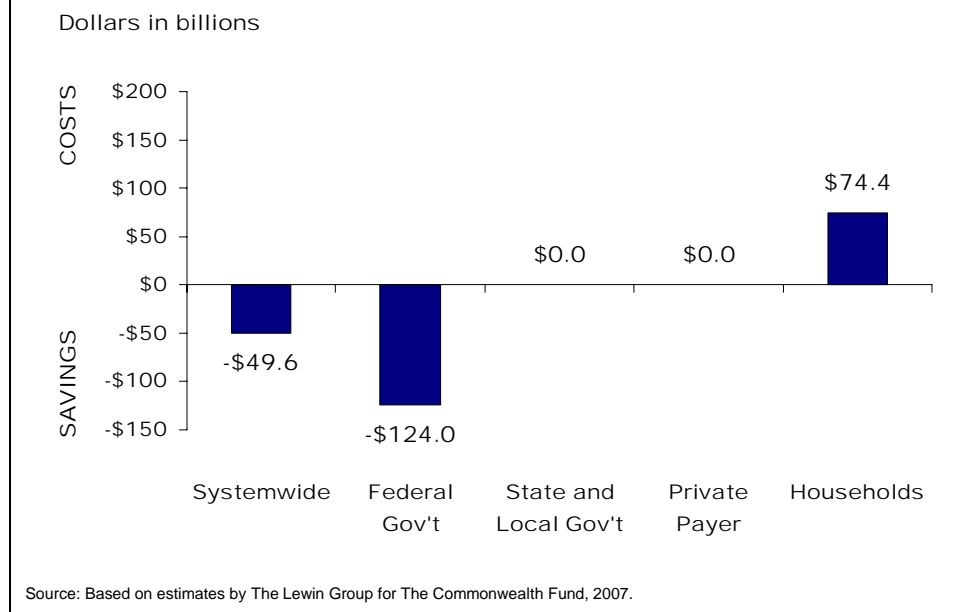
Policy Option

To correct pricing signals in health plan markets to encourage lower-cost plans, this proposal would modify the current payment methodology by setting the benchmark rate for MA plans in each county at the county’s projected per capita spending under traditional Medicare. As is the current policy, if a plan’s bid is below the benchmark, the plan receives a payment equal to its bid plus a rebate of 75 percent of the difference between its bid and the benchmark, and is required to use the rebate to provide additional benefits or reductions in premiums or cost-sharing. As is also current policy, if the plan’s bid is above the benchmark, beneficiaries wishing to enroll in the plan would have to pay a premium equal to the difference between the plan’s bid and the benchmark.

Estimated Effect

This policy results in an estimated net savings to national health expenditures of \$19.5 billion over five years, and \$49.6 billion over 10 years (Exhibit 18). While federal government spending is reduced by \$124.0 billion as a result of the reduced payments to MA plans, Medicare beneficiaries’ spending rises by \$74.4 billion, consisting of additional private premiums for those who attempt to replace some of the additional benefits that are available under the current MA payment rates, as well as extra payments required for those who choose to enroll in plans with bids that exceed the benchmark rate.

Exhibit 18. Distribution of 10-Year Impact on Spending from Reset Benchmark Rates for Medicare Advantage Plans



Discussion

The net savings in national health expenditures produced by this option are the result of lower MA payments, driven by reduced benchmark rates: while the current MA benchmarks are explicitly set to be “no lower” than projected per capita spending under traditional Medicare, this policy option would set them equal to that amount.

The estimated savings to the federal government, however, are partially offset by increased spending by Medicare beneficiaries who are enrolled in MA plans. MA enrollees currently receive cost-sharing reductions or additional benefits that are subsidized by the extra payments that plans receive from Medicare relative to what the enrollees would be expected to cost under traditional Medicare, but those extra payments would be eliminated under this option. In the model used to estimate the effect of this option, beneficiaries would tend to pay extra to replace some of the additional benefits they now receive, by purchasing supplemental benefits either through their MA plan or by enrolling in traditional Medicare and purchasing additional coverage through a separate private plan.

One additional concern that has been raised about proposals to reduce MA plan payments is a possible recurrence of the withdrawal of private plans that occurred after those payments were reduced by the Balanced Budget Act of 1997 (BBA). Between 1999 and 2002, following implementation of the BBA, the number of private plans participating

in Medicare fell from 407 to 240, and the number of Medicare beneficiaries enrolled in private plans fell from 6.9 million to 5.5 million.

The full potential effect of plan withdrawals and reduced enrollment is not reflected in this estimate. If a repeat of the post-BBA exodus were to occur, more beneficiaries would be faced with the loss of access to their current plans and the benefits they offer; the estimated savings to Medicare and to national health spending, however, would be larger than reflected in this estimate.

COMPETITIVE BIDDING

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-6.8	-7.6	-8.3	-9.1	-9.8	-10.7	-11.5	-12.4	-13.4	-14.5	-41.7	-104.2
Federal Government	-19.0	-21.0	-22.8	-24.7	-26.7	-28.9	-31.1	-33.5	-36.0	-38.7	-114.3	-282.5
State and Local Government	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private Employers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Households	12.2	13.4	14.5	15.6	16.9	18.2	19.6	21.0	22.6	24.3	72.6	178.3

Background

The payment received by MA plans for each enrollee is determined by the bid submitted by the plan and a benchmark rate for the county in which the enrollee resides. That benchmark rate is set at the highest of several amounts that are based on the old county-specific average adjusted per capita cost (AAPCC) rate trended forward, the nationwide average of the old AAPCC rates trended forward, minimum rates that apply to rural and small urban areas, respectively, and rates based on recent per capita costs under traditional Medicare. If the plan’s bid is below the benchmark, the plan receives a payment equal to its bid plus a “rebate” equal to 75 percent of the difference between the benchmark and its bid. The plan is required to use the rebate amount to provide additional benefits, or premium or cost-sharing reductions. If the plan’s bid is above the benchmark, beneficiaries wishing to enroll in the plan have to pay a premium equal to the difference between the plan’s bid and the benchmark. The shift in payment methods has increased Medicare costs and, in some markets, undermined access to physicians in traditional Medicare as physicians withdraw and turn to private plans with increased payment rates.

Policy Option

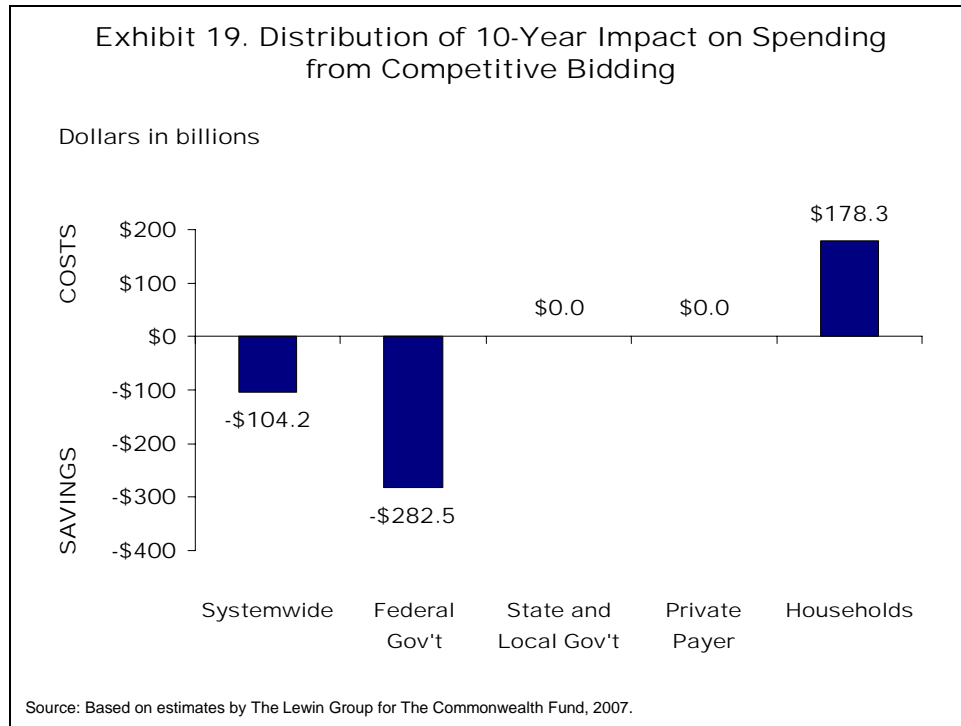
This option would replace the current administered pricing mechanism in Medicare Advantage with increased competition on the basis of quality and efficiency. This policy change would modify the current payment methodology by basing the benchmark in each Medicare Advantage region on the average bid of the plans in the region, rather than on the highest of a set of predetermined rates.⁵⁸ If the average bid in a region is higher than the nationwide projected per capita cost under traditional Medicare, then the benchmark rate for the region would be set to that nationwide average.

If a plan's bid is equal to or below the benchmark, beneficiaries wishing to enroll in that plan would be able to do so at no extra cost (over and above their Part B premium), with the savings accruing to the federal government. If a plan's bid is above the benchmark, beneficiaries wishing to enroll in that plan would have to pay a premium equal to the difference between the plan's bid and the benchmark.

The local projected per capita cost under traditional Medicare for the county in which a beneficiary resides is considered equivalent to traditional Medicare's "bid"; therefore, if that amount is greater than the benchmark for the region, the beneficiary will have to pay an additional premium (equal to the difference between that "bid" and the benchmark) to remain in traditional Medicare. There also may be instances in which beneficiaries will have to pay more to enroll in an MA plan than to stay in traditional Medicare; this will occur if the traditional Medicare "bid" is less than or equal to the benchmark but the plan's bid is above the benchmark.

Estimated Effect

This policy results in an estimated net savings to national health expenditures of \$41.7 billion over five years, and \$104.2 billion over 10 years (Exhibit 19). While federal government spending is reduced by \$282.5 billion as a result of the reduced payments to MA plans, Medicare beneficiaries' spending rises by \$178.3 billion, consisting of the extra payments required for those who choose to enroll in plans with high bids—including some who choose to remain in traditional Medicare, even when that requires them to pay an additional premium—and additional private premiums for those who attempt to replace some of the additional benefits that are available under the current MA payment rates.



Discussion

The net savings to the health care system produced by this option have two distinct components: substantial savings to the Medicare program resulting from sharp declines in payment rates to private plans from their current level at 12 percent above the traditional Medicare costs; and a somewhat smaller, but still large, increase in spending by beneficiaries, as their plan choices require them to make additional payments if they want to stay in high-cost plans or in traditional Medicare (where it is high-cost relative to the available private plans), or if they want to replace lost benefits that their plans used to provide, but no longer do.

