FORK IN THE ROAD: ALTERNATIVE PATHS TO A HIGH PERFORMANCE U.S. HEALTH SYSTEM

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ABSTRACT: A controversial part of the health reform debate is whether a new public insurance plan choice should be offered to the under-65 population. This report analyzes alternative paths to reform and presents estimates of impacts on health spending. The approaches include: 1) a public health plan paying providers at Medicare rates, offered alongside private plans in a national health insurance exchange; 2) a public plan paying providers at rates set midway between Medicare and private plan rates, offered alongside private plans in an insurance exchange; and 3) no public plan, with only private plans offered to employers and individuals through an insurance exchange. All three approaches, if combined with Medicare payment and system reform, would produce substantial savings over time, but option 1 would yield the most—$3.0 trillion in cumulative health system savings over 2010 to 2020, compared with $2.0 trillion (option 2) and $1.2 trillion (option 3).

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EXECUTIVE SUMMARY

The U.S. health system is traveling down a fiscally dangerous road. By 2020, over one-fifth of the nation's economic resources—21.3 percent of the gross domestic product (GDP)—will go toward providing health care without commensurate return in access, health outcomes, or value. In spite of all that spending, an estimated 61 million people will be uninsured in 2020, and more than 30 million more will be underinsured—at risk of incurring medical bills they cannot afford and accumulating debt for health care expenses.

In February 2009, The Commonwealth Fund Commission on a High Performance Health System proposed an integrated plan for putting the U.S. health system on the path to high performance, which would lead to better access, improved quality of care, and greater efficiency by 2020. Major features of this proposal include creation of a national insurance exchange that offers an affordable choice of private and public health insurance plans to all Americans; requirements that individuals obtain coverage and that employers help finance coverage for workers; promotion of more patient-centered, efficient, and integrated health care delivery through the use of innovative provider payment approaches; promulgation of health information technology and comparative-effectiveness research to improve quality and enhance value; and adoption of public health initiatives to reduce obesity and tobacco use and improve overall health and quality of life.

National debate is currently centered on the question of how to slow the growth of health care costs to sustain coverage while ensuring quality of care. A controversial component of this debate is whether to offer a new public plan choice to the under-65 population. This report by Commonwealth Fund staff is intended to inform this debate. It does so by analyzing alternative approaches to defining the role of a public plan and presenting estimates of the potential impacts of the approaches on health spending. These alternative paths to higher performance include:

- **Public Plan with Medicare Payment Rates.** This path includes a public health insurance plan that pays providers at Medicare rates and is offered alongside private plans within a national health insurance exchange.
- **Public Plan with Intermediate Payment Rates.** This path includes a public insurance plan that pays providers at rates set midway between current Medicare and private plan rates and is offered alongside private plans in a national health insurance exchange—and subject to the same market rules as they are.

- **Private Plans.** This path does not include a public plan option; it includes only private plans offered to employers and individuals through a national health insurance exchange.

The analysis assumes that each of the three paths includes the same insurance market reforms to ensure participation and affordability, and that each includes the same Medicare payment reforms and broader health system reforms to align incentives with value and improve the outcomes and efficiency of the health care delivery system. The major features of the three alternatives are summarized in Exhibit ES-1.

Exhibit ES-1. Policy Provisions Under Three Reform Scenarios

	Public Plan at Medicare Rates	Public Plan at Intermediate Rates	Private Plans
Requirements for Coverage			
Individual mandate	X	X	X
Employer shared responsibility	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings
Insurance Exchange			
Plans offered	Public and private	Public and private	Private
Replaces individual insurance market	X	X	X
Income-related premium assistance in exchange	X	X	X
Community rating	X	X	X
Guaranteed access and renewal	X	X	X
Minimum benefit standard	X	X	X
Provider Payment Reform			
Payment on value, not volume	Required for public plan; voluntary for private plans	Required for public plan; voluntary for private plans	Voluntary for private plans
Cost restraints on provider prices	Medicare level for public plan; commercial level for private plans	Midpoint between Medicare and commercial level for public plan; commercial levels in private plans	Unchanged
Medicaid at Medicare rates	X	X	X
Coverage of the uninsured	Bought in at Medicare level	Most bought in at midpoint level	Bought in at commercial level
Changes to Current Public Programs			
Retain current Medicare benefit structure	X	X	X
End Medicare disability waiting period	X	X	X
Expand Medicaid/CHIP	X	X	X
System Reform			
Comparative effectiveness	X	X	X
Health information technology	X	X	X
Public Health	X	X	X

