ON THE ROAD TO A HIGH PERFORMANCE HEALTH SYSTEM: CHANGING COURSE AND MAKING HISTORY

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ON THE ROAD TO A HIGH PERFORMANCE HEALTH SYSTEM:
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Oral Statement

Thank you for this opportunity to present my assessment of the urgent need for health care reform. President Obama has made a forceful case for health reform, stressing the imperative of action on the goals of ensuring stability and security of health insurance coverage for those who have it, providing insurance for those who don't, and slowing the rise in health care costs for employers, families, and government. He set forth a pragmatic plan, building on what works and fixing what doesn't, while signaling his openness to the best ideas from all. Congress has taken unprecedented steps toward passing comprehensive reform that achieves these goals and moves our system down the path to high performance. As the President stressed, after a century of inaction, now is the season to act and failure is not an option. It is too important to those who are harmed by our inadequate insurance system, too important to our economy, and too important to our character as a country.

This forum is aptly titled the "Urgent Need for Health Care Reform." The urgency of action on health reform is compelling in both human and economic terms. Our health care system is at a breaking point, with the uninsured facing extraordinary hardships, small businesses struggling to overcome competitive disadvantages, and taxpayers saddled with unsustainable burdens.

Last Thursday, the Bureau of the Census released the latest data on the number of Americans without health insurance. The number of uninsured individuals rose from 45.7 million in 2007 to 46.3 million in 2008. This increase of 0.6 million uninsured would have been much worse without an offsetting growth in government-provided insurance that brought coverage to 4.4 million people, including a 3.0 million under Medicaid. The latest data show the importance of the nation's safety-net insurance system—Medicaid and the Children's Health Insurance Program (CHIP). The major bright spot in these new data was the fact that the rate of uninsured children is at its lowest since 1987—9.9 percent. Still, more than 7.3 million children remain uninsured, highlighting the importance of Congress's reauthorization and expansion of the CHIP program earlier this year—an action that covered 4 million more uninsured low-income children.

The high cost of health care in the United States—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. Health care already consumes 17 percent of the nation's economy and will reach 21 percent by 2020 if trends continue. With increases regularly exceeding economic growth, ever-higher health spending has directly contributed to stagnating or declining incomes for middle-class families and workers. Health insurance premiums have risen from 11 percent of family income in 1999 to 18 percent today. If we continue on our current course, they will reach 24 percent by 2020.

Nor are we receiving value for what we are spending. The nation is now in last place, behind 18 other high-income countries, on "mortality amenable to health care before age 75"—in other words, deaths that are potentially preventable with timely, effective health care or early efforts to screen and prevent the onset of disease. Too often, we as a nation fail to lead on health outcomes or care experiences: compared with many other advanced countries, U.S. adults are far more likely to report medical errors that result from delays in hearing about diagnostic tests, to encounter duplicative care or coordination gaps, and to lack rapid access to primary care or care after hours. We must change course.

Goals of Health Reform and Congressional Action

The goals of health reform are: 1) to ensure the stability and security of health insurance coverage for those who have it; 2) to provide insurance for those who don't; and 3) to slow the rise in health care costs for employers, individuals, and government.

Impact of Insurance Provisions

The health reform provisions in H.R. 3200 as amended would go a long way toward fixing our broken health insurance system. Consistent with the priorities outlined by the President, the leading congressional proposals, including HR 3200, aim to provide near-universal health insurance by building on the strongest aspects of the existing insurance system—the large-group market and Medicaid and CHIP—and by strengthening the weakest parts of the existing system—the individual and small-group markets—where so many individuals and small businesses face the insurmountable obstacles of medical underwriting, high premiums, astronomical administrative costs, and uncertainty regarding their benefits.

- The Congressional Budget Office (CBO) estimates that the House bill would reduce the numbers of uninsured by 37 million, leaving about 17 million nonelderly residents uninsured.

- Employer-sponsored insurance under the House bill will remain the primary source of insurance for most families, covering 60 percent of the population, or 166 million people.
- The CBO estimates that about 30 million people, or 11 percent of the under-65 population, will gain coverage through the health insurance exchange by 2019.
- Coverage through the Medicaid program would rise by about 9 million people by 2015, and by 11 million by 2019.
- The establishment of insurance market rules, creation of the insurance exchange, and an essential-benefit package, and the provision of sliding-scale premium and cost-sharing assistance would help those Americans who are most adversely affected by the current health system. Health status would no longer affect one's ability to get coverage with a reasonable premium. The shared responsibility of employers to contribute 72.5 percent of health insurance premiums of workers (65 percent for families) would go a long way to making the employee shares of premiums affordable.
- The sliding-scale premium and cost-sharing assistance for those in the exchange would make premiums and cost-sharing more affordable for lower- and moderate-income families.
- The stability of coverage would be improved as people lose or change jobs or experience changes in life circumstances. Most importantly, young adults who leave their parents' insurance policies, widowed or divorced spouses who lose their coverage obtained through a family member, people who lose their job, and adults forced into early retirement by disability or a serious health problem—all would have a place to turn to find affordable coverage.

In short, these key House provisions would ensure that no one becomes bankrupt from ruinous medical bills or struggles to pay medical debts arising from a serious illness.

Impact of System Reform Provisions

To achieve a high performance health system, health reform proposals must go beyond ensuring affordable coverage to address health system changes that will improve health outcomes and the quality of health care, increase efficiency, and slow the growth in total health system costs. The House bill includes key provisions for: investing in primary care; replacing the current Sustainable Growth Rate (SGR) formula for updating physician fees; adjusting for geographic variations; piloting rapid-cycle testing and innovative payment methods, including medical homes, accountable care organizations, and bundled hospital payments; providing a choice of private and public plans; containing costs, including those in the Medicare program; limiting premium increases in

the insurance exchange; and fostering quality improvement. These provisions, in combination with those in the American Recovery and Reinvestment Act of 2009, 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. Specifically:

- Investments in primary care, pilot programs to test new payment methods, and using the purchasing leverage of Medicare and a new public health insurance plan to slow health care spending growth would all help bend the health system cost curve over the long-run. Annual productivity improvements of one percentage point a year are assumed to be possible for providers to achieve, given the reductions in bad debt and charity care and given the opportunity to share in the savings gained from preventing avoidable hospitalizations and hospital readmissions, controlling chronic conditions, and eliminating ineffective and duplicative care.
- The House bill emphasizes the importance of prevention and wellness by eliminating any cost-sharing for preventive services in Medicare and increasing Medicare payments for key preventive services.
- Additional Medicare spending would come from resetting the SGR formula for updating physician fees—$245 billion over the period 2010 to 2019 (including interactions with other provisions). Major new savings come from the productivity improvement requirement and other changes in provider payment updates ($200 billion) and correcting Medicare Advantage payment rates ($172 billion).
- The net effect would be $448 billion of savings before the revision of the SGR formula, and $219 billion after making this adjustment. Including the SGR payments in the baseline projection yields an 8.0 percent annual growth rate in federal health expenditures over the 2010–2019 period, up from 7.6 percent under current law. Applying the other net savings would bend the Medicare spending cost curve and reduce the annual growth rate to 7.3 percent.
- The House bill would also affect trends in total health system spending. Important provisions include the creation of the insurance exchange and insurance market rules, such as minimum medical-loss ratios for plans. Administrative overhead in individual-market plans, now averaging 40 percent and 15 to 35 percent in small-business plans, would fall to 12 to 14 percent within the insurance exchange.
- The House bill seeks to limit the rate of premium increases and calls for a review of any health plan participating in the exchange whose premium increases exceed 150 percent of the medical inflation rate. Private insurance premiums more than doubled over the last decade, and they are projected to double again by 2020. If premiums had increased annually at even 150 percent of medical inflation from

1999 to 2008, family premiums would have been $2,600 lower in 2008. Our studies indicate that slowing premium growth by 1.0 percentage points annually would save $2,571 in 2020 family premiums; slowing it by 1.5 percentage points, as pledged by an industry coalition, would save $3,759 for the average family in 2020.

- CBO estimates that a public plan along the lines of that described in the Ways and Means bill would lower premiums by 10 percent, enrolling about 10 million people. Based on analysis of a plan similar to that in the Ways and Means bill, with a public health insurance plan paying providers at an intermediate rate between Medicare and commercial rates, total health spending would be slowed from an annual rate of 6.5 percent to an estimated 5.6 percent.

Financing Health Reform

The CBO estimates that the cost of providing sliding-scale assistance with premiums and cost-sharing ($773 billion over the 2010–2019 period), expanding Medicaid ($438 billion), and assisting small businesses ($53 billion) would be offset in part by payments made by employers and uninsured individuals, so that the net federal budget impact would be $1.042 trillion over 2010–2019. The Joint Committee on Taxation estimates that new revenues in the Ways and Means bill, primarily increases in the marginal tax rate for upper-income families, would yield $587 billion over this period. Net payment and system reform savings, including the cost of revising the SGR formula, would save $219 billion, for a net impact on the federal budget of $239 billion over the 10-year period, and would be budget-neutral with the resetting of the flawed SGR formula.

It is important to consider that CBO has seriously underestimated savings and overestimated cost in the last three major health reforms. Given these inevitable uncertainties as new terrain is traversed, Congress may well want to establish a system for monitoring actual spending and savings over time. Certain actions or features of health reform could be conditioned on actual experience, rather than hinging totally on what is so inherently difficult to know in advance with any precision.

Areas for Further Consideration

The House of Representatives has fashioned a health reform plan that will fundamentally change our present course—that of rising costs and rising numbers of uninsured and underinsured Americans. Certainly, new ideas could be considered, either when shaping a final bill or as the legislation is implemented. Two areas for further consideration stand out:

- the harmonization of public and private provider payment; and

- the creation of an independent commission.

Moving Forward and Making History

Recognizing the plight of families facing an unraveling safety net of health insurance coverage, there is an urgent need to address the crushing burden of rising health care costs for both businesses and families. 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.

What makes sense is committing to moving forward, carefully and thoughtfully phasing in reforms and measuring our progress in order to make any mid-course corrections that may be necessary. Implementation of a new insurance exchange and testing payment and system reform innovations may well 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 taking any additional policy actions that are needed. 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.

Congress has a historic opportunity to put our health care system on the path to high performance. Though moving in a new direction can be politically difficult, the comprehensive reforms developed by Congress will help spark economic recovery, put the nation back on the road to fiscal responsibility, and ensure that all families are able to get the care they need while having financial security.

The cost of inaction is high. With a clear path before us, the time has come to take bold steps to ensure the health and economic security of this and future generations. Health reform is an urgently needed investment in a better health system and a healthier and economically more productive America.

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Karen Davis, Sara Collins, Rachel Nuzum, and Cathy Schoen

President Obama made a forceful case for health care reform in his address to Congress and the public last week, stressing the imperative of action on the goals of ensuring stability and security of health insurance coverage for those who have it, providing insurance for those who don't, and slowing the rise in health care costs for employers, families, and government. He set forth a pragmatic plan, building on what works and fixing what doesn't, while signaling his openness to the best ideas from all. But most of all he stressed that after a century of inaction, it is now the season to act, and that failure is not an option. It is too important to those who are harmed by our inadequate insurance system, too important to our economy, and too important to our character as a country.