Because there is a net reduction in overall health spending, alternative policies could be built into the bidding process to soften the impact on beneficiaries. For example, beneficiaries who enroll in plans with bids that are below the benchmark could receive a rebate equal to some or all of the difference between the plan's bid and the benchmark; this policy would provide a stronger incentive for beneficiaries to enroll in low-cost plans, and would allow them to replace some of the extra benefits that would no longer be available in most of those plans. Alternatively, plans with bids that are below the benchmark could continue to be required to provide extra benefits; this policy would reduce the total amount of system savings, but would also soften the financial impact on beneficiaries at least those who enroll in low-cost plans.⁵⁹ This option would have to be designed carefully to avoid drawing healthier beneficiaries away from Medicare and to avoid putting at risk elderly and disabled beneficiaries, as well as those with modest incomes.

NEGOTIATED PRESCRIPTION DRUG PRICES

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-2.5	-2.9	-3.1	-3.7	-3.5	-4.3	-4.8	-5.3	-6.5	-6.8	-15.8	-43.4
Federal Government	-4.1	-4.7	-5.2	-6.2	-5.8	-7.0	-7.9	-8.8	-10.7	-11.1	-26.0	-71.5
State and Local Government	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.5	0.5	1.3	3.5
Private Employers	1.0	1.1	1.2	1.5	1.4	1.7	1.9	2.1	2.6	2.7	6.2	17.1
Households	0.4	0.5	0.5	0.6	0.6	0.7	0.8	0.9	1.1	1.2	2.7	7.5

Background

Section 1860D-11 of the Social Security Act, enacted in the Medicare Modernization Act of 2003 (MMA), states that the Secretary of Health and Human Services “may not interfere with the negotiations between drug manufacturers and pharmacies and PDP (Medicare prescription drug plan) sponsors” and “may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs.”

Under current law, therefore, the drugs available to enrollees in each drug plan under Medicare Part D are determined by the formulary set by the plan (subject to certain minimum requirements for inclusion), and the price paid by the plan for each drug is subject to negotiation between the plan and the drug manufacturer or distributor. This provision has been controversial since it was enacted, with proponents arguing that it avoids government price-setting and allows the competitive market to function to the benefit of all parties involved, and opponents arguing that Part D plans (and therefore both Medicare and its beneficiaries) pay higher prices than they should, given the tremendous share of the pharmaceutical market represented by Medicare beneficiaries.

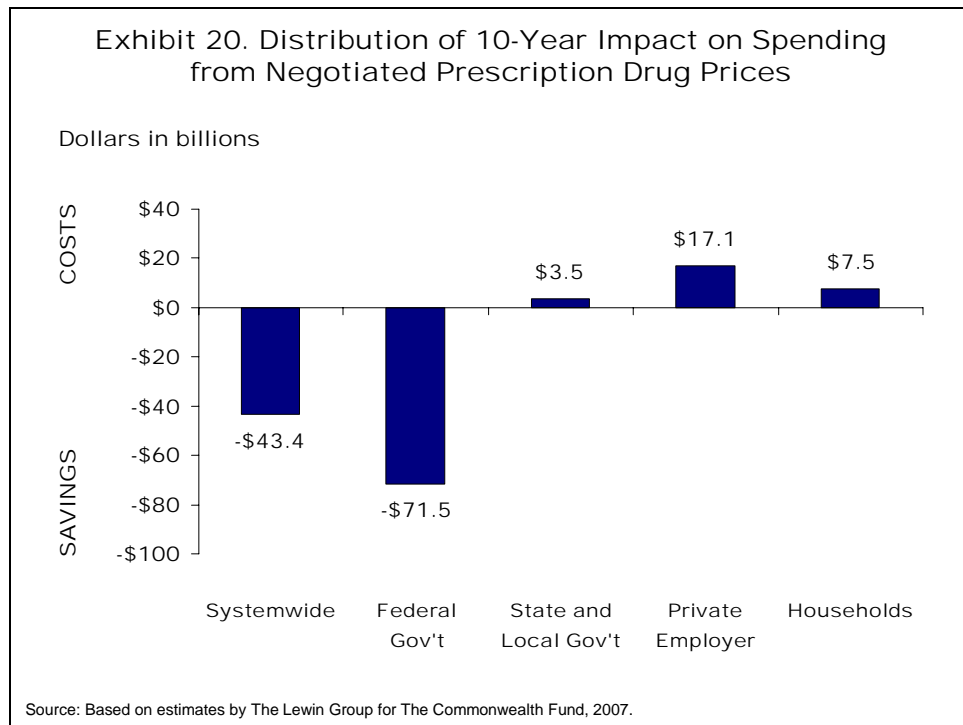
Policy Option

This option would give the Secretary of Health and Human Services the authority to negotiate drug prices for prescription drug plan enrollees. The rationale for this authority is that the Secretary would have greater leverage than the plan’s pharmacy benefit managers do to negotiate greater discounts from drug manufacturers, and costs to Medicare would consequently be reduced.

There are three specific mechanisms under this option for achieving the reduction in drug costs paid by Part D. The first is a mandate that Part D pay the Medicaid rate for prescription drugs for dual eligibles; Frank and Newhouse showed that Medicare is paying a higher rate under Part D for drugs used by dual-eligible beneficiaries than Medicaid pays for the same drugs.⁶⁰ The second, proposed by Frank and Newhouse, is that the Secretary administratively set the price for unique drugs. The third mechanism under this option calls for the Secretary to establish a purchasing collaborative of all public payers. Large employers and multi-employer purchasing groups could participate on a voluntary basis.

Estimated Effect

This policy results in an estimated net savings to national health expenditures of \$15.8 billion over five years, and \$43.4 billion over 10 years (Exhibit 20). The major beneficiary of this policy would be the federal government, which would experience savings of \$71.5 billion over 10 years, while state and local governments, private employers, and households all would experience slight increases in spending over that period.



Discussion

The bulk of the savings under this option would result from paying Medicaid rates for prescription drugs used by dual eligibles under Part D; this provision would reduce Part D spending by \$57.5 billion over 10 years. The additional spending for state and local governments, private employers, and households, as well as some increased spending in

other federal government programs, would result primarily from an increase in drug prices to other payers in response to the decrease in payments for dual eligibles' drugs.

The Congressional Budget Office (CBO) has estimated that modifying the provision that prohibits the Secretary from interfering in drug price negotiations would have a negligible effect on federal spending without the authority to establish a formulary and without other tools to reduce drug prices.⁶¹ While this proposal does not include formulary provisions, it can achieve savings from administered prices for dual eligibles under Part D. Additional savings could be generated if broader tools were included in the proposal. For instance, the Government Accountability Office found that governments in other countries use a range of approaches to limit the amount they pay to acquire drugs, including establishing ceiling prices and negotiating prices directly with drug manufacturers, establishing reference prices for drugs that are therapeutically similar, and limiting profits that can be earned by drug manufacturers in a given period of time.⁶² Careful consideration would have to be given to the impact this option might have on innovation in the development of effective new drugs.

ALL-PAYER PROVIDER PAYMENT METHODS AND RATES

\$ billions	Annual Net Impact										Cumulative Net Impact		
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		2008–2012	2008–2017
National Health Expenditure	1.4	-1.4	-4.9	-8.1	-10.1	-13.8	-17.6	-20.2	-22.3	-25.4		-23.1	-122.4
Federal Government	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0
State and Local Government	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0
Private Payers	1.3	-1.4	-4.3	-6.9	-8.8	-12.1	-15.2	-17.2	-18.8	-21.3		-20.1	-104.7
Households	0.1	0.0	-0.6	-1.1	-1.3	-1.7	-2.4	-3.0	-3.5	-4.1		-2.9	-17.7

Background

The health care system historically has been characterized by cross-subsidies among different payers for most health care services. One factor in the evolution of these cross-subsidies is the large number of patients who lack insurance and therefore can offer no direct payment to providers to offset the cost of the care they use; another is the tendency of Medicaid programs to pay for their beneficiaries' care at rates that are below providers' average costs. Medicare historically has paid at rates that correspond more closely to average cost, but those rates have varied somewhat, and—particularly for physician services under the current sustainable growth rate mechanism—are placing increasing pressure on providers to make up from other sources for absolute or at least relative shortfalls in Medicare revenue. The costs of uninsured, Medicaid, and to some extent Medicare patients traditionally have been offset by payments from private insurers that consistently have exceeded the costs of treating their beneficiaries.

These tacit cross-subsidies have contributed to the steady rise in health care costs. Negotiations between payers and providers based on efficiency (quality and costs) are distorted by the absence of a clearly defined relationship between the costs and the prices of health services. Moreover, when individual payers do attempt to control provider costs by limiting their willingness to underwrite continued cost increases, providers have been able to find other payers from which they are able to extract additional payments to support those cost increases—negating the effects of those cost-dampening efforts.

Policy Option

This option would address the fragmented system under which providers must deal with numerous payment mechanisms, rates, and reporting rules. Under this option, all payers

(except those who make capitated payments to providers) would be required to adopt payment rates and methods like Medicare's for hospitals and physicians, and payment rates for all payers for each type of provider would be posted and publicly accessible. A federal requirement would be established for all hospitals and physicians participating in Medicare that uninsured patients may initially be charged no more than the lowest rate of reimbursement paid by any public or private group insurance payer for similar services received, and balance billing would be prohibited.

Medicare payment rates for hospitals and physicians (and the maximum charge for uninsured patients) would be updated by a mechanism that is based on price change data for each type of provider (the Medicare Hospital Market Basket Index for hospitals and the Medicare Economic Index for physicians), adjusted for annual increases in productivity and the decreases in per-unit costs that result from increased volume; there also would be differential adjustment to payment rates to gradually eliminate the discrepancy in payment rates across payers.