Although all three paths would achieve the goal of health insurance coverage for all, each would have different implications for major stakeholders and sources of coverage. Most important, these approaches would slow the growth of health spending to varying degrees and have different federal budget implications.

Analysis of these alternative paths yields the following results:

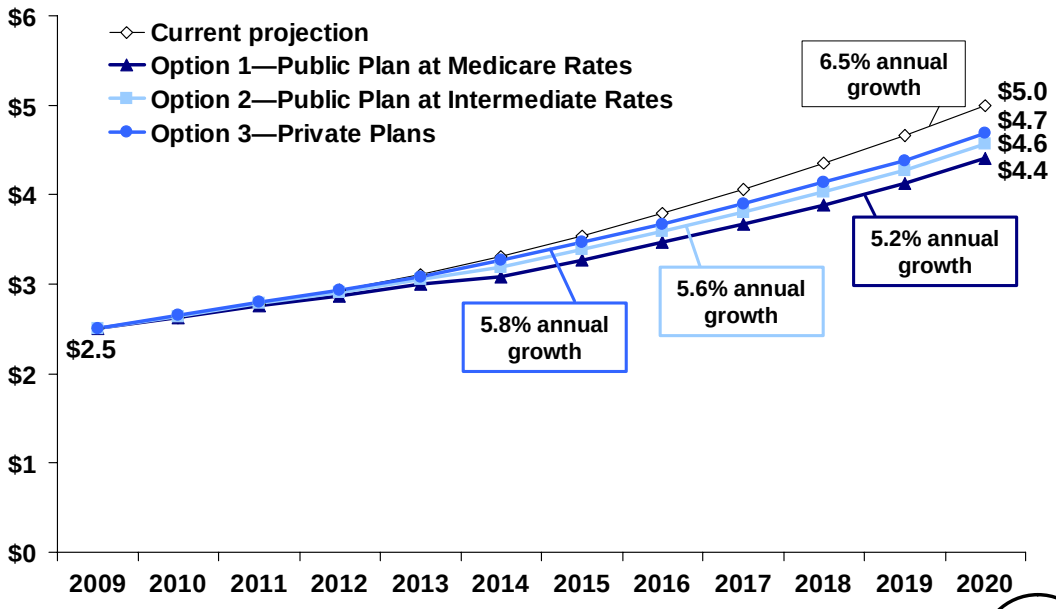
- **Health system savings.** All three paths would produce substantial health system savings over the 11-year period from 2010 through 2020, with cumulative savings of $3.0 trillion under the Public Plan with Medicare Payment Rates scenario, $2.0 trillion under the Public Plan with Intermediate Payment Rates scenario, and $1.2 trillion under the Private Plans scenario.

- **Source of differences in savings.** Differences in system savings under the three scenarios derive from insurance administrative savings realized by the offer of a public health insurance plan in competition with private plans; from the tighter payment rates used by the public plan; and from the application of payment innovations and system reforms to a greater share of the insured population under the two scenarios that feature a public plan.
    - About $265 billion in insurance administrative savings are projected over 2010–2020 in the Public Plan with Medicare Payment Rates path compared with $223 billion in savings in the Public Plan with Intermediate Payment Rates path, while the Private Plans scenario would result in an increase in administrative costs of $32 billion.
    - The great majority of system savings—ranging from $2.7 trillion to $1.2 trillion over 2010–2020 under the three scenarios—comes from greater efficiencies in care delivery and slower growth in health care spending. Revenues of providers continue to grow throughout the period, albeit at a slower rate than at present, and with differential effects across providers. In the absence of reform, cumulative national health expenditures will be $40 trillion over the 11 years.