Congress has taken unprecedented steps toward enacting comprehensive reform, with four of the five committees of jurisdiction having already acted. The coordinated effort by the three committees of jurisdiction in the House of Representatives has resulted in legislation that builds on the strengths of our private–public financing and health care delivery system, but that also addresses its weaknesses: the gaps in insurance coverage, the inadequate and unstable coverage experienced by many, the insufficient choice and competition, and a delivery system driven by fee-for-service incentives that fail to reward providers for getting the best results for the patients and proper stewardship of resources.

Urgent Need for Health Care Reform

This forum is aptly titled the "Urgent Need for Health Care Reform." No one could hear President Obama's speech and fail to be convinced by the urgency of action on health reform. He painted the need for reform in both human and economic terms. He concluded that our health system is at a breaking point, with the uninsured facing extraordinary hardships, small businesses operating at competitive disadvantages, and taxpayers struggling with unsustainable burdens—and that now is the time to act on health reform.

Last Thursday, the Bureau of the Census released the latest data on the number of Americans without health insurance.[1] The number of uninsured individuals rose from 45.7 million in 2007 to 46.3 million in 2008. This increase in the uninsured population of 0.6 million would have been much worse without an offsetting growth in government-provided insurance that brought coverage to 4.4 million people, including 3.0 million under Medicaid.

The latest data show the importance of the nation's safety-net insurance system—Medicaid and the Children's Health Insurance Program (CHIP). The major bright spot in these new data was the fact that the rate of uninsured children is at its lowest since 1987—9.9 percent. This improvement is a reflection of increased coverage for children under government health insurance programs, which rose from 31.0 percent in 2007 to 33.2 percent in 2008. However, more than 7.3 million children remain uninsured, highlighting the importance of Congress's reauthorization and expansion of CHIP earlier this year, which helped cover 4 million more uninsured low-income children.

A few states have also stepped up to the plate to address the issue of the uninsured. Massachusetts, which enacted health reform in April 2006, has moved into first place in the nation, with an uninsured rate of just 5.5 percent in 2008, compared with 25.1 percent in Texas, the state with the highest uninsured rate. Massachusetts leads the nation as a result of its comprehensive health reform.

The most alarming news in the Census release is that the number of adults under age 65 without health insurance is high and rising: 20.3 percent of adults 18 to 64 were uninsured in 2008, up from 19.6 percent in 2007, an additional 1.5 million adults. About 1 million fewer people are receiving coverage through employers, declining from 177.4 million in 2007 to 176.3 million in 2008, including a marked drop in coverage among part-time workers. But even these numbers may understate the number of people affected by the severe and ongoing recession. That's because the Census numbers are based on counts of people with coverage *at any point during the year*. Those who were insured early in 2008 but lost their coverage later in the year are nonetheless counted as insured for 2008. Most certainly, there was an undercount of the number of Americans lacking coverage at the end of 2008. The continued rise in unemployment rates in 2009 likely means many more are uninsured in 2009.

Even an uninsured population of 46.3 million is staggering. But millions more Americans are uninsured at some point during the year, face unstable coverage that can easily vanish with the loss of a job or change in family circumstances, or have inadequate coverage that leaves them exposed to substantial out-of-pocket costs.[2] As a result, millions do not have access to needed health care, struggle under a load of medical debt, and all too often must choose between medical care and other essentials, like food or housing. A study by The Commonwealth Fund found that 72 million Americans ages 18 to 64 have problems paying medical bills or are paying off accumulated medical debt.[3] Nobody should face

bankruptcy or the loss of their income as a result of a serious illness.

The problem of unstable and insecure health insurance coverage is no longer a problem just for lower-income families. About one of five of the uninsured live in households earning $75,000 or more. Individuals with higher incomes who lacked coverage in 2008 increased to 8.2 percent, from 7.8 percent in 2007, an increase of 610,000 people. Our studies show the middle class is increasingly bearing the brunt of rising out-of-pocket costs.[4]

The high cost of health care in the United States—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. Health care already consumes 17 percent of the nation's economy and will reach 21 percent by 2020 if trends continue.[5] 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]

Failing to act will lead to greater and greater numbers of Americans without adequate, affordable insurance—unable to obtain the care they need and struggling under the weight of rising premiums and out-of-pocket costs. Health insurance premiums have risen from 11 percent of family income in 1999 to 18 percent today. If we continue on our current course, they will reach 24 percent by 2020.[7] The average American family simply cannot afford to spend one-fourth of its income on health insurance. By 2020, the average family premium will be $24,000, ranging from $21,000 to $26,700 across states.[8]

In making this extraordinary investment, we should expect the best care. Yet there is clear evidence that the U.S. is not reaping high value commensurate with its investment. Despite devoting the most resources to its health system, the U.S. is failing to keep pace with the gains made by other countries. The nation is now in last place, behind 18 other high-income countries, on mortality amenable to health care before age 75—in other words, deaths that are potentially preventable with timely, effective health care or early efforts to screen and prevent onset of disease.[9] Although the U.S. improved on this measure by 4 percent over five years (1997–1998 to 2002–2003), other countries achieved an average improvement of 16 percent over the same period. The difference between the U.S. and the countries with the lowest mortality rates amounts to 100,000 premature, potentially preventable deaths each year. Too often, we fail to lead on health

outcomes or care experiences: compared with adults in many other countries, U.S. adults are far more likely to report medical errors resulting from delays in hearing about diagnostic tests, to encounter duplicative care or coordination gaps, and to lack rapid access to primary care or care after hours.[10]

We are moving in the wrong direction on many other health system indicators. The Commonwealth Fund Commission on a High Performance Health System's 2008 National Scorecard on U.S. Health System Performance finds disturbing evidence of widespread variations in health care quality and outcomes, poor coordination of care, and complications of chronic disease that could have been prevented with timely access to effective care.[11] Relative to what should be achievable—and to what is achieved in other countries and the best-performing areas of this country—the U.S. falls short across an array of dimensions, including access, quality, equity, and efficiency.

These deficiencies only stand to worsen in the current economic crisis. The soaring costs of health care have already put intense economic pressures on businesses, as well as on patients and their families. Unless we change course, the nation's health and economic security are at risk.

Comprehensive reform is needed to introduce a new dynamic—a chain of events that could realize the triple goals of achieving universal coverage with access for all, improving health outcomes, and significantly slowing cost growth over the next decade. The aim is to provide an integrated systems-based approach to change, with strategic actions interacting with and reinforcing each other to drive the health system in a new direction. The Commonwealth Fund commission identified five key strategies to achieving a high performance health system:[12]

- 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.

There is no silver bullet that will put the U.S. health system on the path to high performance. Rather, a set of policies and actions need to be designed to achieve these objectives. Specifically, the policies would simultaneously:

- expand coverage to ensure access and provide a solid foundation for system reforms to improve quality and efficiency;
- change the way we pay for care to support and stimulate patient-centered, coordinated, effective, and efficient care;
- change the way we deliver care to ensure care is patient-centered, accessible, and coordinated;
- invest in the infrastructure and population health policies necessary to improve care and health; establish benchmarks and assess performance; and drive and monitor improvement in disease prevention and population health outcomes; and
- provide a framework for leadership, with coherent national goals and policies.

Goals of Health Reform and Congressional Action

The goals of health reform are: 1) to ensure the stability and security of health insurance coverage for those people who have it; 2) to provide insurance for those who don't; and 3) to slow the rise in health care costs for employers, individuals, and government.

Improving Health Insurance Coverage

The health reform provisions in H.R. 3200 as amended would go a long way toward fixing our broken health insurance system. Consistent with the priorities outlined by the President, the leading congressional proposals, including H.R. 3200, aim to provide near-universal health insurance coverage by building on the strongest aspects of the existing insurance system—the large-group market and Medicaid and CHIP—and by strengthening the weakest parts of the existing system—the individual and small-group markets—where so many individuals and small businesses face the insurmountable obstacles of medical underwriting, high premiums, astronomical administrative costs, and uncertainty regarding their benefits.

The insurance provisions include insurance market reforms; creation of an insurance exchange; sliding-scale premium assistance and cost-sharing for an essential benefit package; an individual mandate; and shared employer responsibility. For detail on the insurance provisions of H.R. 3200 as amended, see Appendix 1.

Impact of Insurance Provisions

These provisions would substantially meet the goal of closing the gaps in health insurance coverage. The Congressional Budget Office (CBO) estimates that the House bill would reduce the numbers of uninsured by 37 million, leaving about 17 million nonelderly residents uninsured.[13] Excluding unauthorized immigrants, 97 percent of the legal resident population would be insured.

At full implementation in 2015, the CBO estimates that employer-sponsored insurance under the House bill will remain the primary source of insurance for most families, covering 60 percent of the population, or 166 million people. The bill's employer contribution for those not providing coverage—8 percent of payroll—is close to the average share of payroll that employers currently spend on premiums contributions.[14] Thus, the CBO assumes that few employers would drop coverage as a result of the presence of the subsidized exchange. For the first time, U.S. businesses would face largely a level playing field, one in which all businesses share in supporting health coverage for the workforce. Small employers would be exempt from the requirement to offer coverage, and many would be eligible for premium subsidies.

The CBO estimates that 3 million people would be shifted out of employer coverage. As a result of the pay-or-play requirement, an additional 3 million people with employer coverage are estimated to shift to the exchange because their employer premium contributions would be deemed unaffordable under the legislation, and about 3 million part-time workers, who have the option to gain coverage through the exchange even if they are offered employer coverage, would buy coverage through the exchange. About 12 million people who are not now covered under employer plans would gain coverage under the legislation by 2016. The overall effect of the employer requirement to offer health coverage is therefore a net increase of about 3 million in employer plans.

The CBO estimates that about 27 million people, or 10 percent of the under-65 population, would gain coverage through the health insurance exchange by 2015, and 30 million people by 2019. Coverage through the individual insurance market would decline to just 8 million by 2015 as the exchange replaces the individual insurance market, leaving just those enrollees who had individual market coverage at the outset of reform and chose to maintain it.

Coverage through the Medicaid program would rise by about 9 million people by 2015, for a total of 43 million Medicaid beneficiaries, and by 11 million by 2019. Nearly all of the people who would be newly enrolled through Medicaid would have previously been

uninsured.[15] An additional 1 million people previously insured through employer plans would shift to Medicaid.

In addition to closing gaps in insurance coverage, the House bill would markedly improve the security and stability of coverage. The establishment of insurance market rules, the creation of the insurance exchange, the essential benefit package, and sliding-scale premium and cost-sharing assistance would help those who are currently most adversely affected by the current health system. Health status would no longer affect the ability to get coverage at reasonable premiums. Instead, market rules on guaranteed issue and community rating, as well as broad risk-pooling in the exchange, would ensure the availability of coverage and markedly lower premiums for those with preexisting health conditions and serious health risks.

For the first time, an essential benefit package would be defined, setting a standard for an adequate benefit package under both employer plans and plans in the exchange. A national standard would make it easier for people to compare health plans and could help ensure access to care and financial protection—the core goals of insurance. It could also go a long way toward simplifying the complexity that drives up costs in current markets and could help channel competition to slowing total cost growth rather than shifting costs to patients and families.

The shared responsibility of employers to contribute 72.5 percent of health insurance premiums of workers (65 percent for families) would also go a long way toward making the employee share of premiums affordable. Those workers whose share of the premium still exceeds 12 percent of income would be eligible to obtain coverage through the exchange and receive sliding-scale premium assistance. The sliding-scale premium and cost-sharing assistance for those in the exchange would improve the affordability of premiums and cost-sharing for lower- and moderate-income families.

The Ways and Means Committee has prepared charts illustrating premium and out-of-pocket-cost maximums for families and children (see attached chart pack). One chart shows the maximum premium a family of four pays today and the maximum each family would pay under the House bill. Another chart shows the share of health care services covered by the plan for families at different income levels.

The stability of coverage would be improved as people lose or change jobs or experience changes in life circumstances. Employees of small businesses obtaining coverage through the exchange could keep their coverage when they change employment—for example,

when a waiter or chef moves from one restaurant to another. Most importantly, young adults leaving their parents' policies, widowed or divorced spouses losing coverage through a family member, people losing a job, and those forced into early retirement by disability or a serious health problem would always have a place to turn to find affordable coverage. In short, these key House provisions would ensure that no one becomes bankrupt from ruinous medical bills or struggles to pay medical debts arising from a serious illness.

Reforming the Health Care Payment and Delivery System

To achieve a high performance health system, health reform proposals must go beyond ensuring affordable coverage to address health system changes that will improve health outcomes and the quality of health care, increase efficiency, and slow the growth in total health system costs. The House bill includes key provisions for: investing in primary care; replacing the current Sustainable Growth Rate (SGR) formula for updating physician fees; adjusting for geographic variations; piloting programs for rapid-cycle testing of innovative payment methods, including medical homes, accountable care organizations, and bundled hospital payments; ensuring choice of private and public plans; containing costs, including limiting premium increases in the exchange; and fostering quality improvement. These provisions, in combination with provisions of the American Recovery and Reinvestment Act of 2009, 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 health care payment and delivery system reform provisions of H.R. 3200 are detailed in Appendix 1.

Impact of System Reform Provisions

The work of the Commonwealth Fund Commission on a High Performance Health System suggests that substantial health system and federal budget savings are possible through innovative payment reform that moves away from rewarding volume and toward rewarding results—including achieving the best health outcomes and quality of care for patients while sharing in savings gained from the proper stewardship of resources. Our study estimated $1 trillion in total health system savings over the 2010–2020 period, including $750 billion in federal budget savings from payment reforms alone.[16] Achieving these savings requires moving rapidly to institute new payment methods and using the purchasing leverage of Medicare and a new public health insurance plan to slow the health care spending growth. Annual productivity improvements of one percentage point a year are assumed to be possible for providers to achieve, given reductions in bad debt and charity care and given the opportunity to share in savings from preventing avoidable hospitalizations and hospital readmissions, controlling chronic conditions, and

eliminating ineffective and duplicative care. It is critical that payment reforms focus on both the way we pay and the level of payment.

Given some of the specific provisions in the House bill—for example, implementing the exchange in 2013 rather than 2010, and pilot-testing payment reforms rather than immediately adopting them, as well as different estimating assumptions—the CBO has estimated savings more conservatively. Major new Medicare spending comes from the revision of the SGR formula for updating physician fees—$228.5 billion over 2010–2019, or $245 billion including interactions with other provisions. Major new savings come from the productivity improvement requirement and other changes in provider payment updates ($200 billion) and from correcting Medicare Advantage payment rates ($172 billion). Some provisions add to Medicare outlays (e.g., primary care payment increases and geographic adjustments), while others subtract from outlays (e.g., drug price rebates and excess reductions in hospital readmission payments).

The net effect is $448 billion in savings not counting revision of the SGR formula, and $219 billion after making this adjustment. Including the SGR payments in the baseline projection yields an 8.0 percent annual growth rate in federal health expenditures over the period 2010 to 2019, up from 7.6 percent under current law. Applying the other net savings bends the Medicare spending cost curve and reduces the annual growth rate to 7.3 percent. While additional federal outlays are required for covering the uninsured and improving benefits for the underinsured, these are one-time shifts in federal budget outlays. The Medicare provisions set in motion genuine reform that enhances value and slows the underlying rate of growth of outlays, with important long-term implications.

The House bill would also 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 averaging 40 percent and 15 to 35 percent in small-business plans would fall to 12 to 14 percent in the insurance exchange.[17]

The House bill seeks to limit the rate of premium increases and calls for a review of any plan participating in the exchange that has premium increases greater than 150 percent of medical inflation. Private insurance premiums more than doubled over the last decade and are projected to double again by 2020. If premiums had increased annually at even 150 percent of the medical inflation rate from 1999 to 2008, family premiums would have been $2,600 lower in 2008.[18] Our studies estimate that slowing premium growth by 1.0 percentage points annually would save $2,571 in 2020 family premiums; slowing by

1.5 percentage points, as pledged by an industry coalition, would save $3,759 for the average family in 2020.[19]

The insurance market has grown increasingly concentrated in the last decade.[20] In all but three states, two insurance plans account for over 50 percent of enrollment.[21] Without significant competition, plans may 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." Including a public health insurance option and/or private cooperative plan could act as a stimulant to greater competition and lower administrative overhead. Currently an average of 14 to 15 percent of private premiums go to a combination of administrative (marketing, claims, underwriting, and other) and profit margins for the dominant commercial for-profit plans.[22] We should expect these costs to come down if we simplify administration and intensify competition. Our study found that the exchange itself could be expected to lower private plan premiums by 3 percent, while a public health insurance plan paying at rates between Medicare and commercial plans would yield 16 percent premium savings, a difference of 13 percent. The CBO estimated that a public health insurance plan along the lines of the Ways and Means Committee bill would yield a premium 10 percent lower than private plans within the exchange, based on a sophisticated model that takes into account Medicare Advantage bids, where tightly organized health maintenance organizations submit bids 2 percent below the Medicare fee-for-service levels.[23]

Private insurers have argued that they would be unable to meet the premiums of a public health insurance plan. But the insurance industry has also argued that it is possible to slow the growth in health care spending by 1.5 percentage points annually on a voluntary basis.[24] If so, they could close most of the gap with the premium of a public health insurance plan during the four-year start-up. Slowing premium growth by 1.5 percentage points annually would provide substantial relief to businesses and households. Our study estimates that the average family would save $2,300 in 2020 if the rate of increase in health expenditures could be reduced from 6.5 percent annually to even 5.2 percent. [25]

Based on analysis of a plan similar to the Ways and Means bill, with a public health insurance plan paying providers at an intermediate rate that falls between Medicare and commercial rates, total health spending would be slowed from an annual rate of 6.5 percent to an estimated 5.6 percent.[26] A strong public health insurance plan could achieve significant system savings, providing much needed relief to individuals and workers in small businesses. As amended by the Energy and Commerce, the Secretary would negotiate payment rates between Medicare and commercial levels. This, too, would bend

the cost curve, although likely to a somewhat lesser degree than under the Ways and Means provisions.

Financing Health Reform

The CBO estimates that the cost of providing sliding-scale assistance with premiums and cost-sharing ($773 billion over 2010–2019), expanding Medicaid ($438 billion), assisting small businesses ($53 billion) would be offset in part by payments by employers and uninsured individuals, for a net federal budget impact of $1.042 trillion over 20102019. The Joint Committee on Taxation estimates that new revenues in the Ways and Means bill—primarily increases in the marginal tax rate for upper-income families—would yield $587 billion over this period.[27] (See Appendix 1 for details on the modified marginal tax rate.) Net payment and system reform savings, including the cost of revising the SGR formula, would save $219 billion, for a net impact on the federal budget of $239 billion over the 10-year period 2010–2019, or a net surplus of $6 billion other than resetting the flawed SGR formula.

Given the fact that the health sector is now a $2.5 trillion industry, growing to a $5.0 trillion industry in 2020 in the absence of reform, these new fiscal impacts of about $24 billion a year are certainly within any reasonable margin of error. More importantly, it is very difficult to make refined estimates when multiple changes are occurring simultaneously—such as the American Recovery and Reinvestment Act's investments in health information technology and comparative effectiveness research, payment reforms, coverage expansions, and a new marketplace for purchasing insurance. The synergistic effect of multiple changes could easily lead to an underestimate in traditional models that isolate the effect of individual provisions.

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 the problem.[28] Actual savings from the Medicare hospital prospective payment system introduced in 1983 were double that 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. Gabel notes that CBO has particular difficulty estimating savings when it considers more than one change at once. He notes a tendency to grant zero savings when there aren't enough good examples to go by. CBO's projected estimate of zero savings from the pilots on innovative payment methods is such an example. Our own studies of primary care, medical homes, bundling hospital acute-care episode payments with post-hospital care, and productivity improvements yield substantially greater savings.

Given these inevitable uncertainties as new terrain is traversed, Congress may well want to establish a system for monitoring actual spending and savings over time. Certain actions or features of health reform could be conditioned on actual experience rather than hinging totally on what is so inherently difficult to know in advance with any precision.

Areas for Further Consideration

The House of Representatives has fashioned a health reform plan that will fundamentally change our present course—that of rising costs and rising numbers of people uninsured and underinsured. Certainly, new ideas could be considered either when shaping a final bill or as the legislation is implemented. Two areas for further consideration stand out.

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 Payment and System 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 burden associated with existing payment methods and minimize administrative burden for providers faced with responding to these new, innovative methods; and
- Reduce the likelihood of payment distortions across payers and/or regions.

A working group including a cross-section of clinician, consumer, hospital, employer and policy experts has recommended harmonizing public and private payer innovation efforts to facilitate effective payment reform.[29] It suggests that the CMS payment innovation center specifically address the need to harmonize and align public and private payers, and foster Medicare and Medicaid participation in local payment pilots designed by other payers and providers that are responsive to state/regional community needs, as well as support pilots designed and developed by Federal officials that involve the private sector and state payers (e.g., participating in both “bottom up” and “top down” innovation efforts).

Congress should also make clear to CMS 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.

This is not a time for business as usual with limited demonstrations that take years to complete.

Independent Commission

The President in his address to Congress called for creation of an independent commission to identify and spread best practices that achieve savings and eliminate waste. Establishing an independent Commission or Council with authority to make payment decisions within parameters established by Congress and subject to review by the President and Congress would help transform Medicare into a more active purchaser of high-value care, bend the growth in national health expenditures and Medicare expenditures, enhance the long-term financial solvency of Medicare, and bring much-needed national leadership and coherence to the U.S. health care system. It should be possible to fashion a new Council in a way that both ensures accountability to the political process and generates significant health system savings. Such a Commission or Council could also make it possible to coordinate public and private payer payment policies. Currently, private insurer pricing is often chaotic.[30] For markets to work we need to align all payment incentives with quality and efficiency.

Moving Forward and Making History

Recognizing the plight of families facing an unraveling safety net of health insurance coverage, there is an urgent need to address the crushing burden of rising health care costs for both businesses and families. 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 can not afford to continue on our current course.

What makes sense is committing to Congressional oversight as health reform implementation proceeds, identifying the need for further action or mid-course corrections quickly. The new insurance exchange and testing payment and system reform innovations may well call for additional steps as experience is gained and lessons learned. 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.

Congress should insist that the Administration establish a system of tracking performance on major health reform goals with annual reports from the President just as the Council of Economic Advisers provides an annual economic report. At a minimum such a report should report on progress toward the goals the President set forth for health reform and include data on key indicators such as: percent of the population insured, percent with affordable premiums and out-of-pocket costs, trends in total health system spending and

federal health outlays, federal budget impact, cost or savings to employers and households, as well as progress on health outcomes, quality of care, and payment and delivery system reform. The President should also make recommendations for any additional policy actions that may be needed to meet the goals of reform.

Congress has a historic opportunity to put the health system on the path to high performance. Though moving in a new direction can be politically difficult,, the comprehensive reforms developed by the Congress will help spark economic recovery, put the nation back on the road to fiscal responsibility, and ensure that all families are able to get the care they need while having financial security.

The cost of inaction is high. With a clear path before us, the time has come to take bold steps to ensure the health and economic security of this and future generations. Health reform is an urgently needed investment in a better health system and a healthier and economically more productive America.

Appendix 1. Details on Provisions of H.R. 3200 as Amended

Insurance Market Reforms

HR 3200 would require all insurance carriers providing coverage through the new insurance exchange or group insurance markets to accept every individual and employer that applied for coverage (guaranteed issue) and premiums would not be allowed to vary based on health status. Insurers would be unable to drop beneficiaries for becoming sick and plans would be required to ensure that a minimum percentage of premium dollars be allocated to providing medical services as opposed to administrative costs.

Insurance Exchange

An insurance exchange is an organized marketplace managed and regulated by government in which eligible individuals and businesses can purchase a private health plan or a new public plan.[31] The purpose of an insurance exchange in the context of comprehensive health reform is to create broad risk pooling where it does not now exist (the individual and small group markets), establish new ground rules for the sale of health insurance to protect consumers, increase transparency in the choice of health plans by establishing a minimum benefit standard, provide premium subsidies to help low and moderate income families purchase coverage, and reduce the costs of health insurance.

HR 3200 establishes a Health Insurance Exchange that will facilitate the offer of health insurance choices to individuals and small businesses that are eligible to participate. The Exchange would be run by a new independent agency within the executive branch called the Health Choices Administration. The agency would be headed by a Health Choices Commissioner appointed by the President, with advice and consent of the Senate. The Commissioner would be responsible for setting qualified health benefit standards, setting and administering premium subsidies or "affordability credits" for health plans, and establishing and operating the Exchange. States would play a role in the operation of the exchange as state insurance regulators would jointly oversee and enforce requirements for participating plans as well as those that do not sell policies through the exchange. The bill does allow the Commissioner to consider applications by states or groups of states to establish state-based exchanges, but requires that there be only be one exchange per state, that the exchange would have to operate under the same rules and requirements established for the national exchange, and that it not result in a net increase in expenditures to the federal government.

The House bill would open the exchange to individuals who do not have access to employer coverage that meets benefit standards and is deemed affordable (premiums are not greater than 12 percent of income) and are not eligible for Medicaid. The bill would allow employers with 10 or fewer employees to purchase coverage through the exchange in the first year of implementation. Those with up to 20 employees could buy plans in the exchange in year two, and in year three larger employers with more than 20 employees, as permitted by the Commissioner. An amendment adopted by the House Education and Labor Committee increased the eligibility size to 15 employees in year one, 25 in year two and no fewer than 50 employees in year three.

Sliding Scale Premium Assistance, Benefits, and Cost-Sharing Assistance

The House bill establishes premium "affordability credits" on a sliding scale where the reference premium for determining the credit amount is the average of the three lowest premiums for the "basic" plan in the local market area. The exchange would pay the aggregate amount of the credits to qualified health benefit plans for all enrollees eligible for the credits. Credits would be available in years one and two only for the basic plan and then in year three the Commissioner would establish a process by which credits could be used toward an enhanced plan with the enrollee paying the difference between the credit and the premium.

Under the House Energy and Commerce Committee amendments, premium and cost-sharing credits would be available on a sliding scale for families eligible to purchase coverage through the exchange and who have incomes between 133 percent to 400 percent of poverty (those with incomes below 133 percent of poverty are eligible for Medicaid). Eligibility for credits is limited to families with incomes under 400% of poverty who are not employed full time with employer based coverage that meets the standard for a "qualified health benefits plan." But beginning in year two, full time workers with employer coverage whose share of premium costs exceed 12 percent of income would be eligible for coverage and credits through the exchange. Credits would begin by capping individual or family premium payments at no more than 1.5 percent of income for those earning 133 percent of poverty or $29,327 for a family of four and rise to no more than 12 percent of income for those with incomes at 400 percent of poverty, or about $88,200 for a family of four in 2009.

The House bill would instruct the insurance exchange to define an essential benefit package. The exchange would offer four benefit tiers, though only the level of cost-sharing would be allowed to vary across the three lowest tiers. All health plans, including those furnished by employers, must provide at least the "basic" essential benefit package inside and outside the exchange. Cost sharing credits would effectively reduce cost sharing in the basic plan such that costs covered by the basic plan would rise from 70 percent to 97 percent for those earning 133-150 percent of poverty, 93 percent for those earning 150—200 percent of poverty and so on sliding out at 72 percent of costs covered for those earning 350 percent of poverty.

Medicaid Expansion
The House bill expands eligibility for Medicaid up to 133 percent of poverty or $29,327 for a family of four in 2009. People eligible for Medicaid are not eligible for premium subsidies through the exchange.

Individual Mandate
The House bill requires all individuals to have health insurance that is deemed to meet the requirements of a "qualified health benefits plan" or pay a penalty of 2.5 percent of the difference between their adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax filing threshold, up to the cost of the average national premium for the "basic" benefit plan offered through the insurance exchange. A "qualified health benefits plan" provides coverage that meets the applicable requirements in the bill for affordable coverage, the essential benefits package, and consumer protections. All insurance coverage must meet the requirements of the qualified health benefit plan whether it is offered inside or outside the exchange. Oversight and

enforcement of requirements for the qualified health benefits plan would be carried out by the Commissioner in conjunction with State insurance regulators. Exceptions to the mandate would be made for dependents, religious objections, and financial hardship. The Commissioner would establish an auto-enrollment mechanism for exchange eligible individuals, or those who are eligible for premium subsidies and have not selected a plan, and for those people whose plan has been terminated and have not yet enrolled in another plan.

Shared Employer Responsibility

The House bill would require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the bill's "essential" benefits package requirements or pay 8 % of payroll into the Health Insurance Exchange Trust Fund. Under bills reported out of the Ways and Means Committee and the Education and Labor Committee, small businesses with annual payrolls of less than $400,000 would be exempt from the bill's 8% payroll contribution. The contribution would phase in at 2% for firms with annual payrolls between $250,000 and $300,000, rise to 4% for firms with payrolls between $300,000 and $350,000, rise to 6% for firms with payrolls between $350,000 and $400,000, and 8% for firms with payrolls above $400,000. The bill reported out of the Energy and Commerce Committee included an amendment that changed the limits for purposes of applying the affordability credits.[32] Under this amendment, small businesses with payrolls of less than $500,000 would be exempt from the bill's 8% payroll contribution for employers that do not offer health insurance. The contribution would phase in starting at 2 percent for firms with annual payrolls between $500,000 and $585,000, rise to 4% for firms with payrolls between $585,000 and $670,000, rise to 6% for firms with payrolls between $670,000 and $750,000, and 8% for firms with payrolls above $750,000.

Investing in Primary Care

Easy access to basic medical care is key to both better patient outcomes and lower cost.[33] Investing in primary care could have substantial payoff in lower cost, greater equity, and better quality. Yet, in recent years there has been a sharp decrease in newly trained physicians electing primary care practice.[34] The House bill would address this shortage through a number of measures including loan forgiveness, increased resources for the health service corps, and residency training in community health centers.

Most importantly, the House bill includes a five percent payment bonus for primary care services when provided by a physician, nurse practitioner, or other non-physician provider in family medicine, internal medicine, general pediatrics, geriatrics, and obstetrics-gynecology for whom primary care represents a majority of their practice income. The bonus is increased to 10 percent for practice in health professional shortage areas. The Secretary of HHS would periodically identify primary care services that are potentially incorrectly valued through current coding and adjust the values of these services. Medicaid fees for primary care services under Medicaid fee-for-service payment and under managed care plans are phased up to Medicare levels over a three year period.

Physician Fee Updates
The House bill replaces the current methodology for annual changes in Medicare physician fees (the so-called Sustainable Growth Rate formula) with a new methodology with 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 by growth in the gross domestic product (GDP) plus 2 percent for prevention and evaluation and management services and 1 percent for specialized procedures and services. This new methodology for updating physician fees is estimated by the Congressional Budget Office to add $228.5 billion to federal budget outlays over 2010-2019.[35]

Geographic Variations
The House bill calls for a study of geographic variations in health care spending by the Institute of Medicine, along with recommended strategies for addressing this variation by promoting high-value care. Another provision would add 5 percent to Medicare physician payments in geographic areas with the lowest utilization of services (bottom quintile).

Pilots for Rapid Cycle Testing of Innovative Payment Methods
The House bill calls for the creation of a Center on Medicare and Medicaid Payment Innovation charged with rapid cycle testing of innovative payment methods to enhance access to and quality of primary care services. The pilot programs would begin within two years of the enactment of the bill and extend for up to five years. If retrospective review finds the methods are successful in improving quality and/or reducing costs as determined by the Center for Medicare and Medicaid Services (CMS) Chief Actuary, the pilot programs may be extended permanently.

Medical Homes
The bill would establish a medical home pilot program to evaluate the effectiveness of reimbursing qualified patient-centered medical homes for furnishing services to high need beneficiaries. The pilot program would include two medical home models. Starting within six months of the bill's passage, the patient-centered medical home pilots would provide primary care through a physician or nurse practitioner who practices in family medicine, general internal medicine, geriatric medicine or pediatric medicine; provides ongoing primary or principal care; coordinates care provided by a team; provides for all of the patient's health care needs or arranges for appropriate care with other providers; provides continuous access to care; provides support for patient self-management and coordination with community resources; integrates information on patients that enables the practice to treat patients comprehensively and systematically; implements evidence-based guidelines; permits qualified nurse practitioners to lead a patient-centered medical home as permitted under state law; and permits physician assistants to participate in patient care. The Secretary would establish a payment methodology including a risk-adjusted per member per month payment paid prospectively.

A community based medical home would be a nonprofit community based or state based organization that would provide medical home services, headed by a primary care physician or nurse practitioners and employing community health workers. This pilot would provide additional prospective payments to facilitate care coordination: one to the non-profit or State-based organization and one to the primary care practice.

Accountable Care Organizations

The House bill also provides for Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations, and further provide for continuing this model of care permanently if pilot programs prove successful in improving quality or reducing costs. These payment methods could include shared savings for accountable care organizations that slow the growth in Medicare outlays below a target rate. This would provide "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.

Hospital Readmissions and Bundled Fees

The House bill calls for reducing payments under Medicare for potentially preventable hospital readmissions, at an estimated savings of $19 billion over 2010-2019. It authorizes the Secretary to conduct Medicare pilot programs to test payment incentive models for bundling of post acute-care payments. The Center for Medicare and Medicaid Payment Innovation would test payment models that address populations experiencing poor clinical outcomes or avoidable expenditures, and fund an evaluation of all payment innovation models with the authority to expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both.

Choice of Private and Public Plans

The expansion of plan choices through the insurance exchange is intended to improve competition and choice in the insurance market, and guarantee affordable, stable choices for enrollees. These plans could lower premiums initially and over time by lowering administrative overhead in plans, using purchasing leverage to establish provider payment rates, or offering choices of nonprofit or cooperative health care delivery systems that achieve better quality and lower cost through use of best practices in managing chronic conditions and the delivery of integrated, coordinated care that eliminates waste and duplication.

Private plans. The House bill would require that health plans participating through the exchange meet the standards set for "qualified health benefits plans." In addition, plans would have to at least offer the basic benefit plan through the exchange. Offering higher tiers of health plans would be optional, but a carrier could not offer a higher tier plan without offering the basic plan. Participating plans would have to participate in the risk pooling mechanism established by the Commissioner.

Public plan. The House bill provides for the establishment of a public health insurance plan option by the Secretary of Health and Human Services that would be offered under the same conditions as private qualified health plans through the exchange. The Secretary would establish geographically adjusted premium rates for the public health insurance plan that complies with the rules established by the Commissioner and must be at a level that fully finances the cost of health benefits and administration of the public health insurance option. The bill allocates $2 billion in start up funds to establish an initial reserve.

The House bill would allow the Secretary to set rates for the public health insurance plan based on those set for providers in Medicare Parts A and B with a five percent bonus for providers participating in both Medicare and the public plan. This was amended by the Energy and Commerce Committee with provider payment rates to be negotiated by the Secretary between commercial and Medicare rates. Innovative payment initiatives such as incentives for providers to establish medical homes, accountable care organizations, value based purchasing, bundling of payment, differential payment rates, performance based payment, could also be pursued by the Secretary through the public health insurance plan option.

The goals of these new payment methods would be to improve outcomes, reduce disparities, provide efficient and affordable care, prevent or manage chronic illness, and promote care that is integrated, patient centered. In addition, the public health insurance option can modify cost sharing or payment rates to encourage the use of services that promote high value care. Health care providers participating in Medicare are also considered participating providers in the public plan unless they opt out.

Co-op Plan. The House Energy and Commerce Committee adopted an amendment that would establish a Consumer Operated and Oriented Plan program (CO-OP program).[36] The Commissioner would create a Consumer Operated and Oriented Plan (CO-OP) program where the Commissioner could make grants and loans to establish and initially operate non-profit, member-run health insurance cooperatives that provide insurance through the Health Insurance Exchange. The Commissioner, through the CO-OP program, could make loans to cooperatives to assist them with start up costs and meeting state solvency requirements. The amendment would authorize $5 billion between fiscal 2010-14 for grants and loans under the program.

Cost Containment

The House bill incorporates a productivity improvement allowance of one percent across all Medicare services (other than physician services), i.e. the update is reduced by one percentage point a year based on a recognition that such savings are achievable in a reformed health system with substantial reductions in bad debt and charity care and enhanced revenues for care for the newly insured. These productivity improvement requirements and other payment update changes yield a ten-year budget savings of $196 billion (excluding interactions), according to the Congressional Budget Office.[37] Changes to Medicare disproportionate share payments yield an additional $10 billion in savings over the period.

The House bill would require the Secretary of Health and Human Services to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D plans. It would also require drug manufacturers to provide drug rebates for dual-eligibles enrolled in part D plans, and increases the Medicaid drug rebate percentage and extends the prescription drug rebate to Medicaid managed care plans. These provisions, not including the negotiation of drug prices which was added by an Energy and Commerce Committee amendment, would yield an estimated savings of $30 billion over 2010-2019, according to the Congressional Budget Office.[38]

The House bill would restructure payments to Medicare Advantage plans, phasing to 100 percent of fee-for-service payments, with bonus payments for quality. This provision would yield estimated savings of $156 billion (before interactions) over 2010–2019.[39]

The creation of health insurance exchanges would yield substantial administrative savings to individuals and small businesses. Inclusion of a public plan or private co-op plan in the insurance exchange would yield further savings to families and employers, as well as reduce the cost of sliding scale premium assistance. House Ways and Means Committee included a public health insurance plan paying providers at Medicare rates plus a bonus of 5 percent on Medicare and public plan payments for providers participating in both. The Congressional Budget Office estimates this plan would have a premium 10 percent lower than private plans in the exchange and attract 9-11 million out of the 29 million enrollees covered through the exchange.[40]

The House Energy and Commerce Committee departed from this provision and calls for the Secretary of Health and Human Services to negotiate payment rates for providers. Both the Ways and Means Committee and Energy and Commerce Committee restrict entry to the health insurance exchange and the public plan to small firms initially, but would permit a Health Insurance Commissioner at the U.S. Department of Health and Human Services to determine if and when to open the exchange to larger firms.

The Energy and Commerce Committee included a provision requiring a review of all plans in the exchange—public and private—with premium increases more than 150 percent of medical inflation. Premiums would have increased 6.4 percent annually from 1999-2008 if they had increased at 150 percent of medical inflation, instead of 9.1 percent actual annual increases in family premiums for employer-sponsored coverage. Family premiums in 2008 would have been $2,600 lower if they had grown at 150 percent of medical inflation over the decade.

Quality Improvement

The House bill includes numerous provisions aimed at improving quality and reducing variations in care. It would create a Center for Quality Improvement (CQI) headed by the Agency for Healthcare Research and Quality (AHRQ) director. The center would identify existing best practices for high-quality, efficient care; develop, evaluate, and implement new best practices; ensure that best practices are consistent with standards for collecting and reporting quality information using health information technology, and prioritize areas for quality improvement activities in the delivery of health care services such as reducing health care-associated infections, increasing hospital and outpatient surgery safety, improving hospital emergency rooms, and improving the provision of obstetrical and neonatal care,

A new position of Assistant Secretary for Health Information would develop standards for collection, reporting, and publishing of information on key health indicators and performance of the national health care system and publish statistics on such key health indicators. The Assistant Secretary for Health Information would submit an annual report to Congress containing a description of national, regional, or state changes in health or health care on these key health indicators, and a plan and recommendations for addressing gaps.

The House bill also calls for establishment of a Center for Comparative Effectiveness Research to conduct, support, and synthesize research to determine the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically. An independent Comparative Effectiveness Research Commission would oversee and evaluate the activities of the Center.

Financing Health Reform

The CBO estimates that the net cost of the proposal, less payments from employers and uninsured individuals, will be $1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings through Medicare and Medicaid, including the various delivery system and payment reform provisions described above. The majority of the remaining cost of the bill is offset through a marginal tax on wealthy individuals and families: families with modified adjusted gross incomes between $350,000 and $500,000 would face a surcharge of 1% through 2012 and 2% thereafter; those with modified adjusted gross incomes between $500,000 and $1,000,000 would face a 1.5% surcharge through 2012 and 3% thereafter; and families with modified adjusted gross incomes greater than $1,000,000 would face a 5.4% surcharge for 2011 and thereafter. For individuals, the same rates apply at 80% of the above dollar amounts. The Joint Committee on Taxation estimated that this surcharge would yield $544 billion of the total $587 billion from new revenues over ten years.[41] The House bill provides for these percentages to be adjusted if health reform achieves greater than expected federal savings.

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[23] C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork In the Road: Alternative Paths to a High Performance U.S. Health System*, The Commonwealth Fund, June 2009.

[24] Industry letters to President Barack Obama, June 1, 2009.

[25] The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

[26] C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork In the Road: Alternative Paths to a High Performance U.S. Health System*, The Commonwealth Fund, June 2009.

[27] Joint Committee on Taxation, Estimated Effects Of The Chairman's Amendment In The Nature Of A Substitute To The Revenue Provisions Of H.R. 3200, The "America's Affordable Health Choices Act Of 2009," Scheduled For Markup By The Committee On Ways And Means On July 16, 2009, JXC-33-09, submitted July 16, 2009. http://www.jct.gov/publications.html?func=startdown&id=3572

[28] J. Gabel, "Congress's Health Care Numbers Don't Add Up," *New York Times*, August 25, 2009.

[29] Working Group formed by the American Board of Internal Medicine Foundation, *Policy Recommendation -- Harmonize Public and Private Payer Innovation Efforts to Facilitate Effective Payment Reform*, September 2009.

[30] U. E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, January/February 2006; 25(1): 57-69.

[31] P. B. Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, May/June 2008 27(3):675–85.

[32]H. Chaikind, B. Fernandez, C.L. Peterson, P.C. Morgan, *Private Health Insurance Provisions of H.R. 3200*, Congressional Research Service, August 31, 2009.

[33] B. Starfield, L. Shi, J. Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly* 2005; 83(3): 457-502.

[34] T. Bodenheimer, K. Grumbach, R. Berenson, "A Lifeline for Primary Care," *N Engl J Med* 2009; 360: 2693.

[35] Congressional Budget Office, Letter to the Honorable Charles B. Rangel, July 17, 2009.

[36] See http://energycommerce.house.gov/Press_111/20090731/hr3200_ross_2.pdf

[37] Congressional Budget Office, Letters to the Honorable Henry Waxman and the Honorable Charles B. Rangel, July 17, 2009.

[38] Congressional Budget Office, Letters to the Honorable Henry Waxman and the Honorable Charles B. Rangel, July 17, 2009.

[39] Congressional Budget Office, Letters to the Honorable Henry Waxman and the Honorable Charles B. Rangel, July 17, 2009.

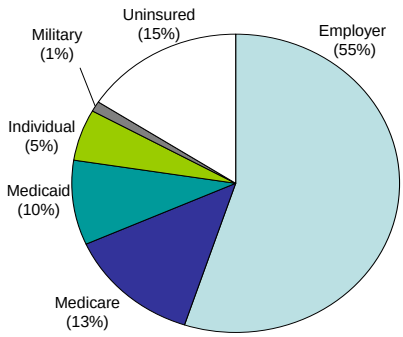
[40] Congressional Budget Office, Letter to the Honorable Charles B. Rangel, July 14, 2009.

[41] Joint Committee on Taxation, Estimated Effects Of The Chairman's Amendment In The Nature Of A Substitute To The Revenue Provisions Of H.R. 3200, The "America's Affordable Health Choices Act Of 2009," Scheduled For Markup By The Committee On Ways And Means On July 16, 2009, JXC-33-09, submitted July 16, 2009. http://www.jct.gov/publications.html?func=startdown&id=3572

1

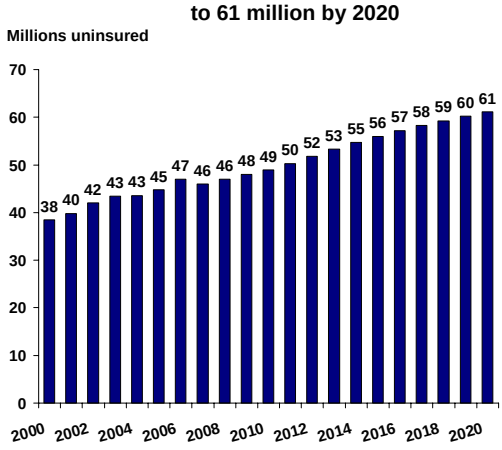
We Can't Continue on Our Current Path: Growth in the Uninsured

46.3 Million Uninsured, 2008



Total population

Uninsured Projected to Rise to 61 million by 2020



Data: K. Davis, *Changing Course: Trends in Health Insurance Coverage 2000-2008*, The Commonwealth Fund at Joint Economic Committee hearing, September 10, 2009.

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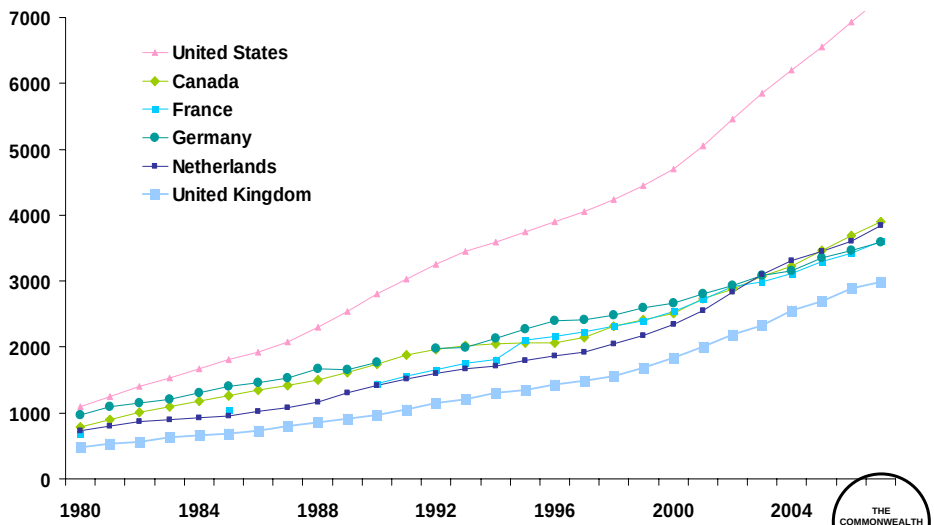
2

We Can't Continue on our Current Path: Growth in National Health Expenditures per Capita

Average spending on health per capita ($US PPP)



Data: OECD Health Data 2009 (June 2009)

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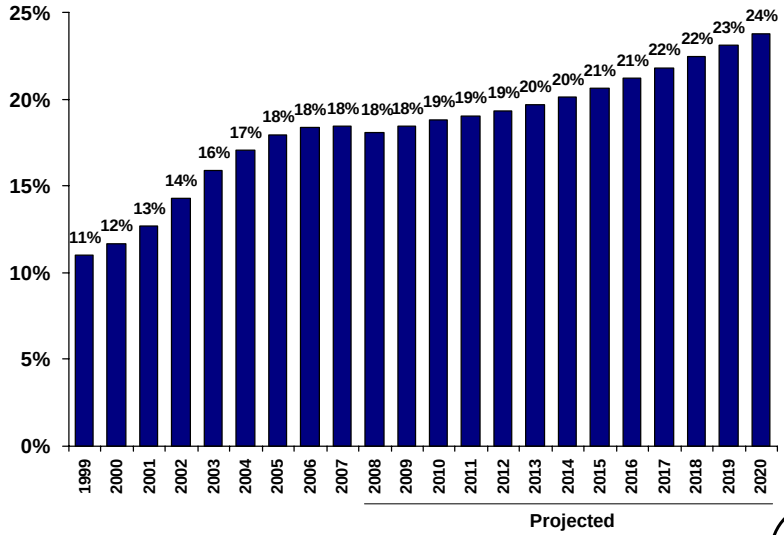
We Can't Continue on our Current Path:

Average Family Premium as a Percentage of Median Family Income, 1999–2020



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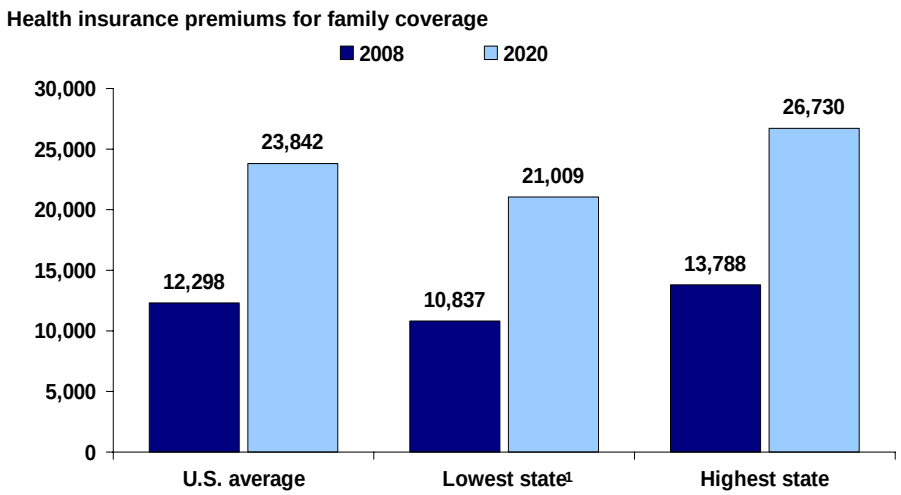
Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums,* The Commonwealth Fund, August 2009.

Employers and Families Can't Afford Rising Premiums

Employer/Employee Premiums for Family Coverage, 2008 and 2020



[1]The lowest state is Idaho; highest state is Massachusetts.

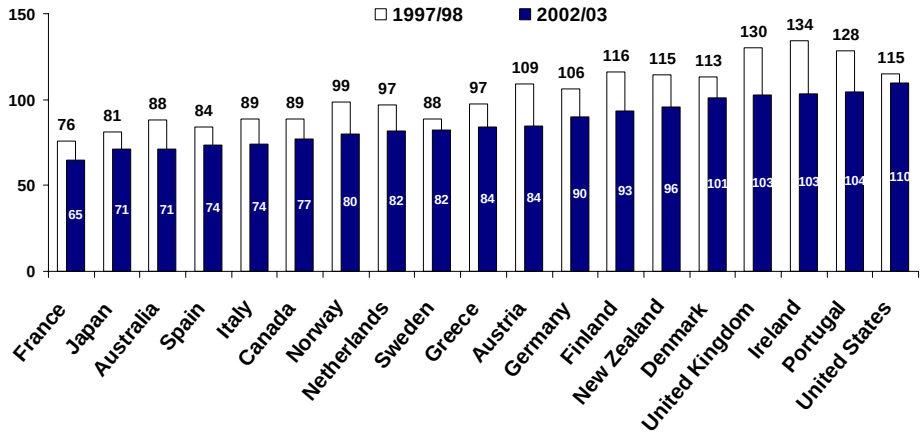
Data: 2008 premium data from Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2008 Medical Expenditure Panel Survey-Insurance Component; Premium estimates for 2020 based on CMS, Office of the Actuary, National Health Statistics Group, national health expenditures per capita annual growth rate.

Source: C. Schoen, J.L. Nicholson, S.D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes, State-by-State Health Insurance Premium Projections With and Without National Reform* (New York: The Commonwealth Fund) August 2009.

We Can't Afford to Continue to Lag on Health Outcomes

Mortality Amenable to Health Care

Deaths per 100,000 population*



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C.M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* Jan.-Feb. 2008, 27(1):58-71 analysis of World Health Organization mortality files.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

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Five Key Strategies for High Performance

1. **Extending affordable health insurance to all**
2. **Organizing care around the patient**
3. **Aligning financial incentives to enhance value and achieve savings**
4. **Meeting and raising benchmarks for high-quality, efficient care**
5. **Ensuring accountable national leadership and public/private collaboration**

Source: Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, The Commonwealth Fund, November 2007

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Features of National Health Reform Proposals, 2008

	President Obama	H.R. 3200 as amended
Coverage Expansion		
Aims to cover everyone	X	X
Regulation of insurance markets	X	X
New insurance exchange	X	X
Premium and cost-sharing assistance for low- to moderate income families	X	X
Medicaid expansion	X	X
Individual requirement to have insurance	X	X
Employer shared responsibility	X	X
Assistance to small businesses	X	X
System Improvements		
Primary care	X	X
Innovative payment pilots: medical homes, accountable care organizations, bundled hospital and post-acute care	X	X
Productivity improvements	X	X
Choice of private and public plans	X	X
Cost containment	X	X
Quality improvement	X	X

Source: Commonwealth Fund analysis of health reform proposals.

Coverage Expansion Provisions of H.R. 3200 As Amended by Energy and Commerce

- **Insurance market reform:**
  - **Guaranteed issue without regard to health status**
  - **Modified community rating (2:1 by age)**
- **Insurance exchange**
- **Premium and cost-sharing assistance up to 400% of poverty**
- **Medicaid expansion up to 133% of poverty Individual mandate**
- **Employer shared responsibility**
  - **Provide 72.5%+ premium contribution for individuals or 65% for families or face penalty of 2%-8% payroll (phased in by firm size)**
  - **Small businesses (<$500,000 payroll) excluded**
  - **Health coverage tax credits for small businesses with <25 employees and average wages <$40,000**
    - **Up to 50% premium costs for employers with up to 10 employees and average wages <$20,000**
    - **Sliding scale by firm size and average wage increases; not available for employees earning $80,000+**

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Premiums Under Current Law and H.R. 3200 As Amended by Energy and Commerce

Federal Poverty Level	2009 Annual Income	Maximum Premiums (Percent of Income)	Maximum Annual Premiums
133% FPL	$29,327	1.5%	$444
150% FPL	$33,075	3%	$996
200% FPL	$44,100	5.5%	$2,424
250% FPL	$55,125	8%	$4,416
300% FPL	$66,150	10%	$6,612
350% FPL	$77,175	11%	$8,484
400% FPL	$88,200	12%	$10,584

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Data: House of Representatives Ways and Means Committee

Cost Sharing Credits Reduce Limits on Cost-Sharing

Actuarial value of plan with credits increased to:	
133-150% FPL	97%
150-200% FPL	93%
200-250% FPL	85%
250-300% FPL	78%
300-350% FPL	72%
350-400% FPL	70%

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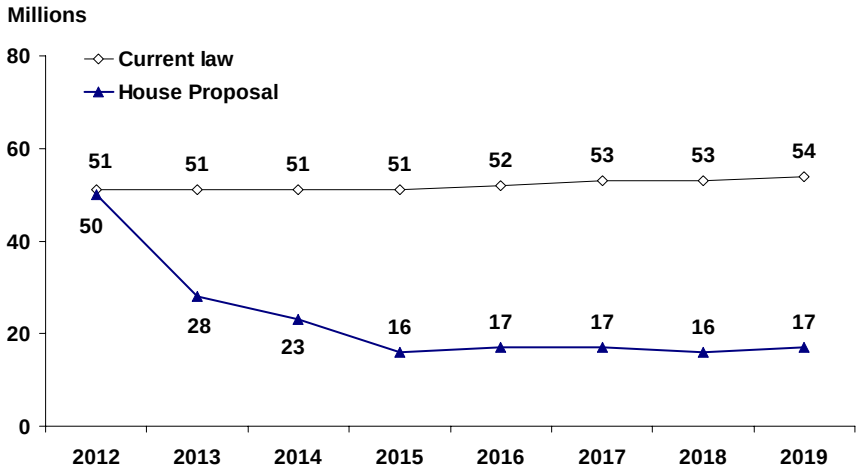
Source: House of Representatives Ways and Means Committee

Trend in the Number of Uninsured, 2012–2020 Under Current Law and H.R. 3200



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 97% of legal nonelderly residents are projected to have insurance under the proposal.
Data: Estimates by The Congressional Budget Office.

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System Reform Provisions of H.R. 3200 As Amended by Energy and Commerce

- **Payment reform**
  - **Enhanced payment for primary care: 5% overall, 10% in shortage areas**
  - **Replaced formula for updating physician fees: separate updates for primary care (GDP+2%) and specialty services (GDP+1%)**
  - **Geographic variations: IOM study; 5% add-on in lowest utilization areas**
- **Rapid cycle testing of innovative payment methods**
  - **Medical homes**
  - **Accountable care organizations**
  - **Bundled payments for hospital and post-acute care**
- **Choice of public and private plans**
- **Cost containment**
  - **Productivity improvement; reduction for high hospital readmissions**
  - **Negotiation of pharmaceutical prices; prescription drug savings**
  - **Resetting Medicare Advantage rates to FFS levels with quality bonuses**
  - **Health insurance exchange administrative savings for individuals and small businesses**
  - **Limit on premium increases to 150% medical inflation**
- **Quality improvement, measurement, public reporting**
- **Health goals and priorities for performance improvement**
- **Center for comparative effectiveness**

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Potential Impact of Payment Reforms on National Health Expenditures Compared with Current Projection, 2010–2020 (in billions)

	Total NHE	Private Employers	State & Local Governments	Households	Federal Budget
Total Payment Reforms	**–$1,010**	**–$170**	**–$10**	**–$82**	**–$749**
Enhanced payment for primary care	**–$71**	**–$28**	**–$2**	**–$11**	**–$30**
Encouraged adoption of Medical Home model	**–$175**	**–$25**	**–$13**	**–$36**	**–$101**
Bundled payment for acute care episodes	**–$301**	**–$75**	**–$4**	**–$11**	**–$211**
Correcting price signals					
• High-cost area updates	**–$223**	**–$64**	**–$3**	**–$29**	**–$127**
• Prescription drugs	**–$76**	**+$22**	**+$12**	**+$5**	**–$115**
• Medicare Advantage	**–$165**	**$0**	**$0**	**$0**	**–$165**

Source: The Commonwealth Fund, *The Path to a High Performance U.S. Health System*, 2009.

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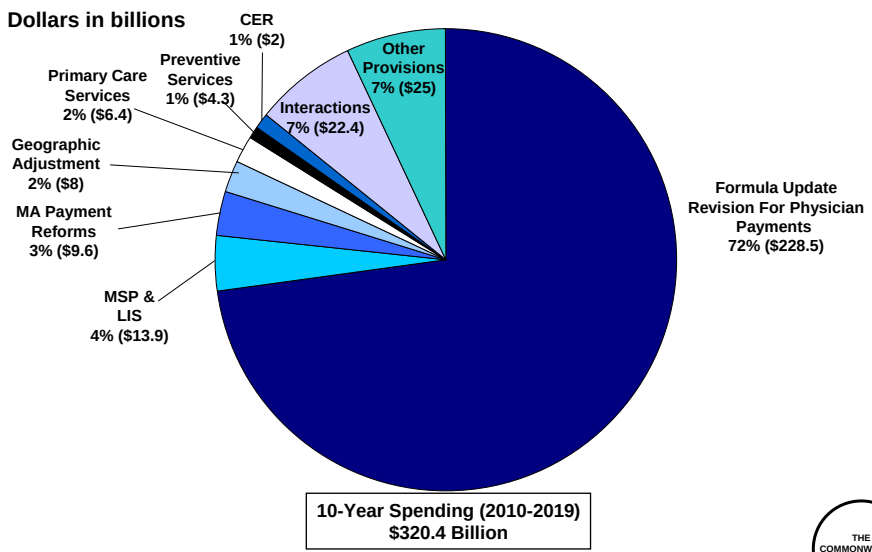
Projected 10-Year Medicare Spending Under H.R. 3200 "America's Affordable Health Choices Act of 2009"



Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on July 17, 2009, and Joint Committee on Taxation (JCT) estimates as provided on July 17, 2009 for H.R. 3200.

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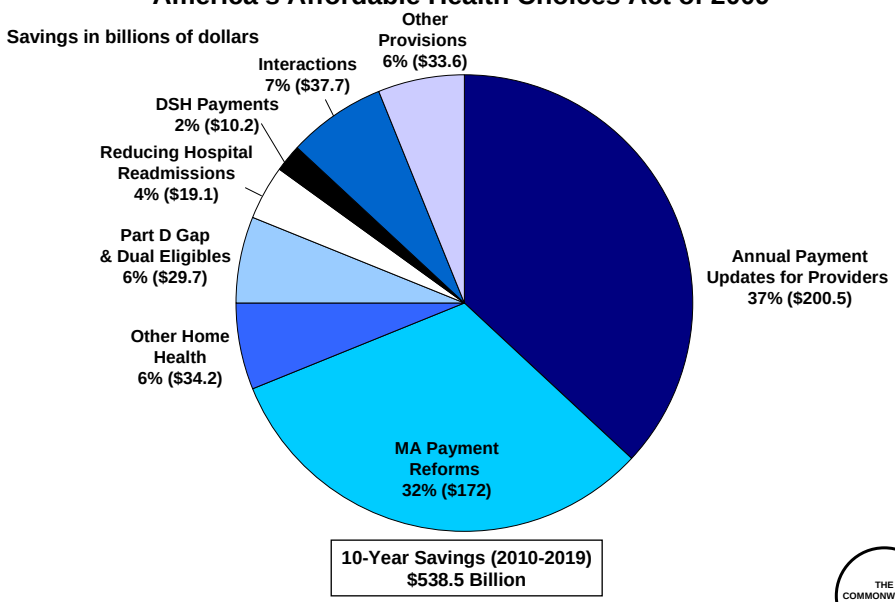
Projected 10-Year Medicare Savings Under H.R. 3200 "America's Affordable Health Choices Act of 2009"



Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on July 17, 2009, and Joint Committee on Taxation (JCT) estimates as provided on July 17, 2009 for H.R. 3200.

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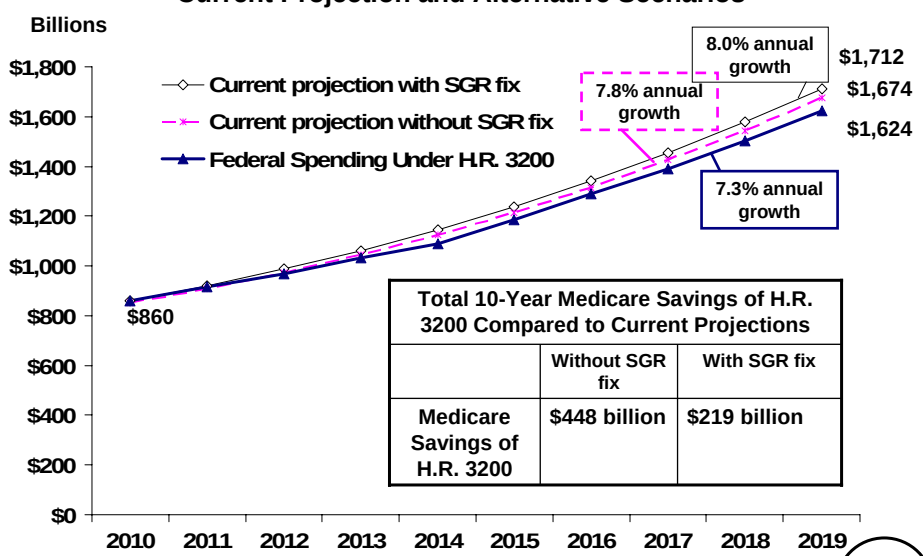
Total Federal Health Expenditures, 2010–2019: Current Projection and Alternative Scenarios



Total 10-Year Medicare Savings of H.R. 3200 Compared to Current Projections		
	Without SGR fix	With SGR fix
Medicare Savings of H.R. 3200	$448 billion	$219 billion

Data: Estimates by The Commonwealth Fund using Congressional Budget Office (CBO) cost estimates as provided on July 17, 2009, and Joint Committee on Taxation (JCT) estimates as provided on July 17, 2009 for H.R. 3200.

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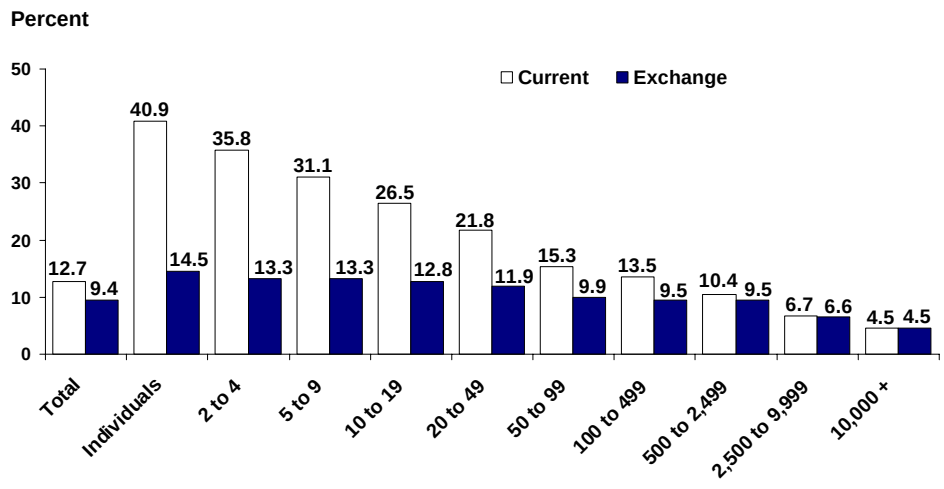
Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size



Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, (New York: The Commonwealth Fund, Feb. 2009).

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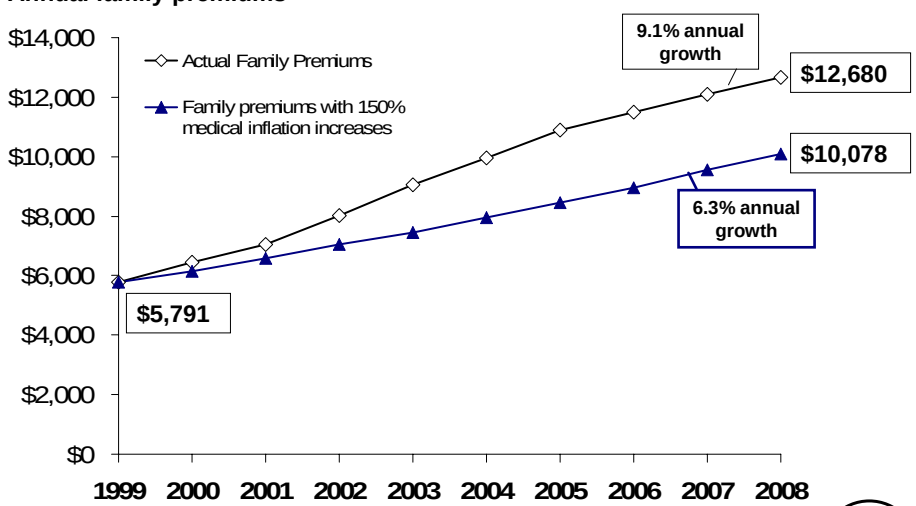
Potential Effect of Limits on Premium Increases

Limit of 150% Medical Inflation

Annual family premiums



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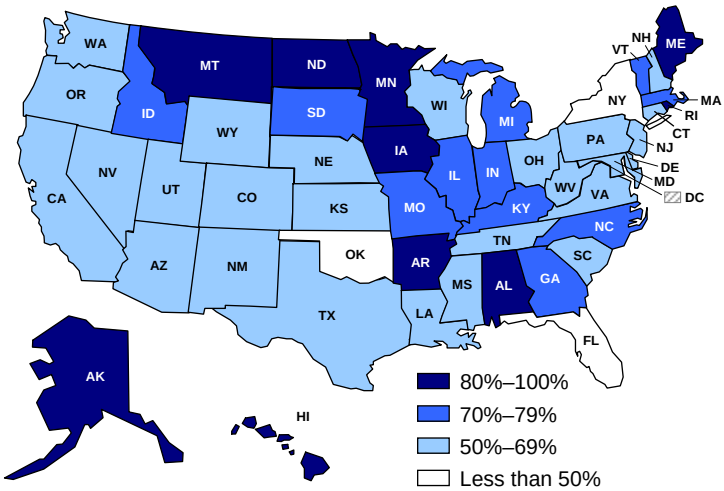
Source: Commonwealth Fund calculations based on U.S. Bureau of Labor Statistics, Kaiser HRET.

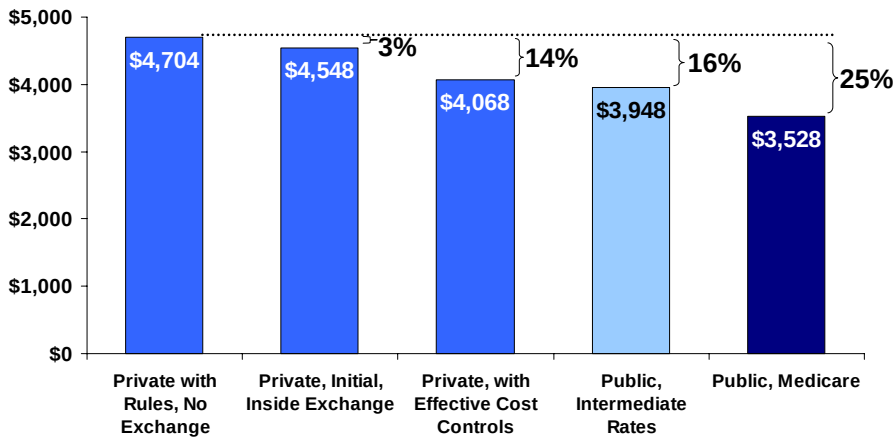
Concentrated Insurance Markets: Market Share of Two Largest Health Plans, by State, 2006



Note: Market shares include combined HMO+PPO products. For MS and PA share = top 3 insurers 2002-2003.
Source: American Medical Association, *Competition in health insurance: A comprehensive study of U.S. markets, 2008 update*; MS and PA from J. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov/Dec 2004; ND from D. McCarthy et al., "The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation," The Commonwealth Fund, May 2008.

Estimated Annual Premiums Under Different Scenarios, 2010

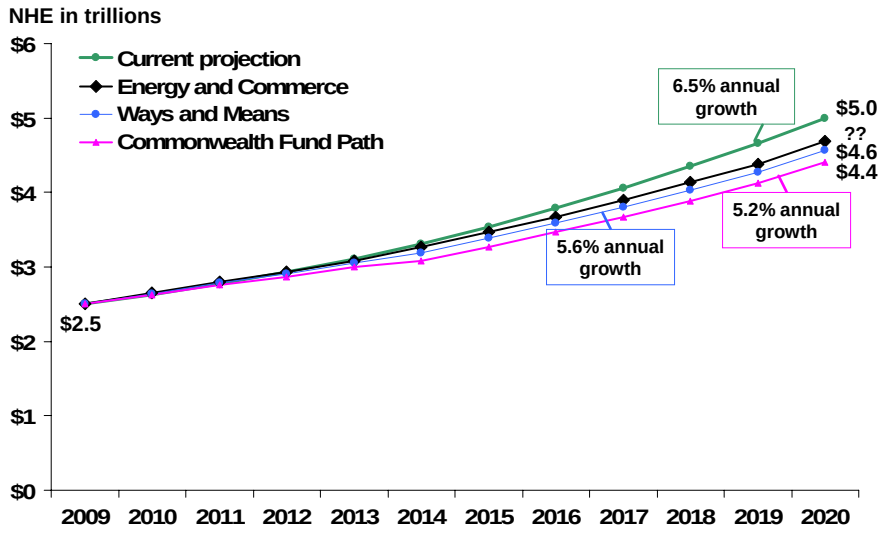
Average annual premium per household for same benefits at community rate*



* Premiums for same benefits and population. Benefits used to model: full scope of acute care medical benefits; $250 individual/$500 family deductible; 10% coinsurance physicians services; 25% coinsurance, no deductible prescription drugs ; full coverage preventive care. $5,000 individual/$7,000 family out-of-pocket cost limit.
Source: C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork In the Road: Alternative Paths to a High Performance U.S. Health System,* The Commonwealth Fund, June 2009.

21

Total National Health Expenditures, 2009–2020: Current Projection, Path, and Illustrative Ways and Means, Energy and Commerce Scenarios

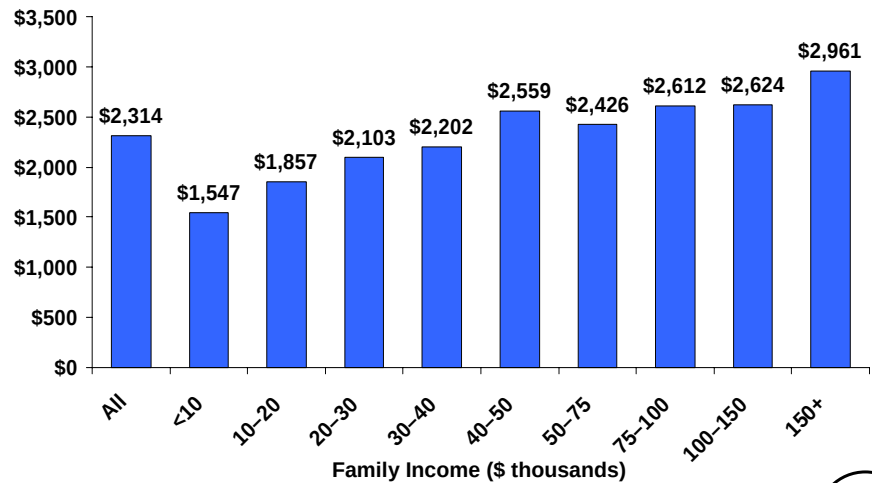


Note: GDP = Gross Domestic Product.
Data: Estimates by The Commonwealth Fund.

22

Average Annual Savings per Family Under Health Reform That Controls Premium Growth, 2020

Savings in health care spending compared with projected trends



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, February 2009).

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Major Sources of Savings And Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019

Dollars in billions

	CBO estimate of H.R. 3200, as of 7.31.09
Coverage Expansion and National Health Insurance Exchange	
• Medicaid/CHIP outlays	$438
• Exchange subsidies	773
• Payments by employers to exchanges	-45
• Small employer subsidies	53
• Payments by uninsured individuals	-29
• Play-or-pay payments by employers	-163
Total Federal Cost of Coverage Expansion and Improvement	***1,042***
Payment and System Reforms	
• Physician payment SGR reform	+229
• Net Medicare and other savings	-448
Total Savings from Payment and System Reforms	***-219***
Revenues	***-583***
Total Net Impact on Federal Deficit, 2010-2019	**239**

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Source: The Congressional Budget Office Analysis of HR 3200, The Affordable Health Choices Act, July 17, 2009, http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf

CBO Estimates of Major Health Legislation Compared to 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

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

Bending the Curve: Options that Achieve Savings

Cumulative 10-Year Federal Budget Savings

Aligning Incentives with Quality and Efficiency	Path estimate	CBO estimate	OMB estimate
• 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	---

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Source: R. Nuzum et al., *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, (New York: The Commonwealth Fund, June 2009).

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**

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Historic Opportunity for Change

- **The U.S. has a historic opportunity to adopt reforms that will achieve a high performance health system; we can't afford to continue on our current course**
- **Goals of stable and secure coverage for all are achievable; requires one-time shift in federal budget to assist uninsured and underinsured**
- **Slowing growth in total health spending and Medicare outlays is achievable**
  - **Investing in primary care**
  - **Rapid cycle testing of innovative payment reforms to reward quality and value**
  - **Productivity improvement**
  - **Correcting market price signals: Medicare Advantage, Rx**
  - **Choice and competition: public/co-op plan; limits on plan premium growth**
  - **Harmonization of private and public payment methods**
  - **Independent commission**
- **Budget-neutrality is achievable through combination of cost-containment and new revenues**
- **Oversight and system of tracking performance will be needed**