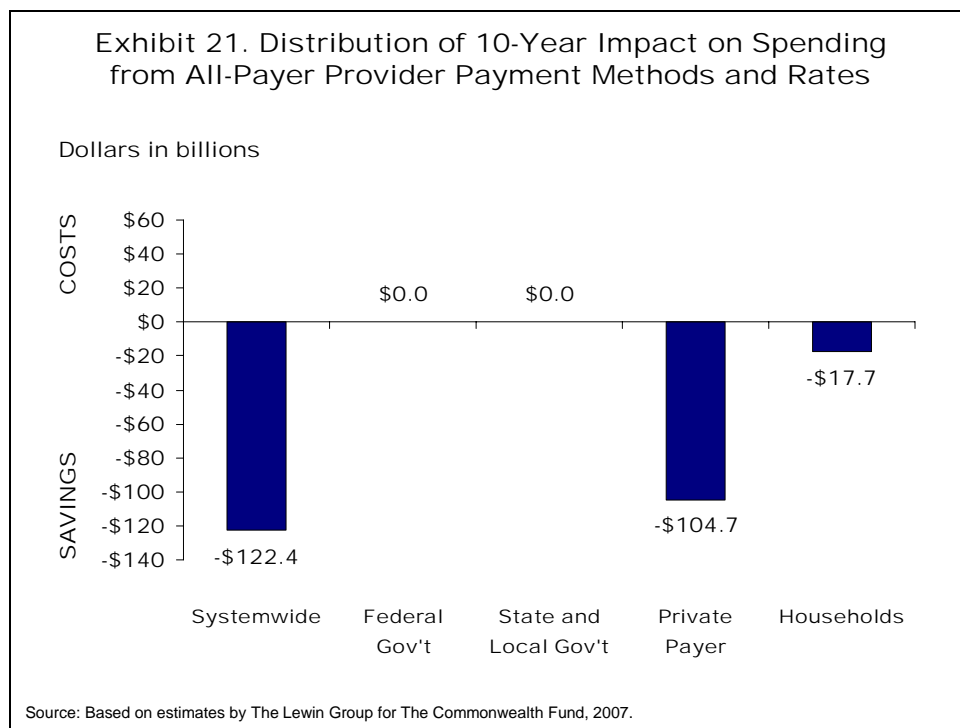
Differential updates would be implemented as follows: each year, payment rates for private payers would be updated by an amount equal to 1 percentage point less than the Medicare update in that year, until the discrepancy between (case-mix adjusted) payment rates for private payers and Medicare is eliminated; each year, payment rates for each state Medicaid program would be updated by an amount equal to 1 percentage point more than the Medicare update in that year, until the discrepancy between (case-mix adjusted) payment rates for Medicaid and Medicare is eliminated.

A supplemental reimbursement pool would be created by an assessment on private insurance premiums equal to one-half of the percentage differential between their payment rates under the reduced update (Medicare update minus 1 percentage point) and what their payment rates would have been if their payment rates had been updated since the first year at the Medicare update. This pool would be used to compensate the states and the federal government for the shares of the additional Medicaid payments they are required to make.

Estimated Effect

This policy results in an estimated net savings to national health expenditures of \$23.1 billion over five years, and \$122.4 billion over 10 years (Exhibit 21). The most direct beneficiary of this option—despite the new assessment that is used to subsidize increased Medicaid payment rates—is the private insurance industry, which consistently has paid more to providers than its patients have cost to treat, subsidizing the uncompensated costs

of providing care to uninsured patients and the low rates paid by Medicaid and other public programs in many states. The benefits to households in this estimate reflect the impact of lower premiums resulting from the lower payment rates that private payers will be required to pay. It is worth noting that the net impact on both the federal and the state budgets is zero, with the subsidies provided from the assessment on private payers offsetting the increased costs of higher Medicaid payment rates.



Discussion

This option will produce some effects not reflected in the estimates presented above. Even after the new assessment on private insurers is used to completely offset the additional costs to the states and the federal government, there remains an unallocated amount (\$34.1 billion). This amount could be used to accomplish several objectives, including (perhaps with an additional assessment on private insurers) creation of an uncompensated care pool to subsidize hospitals for the treatment of uninsured patients—the cost of which is not directly affected in the option as modeled. Alternatively, the pool could be used to fund other improvements in health system performance.

As is the case in most scenarios that address reductions in national health expenditures, the reduction in spending under this option corresponds to a reduction in incomes for some groups—usually some or all providers. In this case, hospitals and physicians receive higher payments from Medicaid, but that increase does not offset a

decrease in the payments they receive from private insurers. Moreover, the distribution of the increase in Medicaid payments does not necessarily match the distribution of the decline in private payments across providers; rather, it favors providers who treat more Medicaid patients (for which payments rise under this option), which may be a more equitable outcome, but does not address the decreases in revenue faced by providers who may treat more uncompensated care patients (for which they do not receive additional payment under this option as modeled). That consideration may further argue for a modification of this policy (again, supplemented perhaps by an increased assessment on private insurers—since they realize net savings of more than \$100 billion on the option as modeled) to create an uncompensated care pool or to help underwrite other initiatives to make insurance more affordable.⁶³ To avoid undermining safety net providers, it would be necessary to use some of the savings either to bolster uncompensated care pools or to finance coverage expansions.

LIMIT PAYMENT UPDATES IN HIGH-COST AREAS

\$ billions	Annual Net Impact										Cumulative Net Impact	
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
National Health Expenditure	-3.7	-6.1	-8.5	-11.0	-13.8	-16.8	-19.7	-22.8	-26.0	-29.3	-43.1	-157.8
Federal Government	-6.1	-10.1	-13.9	-18.1	-22.7	-27.6	-32.5	-37.5	-42.9	-48.3	-70.9	-259.7
State and Local Government	0.3	0.5	0.7	0.9	1.1	1.3	1.6	1.8	2.1	2.3	3.4	12.6
Private Employers	1.5	2.4	3.3	4.3	5.4	6.6	7.8	9.0	10.2	11.5	16.9	62.1
Households	0.6	1.1	1.5	1.9	2.4	2.9	3.4	4.0	4.5	5.1	7.5	27.3

Background

The growth in Medicare spending has been and continues to be a concern, accounting for 3.1 percent of the nation’s gross domestic product (GDP) in 2006—more than double the share of GDP that it represented 25 years earlier.⁶⁴ Over the past two decades, Medicare has shifted from reimbursement based on each provider’s costs or charges to an array of payment systems that provide a fixed payment for each unit of service; the two major examples of these new payment systems are the prospective payment system (PPS) for inpatient hospital services and the resource-based relative value scale (RBRVS) for physician services. Since the implementation of these systems, Medicare spending growth has slowed somewhat, but it continues to exceed GDP growth, and is projected to rise to 6.5 percent of GDP by 2030.

One of the objectives of both the PPS and the RBRVS was to reward efficient providers by providing a payment for each service roughly based on the average costs of providing the service. High-cost providers would therefore face an incentive to reduce their costs below the payment rate while low-cost providers would benefit by retaining the difference between their payment rates and their costs. However, for both hospital and physician services, the overall costs incurred by Medicare depend not only on the payment rate per service, but also on the number of services provided to each patient over the episode of illness—which can vary considerably across geographic areas.⁶⁵

Despite this geographic variation, the updates to both hospital payment rates and physician fees, which are designed to reflect annual increases in the costs of efficiently producing health care, are applied nationally; they are not affected by differences in the

level of costs per beneficiary in each area. The same update is applied in Miami, Florida—where Medicare spending per beneficiary was \$11,352 in 2003—and Salem, Oregon—where Medicare spending per beneficiary was \$4,273 in the same year.⁶⁶

Policy Option

This option would focus pressure on high-cost regions to avoid across-the-board adjustments or constraints that would penalize low- as well as high-cost regions. This policy change would adjust the updates to both hospital payment rates and physician fees in each area (defined for this purpose as a metropolitan area or the combined rural areas in each state) to reflect the level of total Medicare Part A and Part B spending per beneficiary in that area, relative to the national average.

The basic updates for hospital and physician services would be based on the projected increases in the Medicare Hospital Market Basket Index (MBI) and the Medicare Economic Index (MEI), respectively, which reflect the nationwide costs of inputs used in providing those services. The area-level adjustment to the basic updates would be as follows.

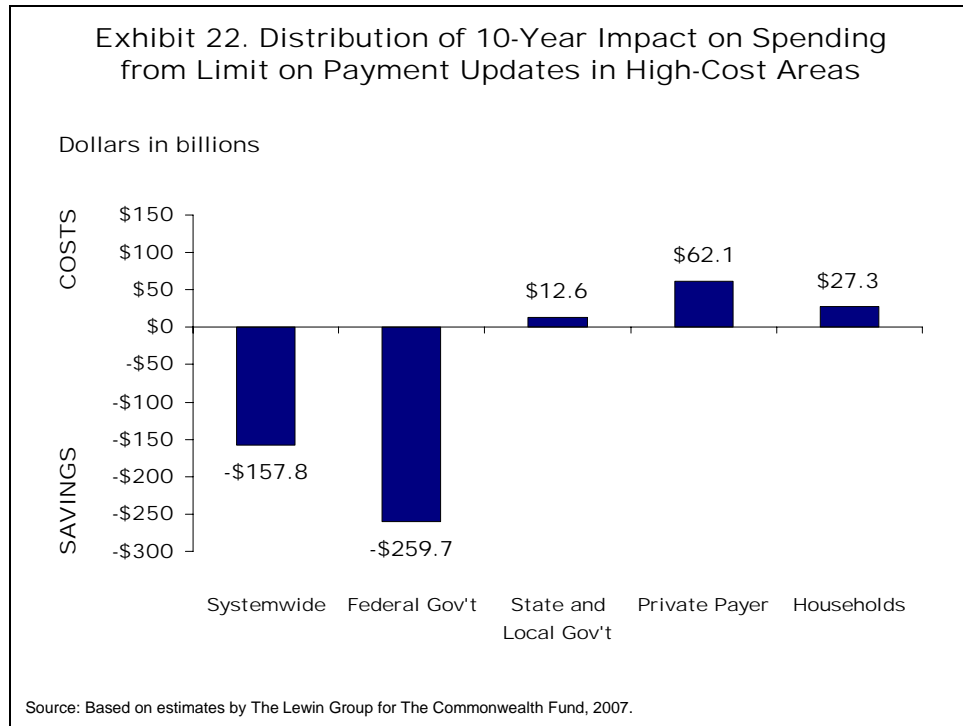
- For areas with Medicare Part A and Part B spending per beneficiary greater than the 75th percentile of the distribution across all areas (weighted by the number of Medicare beneficiaries residing in each area): no update.
- For areas with spending per beneficiary between the 50th and 75th percentiles: a sliding scale from 0 percent to 100 percent of the basic update described above, depending on the ratio of combined Part A and Part B spending per beneficiary in the area to the median combined Part A and Part B spending per beneficiary across all areas.
- For areas with spending per beneficiary at or below the 50th percentile: the full basic update.

For purposes of this mechanism, certain primary care and preventive services (such as evaluation and management services and the administration of pneumococcal vaccine) would not be included in calculating Part A and Part B spending when determining the update formula.

Estimated Effect

This policy results in an estimated net savings to national health expenditures of \$43.1 billion over five years, and \$157.8 billion over 10 years (Exhibit 22). As would be expected, the federal government is the primary beneficiary of this option, with Medicare

savings of \$262.9 billion over 10 years, offset only slightly by an increase in costs to other federal programs of \$3.2 billion due to increases in the volume of services provided by hospitals and physicians in the high-cost areas in which the Medicare payment updates are reduced. State and local governments, private employers, and households similarly experience small spending increases in the option as modeled, due to increases in service volume in response to reduced payment updates in high-cost areas.



Discussion

This option was modeled with basic updates for hospital and physician services determined by annual increases in the MBI and the MEI, respectively. Although that assumption reflects the actual experience with hospital payments in recent years, it reflects neither the recent experience with physician fees nor projections for the near future. Since 1991, the annual update in physician fees has been adjusted to reflect the nationwide growth in the volume and intensity of services and total spending relative to a target.⁶⁷ However, despite this attempt to offset the incentive to provide more—and more complicated—services, physician spending has grown faster than intended. As a result, physician fees have been subject to cuts in every year since 2002, although Congress has intervened in almost every case to avoid those cuts. Meanwhile, it has left the current mechanism in place, because replacing it would remove any nominal mechanism for controlling volume and intensity, and because the elimination of the projected future cuts that are built into the budget

baseline would increase spending counted against the budget deficit by hundreds of billions of dollars over the next decade.

Because the current mechanism is not sustainable in the long run—and because it is difficult to project whether and to what extent Congress may intervene in the future to prevent large decreases in physician fees—this option has been modeled on an alternative update mechanism for physician fees similar to that recommended by the Medicare Payment Advisory Commission for the past several years.⁶⁸ It should be noted, however, that because the current mechanism updates physician fees uniformly across the country, the adjustment of the update to reflect geographic differences in spending might be expected to have a similar effect. However, unless they followed Medicare’s lead, other payers could see higher costs from cost-shifting.

COMBINING SAVINGS OPTIONS WITH AFFORDABLE HEALTH INSURANCE FOR ALL

Universal participation, with insurance that provides access and financial protection, is essential for a high performance health system.⁶⁹ The opportunity to receive high-quality care begins with and depends on access. If designed well, universal coverage also can provide a foundation for improving quality and achieving short- and longer-term savings.

Having a large segment of the U.S. population uninsured or intermittently insured contributes to the high costs of health care and undermines quality, outcomes, and the health of the population. Our fragmented insurance system, with multiple reporting, paperwork, and payment systems, as well as costs associated with churning in and out of coverage, drives up premium costs and also administrative costs for physicians, hospitals, and other components of the health care delivery system.⁷⁰

Under the current fragmented U.S. insurance system, it is also difficult to craft an integrated approach to changing incentives so that they reward rather than discourage improved health care and lower costs. Although Medicare, Medicaid, and private insurance plans can innovate, each accounts for only a share of health care markets and therefore can only partially influence how well those markets work. Thus, in addition to improving access and financial protection, efforts to secure affordable health insurance for all—if they are designed to enable more coherent, integrated, and efficient pricing and payment policies—have the potential to achieve overall health systems savings.

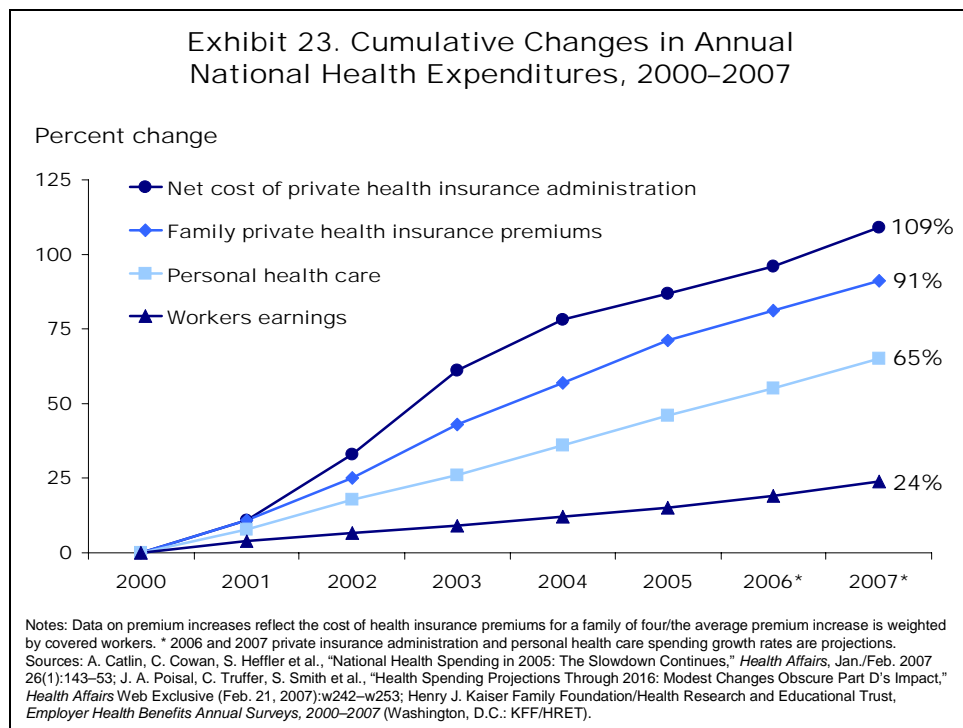
Background

Currently, the U.S. population is insured through a complex mix of public programs and private insurance plans that leaves an estimated 47 million uninsured and millions more underinsured.⁷¹ Affordability is a central concern for low- and modest-income individuals and families. While Medicaid and state children's health insurance programs (SCHIP) are available for children in low-income families, Medicaid is not available for poor or modest-income adults under age 65, except in a few states.⁷²

The current mix of private insurance is expensive to administer, particularly in small-group and individual insurance markets. The net administrative costs of health insurance have more than doubled over the past 10 years—rising much faster than total national health expenditures. These overhead costs currently amount to 7.3 percent of national health expenditures, or more than \$400 per person—two to three times levels in other countries. These higher overhead costs reflect more complex, fragmented insurance arrangements characterized by frequent changes in coverage.

In 2004, if the U.S. had been able to lower the share of health care spending on insurance overhead to the same level found in the three countries with the lowest rates, it would have saved \$97 billion a year.⁷³ If the U.S. had matched the insurance administrative spending of other countries with mixed public/private insurance systems such as Germany and Switzerland, it could have saved \$32 billion to \$46 billion a year. These cost differentials do not take into account the administrative costs within physician practices or hospitals.

Between 2000 and 2005, the net insurance administrative overhead—including both administrative expenses and insurance industry profits—increased by 12.0 percent per year, 3.4 percentage points faster than overall average health expenditure growth.⁷⁴ As illustrated in Exhibit 23, the cumulative increase in net private insurance administrative costs has outstripped premiums and national health expenditures, and far exceeds the increase in average labor costs.



The current insurance system also operates with widely varying payment rates for the same care, depending on the insurance held by the patient. Rate differentials provide incentives and opportunities to “shift” costs by setting prices higher for those with less ability to negotiate market rates. Private insurance payment rates average 20 percent above Medicare rates for physicians, particularly for specialists, and 35 percent higher for hospitals; meanwhile, Medicaid payment rates average 30 percent below Medicare rates

for physicians and 2 percent lower for hospitals.⁷⁵ As a result, it is difficult to develop a coherent set of incentives to align payment and policies to improve performance. Moreover, low Medicaid rates put beneficiaries at risk, since lower reimbursement rates make it more difficult to establish adequate provider networks.

To examine the potential of a bundled approach that combines individual options for achieving savings within a context of affordable coverage for all, we used a policy proposal intended to expand affordable coverage through a blend of private and public group health insurance. As are the individual options described previously in this report, this scenario is presented as one of a range of proposals aimed at accomplishing its intended objective. We refer to it as the Insurance Connector approach.

COMBINING OPTIONS TO ACHIEVE SAVINGS WITH THE INSURANCE CONNECTOR APPROACH

Annual Net Impact: Insurance Connector Approach Plus Savings Options*

Cumulative Net Impact

\$ billions	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

* In some cases, because of rounding, the sum of the payer group impact does not add up to the national health expenditures total. Options include: Promoting Health Information Technology; Center for Medical Effectiveness; Public Health: Tobacco Use and Obesity; Episode of Care Payment; Strengthening Primary Care and Care Coordination; Benchmark Rates for Medicare Plans, and Negotiated Prescription Drug Prices.

The insurance scenario used in this analysis follows the design principles in the Commission report, *Roadmap to Insurance for All: Principles for Reform*. The Lewin Group first modeled estimated spending under the Insurance Connector scenario. Lewin then estimated the net effect if that scenario were combined with policy changes intended to encourage the production and use of better information, promote health and prevent disease, align incentives with quality and efficiency, and correct price signals in the health care market. The specifications used to develop these estimates were as follows:

- ***The Insurance Connector Approach: Mixed Private–Public Group Coverage***

This insurance scenario includes creation of a new, national “Insurance Connector” that builds on and links current private and public group insurance by offering a structured choice of private health plans and Medicare. This option would be available to all individuals lacking access to group coverage and to small firms with fewer than 100 employees. The Medicare option would use current Medicare provider payment rates and fiscal claims intermediaries, and would offer an enhanced benefit package to avoid the need for supplemental coverage. The Connector would also offer a choice of private, integrated health plans. All plans sponsored through the Connector, including Medicare and alternative private plans, would be offered at adjusted community rates.⁷⁶

To ensure that coverage is affordable, the insurance option would include premium assistance related to income and would make Medicaid available for any household with an income at or below 150 percent of the federal poverty level. To equalize and integrate Medicare and Medicaid payment policies, Medicaid payment rates would be increased to Medicare levels. To achieve near-universal and affordable coverage, enrollment in some plan would be required, with automatic enrollment through the tax system. Appendix A provides further details of specifications used for modeling the Insurance Connector approach.

- ***Savings Options Combined with the Insurance Connector Approach***

To illustrate the potential of a multifaceted approach, we examined the first-order savings effects of what might happen if the Insurance Connector approach were combined with options that focused on achieving savings and enhancing value. From the options described above, we selected a subset most likely to be mutually supporting. The savings from this subset also do not “overlap”—that is, we avoided cases in which there would be double-counting of savings.

The options selected include:

- Promoting Health Information Technology
- Center for Medical Effectiveness and Health Care Decision-Making
- Public Health: Reducing Tobacco Use
- Public Health: Reducing Obesity
- Episode-of-Care (for episodes involving acute hospitalizations only)
- Strengthening Primary Care and Care Coordination
- Reset Benchmark Rates for Medicare Advantage Plans
- Negotiated Prescription Drug Prices

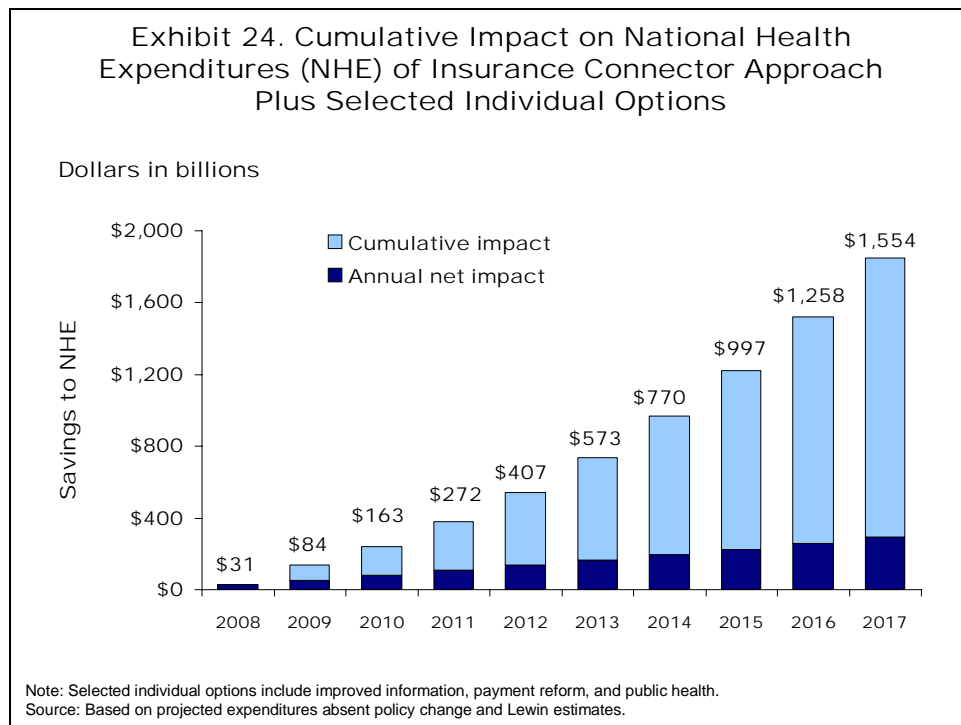
In the context of the Insurance Connector, the payment options that apply specifically to Medicare would apply to a larger share of the population. Lewin thus adjusted the estimates and computed the additive effect of a combination approach.

It is important to note that the modeling here does not account for possible synergistic effects of the individual options or of the individual options with the availability of coverage for all. For example, clinical, coverage, and payment decisions in an environment with both widespread HIT *and* better information on

clinical and cost-effectiveness could improve to a considerably greater degree than they would within a system that had only better HIT or better evidence. Similarly, the effect of combining enhanced payment for primary care and care coordination with more integrated delivery systems connected through information exchange could be more than the sum of the two individual effects. Therefore, the Lewin results represent a conservative “first-order” estimate, and probably understate what could be achieved by combining universal coverage with better information, public health initiatives, aligned incentives, and corrected price signals.

Estimated Effect

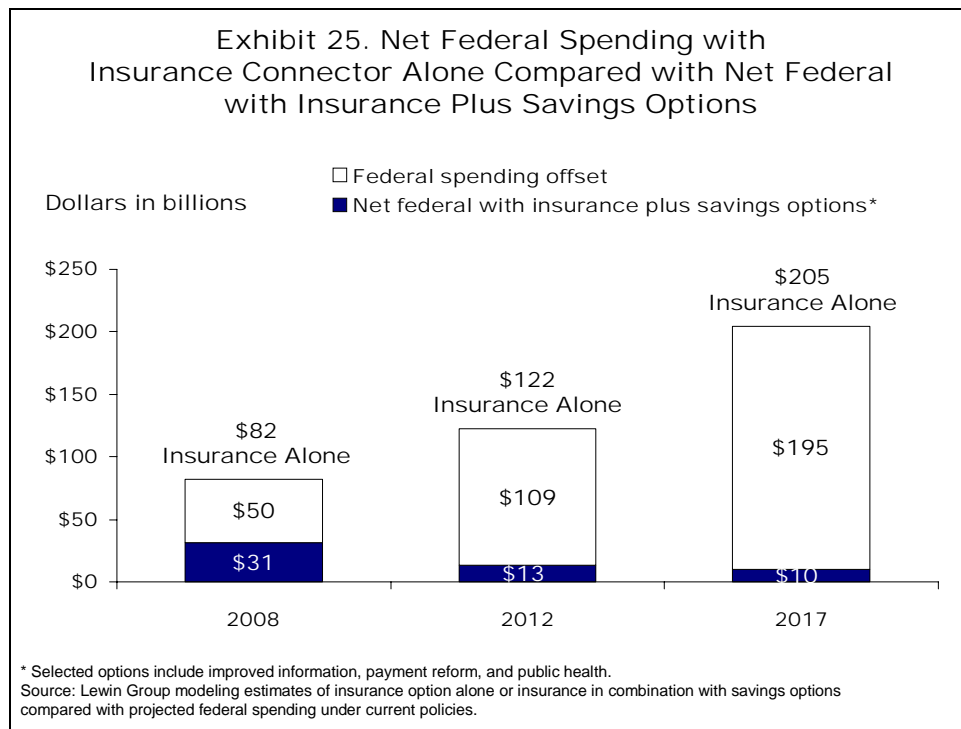
The estimates presented in the table above and in Exhibit 24 below illustrate the potential of multifaceted approaches for addressing short- and longer-term projected cost increases. In the first year, the estimates indicate net national savings of \$31 billion, as savings more than offset the cost of insurance expansion. Over the 10-year period, multiple years of savings add up to a \$1.55 trillion cumulative difference in expenditures below projected trends.



The substantial \$1.5 trillion reduction in national expenditures represents the cumulative effect of relatively small percentage changes in each year. The cumulative effect on expenditures of the combination of options grows rapidly year by year: the estimated reduction over 10 years is more than 50 times larger than that in the first year. Compared with the \$4 trillion the nation is expected to spend 10 years from now—and

the more than \$33 trillion in cumulative spending projected over that 10-year period—the reductions are modest, but they add up to substantial savings that could be available to address other societal needs.

The modeling also indicates the potential of a multifaceted approach for yielding savings that could help offset the federal costs of financing insurance for all. In the first year, savings options could reduce net federal outlays by more than half of what they would be in the Insurance Connector scenario alone. By the end of a decade, the net federal costs could be negligible if bundled with options that focus on improving both the effectiveness and efficiency of care (Exhibit 25).



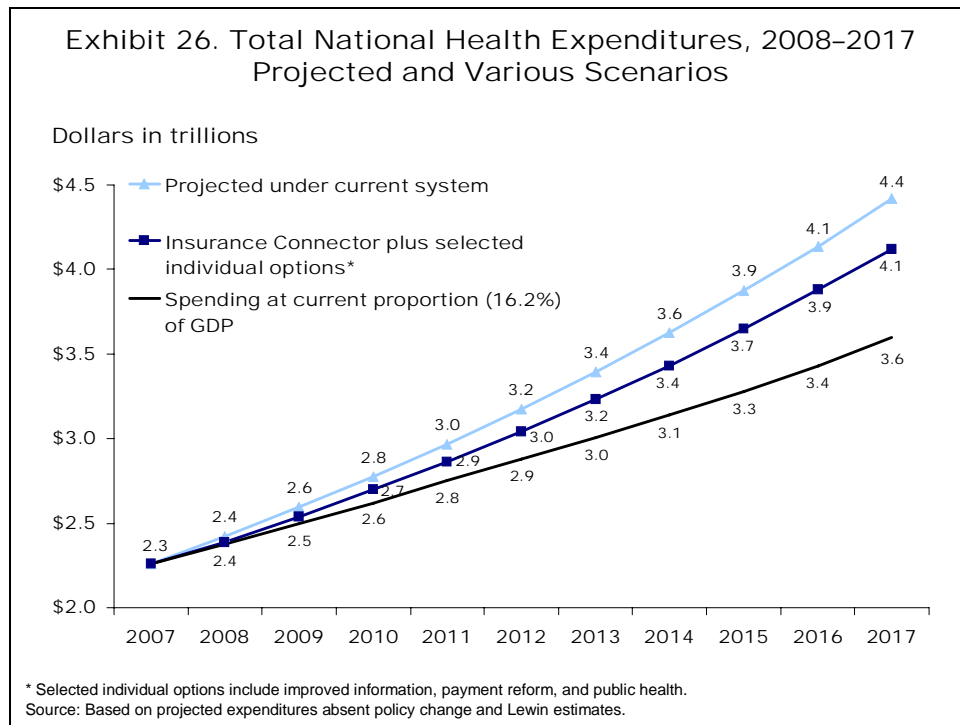
Discussion

This combination option illustrates the potential benefits of combining broad changes intended to achieve universal coverage with specific policy changes to achieve savings in health spending. The universal coverage option by itself is estimated to result in an increase in national health expenditures of \$218 billion over 10 years, but when combined with targeted savings policies described earlier in this report it achieves substantial net savings.

Moreover, the potential exists for sharing savings across all major payer sectors. The federal government, which was projected to experience a large increase in spending over the next 10 years using only the universal coverage option, is projected to experience

modest increases over time with this combination option. State and local governments, which were projected to experience a decrease in spending using only the universal coverage option, are projected to experience still greater savings under the combination of policies modeled here. Private employers, which were expected to experience an increase in spending using only the universal coverage option, are projected to experience a more modest increase in spending under the combined option. Households, under both scenarios, achieve substantial savings.

Savings of this magnitude, although substantial, would succeed in “bending the curve” to about halfway between the currently projected trend and the amount that would maintain the current proportion of national income devoted to health spending. At this rate, as illustrated in Exhibit 26, national health expenditures in 2017 would be held to 18.5 percent, rather than the projected 19.8 percent if current trends continue.



Savings on this scale—\$1.5 trillion—represent an extremely large amount of resources that could be available to address other societal needs or goals, either within the health system or elsewhere in the economy. Moreover, in an environment in which affordable health care is available and markets operate with better information and payment reform, even greater savings might be achievable as policies interact to produce dynamic, synergistic gains over time.

Achieving the necessary changes in the way that health care is delivered and paid for will be a challenge, even though the “savings” from these policy changes would come primarily from reductions in the future growth, not the absolute amount, of health spending. With the level of health spending exceeding \$2 trillion, billions of dollars in revenue and payments for providers and insurers—and tax dollars for the federal as well as state and local governments—are at stake. Changing the way that spending is distributed means changing the flow of income to the many groups that currently depend on and expect future increases. The insurance option modeled in the scenario relies on administrative cost savings and the adoption of Medicare payment rates to providers for a large share of the patients treated by physicians and hospitals. The savings options 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 require effective policies to effect change. And information system enhancements require successful implementation and adoption, which may require substantial investment at the outset.

Embarking on such a multifaceted approach will require building consensus and a focus on gains in performance for the nation. The modeling indicates that potential savings could offset the costs of investing to improve performance and expand insurance to all. The projected cumulative effects point to the need to start sooner rather than later and craft coherent policies that enable a more integrated, whole-system approach.

SUMMARY AND CONCLUSIONS

As noted at the outset, the goal of the analysis is to spark discussion of possible federal policy actions that could put the nation on a path toward more sustainable spending growth, with improved access, quality, and outcomes. This options report was prepared on behalf of the Commission to help inform and assess potential approaches and to galvanize action to move in a new direction. The policies are presented as options rather than recommendations, to spur and inform debate and start to build consensus on a course of action that could address national health care costs in a manner that would yield greater value and better population health. The options represent a range of approaches to addressing inefficiencies and other factors in the current health care delivery and financing systems that contribute to high and rising costs.

The focus in this report is on federal policies, because changes at the federal level would probably have the broadest immediate effects on national health spending and because those changes present the clearest, most definable models. However, states and private payers, as well as the federal government, confront the same underlying factors that contribute to high and rising costs. Many of these options could be implemented by private payers and by states through their Medicaid, state employee, or other state-sponsored programs. Indeed, for most of the options discussed in this report, collaboration across the public and private sectors and at different levels of government would enhance and accelerate the potential to moderate cost trends and achieve better value for the dollars we invest in health care. National leadership will be critical for these efforts, with both the potential benefits and the necessary costs and sacrifices needing to be shared by all.

Federal policy changes will also be essential to achieving nationwide change. Any approach that seeks to change the trajectory of national health expenditures would require federal participation and national leadership as well as coherent policies and actions that span the public and private sectors. With its national scope, Medicare has often been the source of innovations in payment policies, including the prospective payment system for hospitals and the resource-based relative value scale for physicians. The policy innovations have provided encouragement and served as models for private insurance and states to enact their own changes. Moreover, federal leadership will be instrumental in achieving affordable health insurance coverage for all, given the wide geographic disparities and gaps in coverage under the current system.

The findings presented here illustrate that it would be possible to reduce national expenditures over the next decade while also improving access, quality, and population health. Achieving significant savings, however, will require a combination of policies that

enable the production and use of better information for health care decision-making, health promotion and disease prevention, closer alignment of financial incentives with health quality and efficiency, and correction of price signals in the health care market. Applying these policies collectively would capture the synergistic effects of specific innovations and could bring about dynamic change. Moreover, any policies aimed at accomplishing those objectives could be more effective in combination with affordable health insurance coverage for all, because they would apply to a larger share of the population and enable a more integrated approach to health care delivery and financing.

The estimated effects of combining individual options in the context of affordable coverage for all could reduce projected health spending by \$1.5 trillion over the next 10 years. These estimated savings succeed in ‘bending the curve’ about half way from the currently projected trend to the amount that would maintain the current proportion of GDP devoted to health spending. Savings in national health expenditures of \$1.5 trillion represent an extremely large amount of resources that could be available to address other societal needs or wants. Moreover, in an environment in which affordable health care is available and markets operate with better information and payment reform there is reason to believe that even greater savings might be achievable as policies interact to produce dynamic, synergistic gains over time.

Modeling complex policy changes is inherently challenging and risky. The technical challenges include the uncertainty of estimating dynamic effects over a number of years. Also, these estimates are based on the assumption of effective design and implementation, and therefore do not reflect the difficulty of achieving agreement on the design of complex policy changes and the organizational adjustments required to implement them successfully.

The stakes are very high, however, if we continue on the current path of escalating costs and eroding coverage. Envisioning and examining potential new policy directions are critical to the future health and economic security of the nation. Consequently, the Commission has sponsored this analysis of options to stimulate broader discussion of how to move the health care system in the right direction and to illustrate that it would be possible to achieve savings and improve value.

Achieving these savings will require leadership in developing and implementing a set of coherent policies that address the multiple sources of high and rising costs in the U.S. health system. The effort will not be easy, and will require collaboration and a focus on the potential national gain. Building consensus on a shared vision of a better future will

be critical to action. Finding common ground will require a balanced view and a transcending of specific interests or ideologies to develop policies that could put the U.S. on a trajectory toward a health system that leads the world in health outcomes and innovation, reduces the fiscal pressure on federal as well as state and local government, and provides economic security for families and businesses.

Cross-Cutting Themes and Conclusions

Looking across the results of the analysis, several key themes emerge:

- **Improvement is possible and it is urgent to start now.** The consequences of continuing the status quo, with respect to both human and economic costs, are very significant. The numbers of the uninsured are up sharply, and are moving up the economic ladder into middle-income families. Costs are squeezing households, businesses, and the public sector with spreading insecurity. The options illustrate that cost-savings are achievable in the context of a high performance health system. They also demonstrate that earlier enactment of even modest measures has the potential for later long-term benefits.
- **Better information is key to improved performance.** It is difficult to improve the system without information on current performance—nationally, locally, and at the individual provider level. Transparency of information on quality and price is essential to a number of policies aimed at achieving higher performance. A valid, publicly available database on provider performance, appropriately adjusted for patient conditions, is critical to focusing providers on improving both quality and efficiency, enabling payers to construct rewards and other mechanisms that encourage such behavior, and providing patients with the information they need to make appropriate choices. Data on the patterns and causes of variations in spending across geographic areas are essential for developing policies to narrow such variations and provide consistently effective and appropriate care regardless of location.
- **Focusing on total health system costs, not shifting costs among sources of financing, should be the focus of policy action.** Many of the policies proposed in the past have simply shifted costs from one payer source to another—from government to employers or from payers to beneficiaries and patients. Narrow policies to cut governmental budget outlays by simply displacing those costs onto Medicare beneficiaries or paying substandard rates to providers under Medicaid are stop-gap measures that do not fundamentally address underlying health care cost trends.

- **There are no magic bullets that by themselves fully address rising costs and key sources of inefficiency.** Just as the steady increase in costs by comparison with incomes—which is projected to worsen over time—represents the cumulative effect of multiple and interacting factors, tackling cost levels and trends will require a coherent set of policies aimed at rectifying misaligned incentives and structural flaws that permeate our health system and produce the cost pressures we face. Design and effective implementation of policies matter. The solutions are not simple, and will require risk-taking and a willingness to invest, learn, and allow time for health systems and system capacity to improve through innovation.
- **A multifaceted approach integrated with health insurance coverage for all can be designed to achieve substantial reductions in future spending growth.** Using a bundled approach, integrated with universal coverage focused on system performance, we should be able to reduce the growth of spending significantly over the next decade while maintaining and enhancing the health system’s capacity to improve and innovate. But we need to start now, with a strategic, coherent set of goals, policies, and incentives designed to address underlying factors contributing to costs without adding commensurate value.
- **Value means more than savings in national health expenditures.** Higher value includes improved performance on quality, equity, access, and healthy lives, in addition to savings. A policy proposal that generates a modest savings but achieves substantial improvement in access or health outcomes may be as valuable, or more so, than one that generates larger savings, but with minimal improvements in attaining other health system goals. Options that extend health insurance to all, promote the public’s health, improve information and lead to more-informed patient decisions, enhance quality and care coordination, and eliminate waste, duplication, and unnecessary care all contribute to value and performance.
- **Reaching consensus will require a focus on the potential gain for the nation.** This report focused on options that are win-win—that is, that both achieve savings and contribute to improving key dimensions of health system performance. Yet, approaches that substantially reduce projected expenditures over time will by definition decrease revenues for some segments of the health care sector.
- **Achieving high performance will require that every stakeholder take part in finding solutions.** Across the options, the estimated distribution of savings or net new cost varies among major payers—the federal government, state and local governments, employers, and households. Achieving national health system savings may require a shift in payment sources and an increase in federal outlays. It will also require that providers be willing to address past inequities where those

providers caring for the uninsured and poor received lower compensation than those serving privately insured patients. Narrow self-interest is a major barrier to changes that have the potential to benefit all. Constructive approaches will also require political compromises, not ideological purity. As a nation, we will need to move beyond the point where everyone's second choice is the status quo.

- **Leadership is critical.** Building consensus will require leadership and public-private collaboration, and a coherent set of goals, policies, incentives, and tools. Options will work better if public and private policies align toward a common aim of achieving a high performance health system. Consensus will also require a whole-system view: aiming for improved cost trends while improving population health and achieving continuous improvement over time.

In summary, the range of options considered in this report illustrates strategic approaches that could, in combination, ease cost pressures and move toward a higher performance, high-value health system. As a nation, we will all gain if we focus on improving the value we obtain for the \$2 trillion that we are now spending on health care—a sum that will continue to consume a greater share of our nation's economic resources without yielding commensurate gains in value if we fail to act. With rising costs stressing business, family, and public budgets, and with one in four adults uninsured, much is at stake.

NOTES

- ¹ J. Cylus and G. F. Anderson, [*Multinational Comparisons of Health Systems Data, 2006*](#) (New York: The Commonwealth Fund, May 2007).
- ² C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "[U.S. Health System Performance: A National Scorecard](#)," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475.
- ³ J. E. Wennberg, E. S. Fisher, and J. S. Skinner, "Geography and the Debate over Medicare Reform," *Health Affairs* Web Exclusive (Feb. 13, 2002):w96–w114.
- ⁴ K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, [*Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*](#) (New York: The Commonwealth Fund, May 2007).
- ⁵ J. A. Poisal, C. Truffer, S. Smith et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs* Web Exclusive (Feb. 21 2007): w242–w253.
- ⁶ A. Catlin, C. Cowan, S. Heffler et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53.
- ⁷ C. Borger, S. Smith, C. Truffer et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive (Feb. 22, 2006): w61–w73.
- ⁸ C. White, "Health Care Spending Growth: How Different Is the United States from the Rest of the OECD?" *Health Affairs*, Jan./Feb. 2007 26(1):154–61.
- ⁹ C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, [*Public Views on Shaping the Future of the U.S. Health Care System*](#) (New York: The Commonwealth Fund, Aug. 2006).
- ¹⁰ Calculated from the Kaiser Family Foundation/Health Research and Educational Trust Annual Employer Health Benefits Surveys and U.S. Census Bureau data.
- ¹¹ M. Merlis, D. Gould, and B. Mahato, [*Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets*](#) (New York: The Commonwealth Fund, Feb. 2006).
- ¹² E. Gould, *Health Insurance Eroding for Working Families: Employer-Provided Coverage Declines for Fifth Consecutive Year* (Washington, D.C.: Economic Policy Institute, Sept. 2006).
- ¹³ T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* Web Exclusive (Apr. 5, 2005):w5-143–w5-151.
- ¹⁴ C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, 2007).
- ¹⁵ C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "[Insured But Not Protected: How Many Adults Are Underinsured?](#)" *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.
- ¹⁶ National Center for Health Statistics, *Health, United States, 2006* (Hyattsville, Md.: U.S. Department of Health and Human Services, 2006):381.
- ¹⁷ Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2007 Annual Report* (Washington, D.C.: U.S. Department of Health and Human Services, Apr. 2007):34.
- ¹⁸ Poisal, Truffer, Smith et al., "Health Spending Projections," 2007; and Kaiser Family Foundation, *Briefing Charts on the Federal Budget: Implications for Medicare and Medicaid*. (Menlo Park, Calif.: Kaiser Family Foundation), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50837>. Accessed June 16, 2007.
- ¹⁹ Kaiser Family Foundation, *Briefing Charts*, 2007.

- ²⁰ M. E. Chernew, R. A. Hirth, and D. M. Cutler. “Increased Spending on Health Care: How Much Can the United States Afford?” *Health Affairs*, July/Aug. 2003 22(4):15–25.
- ²¹ K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, [*Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*](#) (New York: The Commonwealth Fund, Jan. 2007).
- ²² C. Angrisano, D. Farrell, B. Kocher et al., *Accounting for the Cost of Health Care in the United States* (San Francisco: McKinsey Global Institute, Jan. 2007).
- ²³ Centers for Medicare & Medicaid Services, Office of the Actuary. Data from http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage. Accessed June 17, 2007.
- ²⁴ Davis, Schoen, Guterman et al., *Slowing the Growth*, 2007.
- ²⁵ The Lewin Group worked off specifications provided by Commission staff. John Sheils at the Lewin Group directed the project team that included Jonathan Smith and Randy Haught. Lewin drew on existing studies and their insurance modeling capacity to provide the estimates.
- ²⁶ Centers for Disease Control and Prevention, “Chronic Disease Overview” Web site: <http://www.cdc.gov/nccdphp/overview.htm#2>. Accessed Oct. 2, 2007.
- ²⁷ “Medicare Facts & Figures,” available from the CMS Web site at <http://www.cms.hhs.gov>. Accessed Oct. 2, 2007.
- ²⁸ The Dartmouth Atlas of Health Care contains data from a population-based survey regarding resource inputs, utilization, and outcomes of care among 3,436 hospital service areas and 306 hospital referral regions in the United States and is available at <http://www.dartmouthatlas.org>.
- ²⁹ K. Baicker and A. Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” *Health Affairs* Web Exclusive (Apr. 7, 2004):w4-184–w4-197.
- ³⁰ B. Starfield, L. Shi, and J. Macinko, “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly*, 2005 83(3):457–502.
- ³¹ Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, D.C.: MedPAC, June 2007).
- ³² Catlin, Cowan, Heffler et al., “National Health Spending in 2005,” 2007.
- ³³ The Lewin Group worked off specifications provided by Commission staff. John Sheils at the Lewin Group directed the project team that included Jonathan Smith and Randy Haught. Lewin drew on existing studies and their insurance modeling capacity to provide the estimates.
- ³⁴ B. Chaudry, J. Wang, S. Wu et al., “Systematic Review: Impact of Health Information Technology on Quality, Efficiency, and Costs of Medical Care,” *Annals of Internal Medicine*, May 16, 2006 144(10):742–52.
- ³⁵ A. K. Jha, T. G. Ferris, K. Donelan et al., “How Common Are Electronic Health Records in the United States? A Summary of the Evidence,” *Health Affairs* Web Exclusive (Oct. 11, 2006): w496–w507.
- ³⁶ B. Middleton, “Achieving U.S. Health Information Technology Adoption: The Need for a Third Hand,” *Health Affairs*, Sept./Oct. 2005 24(5):1269–72.
- ³⁷ K. K. Shea, A. Shih, and K. Davis, [*Health Care Opinion Leaders’ Views on the Quality and Safety of Health Care in the United States*](#) (New York: The Commonwealth Fund, July 2007).
- ³⁸ Davis, Schoen, Guterman et al., *Slowing the Growth*, 2007.

³⁹ E. S. Fisher, D. E. Wennberg, T. A. Stukel et al., “The Implications of Regional Variations in Medicare Spending, Part 1: The Content Quality, and Accessibility of Care,” *Annals of Internal Medicine*, Feb. 18, 2003 138(4):273–87.

⁴⁰ A. M. O’Connor, H. A. Llewellyn–Thomas, and A. B. Flood, “Modifying Unwarranted Variations in Health Care: Shared Decision Making Using Patient Decision Aids,” *Health Affairs* Web Exclusive (Oct. 7, 2004):var-63–var-72.

⁴¹ G. Anderson, R. Herbert, T. Zeffiro et al., *Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update* (Baltimore: Partnership for Solutions, Sept. 2004); E. A. McGlynn, S. M. Asch, J. Adams et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, June 26, 2003 348(26):2635–45.

⁴² Wennberg, Fisher, and Skinner, “Geography and the Debate,” 2002.

⁴³ O’Connor, Llewellyn–Thomas, and Flood, “Modifying Unwarranted Variations,” 2004.

⁴⁴ Centers for Disease Control and Prevention, “Tobacco Use Among Adults—United States, 2005,” *Morbidity and Mortality Weekly Report*, Oct. 27, 2006 55(42):1145–48.

⁴⁵ From the Centers for Disease Control and Prevention Web site on obesity trends: <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/index.htm>. Accessed Oct. 10, 2007.

⁴⁶ D. Thompson and A. M. Wolf, “The Medical-Care Cost Burden of Obesity,” *Obesity Reviews*, Aug. 2001 2(3):189–97; and E. A. Finkelstein, I. C. Fiebelkorn, and G. Wang, “National Medical Spending Attributable to Overweight and Obesity: How Much, and Who’s Paying?” *Health Affairs* Web Exclusive (May 14, 2002):w3-219–w3-226.

⁴⁷ D. R. Anderson, R. W. Whitmer, R. Z. Goetzel et al., “The Relationship Between Modifiable Health Risks and Group-Level Health Care Expenditures,” *American Journal of Health Promotion*, Sept./Oct. 2000 15(1):45–52.

⁴⁸ D. W. Edington, L. T. Yen, and P. Witting, “The Financial Impact of Changes in Personal Health Practices,” *Journal of Occupational and Environmental Medicine*, Nov. 1997 39(11):1037–46.

⁴⁹ See Kaiser Daily Health Policy Report, Sept. 20, 2005, for private businesses; See Rhode Island for state examples, see P. Redmond, J. Solomon, and M. Lin, *Can Incentives for Healthy Behavior Improve Health and Hold Down Medicaid Costs?* (Washington, D.C.: Center on Budget and Policy Priorities, June 1, 2007).

⁵⁰ The definitions of these measures may be found at <http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/hqid-measure-spec100106.pdf>.

⁵¹ Congressional Budget Office, Fact Sheet for CBO’s March 2007 Baseline: Medicare, available at http://www.cbo.gov/ftpdocs/78xx/doc7861/m_m_schip.pdf. Accessed March 7, 2007.

⁵² K. Davis, “[Paying for Care Episodes and Care Coordination](#),” *New England Journal of Medicine*, Mar. 15, 2007 356(11):1166–68.

⁵³ Starfield, Shi, and Macinko, “Contribution of Primary Care,” 2005.

⁵⁴ E. T. Momany, S. D. Flach, F. D. Nelson et al., “A Cost Analysis of the Iowa Medicaid Primacy Care Case Management System,” *Health Services Research*, Aug. 2006 41(4 Pt. 1):1357–71.

⁵⁵ Employee contributions can also be exempt through use of Section 125 accounts.

⁵⁶ The Lewin technical report details assumptions about savings and price-elasticity used to model the option.

⁵⁷ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, Mar. 2007).

⁵⁸ The Centers for Medicare and Medicaid Services has defined 26 regions—each consisting of one or more states—that are used to specify the service areas for regional preferred provider organizations that want to participate in Medicare, and for selected other purposes.

⁵⁹ These data can be derived from the Adjusted Community Rate (ACR) reports submitted to Medicare by each MA plan, but the data contained in the ACRs are considered proprietary and not generally available.

⁶⁰ R. G. Frank and J. P. Newhouse, “Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Pricing,” Discussion Paper 2007-03 (Washington, D.C.: Brookings Institution, Apr. 2007, available at http://www3.brookings.edu/views/papers/200704frank_newhouse.pdf. Accessed May 11, 2007.

⁶¹ P. R. Orszag, Director, Congressional Budget Office, Letter to Max Baucus, Chairman, Committee on Finance, U.S. Senate, on the cost impact of removing the “noninterference provision from section 1860D-11(i) of the Social Security Act, available at <http://www.cbo.gov/ftpdocs/79xx/doc7993/DraftLegislationOnMedicare.pdf>. Accessed July 6, 2007.

⁶² J. E. Dicken, Government Accountability Office, testimony before the Senate Finance Committee on “An Overview of Approaches to Negotiate Drug Prices Used by Other Countries and U.S. Private Payers and Federal Programs,” Jan. 11, 2007, available at <http://www.gao.gov/new.items/d07358t.pdf>. Accessed May 11, 2007.

⁶³ It should also be noted that the reduced cost to private insurers of the lower payment rates might be expected to result in lower insurance premiums, which may increase coverage; moreover, the reduction in the generous subsidy historically provided by private insurers, along with the greater equalization of payment rates across payers, may put pressure on the highest cost providers—presumably those who were the principal recipients of those historical subsidies—to exert more control over their costs. These affects are not modeled in this estimate.

⁶⁴ Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2007 Annual Report* (Washington, D.C.: U.S. Department of Health and Human Services, Apr. 2007):33.

⁶⁵ Wennberg, Fisher, and Skinner, “Geography and the Debate,” 2002.

⁶⁶ Data from the Dartmouth Atlas of Health Care Web site, http://www.dartmouthatlas.org/data/download/2003_reimb_table_hrr.xls. Accessed July 5, 2007.

⁶⁷ Through 1997, a Volume Performance Standard, which compared volume and intensity in the previous year to a standard that either was specified by Congress or determined by a formula that reflected the average increase in volume and intensity over the previous five years, was used in determining the update in physician fees; since 1998, a Sustainable Growth Rate (SGR) formula, which compares cumulative spending growth to the growth of per capita GDP, has been used—although the Congress has several times over-ridden the update produced by the SGR formula.

⁶⁸ MedPAC, *Medicare Payment Policy*, 2001.

⁶⁹ The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007); S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

⁷⁰ J. G. Kahn, R. Kronick, M. Kreger et al., “The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals,” *Health Affairs*, Nov./Dec. 2005 24(6):1629–39.

⁷¹ Collins, Schoen, Davis et al., *Roadmap to Health Insurance*, 2007.

⁷² Thirty-four states provide no coverage for childless adults, regardless of how poor unless disabled or age 65 or older. Thirty-five states set eligibility for parent below 100 percent of poverty; in 14 states family income would have to be below 50 percent of poverty for parents to qualify. Only 14 states cover low-income parents up the same income levels as for their children. See J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, [*Aiming Higher: Results from a State Scorecard on Health System Performance*](#) (New York: The Commonwealth Fund, June 2007).

⁷³ Davis, Schoen, Guterman et al., *Slowing the Growth*, 2007.

⁷⁴ Catlin, Cowan, Heffler et al., “National Health Spending in 2005,” 2007.

⁷⁵ Lewin Group estimates. For a discussion of primary versus specialist relative rates, see also T. Bodenheimer, R. A. Berenson, and P. Rudolf, “The Primary Care–Specialty Income Gap: Why It Matters,” *Annals of Internal Medicine*, Feb. 20, 2007 146(4):301–06.

⁷⁶ The Medicare option would be self-insured. Federal funds would underwrite costs of any adverse selection in the Connector to maintain the average community rates.

⁷⁷ Medicare enhanced benefits would include Part A and Part B plus drugs with a single \$250 deductible for Part A and B, exempting Part D drugs or preventive care. Cost-sharing includes a 10% for Part B and 25% for prescription drugs, excluding prevention, with a \$5,000 out-of-pocket maximum.

⁷⁸ The mandate results in an increase of \$45 billion for those not currently providing coverage and decrease of \$24 billion for employer providing insurance as the costs of dependents are shared.

**APPENDIX. THE INSURANCE CONNECTOR APPROACH:
PROVIDING AFFORDABLE COVERAGE FOR ALL WITH
MIXED PRIVATE-PUBLIC GROUP INSURANCE COVERAGE**

SPECIFICATIONS AND MODELING RESULTS

Specifications

This policy option would use a blended private–public insurance approach to achieve affordable coverage for all that builds on and connects private group insurance and public insurance by creating a new federally sponsored “connector.” The Insurance Connector would offer a structured choice between a self-insured, Medicare-sponsored option and a selection of integrated health plans. To reach near-universal coverage with affordability, it includes an individual mandate and premium assistance, with automatic enrollment through the tax system. This insurance approach includes the following core features:

- **Connector.** The private and public sectors would be “connected” by offering a structured choice of health plans for individual and small firms (under 100 employees). The choices would include a self-insured option run by Medicare, using Medicare payment rates and fiscal intermediaries to pay claims. Medicare benefits would be enhanced to include prescription drugs and unified cost-sharing.⁷⁷ The Connector would also provide a choice of integrated plans offered to federal employees, Congress, and the Medicare population.
- **Medicaid.** The Medicaid program would be expanded to cover all those with incomes up to 150 percent of the federal poverty level for acute-care medical services. Medicaid provider rates would be increased to Medicare levels. Federal matching would be at the enhanced SCHIP rate.
- **Medicare Expansion.** The two-year waiting period for the disabled would be eliminated. Adults age 60 and older would be eligible to buy in early. All Medicare beneficiaries would have the option of buying an integrated supplemental plan from Medicare.
- **Individual Mandate with Premium Assistance.** All residents would be required to have insurance meeting minimum criteria. Tax credits/premium assistance would be available to limit premium costs to 5 percent of income for households in the lowest income tax bracket and 10 percent of income in higher-income households.
- **“Play or Pay.”** Employers would be required to provide coverage or contribute 7 percent of payroll, up to \$1.25 an hour, into a national insurance trust fund. The maximum age for dependent children for family coverage would be increased to 26.

- **Broad Risk Pooling.** To protect against adverse selection and avoid competition based on health risks, the Connector and premium assistance would be available only in states that require modified community rating and guaranteed issue.
- **Financing.** As partial financing, the option includes assessments of 4 percent of hospital revenues and 2 percent of physician revenues. Federal funds for uninsured and Medicaid patients (e.g., disproportionate share hospital, or DSH, payments) would be reallocated to the trust fund.

Coverage and Costs of Insurance Expansion Without Other Policy Changes

Coverage. The mixed private-public approach with required participation would achieve near-universal coverage, insuring about 45 million of the estimated 48.3 million uninsured in 2008. The modeling estimates that about 20 percent of the population—60 million people—would enroll in the Insurance Connector. Of these, an estimated two-thirds would select Medicare and one-third would opt for integrated plans. Including those choosing Medicare through the Connector, Medicare total enrollment would double. Medicaid/SCHIP would have a net expansion of about 4 million. The individual insurance market share would decline as participants opted for other sources.

Employers would continue to be the primary sponsors of coverage for the under-65 population. An estimated 141.5 million people would receive insurance through employers purchasing coverage directly. Another 46 million people working for small employers would join the Connector as those employers opted in. As a result, 63 percent of the population would have employer-sponsored coverage.

Annual Net Impact if Insurance Reforms Alone, Without Savings Options

Cumulative Net Impact

\$ billions	Annual Net Impact if Insurance Reforms Alone, 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	1346.1
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	-1232.2

Spending. If the Insurance Connector is implemented with no other changes, the modeling estimates that it would result in a net increase in national health expenditures of \$15 billion—on a base of over \$2 trillion expected in 2008. Increases in total national health expenditures resulting from covering the uninsured and improving coverage would be partially offset by reductions in health insurance administrative costs (\$15.4 billion) and net savings in provider reimbursement (\$20.8 billion). The net administrative savings derive from using Medicare’s claims payment arrangements and savings from more efficient supplemental coverage for Medicare beneficiaries. The net savings from provider reimbursement result from extension of Medicare’s payment rates to a larger share of the population and provider assessments offsetting the costs of raising Medicaid payment rates to Medicare levels.

The Lewin model estimates that the approach would amount to a cumulative increase in total national health spending of \$218 billion over 10 years. As specified, the option would result in a net reduction in state and local spending as well as household spending. There would be a net increase in employer spending for premium contributions of \$267 billion as a result of the employer mandate.⁷⁸

Federal expenditures would increase to pay for premium assistance, the increased federal match for low-income programs, and improved financial protection for Medicare beneficiaries. These expenses would be partially offset by the reallocation of DSH funds and by provider assessments. However, there would be a net increase in federal spending of about \$82 billion in the first full year. The table above shows the estimated cumulative effect over five and 10 years. Assuming that health care expenditures continue to grow faster than incomes, the cost of the federal tax credits to make premiums affordable in relation to income would mount over time. Full financing of the estimated net increase in federal expenditures would require additional sources of revenue or offsets from other federal policy changes.

Discussion

This private-public group insurance approach to insurance for all would allow those with insurance to remain with their current coverage while providing new choices. Achieving the goal of seamless, continuous coverage would require mechanisms that make it easy to enroll and stay covered. There would also be a need to protect the safety net capacity to care for those remaining uninsured.

The approach builds on Medicare’s nationwide scope and claims-payment arrangements across the country. Yet it also maintains a competitive market for insurance

with a substantial role for private plans, and introduces a new competitive dynamic with Medicare and private plans competing. Private insurance plans, particularly those active in small group and individual insurance markets, would likely see such competition as a threat.

Offering Medicare as an option for a greater share of the population would mean extending Medicare provider rates to more patients. Providers that currently see mainly private patients would stand to lose revenue. However, if more-unified insurance systems reduced administrative costs for physicians and hospitals, those savings would accrue to providers.

There is evidence that current Medicare rates underpay for primary care and managing chronic disease while favoring more specialized care and procedures. Efforts to build on Medicare would therefore need to consider changes in payment methods to enhance primary care and improve coordinated care.

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Karen Davis, Ph.D., president of The Commonwealth Fund, is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, she received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also

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FURTHER READING

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*A High Performance Health System for the United States: An Ambitious Agenda for the Next President*](#) (November 2007). The Commonwealth Fund Commission on a High Performance Health System.

[*Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States*](#) (November 2007). Katherine K. Shea, Anthony Shih, and Karen Davis.

[*A Roadmap to Health Insurance for All: Principles for Reform*](#) (October 2007). Sara R. Collins, Cathy Schoen, Karen Davis, Anne Gauthier, and Stephen C. Schoenbaum.

[*An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part II, Quality and Efficiency*](#) (July 2007). Karen Davis, Sara R. Collins, and Jennifer L. Kriss.

[*Denver Health: A High-Performance Public Health Care System*](#) (July 2007). Rachel Nuzum, Douglas McCarthy, Anne Gauthier, and Christina Beck.

[*Health Care Opinion Leaders' Views on the Quality and Safety of Health Care in the United States*](#) (July 2007). Katherine K. Shea, Anthony Shih, and Karen Davis.

[*Measuring Hospital Performance: The Importance of Process Measures*](#) (July 2007). Anthony Shih and Stephen C. Schoenbaum.

[*Aiming Higher: Results from a State Scorecard on Health System Performance*](#) (June 2007). Joel C. Cantor, Cathy Schoen, Dina Belloff, Sabrina K. H. How, and Douglas McCarthy.

[*Health Care Opinion Leaders' Views on Priorities for SCHIP Reauthorization*](#) (April 2007). Katherine K. Shea, Karen Davis, Anne Gauthier, Rachel Nuzum, Barry Scholl, and Edward L. Schor.

[*An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part I, Insurance Coverage*](#) (March 2007). Sara R. Collins, Karen Davis, and Jennifer L. Kriss.

[*The Agency for Healthcare Research and Quality's 2006 National Healthcare Quality Report*](#) (March 2007). Stephen C. Schoenbaum, Douglas McCarthy, and Cathy Schoen.

[*State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers*](#) (January 2007). Alice Burton, Isabel Friedenjohn, and Enrique Martinez-Vidal.

[*Public Reporting and Transparency*](#) (January 2007). John M. Colmers.

[*Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*](#) (January 2007). Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum.

[*Enhancing Value in Medicare: Demonstrations and Other Initiatives to Improve the Program*](#) (January 2007). Stuart Guterman and Michelle P. Serber.

[*The State Children's Health Insurance Program: Past, Present, and Future*](#) (January 2007). Jeanne M. Lambrew.

[*Health Care Opinion Leaders' Views on Priorities for the New Congress*](#) (January 2007). Alyssa L. Holmgren, Karen Davis, Stuart Guterman, and Barry Scholl.

[*Health Care Spending: An Encouraging Sign?*](#) (January 2007). Stephen C. Schoenbaum, Karen Davis, and Alyssa L. Holmgren.

[*The National Committee for Quality Assurance's The State of Health Care Quality 2006*](#) (November 2006). Stephen C. Schoenbaum and Alyssa L. Holmgren.

[*U.S. Health System Performance: A National Scorecard*](#) (September 20, 2006). Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum. *Health Affairs* Web Exclusive (*In the Literature* summary).

[*Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*](#) (September 2006). The Commonwealth Fund Commission on a High Performance Health System.

[*Framework for a High Performance Health System for the United States*](#) (August 2006). The Commonwealth Fund Commission on a High Performance Health System.

[*Public Views on Shaping the Future of the U.S. Health System*](#) (August 2006). Cathy Schoen, Sabrina K. H. How, Ilana Weinbaum, John E. Craig, Jr., and Karen Davis.

[*Toward a High Performance Health System for the United States*](#) (March 2006). Anne K. Gauthier, Stephen C. Schoenbaum, and Ilana Weinbaum.