- **Bending the curve in health spending.** The currently projected 6.5 percent annual rate of growth in national health expenditures over the 2010–2020 period would be reduced to 5.2 percent with the Public Plan with Medicare Payment Rates path, 5.6 percent with the Public Plan with Intermediate Payment Rates path, and 5.8 percent with the Private Plans path (Exhibit ES-2). The Public Plan with Medicare Payment Rates approach is the most aggressive in controlling costs but still slows health care

cost growth less than the 1.5-percentage-point annual savings commitment recently offered by industry groups.

Exhibit ES-2. Total National Health Expenditures (NHE), 2009–2020: Current Projection and Alternative Scenarios

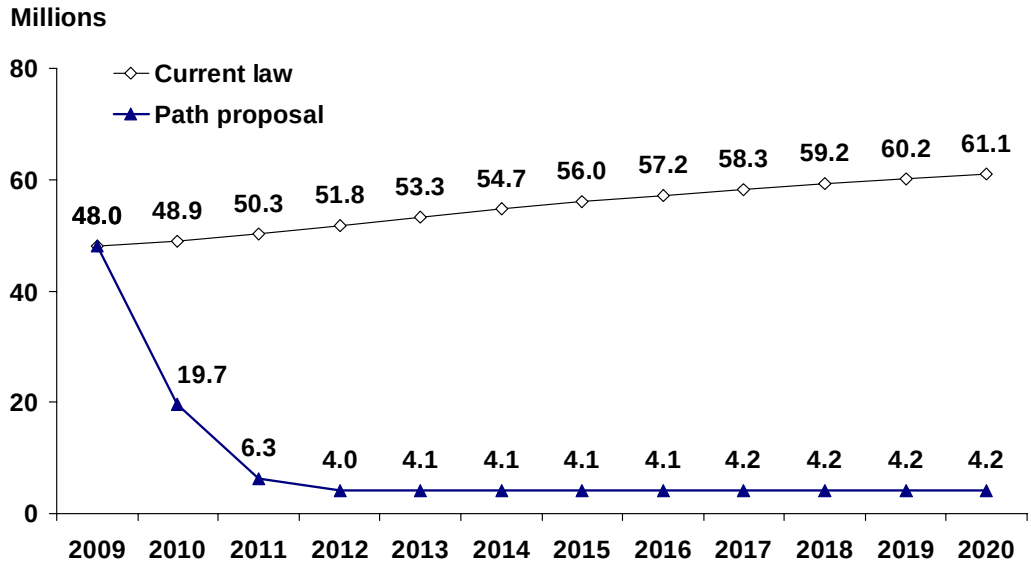


Data: Estimates by The Lewin Group for The Commonwealth Fund.

- **Share of economic resources.** Although the percentage of GDP spent on health care would be lower in 2020 under each scenario compared with the currently projected 21.3 percent, health spending would in each case account for a higher share of the U.S. economy than the 17.6 percent expected in 2009—18.7 percent under the Public Plan with Medicare Payment Rates approach, 19.4 percent under the Public Plan with Intermediate Payment Rates approach, and 19.9 percent under the Private Plans approach.

- **Expanded coverage.** Under all three scenarios, the insurance expansion would bring about near-universal coverage. The number of uninsured would drop from an estimated 48 million in 2009 (16% of the population) to 4 million by 2012 (1% of the population), with that extent of coverage maintained through the end of the decade (Exhibit ES-3). Absent reform, the number of uninsured is projected to rise to at least 61 million by 2020.

Exhibit ES-3. Trend in the Number of Uninsured, 2009–2020 Under Current Law and Three Path Scenarios



Note: Assumes insurance exchange opens in 2010 and take-up by uninsured occurs over two years. Remaining uninsured are mainly non-tax-filers.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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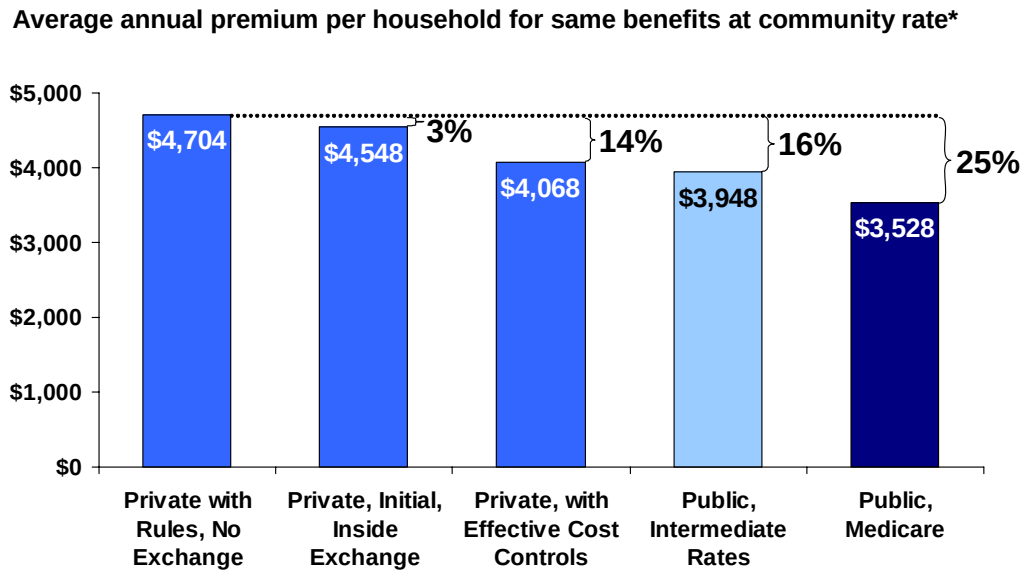
- **Impact on premiums.** Estimates indicate that premiums for the public plan choice in the Public Plan with Medicare Payment Rates path would initially be 25 percent below those currently available for a comparable benefit package in the private individual/small firm market and 16 percent lower under the Public Plan with Intermediate Payment Rates scenario (Exhibit ES-4). Private plan premiums would initially be 3 percent lower within the exchange as it facilitates the process of choosing plans and reduces administrative costs, especially for individuals and small businesses.

Exhibit ES-4. Estimated Annual Premiums Under Different Scenarios, 2010



* 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.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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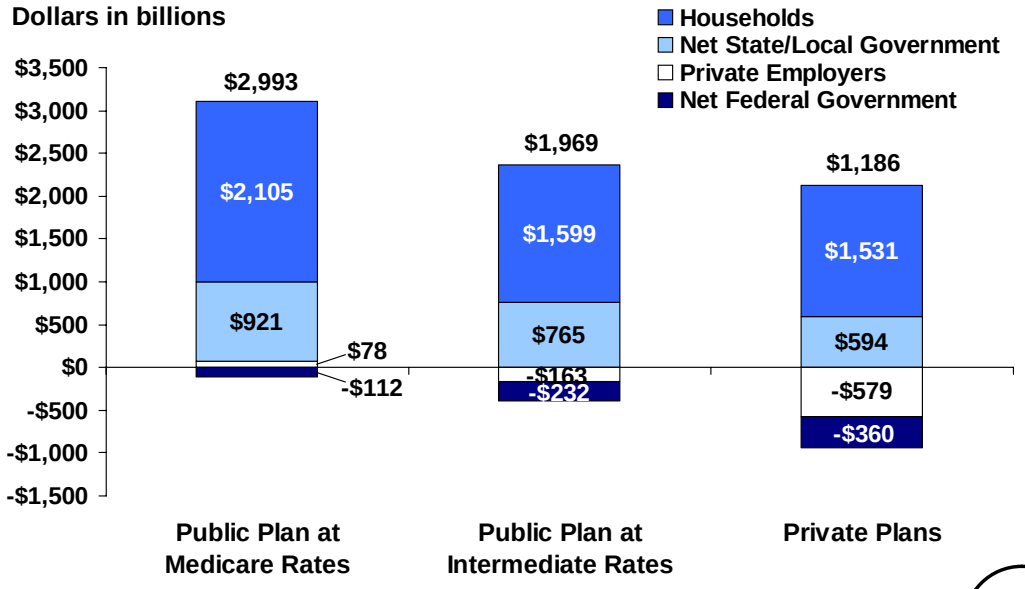
- **Effective private-sector cost containment.** Offering a public health insurance plan as an alternative choice should be a catalyst for private plans to innovate in the way they operate and pay for care. It would help them reduce their administrative costs and implement payment and system reforms that lead to more appropriate utilization, better care, and slower cost growth—and, in the process, contribute to reduced premiums. Community health plans partnering with integrated health care delivery systems in particular have considerable potential to achieve economies through redesign of care, control of chronic conditions, and prevention of avoidable hospitalizations. Private plans could also be given the authority to adopt public plan payment methods and rates. If private plans adopt effective cost-containment measures sufficient to slow a rise in their premiums relative to trends in public plan premiums, over a three-to-five-year period public plan premiums and private plan premiums within the exchange would be roughly comparable.

- **Impact on federal budget.** Over the 2010–2020 period, the cumulative net increase in federal budget outlays is estimated to be $112 billion under the Public Plan with Medicare Payment Rates scenario, $232 billion under the Public Plan with Intermediate

Payment Rates scenario, and $360 billion under the Private Plans scenario (Exhibit ES-5). The federal budget costs of covering the uninsured and providing premium assistance to low-to-moderate-income working families are lowest under a public plan paying at Medicare rates and highest under private plans paying commercial provider payment rates. Under each scenario, most federal budget costs are incurred in the first five years, as the uninsured are covered and premium assistance is provided to low-to-moderate-income individuals (Exhibit ES-6). Over the longer term, most of the federal budget offsetting savings comes from Medicare payment and system reforms, as well as from increased taxes on tobacco, alcohol, and sugared soft drinks.

Exhibit ES-5. Net Cumulative Impact on National Health Expenditures, 2010–2020 Compared with Baseline, Three Insurance Exchange Scenarios, by Major Payer Groups



Note: A negative number indicates spending increases compared with projected expenditures; a positive indicates spending decreases (i.e., savings).
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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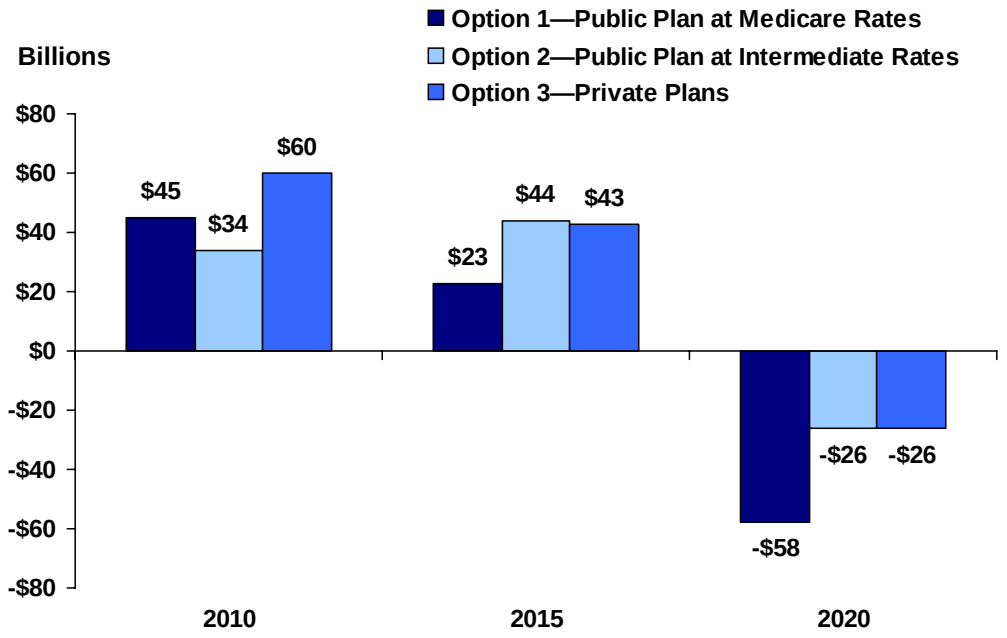
Exhibit ES-6. Change in Net Federal Spending Under Three Path Scenarios



Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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- **Impact on employer costs.** In all three scenarios, employers are required to cover workers or contribute 7 percent of workers' earnings up to $1.25 an hour to a health insurance fund. As a result, those employers who do not now cover their employees would bear added cost. However, employers who now cover their workers would benefit from insurance, payment, and system reforms that lower insurance premiums and slow future growth in health care costs. Employers would fare best when their employees have access to a public health insurance plan that provides value for the premium dollar. Over the 2010–2020 period, payment and system savings with the Public Plan with Medicare Payment Rates path would offset any additional costs that health reform might produce for employers and workers as slower premium growth would result in net cumulative employer savings of $78 billion—although the effects on different employers would vary (Exhibit ES-5). Employers would incur $163 billion in increased cost under the Public Plan with Intermediate Payment Rates path and $579 billion under the Private Plans path over the 2010–2020 period.

- **Impact on households.** In all three scenarios, the bulk of total savings over time would benefit individuals and families as a result of slower growth in premiums and

out-of-pocket spending, the availability of federal premium assistance, and the expansion of public programs to make insurance affordable. These savings would accrue across all income groups. By 2020, annual savings per household would average $2,228 under the Public Plan with Medicare Payment Rates scenario, $1,634 under the Public Plan with Intermediate Payment Rates scenario, and $1,576 under the Private Plans scenario. Total savings to households over the period from 2010 through 2020 under the three scenarios are estimated to be $2.1 trillion, $1.6 trillion, and $1.5 trillion, respectively (Exhibit ES-5).

In short, the presence of a public plan and the payment policies that it encompasses account for most of the total health system savings and federal budget cost differences among the alternative scenarios. Differing results reflect the relative aggressiveness and effectiveness of various cost-containment strategies and the creation of a new dynamic for transforming both health insurance and the provision of health care. The choice of a public plan provides a less-expensive base for expanding coverage than private plans, because a public plan would, at least initially, be paying at lower rates than private plans currently do (but at higher rates than most providers now receive for uninsured and Medicaid patients). Adoption of a public plan would also enable more rapid spread of payment reforms, since more people would be covered under plans that adopt those reforms. The public plan also achieves economies through lower insurance administrative costs. Although the outcome is difficult to predict, private plans, too, could be expected to respond to the new competitive dynamic, by partnering with integrated delivery systems to provide incentives and tools for more effective care, as well as to eliminate ineffective, avoidable, or duplicative care and achieve economies in insurance administration.

Although spending growth would slow, most providers would experience rising revenues and opportunities for shared savings, as preventable hospitalizations and greater efficiency in delivery of care are realized. Coverage of the uninsured and improved benefits for them would reduce bad debts and infuse new revenues into the health system in the early years, benefitting in particular the safety-net providers that now offer charity care to those who cannot pay.

At this critical juncture, the national reform debate should stay focused on the key coverage, payment, and system reforms that are necessary to put the nation on a path to high performance in health care. Recently, debate has centered on which direction the nation should take to move forward. However coverage is provided, reforms should ensure that everyone has the benefit of insurance plans that serve as agents for the public by pooling risk, paying for effective care, and requiring accountability for outcomes. The

key issues should be how best to provide access to high-quality, affordable care for all, now and into the future. That is the goal of comprehensive health reform, and we should be careful not to lose sight of it.

All three paths described here, combined with an integrated set of payment and system reforms, would represent major steps toward the goal of covering the uninsured. But with the nation's economic and fiscal future at risk, health reform must pay particular attention to effective strategies for altering the future course of spending for health care and increasing value obtained for the resources devoted to the health system.

FORK IN THE ROAD:
ALTERNATIVE PATHS TO A
HIGH PERFORMANCE U.S. HEALTH SYSTEM

INTRODUCTION

The U.S. health system is traveling down a fiscally dangerous road. By 2020, over one-fifth of the nation's economic resources—21.3 percent of the gross domestic product (GDP)—will go toward providing health care without commensurate return in access, health outcomes, or value of services. In spite of all that spending, an estimated 61 million people will be uninsured in 2020, and over 30 million more will be underinsured, at risk of incurring medical bills they cannot afford and accumulating debt for health care expenses. We simply cannot continue on our current course.

The Commonwealth Fund Commission on a High Performance Health System has set forth an integrated framework for putting the U.S. health system on the path to reaching a high performance health system which yields better access, improved quality of care, and greater efficiency by 2020.[1] The framework lays out five essential goals for comprehensive reform:

- Affordable coverage for all;
- Align incentives with value and effective cost control;
- Accountable, accessible, patient-centered, and coordinated care;
- Aim high to improve quality, health outcomes, and efficiency; and
- Accountable leadership and collaboration to set and achieve national goals.

That framework, published in February 2009, built on President Obama's campaign health reform plan and was consistent with the eight principles for health reform set forth in his administration's budget blueprint.[2] Key features include creation of a national exchange that offers to everyone a choice of private insurance plans and a new public health insurance option; requirements that individuals obtain coverage and employers help finance health coverage for their workers; promotion of more efficient and integrated health care delivery through the use of innovative provider payment approaches; promulgation of health information technology and comparative-effectiveness research to improve quality of care and enhance value in health care spending; and adoption of public-health initiatives to reduce obesity and tobacco use. Modeling based on an illustrative set of policies indicated that such a comprehensive,

integrated approach has the potential to extend affordable coverage to everyone, improve health outcomes, and slow the growth of health care spending.

THREE SCENARIOS

National debate is currently centered on the question of how to slow the growth of health care costs to sustain coverage while ensuring quality care. A controversial component of this debate is whether to offer a new public insurance plan choice to the under-65 population. This report by Commonwealth Fund staff is intended to inform that debate. It analyzes alternative approaches to defining the role of a public health insurance plan and presents estimates of the potential impacts of those approaches on health spending. The three alternative paths to high performance include:

- **Public Plan with Medicare Payment Rates.** This path includes a public health insurance plan that pays providers at Medicare rates and is offered alongside private plans within a national health insurance exchange.
- **Public Plan with Intermediate Payment Rates.** This path includes a public health insurance plan that pays providers at rates midway between current Medicare and private plan rates and is offered alongside private plans within a national health insurance exchange and subject to the same market rules as they are.
- **Private Plans.** This path does not feature a public plan option, but rather includes only private plans offered to employers and individuals through a national health insurance exchange.

As the reform debate has evolved, attention has turned to increasing the effectiveness of the insurance exchange and trimming federal budget costs. Accordingly, this report modifies some of the Commission on a High Performance Health System's original "Path" specifications in all three scenarios. Revised policy assumptions include:

- Requiring that all individual coverage be purchased through the national health insurance exchange to lower administrative costs and pool risks;
- Limiting the availability of income-related premium assistance to coverage purchased through the exchange to achieve efficient distribution;
- Targeting of premium assistance to low-to-moderate-income households; and
- Keeping the current Medicare benefit structure rather than offering a new Medicare supplement.

To focus on the difficulties associated with designing and offering a public health insurance plan option, the modeling assumes that each of the three insurance framework options include the same insurance market reforms—in order to ensure participation and affordability—and that each institutes the same Medicare payment and system reforms to align incentives with value and improve the outcomes and efficiency of the health care delivery system. Exhibit 1 outlines the shared set of integrated policies and contrasts key differences in the choice of plans and provider payment rates under the three scenarios offered through the insurance exchange. Modification of the Path framework is noted in the more detailed Appendix (see page 37). These estimates differ from earlier ones because of these policy changes as well as the February revisions in baseline spending projections by the Centers for Medicare and Medicaid Services.

Exhibit 1. