



**STARTING ON THE PATH TO A HIGH PERFORMANCE
HEALTH SYSTEM: ANALYSIS OF HEALTH SYSTEM
REFORM PROVISIONS OF REFORM BILLS IN THE
HOUSE OF REPRESENTATIVES AND SENATE**

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ABSTRACT: This report analyzes the health reform bill passed by the U.S. House of Representatives and the reform provisions under consideration in the Senate that would affect providers' financial incentives, the organization and delivery of health care services, investment in prevention and population health, and the capacity to achieve the best health care and health outcomes for all. The bills represent a pragmatic approach to closing the gaps in insurance coverage by: building on a mix of employer coverage, other private plans, and a public plan in a health insurance exchange, or exchanges; strengthening Medicare; and expanding Medicaid. Even under current estimates, 18 million to 23 million people will remain uninsured, however, and many others will still face financial barriers to obtaining needed care or hardship in paying premiums or medical bills.

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EXECUTIVE SUMMARY

To achieve a high performance health system, health reform must go beyond ensuring affordable coverage to addressing health system changes that will improve Americans' health outcomes and the quality of health care, increase efficiency, and slow the growth in total health system costs. This report analyzes how the health reform bills passed by the U.S. House of Representatives and the Senate would affect providers' financial incentives, the organization and delivery of health care services, investment in prevention and population health, and the capacity to achieve the best health care and health outcomes for all.

Congress has fashioned health reform plans that will fundamentally change our present course of rising costs and increasing numbers of uninsured and underinsured people. The bills represent a pragmatic approach to closing the gaps in insurance coverage by: building on a mix of employer coverage and other private plans in a health insurance exchange, or exchanges; strengthening Medicare; and expanding Medicaid. Most of the ideas that have been advanced by policymakers and health care opinion leaders to deal with rising costs are reflected in the bills (Exhibit ES-1).

**Exhibit ES-1. Projected Savings and Effectiveness of System Reform Provisions in House and Senate Reform Bills
2010–2019 (in billions)**

| | CBO Estimate of Budget Savings, House of Representatives Bill 11/05/09 | CBO Estimate of Budget Savings, Senate Bill 12/19/09 | Percent Opinion Leaders Favor, or View as Effective | Projected System Cost Containment Effectiveness |
|---|--|--|---|---|
| Establish a health insurance exchange with market rules; repeal antitrust exemption | | | 92% ^a | ++ |
| Public health insurance plan option | –\$5 | — | 76% ^a | ++ |
| Institute payment innovation to reward physicians and hospitals for value not volume | –\$2 | –\$8 | 97% ^b | +++ |
| Require annual provider productivity improvements | –\$177 | –\$151 | | +++ |
| Independent commission | — | –\$28 | 75% ^d | ++ |
| Negotiate pharmaceutical prices | –\$75 | — | 81% ^d | ++ |
| Increase payment for primary care services | –\$6 | \$6 | 61% ^b | + |
| Cover preventive services and invest in community and employer prevention and wellness programs | \$48 | \$17 | | + |
| Institute value-based benefit design linked to comparative effectiveness research | | | 86% ^d | + |
| Level the playing field between Medicare Advantage plans and traditional Medicare coverage | –\$170 | –\$136 | 77% ^b | + |
| Tax on premiums in excess of threshold | — | –\$149 | 58% ^c | + |

Authors' views of long-term effectiveness in controlling total health system spending: Very effective = +++, Effective = ++, Somewhat effective = +. Health Care Opinion Leaders Surveys: ^a Dec. 2008; ^b April 2009; ^c June 2009; ^d Oct. 2009.
Source: Commonwealth Fund estimates; Congressional Budget Office, Letter to the Honorable John D. Dingell, Nov. 20, 2009; Letter to the Honorable Harry Reid, Dec. 19, 2009.



KEY PROVISIONS TARGETING COSTS AND QUALITY

Following are the key changes that the House and Senate bills would make to help ensure long-run cost containment and improve the quality of health care.

1. Changing the Insurance Market

Both the House and Senate bills would establish a health insurance exchange, or exchanges, with a choice of plans; rules to shift insurers from competing for healthier enrollees to competing on value; and greater transparency. While the Congressional Budget Office (CBO) does not credit savings that would be generated from increased competition among plans, it estimates that the insurance exchange would lower administrative overhead by four to five percentage points. In the authors' view, the House provisions for the insurance exchange would be effective over the long term in mitigating the rise in premiums and costs to employers and households. These provisions include: creation of an 85 percent medical-loss ratio standard (80 percent in the Senate for individual and small-group insurance plans, and 85 percent for large-group plans); standardized benefit tiers to facilitate comparison of plan premiums; review of plan premiums by the Secretary of Health and Human Services (HHS), who would have the authority to reject plans with excessive increases (or those with unjustified premium increases prior to implementation of reform in the Senate); and repeal of the health insurance companies' exemption from antitrust regulation. These positive effects would grow if the exchange is gradually opened to larger firms (an option after the year 2015 in the House bill, and after 2017 in the Senate bill). According to a recent Commonwealth Fund survey of health care opinion leaders, support for establishment of a health insurance exchange is overwhelming (92%).

2. Offering a Public Plan

The House bill would offer a public health plan in the insurance exchange. The HHS secretary would be charged with negotiating provider payment rates and authorized to use an array of proven value-based purchasing payment methods. Providers participating in Medicare would be assumed to participate in the public health insurance plan unless they opt out. CBO estimates that the public plan will have lower administrative costs than private plans but also will attract sicker individuals, with the net effect that its premium will be slightly higher than those for private plans. The CBO estimates that nearly all of the 6 million people who enroll in the public plan (of the nearly 30 million covered through the exchange) would be people who are currently uninsured and who would be eligible for premium subsidies.

The Senate bill does not include a public plan, but calls for the Office of Personnel Management, which administers the Federal Employees Health Benefits Program, to develop at least two multi-state plan offerings, at least one of which would be nonprofit. Both the House and the Senate bills include provisions for nonprofit consumer cooperative health plans. The CBO estimated that neither the multi-state plan option under the Senate bill nor the nonprofit health insurance cooperative would have much of an effect on either coverage or costs. CBO estimates that the cooperatives would have difficulty competing in most state markets dominated by one or two large carriers.

There is great uncertainty over the long-term effectiveness of the public plan option. Initially, health care providers that treat the uninsured are likely to participate, even at payment rates well below commercial rates because most of those newly covered would be low-income patients for whom safety-net providers now receive little or no payment.

A Commonwealth Fund study found that a health reform proposal that includes a robust public health insurance plan—with provider payment tied to Medicare and open to all employers and individuals—could save \$3 trillion in total health expenditures over the period 2010–2020. The same proposal, but with an intermediate public plan having rates between commercial providers' and Medicare's, was estimated to save \$2 trillion. A proposal with no public plan but with Medicare reforms only, meanwhile, saved an estimated \$1.2 trillion. Depending on how effective the HHS secretary is in negotiating rates and lowering administrative costs, the public plan could put significant pressure on private insurers to slow the growth in premiums for employers and workers over time as the exchange is opened to larger firms. Three-fourths of surveyed health care opinion leaders support inclusion of a public health insurance option in the exchange.

3. Instituting Provider Payment Reform

The House and Senate bills would establish a Center for Medicare and Medicaid Innovation with broad authority for the HHS secretary to test innovative payment methods for medical homes that provide patient-centered coordinated care, for accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, and for bundled hospital acute and post-acute care. The Senate bill also would implement a national, voluntary shared savings program for accountable care organizations. The secretary would have broad authority to sustain and spread effective payment methods.

The House bill calls for two studies to be conducted by the Institute of Medicine. The secretary would be authorized to implement the recommendations of one study, on geographic adjustment factors in Medicare payment. The secretary also would be authorized to implement the recommendations of the second study, on geographic variation in health spending and promotion of high-value health care in Medicare, unless Congress votes to disapprove it. Nearly all health care opinion leaders (97%) in the Commonwealth Fund survey support reforming provider payment to promote quality and efficiency.

4. Adjusting Payment for Productivity Improvement

The hospital industry agreed to slow increases in Medicare payment rates in recognition of the increased revenue realized through covering more uninsured Americans and the potential for significant ongoing productivity improvements. Slowing in Medicare payment rates for all health care providers (other than physicians, whose payments are considered separately) yields \$150 billion to \$180 billion federal budget savings over 2010–19, according to CBO, and establishes the principle that rising expenditures cannot continue at projected rates.

5. Controlling Spending Growth

The Senate bill would establish an Independent Payment Advisory Board within the executive branch that has significant authority to identify areas of waste and additional federal budget savings. The board would first review physician and home health services; hospitals would be exempt initially. Congress would be required to make an up-or-down vote on its annual recommendations. CBO estimates the board would generate \$28 billion in savings over 2010–19, mostly in the out-years. Three-fourths of health care opinion leaders (75%) support creation of an independent advisory council that has the authority to make decisions within parameters established by Congress and subject to review by the president and Congress.

6. Negotiating Pharmaceutical Prices

The House bill calls for negotiating pharmaceutical prices and for increased prescription drug rebates for beneficiaries covered by both Medicare and Medicaid. The Senate bill includes rebates, but not negotiation of pharmaceutical prices—the result of an agreement among the chairman of the Senate Finance Committee, the White House, and the pharmaceutical industry, in which the industry agreed to provide discounts of half the cost of brand-name drugs in the Medicare coverage gap, or “doughnut hole.” While CBO does not score savings from the authority to negotiate prices, the experience of other countries suggests that it could in fact yield substantial savings were it to be included in a

final reform bill. Four-fifths of health care opinion leaders (81%) favor using Medicare's leverage to negotiate pharmaceutical drug prices.

7. Incentivizing Primary Care and Prevention

The House and Senate bills include a number of provisions to increase primary care payment rates under Medicare and Medicaid, cover effective preventive services without patient cost-sharing, and support community and employer prevention and wellness programs. These provisions could begin to change the orientation of our health system toward primary care and away from specialty care, counter the impending shortage of primary care providers, and lay the groundwork for more fundamental payment reforms.

8. Utilizing Value-Based Benefit Design

Both the House and Senate bills contain provisions that would permit patient cost-sharing and payment rates to be modified to encourage the use of services that promote health and value. The House bill allows value-based benefit design in the public health insurance plan, while insurance plans that reduce or eliminate cost-sharing for clinically beneficial care are exempt from certain requirements under the Senate proposal. These approaches could begin to reduce the use of overpriced and/or ineffective services and procedures over time. Eighty-six percent of health care opinion leaders favor granting an independent Medicare advisory council the authority to alter beneficiary incentives based on the effectiveness of services, drugs, and devices.

9. Promoting Quality Improvement and Public Reporting

The Senate bill would reduce payment for hospital-acquired conditions, and both the House and Senate bills would enhance public reporting of quality and cost. Under the Senate proposal, hospitals with high rates of hospital-acquired conditions would have their Medicare reimbursement rates cut by 1 percent. The House bill would require all hospitals to publicly report their infection rates.

10. Encouraging Medicare Private Plan Competition

Both the House and Senate bills would level the playing field between Medicare private plans and the traditional Medicare public health insurance plan. This would yield \$140 billion to \$170 billion in federal budget savings over 2010–19, according to CBO.

Moreover, this policy change could provide further impetus for plans to compete on value, creating at least some downward pressure on health care costs. Three-fourths of health care opinion leaders (77%) support such a provision.

ASSESSING THE BILLS' POTENTIAL IMPACT

Consistent with the President's belief that health reform should be financially sustainable and not add to the federal deficit; both the Senate and the House bills offset the cost of expanding and improving coverage with a mixture of system savings and new revenue sources.

According to CBO, the total net impact of the Senate bill on the federal budget deficit is a reduction of \$132 billion over the 10-year period 2010–2019. This figure reflects the net federal costs of expanding coverage (\$763 billion), offset by reductions in federal health spending (\$483 billion) as well as new revenues (\$413 billion). Under the House bill, the total net impact on the federal budget deficit in the 10-year period 2010–2019 is a reduction of \$138 billion. This figure reflects the net federal costs of expanding coverage of \$891 billion, offset by reductions in federal health spending of \$456 billion and by increased total revenue of \$574 billion.

Federal reforms have the potential to produce substantial total health system savings for the nation—well beyond what is reflected in the estimated federal budget impact. The combined effect of these provisions on trends in national health expenditures, however, is difficult to estimate, and CBO has indicated that it does not have the modeling capacity to do so. Estimates released by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) indicate that the legislation could produce modest increases in national health expenditures, but this estimate gives little credit for savings to measures that would reform provider payment, negotiate prescription drug prices, increase competition among plans in an insurance exchange, encourage public reporting, or apply the results of comparative effectiveness research. Yet these measures are a crucial platform for developing and implementing further policies to contain health care cost growth. As such, they have broad support from health care opinion leaders and business leaders as effective ways to control costs.

For example, a recent analysis by the Business Roundtable, prepared by Hewitt, found that such legislative reforms could potentially reduce the trend line in employment-based health care spending by \$3,000 per employee by 2019. One recent independent analysis put health system spending savings at \$683 billion over the 2010–2019 period, slowing the annual growth in health expenditures from 6.4 percent to 6.0 percent.

CBO's estimates of federal budget impact are fraught with uncertainty, given the multitude of changes and their potentially synergistic effects. On the last three occasions when CBO has estimated the savings or costs of major health reforms (the 1982–83

Medicare changes in hospital payment, the 1997 Balanced Budget Act, and the 2003 Medicare Modernization Act covering prescription drugs), the estimates were wide of the mark—with savings more than double those estimated in the first two cases and costs overstated by 40 percent in the third.

The measures incorporated in the bills under consideration would stimulate significant changes in the organization and delivery of health services and create powerful incentives to improve efficiency and productivity. Given the uncertainties that now exist, however, it will be especially important to establish a system for monitoring progress on agreed-upon health reform goals and to provide a mechanism for mid-course corrections and further changes as needed to move the United States toward a high performance health system by 2020. Stronger measures may be required over time to move providers toward value-based methods of payment. Estimates of cost and savings could be seriously underestimated or overestimated; if so, corrective actions may be required.

Even under current estimates, 18 million to 23 million people will remain uninsured, and many others will still face financial barriers to obtaining needed care or hardship in paying premiums or medical bills. Additional steps may be required to ensure affordability for families as well as stable financing.

Finally, the one major disappointment in the proposed health reform bills is the absence of significant incentives or levers for private insurers to control health care costs. Private insurers, in opposing a public plan, essentially have argued that they do not have the ability to slow premium growth or achieve economies, because of demands for higher prices from a powerful and increasingly consolidated health care provider sector. It is important that the HHS secretary use new discretionary authority to test multipayer provider payment reforms and to be responsive to requests from states or local groups to test innovative multipayer approaches. Over time, as experience is gained with new provider payment methods, strategies for harmonizing public and private provider payment and leveraging their joint purchasing power will be needed to avoid having public and private provider incentives working at cross-purposes.

Congress has a historic opportunity to pass comprehensive health care reform legislation this year. Multiple strategies for improving quality and slowing the growth in total health system spending will help spark economic recovery, put the nation back on the road to fiscal responsibility, and ensure that families are able to get the care they need while having financial security and relief from rising insurance premiums.

STARTING ON THE PATH TO A HIGH PERFORMANCE HEALTH SYSTEM: ANALYSIS OF HEALTH SYSTEM REFORM PROVISIONS OF HOUSE OF REPRESENTATIVES AND SENATE HEALTH REFORM BILLS

The test of health reform should be whether it puts the United States on a path to a high performance health system with better access, improved quality, and greater efficiency. Extending coverage to all—as essential as it is to ensuring access, quality, and efficiency—is not sufficient to achieve value for health spending and slow the growth in health care costs. Instead, becoming a high performance health system requires fundamental reforms in the organization, delivery, and financing of health care, as well as investment in the capacity and infrastructure to reach attainable goals on health outcomes, quality, access, equity, and efficiency.

This report analyzes those elements of the health reform proposals passed by the U.S. House of Representatives and Senate that will affect health care providers' financial incentives, the organization and delivery of health services, investment in prevention and population health, and the capacity to achieve the best care and outcomes for all. For more details on the provisions in the bills passed by the House and Senate, see the recent Commonwealth Fund report summarizing those provisions pertinent to achieving a high performance health system.¹ In addition, a companion to this report analyzes the extent to which the bill passed by the House and Senate would cover the uninsured and ensure affordability of coverage and care for all.²

STRATEGIES FOR ACHIEVING THE GOALS OF HEALTH REFORM

President Obama has stressed three major goals of health reform: ensuring stability and security of health insurance coverage for those who have it, providing insurance for those who do not, and slowing the rise in health care costs for employers, families, and government. He has taken a pragmatic approach, building on what works and fixing what does not, while signaling his openness to the best ideas from all sources. Congress has taken unprecedented steps toward passing comprehensive reform that achieves these goals and moves the health system down the path to high performance.

The proposals fashioned by Congress embrace the five essential strategies for comprehensive health system reform set forth by The Commonwealth Fund Commission on a High Performance Health System in the February 2009 report, *The Path to a High Performance Health System*.³ These include:

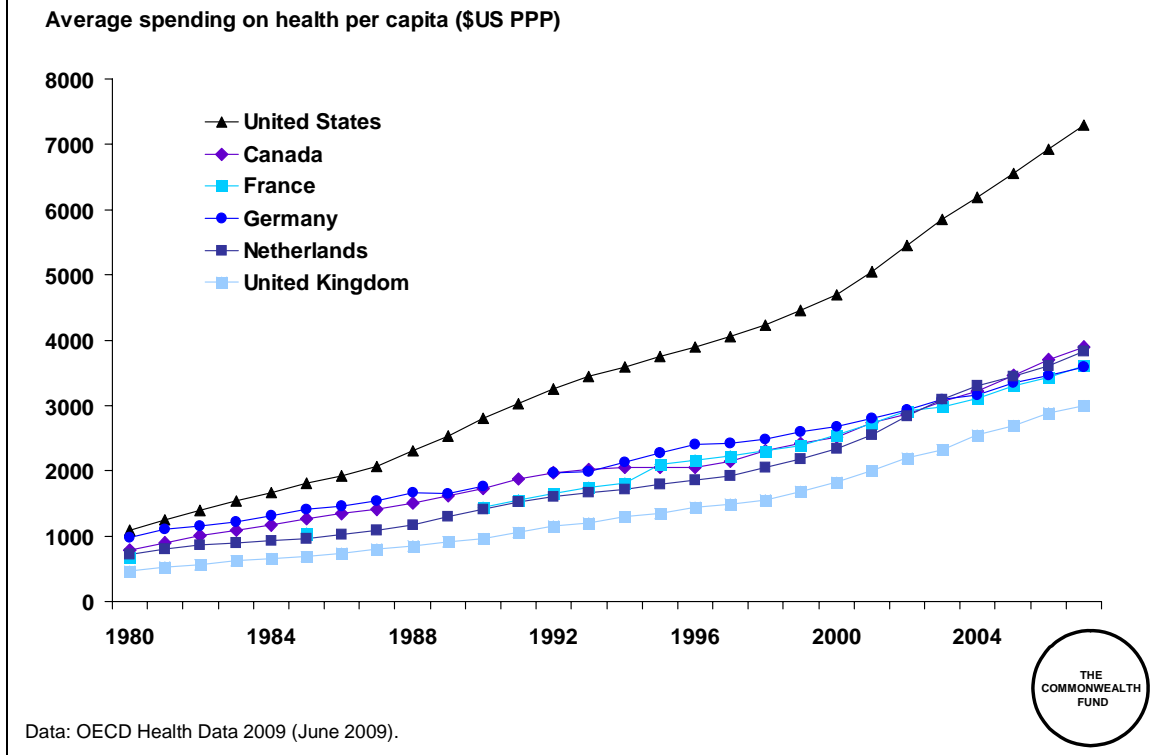
- extending affordable coverage for all;
- aligning incentives to enhance value and achieve savings;
- organizing care delivery systems to ensure accountable, accessible, patient-centered, coordinated care;
- meeting and raising benchmarks for better health outcomes, higher quality, and greater efficiency; and
- ensuring accountable leadership and public–private collaboration to set and achieve national goals.

THE NEED FOR HEALTH REFORM

The need for health reform is compelling. The recent *State Scorecard on Health System Performance* issued by the Commonwealth Fund Commission has documented twofold to threefold variation within the U.S. on indicators of access, quality, equity, cost, and health outcomes.⁴ It concluded that national reform is needed to raise performance in all areas of the U.S. to the best achievable levels.

Addressing the rising cost of health care and wide variation in quality throughout the U.S. requires that reforms go beyond expanding coverage to transforming the health system through information, rewards, and assistance with meeting benchmark levels of performance. Slowing the growth in health care costs is particularly urgent in the current economic crisis. The cost of health care in the U.S.—higher than anywhere else in the world and rising faster than our gross domestic product—is taking its toll on families, employers, and government. U.S. health care spending is more than twice the per-person spending of other major industrialized countries, with costs projected to continue to rise rapidly over the next decade (Exhibit 1). Health care already consumes 17 percent of the nation’s economy, and will reach 21 percent by 2020 if trends continue.⁵

Exhibit 1. National Health Expenditures per Capita, 1980–2007



With increases regularly exceeding economic growth, ever-higher health spending has directly contributed to stagnating or declining incomes for middle-class families and workers.⁶ Family health insurance premiums under employer plans have risen from 11 percent of family income in 1999 to 18 percent today, undermining wage increases and family financial security.⁷ If we continue on our current course, premiums will reach 24 percent by 2020.

Economists differentiate between those factors that cause the level of health care costs to vary across the U.S. or across countries and those factors that drive the rate of increase in costs.⁸ Addressing the first problem may yield one-time savings that shift the cost curve downward but continue at the same rate of growth. Addressing the latter will permanently bend the cost curve downward. One-time savings, however, lead to permanently lower costs over time, and a series of one-time savings year after year reduces the slope of the curve. Just as productivity improvements of 1 percent a year fuel economic growth, annual productivity improvements or reductions in waste would have a marked impact on slowing the growth in health care costs. It is important to understand the sources of each type of savings and fashion policies that will reduce cost growth both immediately and over time.

One-time savings are likely to derive from approaches that address factors contributing to current high levels of U.S. expenditures, inefficiency, and waste. These factors include:

- overuse, inappropriate use, or ineffective use of care;
- payment incentives that reward the delivery of more services and more intensive services, without considering clinical value or cost-effectiveness;
- market power of insurers, providers, and the health industry—including pharmaceutical companies, device manufacturers, and other suppliers—to set prices above what would be competitive levels;
- a low ratio of primary to specialty care physicians and services;
- access barriers to preventive and primary care that contribute to avoidable hospital admissions, emergency department use, and complications of chronic and acute disease;
- a lack of coordination that leads to unsafe, duplicative, or conflicting care;
- inadequate information systems and information exchange; and
- high administrative costs, including the high proportion of insurance premiums devoted to overhead costs, the complexity of insurance benefit design and duplicative and uncoordinated requirements, and the resulting administrative costs for providers.

The principal factors that contribute to long-term trends in rising expenditures that might be amenable to policy change are somewhat different. They include:

- introduction of new technologies and innovations without comparative information on clinical outcomes or cost-effectiveness to guide decisions on adoption and use;
- lack of an effective market for provider-purchased goods and provider services, leading to price inflation;
- growing market power and consolidation of insurers, providers, and the health industry—including pharmaceutical companies, device manufacturers, and other suppliers—contributing to less choice and higher prices; and
- the increasing prevalence of chronic diseases.

Some of these factors are desirable, such as medical research that discovers new cures and new technologies that extend and improve the quality of life. Other factors, such as the rise in chronic disease, are difficult to address. Though specific policies targeting such factors may be warranted, such policies may not have large short-term or near-term effects on the costs of care.

The keys to long-run cost containment that can be most effectively addressed in health reform include:

- **Changing the insurance market**
 - Establish a health insurance exchange with choice, rules, and transparency.
- **Offering a public plan**
 - Transform competitiveness of insurance markets with public health insurance plan option.
 - Leverage purchasing power to obtain fair and reasonable rates of provider payment.
- **Instituting provider payment reform**
 - Institute payment innovation to reward physicians and hospitals for value and safety, not volume.
- **Adjusting payment for productivity improvement**
 - Require ongoing provider productivity improvements by limiting payment updates.
- **Controlling spending growth**
 - Establish an independent commission to identify and correct overpriced services and wasteful practices and harmonize public and private payer policies to enhance value.
- **Negotiating pharmaceutical prices**
- **Incentivizing primary care and prevention**
 - Strengthen prevention and primary care through changes in payment rates.
 - Develop models that emphasize population health needs and coordinated care.
- **Utilizing value-based benefit design**
 - Institute value-based benefit design linked to comparative effectiveness research and information to patients and clinicians.

- **Promoting quality improvement and public reporting**
 - Publicly report total price, quality, and outcomes for treatment of conditions, services, procedures, devices, and pharmaceutical products.
- **Encouraging Medicare private plan competition**
 - Require private plans to compete with traditional Medicare public coverage on quality and responsiveness to beneficiary needs.

Most of these strategies are included in health reform proposals under consideration. Taken together, they would achieve savings to offset the federal budget cost of covering the uninsured and making coverage affordable for low- and moderate-income families, and they would slow the growth of national health expenditures. One major cost-containment strategy not included in the congressional proposals is harmonizing public and private provider payment and gaining leverage from the combined purchasing power of private and public coverage through coordinated payment policies; this strategy would be an effective tool for aligning payment incentives with the goals of health reform systemwide.

MAJOR HEALTH SYSTEM REFORM PROVISIONS IN THE CONGRESSIONAL PROPOSALS

The following sections assess the extent to which provisions in the health reform proposals passed by the House and Senate embody these strategies and recommendations, and are likely to be effective in achieving a high performance health system. They include key provisions on transforming the health insurance market; reforming provider payment and changing the health care delivery system; creating an independent advisory board to seek consensus and speed legislative action on measures to achieve savings and improve quality; changing patient incentives; improving quality and safety; and fostering greater competition on value between private plans and Medicare for coverage of Medicare beneficiaries. A summary of key provisions is contained in Exhibits 2 through 4, and more detailed descriptions of the provisions are available in a recent Commonwealth Fund report.⁹

Exhibit 2. System Improvement Provisions of National Health Reform Proposals, 2009

| | House of Representatives 11/05/09 | Senate 12/19/09 |
|---|---|--|
| Exchange Standards and Plans | National or state exchanges; private, public, or co-op plans offered; essential health benefits 70%–95% actuarial value, four tiers; insurers must meet specified medical loss ratio of 85 percent | State or regional exchanges; private and co-op plans offered; essential health benefits 60%–90% actuarial value, four tiers plus young adults policy; insurers must meet medical loss ratio of 80 percent for individual and small groups, 85 percent for large groups |
| Innovative Payment Pilots: Medical Homes, Accountable Care Organizations, Bundled Hospital and Post-Acute Care | Adopt medical homes, ACOs, and bundled payments on large scale if pilot programs prove successful; Center for Payment Innovation | Allow Medicaid beneficiaries to designate medical home; ACOs to share savings in Medicare; CMS Innovations Center |
| Productivity Improvements | Modify market-basket updates to account for productivity improvements | Modify market-basket updates to account for productivity improvements |
| Primary Care | Increase Medicare payments for PCPs by 5%; bring Medicaid PCPs up to Medicare level | 10% bonus payments for 5 years |
| Prevention and Wellness | Develop a national prevention and wellness strategy; establish a Prevention and Wellness Trust Fund; remove cost-sharing for proven preventive services; grants to support employer wellness programs | Provide annual wellness visit and/or health risk assessment for Medicare beneficiaries; strengthen state and employer wellness programs; remove cost-sharing for proven preventive services |
| Comparative Effectiveness | Establish Center for Comparative Effectiveness Research within AHRQ | Create Patient-Centered Outcomes Research Institute |
| Quality Improvement | Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices; develop national priorities for performance improvement and quality measures | Direct HHS to develop national quality strategy, public reporting |

Note: ACO = accountable care organization; PCP = primary care physician; AHRQ = Agency for Healthcare Research and Quality. HHS = Department of Health and Human Services
Source: Commonwealth Fund analysis.



Exhibit 3. System Reform Provisions of House Bill

- **Health Insurance Exchange, Rules, and Choice of Public and Private Plans**
 - Health insurance exchange administrative savings for individuals and small businesses
 - Public plan authorized to use new innovative payment methods; secretary of HHS negotiates rates
 - Minimum Benefit Package; Review premium increases; 85 percent minimum medical loss ratio
- **Change Provider Payment**
 - Rapid-cycle testing of innovative payment methods
 - Medical homes
 - Accountable care organizations
 - Bundled payments for hospital and post-acute care
 - Authority to spread in Medicare and incorporate in public plan
 - Geographic variations: IOM study; Congressional up-or-down vote on recommendations
 - Productivity improvement; reduction for high hospital readmissions
- **Strengthen Prevention and Primary Care**
 - Improved coverage of preventive services and elimination of cost-sharing
 - Enhanced payment for primary care: 5 percent overall, 10 percent in shortage areas
- **Correct Overpriced Services and Plans**
 - Negotiation of pharmaceutical prices; prescription drug savings
 - Resetting Medicare Advantage rates to fee-for-service levels with quality bonuses
- **Center for Comparative Effectiveness and Value-Based Benefit Design**
- **Quality Improvement, Measurement and Public Reporting**
- **Medical Malpractice Demonstrations**
- **Repeal of Insurance Antitrust Exemption**



Exhibit 4. System Reform Provisions of Senate Bill

- **Health Insurance Exchange and Rules**
 - Health insurance exchange administrative savings for individuals and small businesses
 - Minimum benefit package; insurers must meet 80–85 percent minimum medical loss ratio; ability to reject plans with unjustified premium increases prior to implementation
 - Choice of private plans, new private multi-state plans developed by OPM, and consumer cooperative plans
- **Strengthen Prevention and Primary Care**
 - Provide PCPs a 10% Medicare payment bonus for 5 years beginning in 2011
 - Increase the number of GME training positions
 - Establish a Workforce Advisory Committee to develop and implement a national workforce strategy
 - Eliminate cost-sharing for annual wellness visits and evidence-based preventive services
- **Change Provider Payment**
 - Shared savings initiative for accountable care organizations
 - Rapid-cycle testing of innovative payment methods through CMS Innovations Center
 - Medical homes
 - Bundled payments for hospital and post-acute care
 - Authority to spread in Medicare
 - Productivity improvement; reduction for high hospital readmissions
- **Restructure payments to Medicare Advantage plans**
- **Create a private, nonprofit Patient-Centered Outcomes Research Institute**
- **Goals and Reporting**
 - Quality improvement, measurement, public reporting
 - Health goals and priorities for performance improvement

Note: PCP = primary care physician.



Changing the Insurance Market

The reform proposals in both the House and Senate would enhance value, lower administrative costs, and foster competition in the insurance market by creating a health insurance exchange to facilitate choice and promote competition for enrollees. The insurance exchange initially would be open to individuals and small businesses and could gradually be opened to larger firms.

Under the Senate bill, individuals and small businesses with up to 50 employees would be eligible to purchase coverage in the exchange. Beginning in 2015, states must open the exchange to businesses with up to 100 employees, and may allow businesses with more than 100 employees to purchase coverage through the exchange beginning in 2017. Under the House bill, individuals who do not have access to employer coverage and who are not eligible for Medicaid may purchase coverage through the exchange. Employers with 25 or fewer employees would be eligible in the first year, those with 50 or fewer employees would be eligible in the second year, and those with 100 or fewer employees would be eligible in the third year. Also in the third year, the commissioner of the exchange would have the authority to decide whether and when to open the exchange to larger firms.

All plans, whether offered through the exchange or independently, must meet certain standards, including open enrollment to all, regardless of health status, and community-rated premiums that do not vary with health status. Premiums can vary with age, but the spread is limited (to 2:1 between older and younger adults in the House and 3:1 in the Senate version). The House bill also repeals the insurance industry McCarran–Ferguson exemption from the antitrust laws.

In the insurance exchange, plans would offer standardized benefits within each of four tiers, making it easy to compare premiums for plans with comparable benefits. The House bill further requires plans to devote 85 percent of premiums to medical care, while the Senate bill establishes minimum medical-loss ratios of 80 percent for insurance plans offered in the individual and small-group markets and 85 percent for plans in the large-group market. Under the House bill, the insurance exchange would have the authority to review and reject premium increases. The Senate bill instructs state exchanges to require insurance carriers seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. The exchange is then required to take the information into consideration when determining whether to allow the sale of the plan through the exchange.

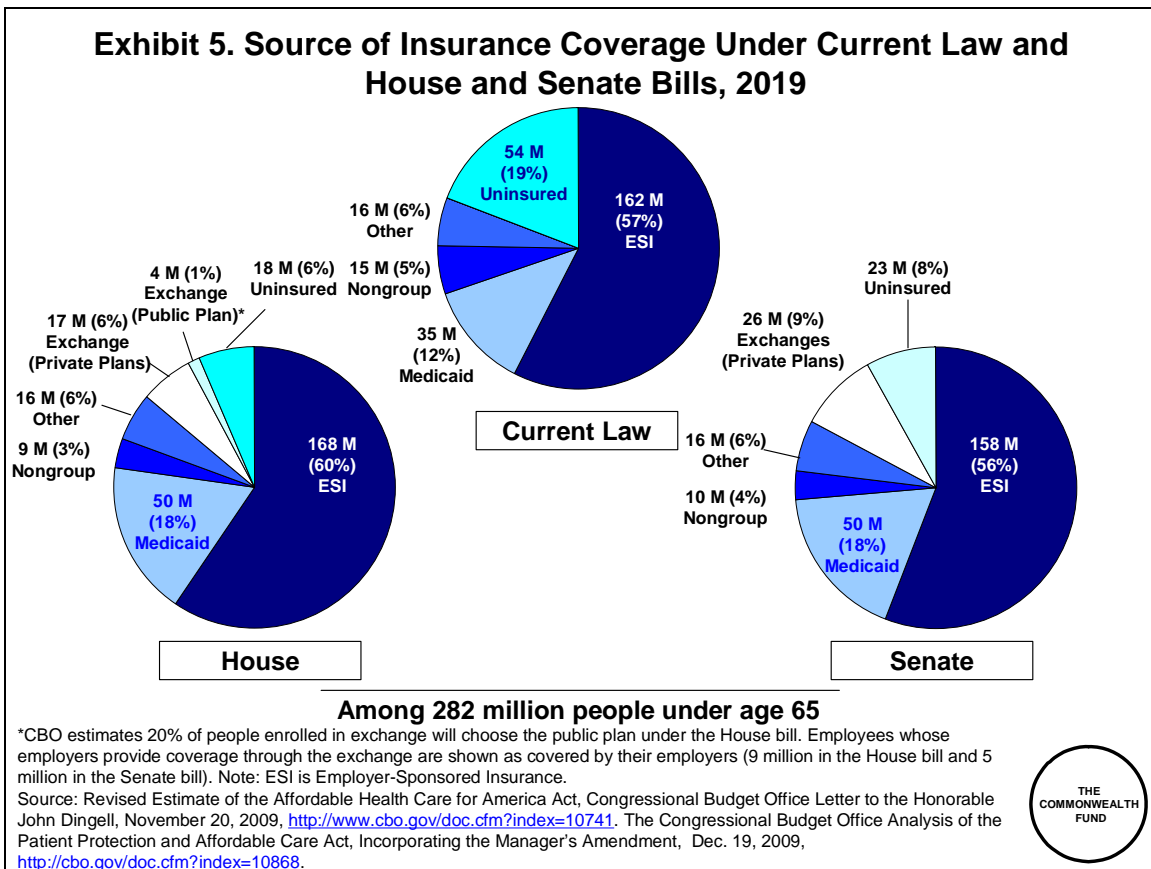
These provisions would increase the number of choices available to individuals and employees of small businesses and make their coverage more stable, since they could keep their health plan if they move from one firm to another firm participating in the exchange. Pooling risks across a larger group of individuals should also lower premiums. The Senate version would allow states to establish separate pools for individuals and small businesses, though states would have the option of establishing one exchange serving both individuals and small businesses, as long as separate resources were available to assist both.

CBO estimates that the exchange would lower administrative overhead by four to five percentage points.¹⁰ These savings come primarily from eliminating underwriting and reducing reliance on insurance brokers to select plans. The ability to compare plans should increase competition and lead to lower premiums, although no savings are attributed by CBO to this dynamic.

Offering a Public Health Insurance Plan

In the House proposal, a public health insurance plan would be offered through the exchange, along with private plans meeting specified standards. The House bill would include a national public health insurance plan, administered by the HHS secretary,

which negotiates provider payment rates. Further, the secretary would have discretion to use new payment methods that reward value, rather than the current fee-for-service payment system. Medicare providers would be assumed to participate in the public plan unless they opt out. CBO estimates that the public plan in the House version would achieve administrative savings, pay providers at rates equivalent to those in private plans, and attract sicker individuals compared with those in private plans. As a result, the public plan premium would be slightly above private plan premiums, and it would enroll approximately 6 million people, or one-fifth of the nearly 30 million covered through the exchange in 2019 (Exhibit 5).¹¹



The Senate bill does not include a public plan, but calls for the Office of Personnel Management, which administers the Federal Employees Health Benefits Program, to develop at least two multi-state plan offerings, at least one of which would be nonprofit. Both the House and the Senate include provisions for nonprofit consumer cooperative health plans. The CBO estimated that neither the multi-state plan option under the Senate bill nor the nonprofit health insurance cooperative would have much of an effect on either coverage or costs. CBO estimates that the cooperatives would have difficulty competing in most state markets dominated by one or two large carriers.

Health care opinion leaders have been broadly supportive of the establishment of a health insurance exchange with market rules and a public plan option. More than nine of 10 (92%) support allowing individuals who do not have coverage through their employers, Medicaid, or the Children's Health Insurance Program to purchase a plan through a national exchange.¹² Seven of 10 (70%) favor giving the governing body of the exchange the authority to enforce standards of participation, standardize benefits, set rating rules, and review or negotiate premiums.¹³ Meanwhile, 76 percent favor including a public plan option in an exchange so that individuals could choose between private and public plans.¹⁴

Instituting Provider Payment Reform

Key to improving health care quality and achieving greater efficiency is changing the way in which providers are paid, to reward the delivery of higher quality and safer care and appropriate stewardship of resources. This would require moving away from the current fee-for-service payment system toward one that emphasizes the value rather than the volume of services provided, and fosters the growth of organizations that are accountable for offering accessible, well-coordinated, and patient-centered care that is responsive to patients' needs and efficiently provided. While the House and the Senate bills do not immediately implement fundamental payment reform, they lay the groundwork for it through an intensive period of testing new payment and delivery system innovations. These payment innovations are supported by almost all health care opinion leaders (97%).¹⁵

Medical Homes

The House bill calls for creation of a Medicare and Medicaid Innovation Center within the Centers for Medicare and Medicaid Services (CMS) that would be responsible for rapid-cycle testing of innovative payment models that provide high quality and efficient care. It mandates a pilot program to test three models: one for independent patient-centered medical homes, one for community-based medical homes, and one for home-based primary care targeted at high-need beneficiaries. Further, it instructs the HHS secretary to adopt the medical home model on a large scale to the extent that it is found to be successful in improving quality and/or reducing costs, as determined by the CMS chief actuary, and to incorporate successful payment methods in the public plan offered through the insurance exchange.

The Senate similarly calls for creation of a center within CMS to test innovative payment and service delivery models for reducing program expenditures while preserving or enhancing the quality of care provided to Medicaid and Medicaid beneficiaries.

Preference is to be given to models that aim to improve the coordination, quality, and efficiency of health services. Models include: broad payment and practice reforms in primary care, including patient-centered medical homes for high-need individuals; medical homes that address women’s unique health needs; and initiatives focused on transitioning primary care practices away from fee-for-service and toward comprehensive payment or salary-based payment.

The Senate bill would also allow states to test and evaluate fully integrating Medicare- and Medicaid-covered health services provided to “dual eligibles,” and allow states to test and evaluate systems of all-payer payment reform. In addition, it gives states the option of allowing Medicaid beneficiaries with chronic conditions to designate a provider as a medical home, with qualified providers required to report applicable quality data. Finally, the bill would provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model.

These provisions would move the U.S. toward a delivery system in which everyone has a personal source of care that is accessible, coordinates care, and is accountable for obtaining the best health results. To achieve such a system, it will be important to give patients a financial incentive to designate a personal source of care and to reward physician practices serving as medical homes.¹⁶ Savings from this model—for example from reduced numbers of avoidable hospitalizations and emergency room visits—should be distributed to medical homes on the basis of provider performance.

CBO does not attribute savings to the medical home payment pilots.¹⁷ RAND researchers, however, have found that while medical homes are unlikely to produce substantial savings, they could have a synergistic effect when combined with the use of health information technology and other reforms.¹⁸

Accountable Care Organizations

Coordinating care across the continuum of health care services is most easily accomplished within a larger organization that directly provides those services and/or has contractual relationships with providers to deliver some subset of services. For example, a multispecialty physician group practice that includes primary and specialty care can coordinate care through a common electronic information system that shares medical records among providers, a scheduling system that facilitates prompt and easy referral to specialists, and timely and effective communication among physicians caring for a patient with complex health conditions. An integrated delivery system, including one or

more hospitals and a multispecialty physician group practice, can ensure effective transitions between inpatient and outpatient care.

The House bill would require the HHS secretary to set specific goals for the number of accountable care organizations (ACOs), providers, and patients to be included in the pilot program. It also specifies the testing, to the extent practicable, of some payment incentive models: the performance target (shared savings) model, in which ACOs would share any savings relative to a target spending level or rate of growth; and the partial capitation model, in which the ACO would bear some, but not all, of the risk for the spending generated by its patients. Participants in both of these models would be subject to quality improvement requirements. Under both the House and Senate bills, participants would receive additional payments for savings relative to a cost benchmark, subject to quality improvement requirements.

The Senate bill includes more specific details regarding qualifying ACOs and payment models. To be eligible, an ACO must have a mechanism for shared governance, and may include professionals in group practice arrangements, networks of individual practices of ACO professionals, hospitals employing ACO professionals, or partnerships or joint venture arrangements between hospitals and ACO professionals. The ACO must be willing to be accountable for the quality, cost, and overall care of Medicare fee-for-service beneficiaries assigned to it for at least a three-year period, and have a formal legal structure to distribute shared savings. It must have sufficient primary care professionals to care for its patients; have a leadership and management structure that includes clinical and administrative systems; report information on participating professionals, quality of care, and other information required for the determination of savings; and define processes to promote evidence-based medicine and patient engagement and meet various patient-centered criteria specified by the HHS secretary.

Several payment models are outlined in the Senate bill, including: sharing in savings relative to projected growth in national per capita Medicare Parts A and B expenditures, adjusted for beneficiary characteristics and other appropriate factors; partial capitation for highly integrated systems of care capable of bearing risk; or other payment models that the secretary determines will improve the quality and efficiency of care.

Medical homes and ACOs are complementary models of care delivery.¹⁹ The medical home emphasizes primary care that is patient-centered, delivered in practice settings with 21st-century infrastructure, and based on evidence-based processes. The ACO is a larger provider organization that is willing to deliver or manage the full

continuum of care and be accountable for the overall costs and outcomes of care for its defined population. ACOs provide an organizational structure that enables providers to contract with payers to align financial incentives with the goal of improving clinical performance, slowing the growth in spending, and achieving better outcomes and greater efficiency. High-performing primary care is critical to the success of an ACO. These complementary and mutually reinforcing models can work together to meet the goals of health reform—achieving better quality and slowing the rate of health care spending.

The House bill would launch Medicare and Medicaid pilot programs to test payment incentive models for ACOs and would spread these models broadly, if the pilot programs reduce costs without reducing quality. Full capitation payment, with rewards for delivering high-quality care, would provide strong incentives for ACOs to be prudent stewards of resources, while still being accountable for their patients' health outcomes and quality of care. The experience with capitated contracts under managed care plans in the 1990s, however, has made many physician group practices and health care organizations wary of assuming insurance risk for factors beyond their control.

More attractive to providers are payment methods that provide shared savings for ACOs that slow the growth in Medicare outlays below a target rate. This is the basic model in the Medicare physician group practice demonstration, which provides “upside” rewards for productivity and efficiency gains, without the “downside” financial risk of a fixed premium, which could lead to losses if expenses exceed premium revenues. The Senate bill includes a national voluntary program under which ACOs can share in savings they generate for Medicare over a span of three years. As noted above, the secretary could employ a variety of payment methods, including shared savings and partial capitation.

Flexibility for the HHS secretary to test a variety of shared-risk and shared-savings models would provide much-needed evidence and experience and would form the basis for future payment reforms. The House bill requires the secretary to set targets for provider participation levels in both the ACO and medical home models that are sufficient to ensure sufficient scale for determining the potential for broader success of the models. In addition, the secretary would have the authority to extend or expand the pilots if they prove successful at reducing costs or improving quality.

In addition, ACOs that have or develop insurance products, or partner with insurance plans to offer a choice of enrollment in their systems of care through the insurance exchange, stand to gain market share if they are able to provide high-quality

care more efficiently than their competitors. Under the “Path” proposal advanced by the Commonwealth Fund Commission on a High Performance Health System, such insurance products would be available on a regional basis through the national health insurance exchange, thus expanding their market substantially beyond what now prevails.²⁰

CBO estimates that the accountable care organization pilot program included in the House bill will save \$2.6 billion over the 10 years from 2010 to 2019.²¹ In the Senate bill, providing ACOs with shared savings is estimated by CBO to save \$4.9 billion over that period.²²

Bundled Payment for Acute-Care Episodes

Hospital readmission rates and post-acute care expenses vary widely from hospital to hospital.²³ Avoidable hospital readmissions are both undesirable for patients and costly for the system. Approximately \$12 billion a year could be saved by reducing the number of avoidable hospital readmissions.²⁴

New payment methods applied to acute-care episodes (including the hospital stay plus 30 days after discharge) would encourage hospitals and other providers to collaborate in developing the capacity to improve care transitions and reduce the number of avoidable hospitalizations. Bundling payment for the initial hospitalization and follow-on care would reward providers that achieve fewer complications, better transitional care, and lower total expenditures for hospitalization of patients with acute episodes. Under the current fee-for-service payment system, such providers stand to lose.

The House bill would reduce Medicare payments for potentially preventable hospital readmissions, at an estimated savings of \$9 billion over 2010–19.²⁵ It authorizes the HHS secretary to conduct Medicare pilot programs to test payment incentive models for bundling of post-acute care payments. The new Center for Medicare and Medicaid Innovation would develop and implement payment models targeted at populations that experience poor clinical outcomes or avoidable expenditures, and it would have the authority to expand those models found to improve quality without increasing spending, reduce spending without reducing quality, or both.

The Senate bill calls for development of a voluntary pilot program to encourage hospitals, doctors, and post-acute providers to achieve savings for Medicare through better collaboration and coordination, allowing providers to share in the savings. It would reduce payments for hospitals with high readmission rates if patients are rehospitalized

for three conditions for which there are risk-adjusted readmission measures endorsed by the National Quality Forum. The secretary would have the authority to expand the policy to additional conditions in future years. The bill also creates a Community Care Transitions Program to fund eligible hospitals and community-based organizations that provide patient-centered, evidence-based transitional care services to Medicare beneficiaries at highest risk of preventable rehospitalization. The Senate bill requires hospitals to report preventable readmission rates for certain conditions.

Bringing all providers under the same payment umbrella would encourage communication and collaboration between physicians and hospitals. Having a pilot-testing period would give providers time to prepare for the new system and Medicare time to develop rates that reflect the cost of efficient provision of various bundles of care. Giving the Secretary authority to spread successful payment models broadly in Medicare—and, in the case of the House bill, adopt those methods in a new public health insurance plan—would go a long way toward changing financial incentives to reward results.

RAND estimates that one bundled- payment approach (the Prometheus model), if used for six chronic and four acute conditions, has the potential to reduce national health expenditures by 5.4 percent between 2010 and 2019.²⁶

Pay-for-Performance

The Senate bill would begin to establish a value-based purchasing program to pay hospitals based on their performance on quality measures. Hospitals with high rates of hospital-acquired conditions also would have their Medicare reimbursement rates cut by 1 percent. It also would establish a physician value-based purchasing program to improve on the current Physician Quality Reporting Initiative. The program would reward physicians who participate beginning in 2011 and penalize those who are eligible but do not participate by 2014. It would establish payment incentives to encourage appropriate use of high-cost imaging services, expand the Medicare physician feedback program, and penalize physicians who use significantly more resources than their peers.

Geographic Disparities

There are wide variations across the U.S. in the cost and quality of care, yet there is no systematic relationship between the two.²⁷ Providers in some geographic areas provide high-quality care at lower cost, while providers in other areas have Medicare expenditures per beneficiary that are twice as high as similar geographic areas—without better quality or patient outcomes.²⁸ The House bill calls for two studies by the Institute of Medicine (IOM). One of these studies is to examine geographic adjustments to the

Medicare payment rates for hospital and physician services; the HHS secretary would be authorized to implement the IOM recommendations without congressional action, with \$4 billion for each of two years set aside for this purpose. In addition, the IOM would be charged with addressing geographic variation in spending by studying the desirability of changing Medicare payment to reward quality. Again, the secretary would be authorized to implement the IOM's recommendations, unless disapproved by Congress. The Senate bill modifies the adjustments to the Medicare fee schedule that are intended to reflect geographic differences in the cost of resources needed to produce physician services: physician work, practice expenses, and medical malpractice insurance. Medicare payment also would be linked to quality of care under the Senate bill (see below).

Physician Fee Update

The House and Senate bills do not address the 21 percent reduction in Medicare payments to physicians, scheduled for 2010; instead, a companion bill (H.R. 3961, the Medicare Physician Payment Reform Act of 2009) passed by the House on November 19, 2009, would replace the current methodology (the so-called sustainable growth rate formula) that in recent years has produced across-the-board annual cuts in Medicare physician fees (which have been superseded by Congress each year) with a new methodology.

The methodology proposed by the House would apply annual updates separately to two categories of physician services: 1) preventive care and evaluation and management services; and 2) specialized procedures and services. Fees would be increased each year according to the rate of growth in the gross domestic product (GDP), plus 2 percentage points for prevention and evaluation and management services, and the GDP growth rate, plus 1 percentage point for specialized procedures and services. This new methodology for updating physician fees is estimated by CBO to add \$210 billion to federal budget outlays over 2010–19.²⁹

Adjusting Payment for Productivity Improvement

The major hospital associations entered into an agreement with the Obama administration to save \$155 billion in Medicare outlays over the period 2010–19.³⁰ They proposed that this be achieved by lowering the projected Medicare increases in hospital payment by 1 percentage point a year and phasing out a portion of disproportionate share payments to hospitals as the uninsured receive coverage. This agreement reflects an understanding that the hospital sector can improve productivity and that it will be the beneficiary of increased payments for the uninsured and reduced bad debt. The Commonwealth Fund Commission's *Path* report also included an adjustment to payments for annual hospital

productivity improvements of 1 percent, with the view that new methods of payment would provide an opportunity to reduce complications, shorten lengths of stay, and reduce hospital readmissions.³¹

The House bill incorporates the productivity improvement allowance of 1 percentage point across all Medicare services (other than physician services, which are considered separately). These productivity improvement requirements and other payment update changes yield a 10-year budget savings of \$177 billion from 2010–19 in the House and \$151 billion in the Senate bill, according to CBO (Exhibit 6).³² Changes to Medicare and Medicaid disproportionate share payments would yield \$20 billion in savings over the same time period in the House bill and \$43 billion in the Senate bill.

Exhibit 6. House and Senate Payment and System Reform Savings, 2010–2019

Dollars in billions

| | CBO estimate of House Bill | CBO estimate of Senate Bill |
|--|-------------------------------|--------------------------------|
| Total Savings from Payment and System Reforms | -\$456 | -\$483 |
| • Productivity improvement/provider payment updates | -177 | -151 |
| • Medicare Advantage reform | -170 | -136 |
| • Primary care, geographic adjustment | -6 | 6 |
| • Payment innovations | -2 | -8 |
| • Hospital readmissions | -9 | -7 |
| • Disproportionate share hospital adjustment | -20 | -43 |
| • Prescription drugs | -75 | 6 |
| • Home health | -55 | -39 |
| • Independent board | — | -28 |
| • Other improvements and interactions | 58 | -83 |

Source: The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, <http://www.cbo.gov/doc.cfm?index=10741>. The Congressional Budget Office Analysis of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment, Dec. 19, 2009, <http://www.cbo.gov/doc.cfm?index=10868>.



Controlling Spending Growth

In his address to Congress, the President Obama called for creation of an independent commission to identify and spread best practices that achieve savings and eliminate waste. The Senate bill establishes an Independent Payment Advisory Board with a mandate to make payment decisions within parameters established by Congress and subject to review by the president and Congress. It is intended to slow the rate of

Medicare spending growth and enhance the long-term financial solvency of the program. However, the levers available to the board are sharply circumscribed. Recommendations could not pertain to benefits or eligibility and, at least in the beginning, exclude the major providers, such as hospitals.

Authority for the new board might appropriately be broadened to enable it to harmonize public and private payer payment policies and leverage purchasing power across the health system to reduce national health expenditures. Currently, private insurer pricing is often chaotic; for health care markets to work properly, payment incentives need to be aligned across payers, with consistent goals for health care quality and efficiency.³³ Seventy-five percent of health care opinion leaders in the Commonwealth Fund survey favor the creation of an independent Medicare advisory council that has the authority to make payment and benefit design decisions within parameters established by Congress and subject to review by the president and Congress.³⁴ Nearly nine of 10 (89%) leaders favor granting such a council the authority to collaborate in multipayer initiatives that include Medicare, private payers, and Medicaid, and 79 percent support allowing an independent council to develop policies that could be applied by Congress not only to Medicare, but also to Medicaid and other payers to align incentives across the health care system.

Negotiating Pharmaceutical Prices

Pharmaceutical costs account for more than 10 percent of Medicare outlays, and they have been among the most rapidly rising components of national health expenditures.³⁵ In the U.S., prices for many brand-name drugs are higher than in other countries, and Americans take more medications.³⁶ As a result, U.S. pharmaceutical spending per capita is among the highest in the world.³⁷

The House bill would require the HHS secretary to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare standalone Part D plans and Medicare Advantage Part D plans. CBO does not attribute any savings to this provision. The House bill also would require drug manufacturers to provide rebates for “dual-eligibles” (those individuals eligible for both Medicare and Medicaid) who are enrolled in part D plans, and would increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. It requires disclosure of financial relationships among health entities (e.g., among physicians and drug companies). More than eight of 10 (81%) health care opinion leaders favor using Medicare’s leverage to negotiate pharmaceutical drug prices.³⁸

Setting the price at the average global price for single-source drugs for which there are no therapeutic alternatives (i.e., noncompeting single-source drugs), a category for which private drug plan and Medicare Advantage drug plan negotiation has been relatively unsuccessful, would be particularly deserving of inclusion in the final legislation.³⁹

The Senate would require pharmaceutical and device manufacturers to disclose payments and incentives to providers. It would increase the Medicaid drug rebate percentage, increase the Medicaid rebate for non-innovator, multiple-source drugs, and extend the prescription drug rebate to Medicaid managed care plans. As part of an agreement between the pharmaceutical industry, the White House, and the chairman of the Senate Finance Committee, the industry would provide a 50 percent discount on brand-name prescriptions for enrollees in the Medicare Part D coverage gap, or “doughnut hole,” except for those who receive low-income subsidies and those with higher incomes.⁴⁰ The Senate bill would also require pharmaceutical benefit managers to disclose discounts negotiated with drug makers and pass on savings to consumers.

Incentivizing Primary Care and Prevention

Easy access to basic medical care is key to both better patient outcomes and lower costs.⁴¹ Yet the U.S. health care system disproportionately rewards specialty care, which in recent years has contributed to a sharp decrease in newly trained physicians who elect primary care practice.⁴² Rectifying the imbalance between primary and specialty care compensation is essential to reversing this trend.

The House bill includes a 5 percent payment bonus for evaluation and management services (i.e., office visits) and other services associated with ensuring accessible, continuous, coordinated, and comprehensive care when provided by a physician or other practitioner who specializes in family medicine, general internal medicine, general pediatrics, or geriatrics and for whom primary care represents a majority of his or her practice income. It provides an additional 5 percent allowance for practice in areas where there is a shortage of health professionals. Medicaid fees for primary care services, under both fee-for-service payment and managed care plans, would be raised to Medicare levels over a three-year period.

The Senate bill seeks to strengthen primary care by providing 10 percent bonus payments to primary care providers (and general surgeons) for five years. In addition, the Senate bill strengthens chronic care management by providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition.⁴³

These increases in payments for primary care and chronic care management are an important step toward addressing the imbalance in payment incentives that reward specialized procedures over primary care. A substantial majority (61%) of health care opinion leaders feel that increasing the supply of primary care providers through payment reform would be an effective strategy for reducing the growth in health care costs.⁴⁴ Favored policies include raising payments for primary care services, providing additional payments for providers who serve as a patient-centered medical home accountable for quality and efficiency, rewarding providers for high-quality and coordinated care, and offering incentives that encourage patients to enroll in medical homes.

The House and Senate bills would improve the coverage of preventive services by covering proven preventive services under Medicare and Medicaid and eliminating any cost-sharing for preventive services in Medicare. The Senate bill would go further by prohibiting private insurance plans from charging cost-sharing for preventive services (except for existing grandfathered plans and those that use a value-based insurance design). The bill also would expand the number of covered preventive services, including an annual wellness visit under Medicare and a comprehensive health risk assessment, personalized prevention plan, and tobacco-cessation programs for pregnant women under Medicaid.

Both the House and Senate bills call for development of a national prevention and health-promotion strategy that sets specific goals through a variety of mechanisms, including a prevention and public-health investment fund, competitive grants to state and local governments and community-based organizations, and creation of task forces on clinical and community preventive services that foster greater attention on prevention. They also would provide support for employer wellness programs, with grants for qualified employer-wellness programs in the House and technical assistance to small businesses in the Senate bill. Care would need to be taken to ensure that federal funds do not substitute for dollars now being spent by employers and state and local government, or prematurely cover programs of unproven effectiveness.

Utilizing Value-Based Benefit Design

A key to obtaining value for health spending is having evidence of which treatments are effective, how they work in different circumstances and for different patients, and how well they work relative to available alternatives. Armed with such evidence, physicians and patients can make informed choices about which medications to take, which surgical procedures to undergo, and which medical devices (such as artificial hips) are reliable. Tying such information to insurance benefit design and payment can further enhance

incentives for physicians and patients to select the most effective and most cost-effective treatment option. For example, many countries use “reference pricing” for prescription drugs—that is, paying the price of the lowest-cost equally effective drug for treatment of a condition. If a physician and patient opt for a more expensive, but no more effective, drug, the patient has that option but pays the difference in price. This provides a powerful market incentive for pharmaceutical manufacturers to lower prices to reflect the value of the drugs they produce.

The American Recovery and Reinvestment Act of 2009 (ARRA) included \$1.1 billion for comparative effectiveness research, including \$700 million to the Agency for Healthcare Research and Quality (AHRQ), of which \$400 million is to be transferred to the National Institutes of Health. An additional \$400 million is to be used by the HHS secretary to conduct, support, or synthesize comparative effectiveness research and to encourage the development and use of infrastructure and systems to generate or obtain outcomes data. The provision also establishes an interagency advisory panel to help coordinate and support comparative effectiveness research.

The House bill would support establishment of a Center for Comparative Effectiveness Research within AHRQ to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent Comparative Effectiveness Research Commission would oversee the activities of the center. The Senate bill would create an independent Patient-Centered Outcomes Research Institute to set a national research agenda and conduct comparative clinical effectiveness research.

The debate over the ARRA provision was acrimonious—with opponents arguing that funding comparative effectiveness research would result in the government telling physicians which medications to prescribe or denying life-saving treatment to the elderly and disabled. As a result, there are only modest provisions on comparative effectiveness in the health reform bill. Still, 54 percent of health care opinion leaders believe establishing a center for comparative effectiveness research to produce and disseminate information on effectiveness, guide clinical practice, and inform benefit design would be an effective strategy for reducing the growth in health care costs.⁴⁵

The House and Senate bills include modest provisions that would utilize comparative effectiveness research in designing patient financial incentives, called value-based insurance design. Under the House bill, the HHS secretary would have the authority to alter patient cost-sharing and payment rates in the public health insurance

plan option to encourage the use of services that promote health and value. The Senate bill exempts value-based insurance plans from certain requirements. Such strategies could create financial incentives for patients and physicians to avoid high-cost treatments that are no more effective than other, lower-cost alternatives. Benefit designs also could require use of patient decision aids or prior authorization systems for cases in which a treatment's effectiveness depends on the patient's preferences or specific health condition. Eighty-six percent of health care opinion leaders favor granting an independent Medicare advisory council the authority to alter Medicare beneficiary incentives based on the effectiveness of services, drugs, and devices.⁴⁶

RAND reports that, while there is substantial evidence that value-based insurance design leads to better adherence to chronic care drug regimens, the total effect on health system spending would be small.⁴⁷ Under the most optimistic scenario, they estimate that value-based benefit design would reduce national health expenditures by 0.3 percent between 2010 and 2019.

Promoting Quality Improvement and Public Reporting

The Commonwealth Fund Commission has documented wide variation in quality of care across the U.S. By setting targets and implementing policies that meet and raise benchmarks of top performance, the U.S. could save lives, improve Americans' quality of life and care experiences, lower safety risks to patients, and prevent the onset of disease and complications. For example, the *Path* report notes that up to 100,000 lives could be saved annually if the U.S. reduced rates of mortality amenable to medical care to those achieved in the best three countries. It also finds that the proportion of adults receiving recommended preventive care could be increased from 50 percent to 80 percent if the U.S. reached attainable benchmark rates of preventive care.⁴⁸

Both the House and Senate bills call for public reporting on the quality and efficiency of care. This effort would build on current Medicare databases on the quality of hospital, nursing home, and home health care and would be expanded to include health outcomes and cost comparisons. National, regional, and state databases also would include standardized reporting of insurance revenues and claims to enable comparisons of administrative, marketing, and other overhead costs, as well as medical-loss ratios and insurers' margins. Publicly reported data would help inform improvement efforts by providing benchmarks based on top performance. Spread of health information technology would enable an ever-richer information resource that could be used to identify and learn from efforts to reach and raise benchmarks of top performance in health outcomes and patient care experiences.

The Senate bill lays out a comprehensive strategy for quality improvement. It would require HHS to develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health and publish an annual national health care quality report card. It calls for development of quality measures that would enable assessments of health outcomes, continuity, and coordination of care; safety, effectiveness, and timeliness of care; health disparities; and appropriate use of health care resources. It also requires public reporting on quality measures through a user-friendly Web site, and requires hospitals to report preventable readmission rates. It creates an interagency working group to coordinate and streamline federal quality activities.

Encouraging Medicare Private Plan Competition

Currently, Medicare beneficiaries have a choice of enrolling in a private Medicare Advantage (MA) plan or being covered under the Medicare fee-for-service program. Initially, private managed care plans were paid at 95 percent of projected Medicare per capita fee-for-service costs in each county, to allow the government to share in anticipated savings from this model of care and to account for any “favorable selection”—the tendency for healthier (and less costly) beneficiaries to enroll in managed care plans—that might occur.

Medicare beneficiary enrollment in private plans grew rapidly in the 1990s, but then declined markedly when the 1997 Balanced Budget Act, which tightened fee-for-service payment rates for providers in the traditional Medicare program, resulted in slower growth in private plan payment rates as well.⁴⁹ The 2003 Medicare Modernization Act not only covered prescription drugs but established a new payment system for managed care and other types of private plans; this system has led to payments that now average about 113 percent of Medicare fee-for-service costs.⁵⁰

MA plans submit bids that represent the payment rate they would require to be able to provide the same benefits offered by traditional Medicare. The payment received by the plan for each enrollee is based on the relationship of its bid to a benchmark rate established for each county and updated annually. If the plan’s bid is below the benchmark, the plan receives the amount of the bid plus 75 percent of the difference between the bid and the benchmark. These additional funds must be returned to beneficiaries through additional services or premium reductions. If a plan’s bid is at or above the benchmark, it receives the benchmark amount.

The House bill would restructure payments to MA plans, phasing the benchmarks down to 100 percent of fee-for-service costs in each county and offering bonus payments

for quality. The Senate restructures payments to MA plans using new benchmarks computed from the weighted average of plan bids, with bonus payments for quality, performance improvement, care coordination, and efficiency. Although the average benchmark under the Senate provision would approximately equal 100 percent of fee-for-service costs nationwide, there could be large differences between MA payments and fee-for-service costs in many counties.⁵¹ The Senate bill cushions the change for beneficiaries in those counties by requiring the HHS secretary to provide additional transitional benefits to beneficiaries who experience a reduction in benefits under competitive bidding. CBO estimates 10-year federal budget savings of \$170 billion from the House bill and \$136 billion from the Senate bill.

Recognizing that overpayment sends a price signal that discourages efficiency and value, these provisions would eliminate, in the aggregate, excess payment to MA plans. Doing so would address the inequity of providing funding that is used for extra benefits to Medicare beneficiaries who enroll in these plans but not for those in traditional Medicare, and ensure that the federal government does not reward higher-cost coverage. More than three-fourths of health care opinion leaders (77%) support bringing payment of Medicare managed care plans in line with the traditional fee-for-service Medicare program.⁵²

SYSTEM REFORM PROVISIONS AND THE FEDERAL BUDGET

To achieve a high performance health system, reform proposals must go beyond ensuring affordable coverage to address health system changes that will improve outcomes and the quality of care, increase efficiency, and slow the growth in total health system costs. The House and Senate bills include key provisions that would affect the way we pay for care by giving providers an incentive to deliver high-value care, as well as slow the rate of increase in health care costs over time by requiring ongoing productivity improvements. In combination with provisions of the American Recovery and Reinvestment Act of 2009, they would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term.

The federal budget impact of the health care payment and delivery system reform provisions of the House bill and the Senate bill are detailed in Exhibit 6. The House bill has \$456 billion of payment and system reform savings, compared with \$483 billion in the Senate bill. New savings come primarily from the productivity improvement requirement and other changes in provider payment updates (\$177 billion in the House bill and \$151 billion in the Senate bill) and from correcting Medicare Advantage payment rates (\$170 billion in the House bill and \$136 billion in the Senate bill). Some provisions


add to Medicare outlays, at least over the 10-year budget horizon, while improving health system performance and laying a foundation for future changes and eventual savings.

CBO estimates that, from 2010 to 2019, the insurance coverage expansions and improvements in the House bill will cost \$891 billion and those in the Senate bill will cost \$763 billion—the difference occurs primarily because the House bill goes further to make coverage affordable for low- and moderate-income families (Exhibit 7). These costs would be more than offset by system savings and new revenues. Over the same time period, provisions in the Senate bill would reduce the deficit by \$132 billion and those in the House bill would reduce the deficit by \$138 billion. CBO further estimates that both bills would reduce the federal deficit in the following decade.

Exhibit 7. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019
Dollars in billions

| | CBO estimate of House bill (H.R. 3962) | CBO estimate of Senate bill (H.R. 3590) |
|---|---|--|
| Total Net Impact on Federal Deficit, 2010–2019 | –\$138 | –\$132 |
| Total Federal Cost of Coverage Expansion and Improvement | \$891 | \$763 |
| Gross Cost of Coverage Provisions | \$1,052 | \$871 |
| • Medicaid/CHIP outlays | 425 | 395 |
| • Exchange subsidies | 602 | 436 |
| • Small employer subsidies | 25 | 40 |
| Offsetting Revenues and Wage Effects | –\$162 | –\$108 |
| • Payments by uninsured individuals | –33 | –15 |
| • Play-or-pay payments by employers | –135 | –28 |
| • Associated effects on taxes and outlays | 6 | –65 |
| Total Savings from Payment and System Reforms | –\$456 | –\$483 |
| • Productivity updates/provider payment changes | –177 | –151 |
| • Medicare Advantage reform | –170 | –136 |
| • Other improvements and savings | –109 | –196 |
| Total Revenues | –\$574 | –\$413 |
| • Excise tax on high premium insurance plans | — | –149 |
| • Surtax on wealthy individuals and families | –461 | — |
| • Other revenues | –113 | –264 |

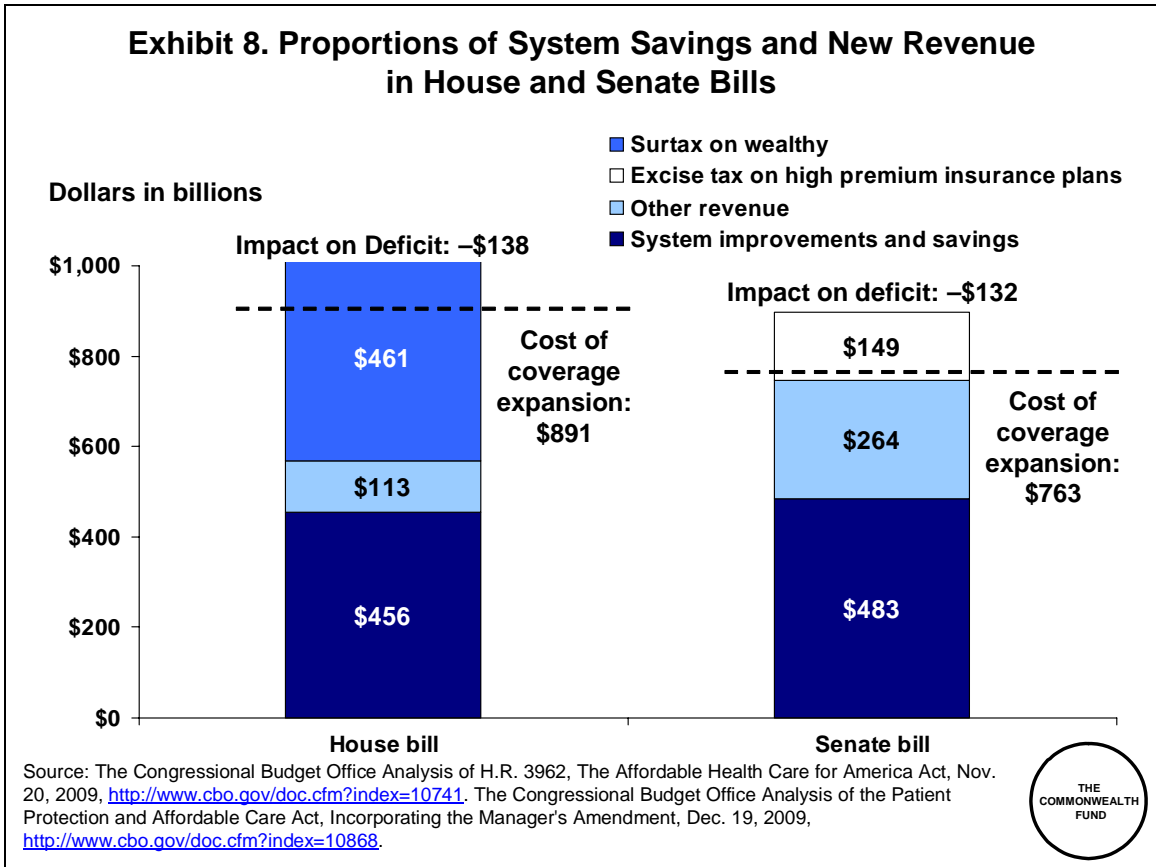
Note: House totals do not reflect net impact on deficit due to rounding.
Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, <http://www.cbo.gov/doc.cfm?index=10868>. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, <http://www.cbo.gov/doc.cfm?index=10741>.



New Revenue Sources

Savings from delivery system reforms and improvements would offset nearly two-thirds of the net cost of coverage expansion in the Senate bill and just over half of the net cost of coverage expansion in the House bill. In both bills, new revenues would more than offset the remainder of the costs (Exhibit 8). Both the House and the Senate look to the health industry as a source of financing and include new taxes or fees on medical device

manufacturers, manufacturers and importers of branded drugs, and health insurance providers.



In the House bill, three-fifths of the new revenues come from a surcharge on wealthy families earning more than \$1,000,000, or individuals earning more than \$500,000, per year. This surcharge would not be indexed for inflation; despite this, the surcharge is unlikely to burden a significantly larger share of the population in the next decade.⁵³ The Joint Committee on Taxation (JCT) estimates that this surcharge would yield \$461 billion in new revenues over 2010–2019.⁵⁴

In the Senate bill, the largest source of new revenues, accounting for nearly a third of the new revenues, would be a tax on high-premium health insurance plans. The bill would impose a 40 percent excise tax on health insurance premiums over a given threshold (\$8,500 for individual policies and \$23,000 for family policies) beginning in 2013. The premium threshold would be indexed to the consumer price index plus one percentage point in subsequent years; this increase would be slower than the rate of health care cost growth, resulting in an annual increase in the number of people with

plans that exceed the threshold unless health care cost growth slows substantially. The JCT estimates this would yield revenues of \$149 billion over 2010–19.

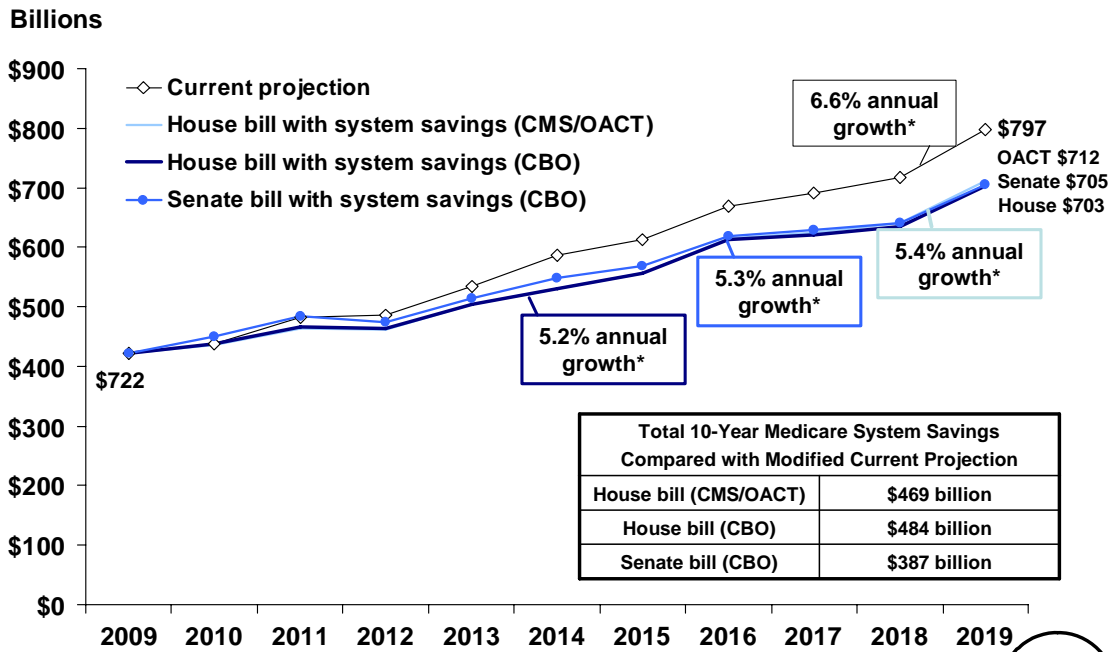
The theory is that such a tax would reduce the use of “Cadillac” plans that offer excessive benefits and, as a result, employers would offer more basic plans and use the reduction in premium expenses to raise employee wages, which would generate income and payroll tax revenue. By this reasoning, the reduced coverage of excessive benefits also would control the growth in utilization of services. A majority of health care opinion leaders (58%) support ending the federal income tax exemption for employer-financed premiums above a certain level as an approach to financing coverage expansion.

In the authors’ view, however, there is little empirical evidence that a tax on high-premium plans would target those plans that provide excessive benefits, and thus little evidence the tax would have a significant effect on health care spending.⁵⁵ Moreover, Commonwealth Fund researchers have found that ending the income tax exemption across-the-board could adversely affect individuals who are already at high risk of losing their health coverage.⁵⁶ Evidence suggests that such a policy could disproportionately affect workers in small firms, older workers, and wage earners in industries with high expected claims costs. 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, a cap on the tax exemption for plan premiums would have to take into account the health characteristics of enrollees. A better alternative would be a tax on nonessential benefits that go below the benefit packages offered through the insurance exchange.

ASSESSING THE BILLS’ POTENTIAL IMPACT

Medicare expenditures are currently projected to grow 6.6 percent annually over 2010 to 2019 (Exhibit 9). Applying the net Medicare savings in both the House and Senate bills bends the Medicare spending curve and reduces the projected annual growth rate to 5.2 and 5.3 percent, respectively, according to CBO. The CMS actuary, in a separate estimate, projects Medicare cost growth at 5.4 percent under the House bill.⁵⁷ Although additional federal outlays are required to cover the uninsured and improve benefits for the underinsured, these are one-time shifts in spending. The Medicare provisions in the reform bills set in motion genuine reform that enhances value and slows the underlying rate of spending growth, with important long-term implications. Total 10-year savings resulting from Medicare and other federal budget reforms in the House bill are estimated at \$484 billion by CBO, and \$469 billion by the CMS actuary. Medicare system savings are projected by CBO to total \$387 billion over 10 years under the Senate proposal.

**Exhibit 9. Medicare Spending with System Savings, 2010–2019:
Current Projection and Alternative Scenarios**



* Notes: Compound annual growth rate.
Data: Estimates by CMS using Congressional Budget Office (CBO) cost estimates as provided on Nov. 6, 2009 and Nov. 18, 2009 and OACT estimates as provided on Nov. 14, 2009.



Projecting the savings and costs of policy changes is, in many ways, an art rather than a science. Certainly, CBO tries to produce reasonable estimates, as do agencies and organizations such as the Office of Management and Budget (OMB). Yet estimates can vary significantly as a result of differences in the way policies are designed and assumptions built into the estimating models. Exhibit 10 illustrates differences among the estimated savings of health reform options outlined in *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, a Commonwealth Fund report; proposals from the president estimated by the OMB, and estimates by CBO.⁵⁸ As shown, the estimates vary widely across these sources. Although some portion of these differences may be related to alternative specifications of the proposed policies, CBO is particularly conservative in estimating savings based on changed incentives for providers, since it maintains that more evidence is required as a firm basis for such projections.

**Exhibit 10. Bending the Curve:
Options that Achieve Savings
Cumulative 10-Year Federal Budget Savings**

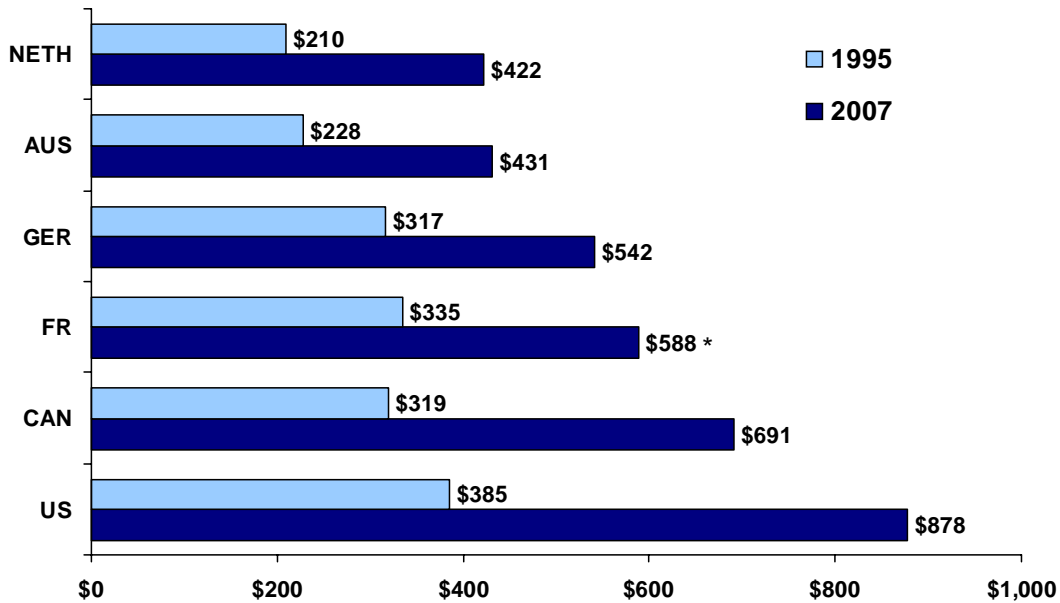
| | Path Estimate | CBO Estimate | OMB Estimate |
|---|----------------|----------------|----------------|
| Aligning Incentives with Quality and Efficiency | | | |
| • Hospital pay-for-performance | -\$ 43 billion | -\$ 3 billion | -\$ 12 billion |
| • Bundled payment with productivity updates | -\$123 billion | -\$201 billion | -\$110 billion |
| • Strengthening primary care and care coordination | -\$ 83 billion | +\$ 6 billion | — |
| • Modify the home health update factor | — | -\$ 50 billion | -\$ 37 billion |
| Correcting Price Signals in the Health Care Market | | | |
| • Reset Medicare Advantage benchmark rates | -\$135 billion | -\$158 billion | -\$175 billion |
| • Reduce prescription drug prices | -\$ 93 billion | -\$110 billion | -\$ 75 billion |
| • Limit payment updates in high-cost areas | -\$100 billion | -\$ 51 billion | — |
| • Manage physician imaging | -\$ 23 billion | -\$ 3 billion | — |
| Producing and Using Better Information | | | |
| • Promoting health information technology | -\$ 70 billion | -\$ 61 billion | -\$ 13 billion |
| • Comparative effectiveness | -\$174 billion | +\$ 1 billion | — |
| Promoting Health and Disease Prevention | | | |
| • Public health: reducing tobacco use | -\$ 79 billion | -\$ 95 billion | — |
| • Public health: reducing obesity | -\$121 billion | -\$ 51 billion | — |
| • Public health: alcohol excise tax | -\$ 47 billion | -\$ 60 billion | — |

Source: R. Nuzum, S. Mika, C. Schoen, and K. Davis, *Finding Resources for Health Reform and Bending the Health Care Cost Curve* (New York: The Commonwealth Fund, July 2009).



Another example of the potential for different perspectives on the potential effects of specific policies is CBO’s estimates of savings from negotiating pharmaceutical prices. CBO estimates no savings from negotiation of pharmaceutical prices by the HHS secretary over those currently obtained by pharmaceutical benefit managers. Yet other countries achieve substantially lower drug prices than the U.S. through systems of price negotiation on behalf of their entire population. The U.S. pays far more per capita for pharmaceutical products than other countries, with the differences growing wider over the last 15 years (Exhibit 11). Countries such as Germany and Denmark have had great success with “reference pricing”—paying the price of the lowest-cost drug in a given category, with patients paying the difference. Through such a system, patients have an incentive to select the lowest-cost, equally effective alternative. In the U.S., such concepts are labeled value-based benefit design.⁵⁹

**Exhibit 11. Pharmaceutical Spending per Capita: 1995 and 2007
Adjusted for Differences in Cost of Living**



* 2006
Source: OECD Health Data 2009 (June 2009).



These differences in perspective have led CBO to substantially underestimate the savings from and overestimate the costs of the proposals included in the last three major health reforms (Exhibit 12). A recent analysis of CBO estimates of health reforms in the past three decades by Jon Gabel of the National Opinion Research Center illustrates the magnitude of this tendency.⁶⁰ Actual savings from the Medicare hospital prospective payment system introduced in 1983 were double those estimated by CBO. Health care savings from the Balanced Budget Act of 1997 were 113 percent greater in 1999 than CBO projections. Actual spending under the Medicare Modernization Act was 40 percent lower than projected.

**Exhibit 12. CBO Estimates of Major Health Legislation
Compared with Actual Impact on Federal Outlays**

| Health Provision | CBO Projection | Actual Impact |
|--|--|--|
| Medicare hospital PPS, 1982–1983 | \$10 billion savings, 1983–1986 | \$21 billion savings, 1983–1986 |
| BBA 1997: skilled nursing facilities; home health; and fraud, waste, and abuse reduction | \$112 billion savings total, 1998–2002 | Actual savings 50% greater in 1998 and 113% greater in 1999 than CBO projections |
| MMA 2003: Medicare Part D | \$206 billion additional spending | Actual spending 40% lower than projection |

Source: J. Gabel, "Congress's Health Care Numbers Don't Add Up," *New York Times*, Aug. 25, 2009.



Gabel notes that CBO has particular difficulty estimating savings when it considers more than one change at a time. He notes CBO's reluctance to project savings from initiatives that represent significant changes from current policy; for example, its projected estimate of zero savings from the pilots on innovative payment methods. Commonwealth Fund studies of ways to invest in primary care, create medical homes, bundle hospital acute-care episode payments with post-hospital care, and make productivity improvements find that such policies have the potential to yield considerable savings.⁶¹

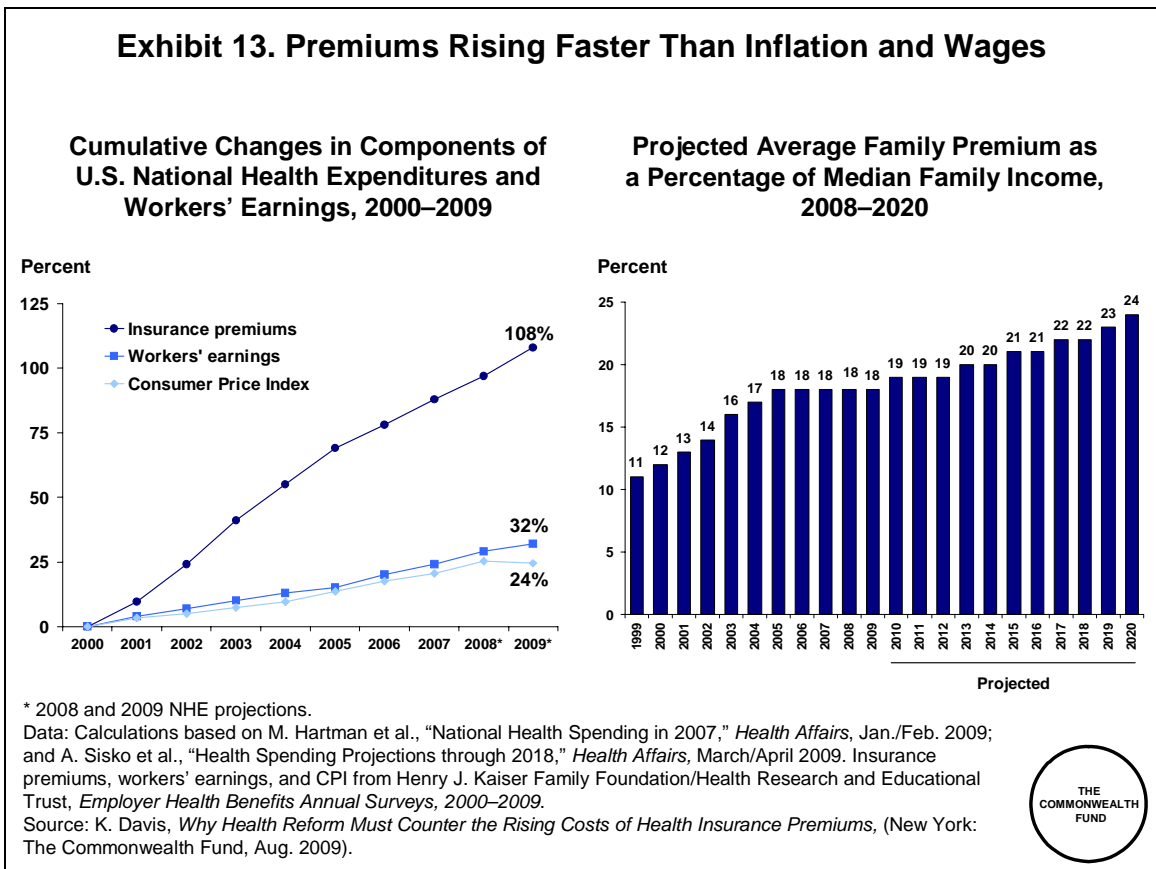
Given the inevitable uncertainties as new terrain is traversed, Congress may want to establish a system for monitoring actual spending and savings, as well as access and quality, over time. Certain actions or features of health reform could be conditioned on actual experience, rather than hinging on information that is inherently difficult to project with any precision.

NATIONAL HEALTH SPENDING AND OTHER IMPACTS

By mandate, CBO focuses on federal budget cost. It does not provide estimates to Congress of the effect of policies on cost-containment across the health system. By contrast, the Commonwealth Fund *Bending the Curve* report focuses on total health

spending, including spending by employers and households.⁶² If a certain policy saves money for employers or households because, for example, premiums are reduced or rise at a slower rate, those would be desirable and much-needed savings. Such savings are just as beneficial to American families and businesses as a tax cut and deserving of much greater attention.

In fact, over the last decade health insurance premiums have taken a toll on real incomes of working families. Health insurance premiums have more than doubled, rising by 108 percent while workers' earnings have increased by 32 percent, and the consumer price index has increased by 24 percent (Exhibit 13). Family premiums as a percentage of family incomes have increased from 11 percent at the beginning of this decade to 18 percent today. With increases in employer health insurance premiums regularly exceeding economic growth, ever-higher health spending has directly contributed to stagnating or declining incomes for middle-class families and workers.⁶³



High and rapidly rising premiums reflect the lack of competition in the health insurance market, high administrative costs, and the absence of effective private sector cost containment tools. A public plan is an important element of an overall strategy to

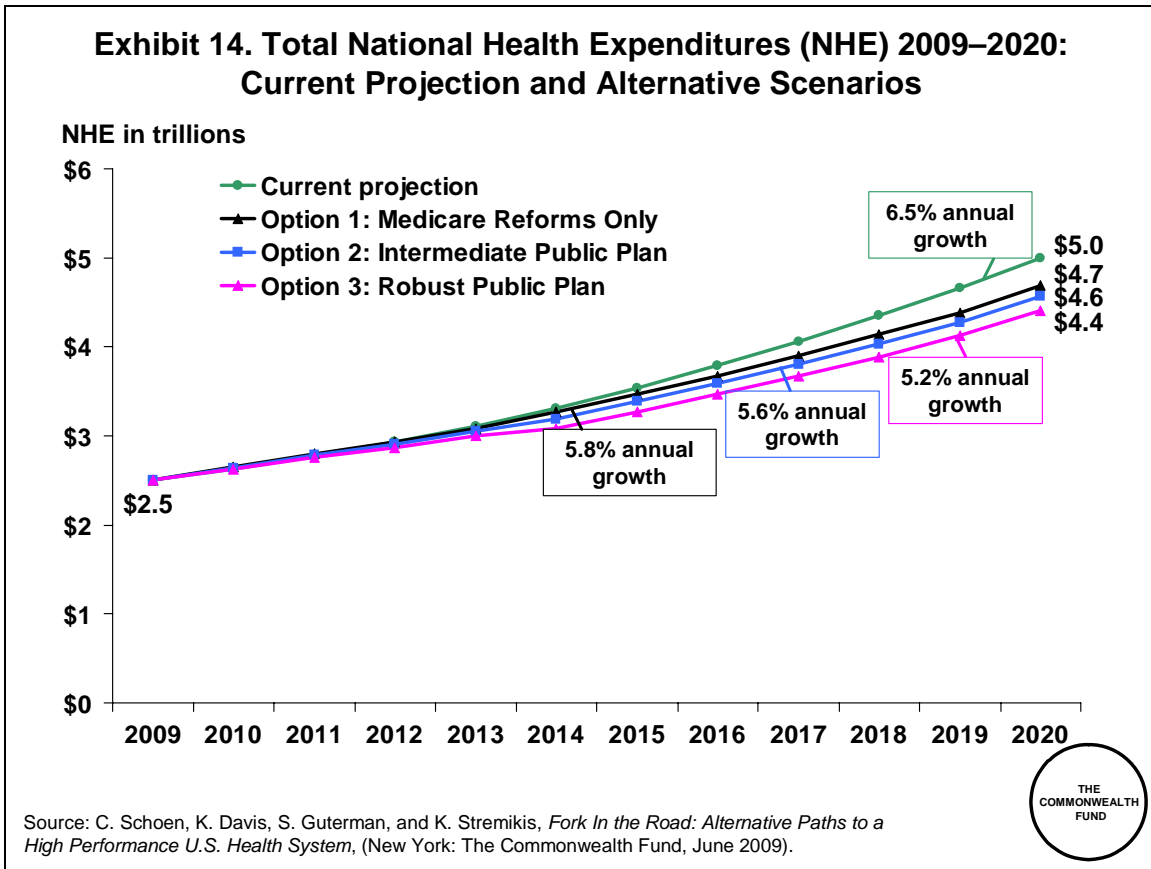
transform the insurance market and slow the growth in total system costs in the long term. CBO estimated that a robust public health insurance plan, with the authority to use Medicare payment rates and implement innovative payment methods (along the lines of the bill that was passed by the Ways and Means Committee), would yield a premium 10 percent lower than private plans within the exchange and would enroll about 10 million people.⁶⁴ Even more important, a public plan could slow the rate of increase in premiums over time by incorporating requirements for productivity improvement.

The House bill, however, dropped the link between the public plan and Medicare payment rates, substituting a provision requiring the HHS secretary to negotiate provider payment rates. CBO estimated that the enacted House bill would cover only 6 million Americans under the public plan, or 2 percent of the 282 million people under age 65, in 2019.

Nearly all of the individuals covered through the exchange, including through the public plan, are currently uninsured and would be eligible for premium subsidies. Employer-based coverage would remain the mainstay of the American insurance market, with 168 million Americans, or 60 percent of those under age 65, holding employer-sponsored plans under the House bill and 158 million, or 56 percent of those under age 65, under the Senate bill.

There is great uncertainty about the long-term effectiveness of the public plan option in slowing cost growth. Initially, providers that care for uninsured and low-income patients are likely to participate, even with payment rates well below commercial rates, as most of those newly covered would be patients for whom safety-net providers now receive little or no payment.

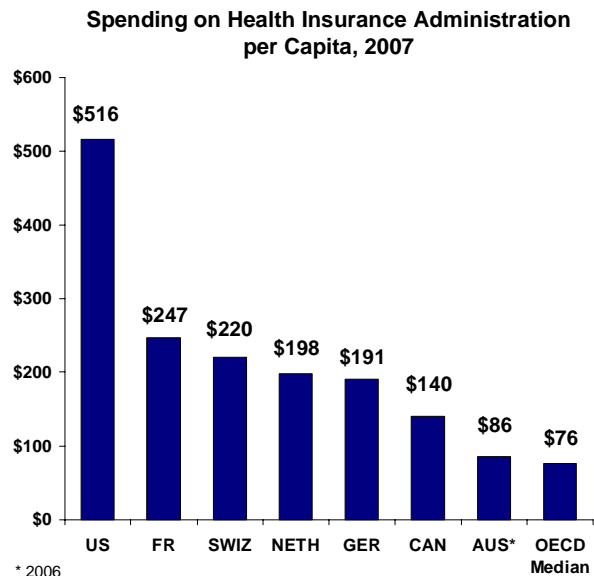
A Commonwealth Fund analysis of trends in national health expenditures finds that inclusion of a robust public plan could achieve system savings of \$3 trillion, slowing the growth rate in national health expenditures over 2010–20 from 6.5 percent to 5.2 percent. Even an intermediate public plan option, closer to the House version and the Senate Health, Education, Labor, and Pensions Committee version, would yield \$2 trillion in savings by slowing growth from 6.5 percent to 5.6 percent (Exhibit 14).⁶⁵ A strong public health insurance plan could achieve significant system savings, providing much-needed relief to individuals and small-business workers. Three-fourths of health care opinion leaders support including a public health insurance option in the exchange.⁶⁶



Depending on how effective the secretary is in negotiating provider payment rates and lowering administrative costs, the public plan could put significant pressure on private insurers to slow growth in premiums for employers and workers over time, as the exchange is opened to larger firms. Currently, the U.S. health system has the highest administrative costs of any country—with \$516 per capita spent on administration in 2007, compared with an OECD median of \$76 (Exhibit 15). A McKinsey report estimates that high administrative costs add an unnecessary \$90 billion a year to health spending—costs borne both by employers and workers.⁶⁷

Exhibit 15. High U.S. Insurance Overhead: Insurance Related Administrative Costs

- **Fragmented payers + complexity = high transaction costs and overhead costs**
 - McKinsey estimates adds \$90 billion per year*
- **Insurance and providers**
 - Variation in benefits; lack of coherence in payment
 - Time and people expense for doctors/hospitals



* McKinsey Global Institute, *Accounting for the Costs of U.S. Health Care: A New Look at Why Americans Spend More* (New York: McKinsey, Nov. 2008).



The House bill also would affect trends in total health system spending. Important provisions include the creation of the insurance exchange and insurance market rules, including, for example, minimum medical-loss ratios for plans. Administrative overhead in individual plans now averaging 40 percent, and 15 to 35 percent in small-business plans, would fall to 12 to 14 percent in plans offered through the insurance exchange.⁶⁸ On average, 13 to 18 percent of private premiums now go toward administration (e.g., marketing, claims, and underwriting) and profit margins for the dominant commercial for-profit plans.⁶⁹ We should expect these costs to decline if we simplify administration and intensify competition. CBO estimates that the exchange would lower administrative costs by four to five percentage points.⁷⁰

The insurance market has grown increasingly concentrated in the last decade.⁷¹ In all but three states, two insurance plans account for over 50 percent of enrollment.⁷² Without significant competition, plans can increase profit margins and simply pass along higher prices demanded by providers to employers and households, with administrative costs going up at the same rate in a form of “cost-plus” pricing. Including a public health insurance option or private cooperative plan in the exchange could act as a stimulant to increase competition and lower administrative overhead.

The House bill would provide for review of the rate of premium increases in plans participating in the exchange, and the Senate bill would give the exchange authority to reject plans with unjustified premium increases prior to implementation. Commonwealth Fund studies estimate that slowing premium growth by 1.0 percentage points annually would save \$2,571 in family premiums in 2020; slowing by 1.5 percentage points annually, as pledged by an industry coalition, would save \$3,759 for the average family in 2020.⁷³ Slowing growth in national health expenditures by 1.5 percentage points annually would provide additional relief to businesses and households: the average family would save \$2,200 in 2020 if the rate of increase could be reduced from 6.5 percent annually to even just 5.2 percent.⁷⁴

In short, federal reforms have the potential to produce substantial total health system savings for the nation—well beyond what is reflected in the estimated federal budget impact. The combined effect of these provisions on trends in national health expenditures, however, is difficult to estimate, and CBO has indicated that it does not have the modeling capacity to do so. Estimates released by the CMS Office of the Actuary indicate that the legislation could produce modest increases in national health expenditures, but this estimate gives little credit for savings to measures that would reform provider payment, negotiate prescription drug prices, increase competition among plans in an insurance exchange, encourage public reporting, or apply the results of comparative effectiveness research. Yet these measures are a crucial platform for developing and implementing further policies to contain health care cost growth. As such, they have broad support from health care opinion leaders and business leaders as effective ways to control costs.

AREAS FOR FURTHER ATTENTION

The health reform proposals now passed in the House and Senate will fundamentally change our present course of rising costs and increasing numbers of uninsured and underinsured people. The bills represent a pragmatic approach to closing the gaps in insurance coverage, building on a mix of employer coverage and private plans in a health insurance exchange or exchanges, retention of Medicare, and expansion of Medicaid. Most of the ideas that have been advanced by policymakers and health care opinion leaders to deal with rising costs are reflected in the bills.

Yet the U.S. health system is unlikely to reach its potential without more far-reaching measures in the coming years. Even including the additional outlays for coverage of the uninsured and improved coverage of the underinsured, an estimated 18 to 23 million people will remain uninsured and the costs of coverage and care will create

financial burdens for many others. The proposed reforms should lead to a substantial slowing of the growth in health spending, but further reforms may be needed to hold rates of increase in national health expenditures to a course that is sustainable and affordable to employers, households, and government.

Regardless of the shape of health reform legislation, it will be especially important to establish a system for monitoring progress on agreed-upon health reform goals, with a mechanism for making mid-course corrections and further changes as needed to move the U.S. health system toward a high performance health system by 2020. Estimates of cost and savings could be seriously under- or overestimated; if so, corrective actions may be required. Additional steps may be required to ensure affordability for families as well as stable financing. In addition, as experience is gained with new provider payment methods, strategies for harmonizing public and private provider payment will be needed to avoid having public and private incentives for providers working at cross-purposes.

Health Goals, Monitoring, and Reporting

Explicit goals for health reform should be detailed in the legislation and a system instituted for monitoring progress toward those goals. They should include achievable goals by 2020 for: health outcomes; the share of population receiving care from patient-centered medical homes and accountable care organizations; performance on quality, safety, and disparities in care; the share of population covered by health insurance meeting an affordability standard; and progress in bending the health care cost curve. Exhibit 16 presents illustrative health system performance goals for 2020 and examples of possible shorter-range target indicators.

Exhibit 16. Illustrative Health Reform Goals and Tracking Performance

- 1. Secure and Stable Coverage for All**
 - Percent of population insured
 - Percent of population with premiums and out-of-pocket expenses within affordability standard
- 2. Slowing Growth of Total Health Spending and Federal Health Outlays**
 - Annual growth rate in total health system expenditures
 - Annual growth rate in Medicare expenditures
 - Impact on federal budget: new spending, net savings, new revenues
- 3. Health Outcomes and Quality**
 - Percent of population receiving key preventive services or screenings
 - Percent of population with chronic conditions controlled
 - Percent reduction in gap between benchmark and actual levels of quality and safety
- 4. Payment and Delivery System Reform**
 - Percent of population enrolled in medical homes
 - Percent of physicians practicing in accountable care organizations
 - Percent of provider revenues based on value



Coordinating national leadership for all of these components of the health system would enable the federal government to: 1) assign clear responsibility and authority for the key aspects of the health system, and 2) provide the necessary capacity to enable agencies and organizations to act to secure access for all, better health outcomes, and slow the rate of cost growth. The new leadership roles needed to provide a coordinated and systemic approach to improving population health and wresting better value from health spending should be addressed as part of health reform legislation.

Harmonization of Public and Private Provider Payment

While the House bill makes a major start on rapid-cycle testing of payment innovation in Medicare, it does not specifically address private sector payment. Broadening the mandate of the Center for Medicare and Medicaid Innovation to include both public and private sector payment would:

- amplify the power of effective incentive approaches by sending the same signals about what is valued across different payers;

- simplify administrative complexity and reduce burdens associated with existing payment methods, as well as minimize administrative burden for providers who must respond to these new methods; and
- reduce the likelihood of payment distortions across payers or regions.

A working group including a cross-section of clinicians, consumers, hospitals, employers, and policy experts has recommended harmonizing public and private payer innovation efforts to facilitate effective payment reform.⁷⁵ It suggests that a Center for Innovation specifically address the need to harmonize and align public and private payers. The group also suggests that the center should foster Medicare and Medicaid participation in local payment pilots designed by other payers and providers that are responsive to state and regional community needs, as well as support pilots designed and developed by federal officials that involve the private sector and state payers—thus participating in both bottom-up and top-down efforts.

Congress also should make clear that it wants rapid-cycle testing and learning, coordination across pilots so that providers desiring to participate in both medical home and accountable care organizations can do so, and rapid spread of successful innovations. It should provide the tools that CMS needs to carry out this function and make the HHS secretary accountable for doing so.

Perhaps most important, Medicare, Medicaid, and private and public plans participating in the health insurance exchange (or exchanges) should incorporate proven payment methods as they emerge from rapid-cycle testing. Health reform should include provisions to harmonize provider payment rates under private plans, Medicare, Medicaid, a public plan, and/or health cooperative plans. A commission should be established and authorized to institute such a harmonized payment system as rapidly as possible, including making payment methods that are found to be effective in improving quality and/or slowing costs the basis of payment across payers—with payment from any source linked to provider participation in all such plans. Productivity improvement requirements on increases in provider payment for plans covering those under age 65 should be similar to those required for Medicare payment increases.

MOVING FORWARD AND MAKING HISTORY

There is an urgent need to relieve both businesses and families of the crushing burden of rising health care costs. No one would argue that all of the benefits, costs, and consequences of health reform are known with certainty. What is known is that we cannot afford to continue on our current course.

The House and Senate bills contain several provisions that would go a long way toward changing the financial incentives and support required to transform the organization and delivery of health care (Exhibit 17). Keys to long-run cost containment and improving quality of care that are incorporated in the House and Senate health reform bills include:

1. Changing the insurance market
2. Offering a public plan
3. Instituting provider payment reform
4. Adjusting payment for productivity improvement
5. Controlling spending growth
6. Negotiating pharmaceutical prices
7. Incentivizing primary care and prevention
8. Utilizing value-based benefit design
9. Promoting quality improvement and public reporting
10. Encouraging Medicare private plan competition.

Exhibit 17. Projected Savings and Effectiveness of System Reform Provisions in House and Senate Reform Bills
2010–2019 (in billions)

| | CBO Estimate of Budget Savings, House of Representatives Bill 11/05/09 | CBO Estimate of Budget Savings, Senate Bill 12/19/09 | Percent Opinion Leaders Favor, or View as Effective | Projected System Cost Containment Effectiveness |
|---|--|--|---|---|
| Establish a health insurance exchange with market rules; repeal antitrust exemption | | | 92% ^a | ++ |
| Public health insurance plan option | -\$5 | — | 76% ^a | ++ |
| Institute payment innovation to reward physicians and hospitals for value not volume | -\$2 | -\$8 | 97% ^b | +++ |
| Require annual provider productivity improvements | -\$177 | -\$151 | | +++ |
| Independent board | — | -\$28 | 75% ^d | ++ |
| Negotiate pharmaceutical prices | -\$75 | — | 81% ^d | ++ |
| Increase payment for primary care services | -\$6 | \$6 | 61% ^b | + |
| Cover preventive services and invest in community and employer prevention and wellness programs | \$48 | \$17 | | + |
| Institute value-based benefit design linked to comparative effectiveness research | | | 86% ^d | + |
| Level the playing field between Medicare Advantage plans and traditional Medicare coverage | -\$170 | -\$136 | 77% ^b | + |
| Tax on premiums in excess of threshold | — | -\$149 | 58% ^c | + |

Authors' views of long-term effectiveness in controlling total health system spending: Very effective = +++, Effective = ++, Somewhat effective = +. Health Care Opinion Leaders Surveys: ^a Dec. 2008; ^b April 2009; ^c June 2009; ^d Oct. 2009. Source: Commonwealth Fund estimates; Congressional Budget Office, Letter to the Honorable John D. Dingell, Nov. 20, 2009; Letter to the Honorable Harry Reid, Dec. 19, 2009.



The combined effect of these provisions on trends in national health expenditures is difficult to estimate, and CBO has indicated that it does not have the modeling capacity to do so. The CMS actuary estimates modest increases in trends in national health expenditures from these provisions, but similarly gives little credit for savings to measures that would reform provider payment, negotiate prescription drug prices, increase competition among plans in an insurance exchange, encourage public reporting, or apply the results of comparative effectiveness research.⁷⁶ Yet these measures are a crucial platform for developing and implementing policies to contain health care cost growth. As such, they have broad support from health care opinion leaders and business leaders as effective ways to control costs.

For example, a recent analysis by the Business Roundtable, prepared by Hewitt, found that such legislative reforms could potentially reduce the trend line in employment-based health care spending by \$3,000 per employee by 2019.⁷⁷ One recent independent analysis put health system spending savings at \$683 billion over the period 2010–2019, slowing the annual growth in health expenditures from 6.4 percent to 6.0 percent.⁷⁸

Both CBO and the CMS actuary assume that these provisions would bring significant savings to Medicare, of \$484 billion and \$469 billion, respectively, over 2010–19. Medicare outlays are projected to grow 6.6 percent annually from 2010–19 under current law. This growth would be slowed to 5.2 percent annually under CBO estimates and 5.4 percent annually under the CMS actuary estimates. In 2019, Medicare spending as a percent of gross domestic product would be 3.8 percent under current law; it would fall to 3.3 percent under the House bill, according to CBO estimates.

CBO's estimates of federal budget impact, however, are fraught with uncertainty, given the multitude of changes and potentially synergistic effect. As detailed above, on the last three occasions when CBO has estimated the savings or costs of health reforms (the 1982–83 Medicare changes in hospital payment, the 1997 Balanced Budget Act, and the 2003 Medicare Modernization Act covering prescription drugs), it was wide of the mark—with savings more than double those estimated and cost overstated by 40 percent.

There is good reason to be optimistic that the measures incorporated in the bills under consideration would stimulate significant changes in the organization and delivery of health services, and create powerful incentives to improve efficiency and productivity. Given the uncertainties that now exist, however, it will be especially important to establish a system for monitoring progress on agreed-upon health reform goals and provide a mechanism for mid-course corrections and further changes as needed to move

the U.S. toward a high performance health system by 2020. Estimates of costs and savings could be seriously under- or overestimated; if so, corrective actions may be required. Implementing a new insurance exchange and testing payment and system reform innovations may call for additional steps as experience is gained and lessons are learned.

Congressional oversight will be critical as health reform implementation proceeds. Congress should insist that the administration establish a system for tracking performance on major health reform goals, with annual reports issued by the president and recommendations for additional policy actions. If necessary, Congress can act in future years to modify reform, including phasing in various provisions more slowly or quickly, or adding additional safeguards or savings.

Even under current estimates, 18 to 23 million people will remain uninsured and many others will still face financial barriers to obtaining needed care. Additional steps may be required to ensure affordability for families as well as stable financing.

Finally, the one major disappointment in the proposed bills is the absence of significant incentives or levers for private insurers to control health care costs. Private insurers, in opposing a public plan, have basically argued that they do not have the ability to slow premium growth or achieve economies because of demands for higher prices from a powerful health care provider sector. Over time, as experience is gained with new provider payment methods, strategies for harmonizing public and private provider payment will be needed to avoid having public and private provider incentives working at cross-purposes.

Congress has a historic opportunity to pass comprehensive health care reform legislation this year. Multiple strategies for improving quality and slowing the growth in total health system spending will help spark economic recovery, put the nation back on the road to fiscal responsibility, and ensure that millions more families will be able to get the care they need, while having financial security and relief from rising insurance premiums.

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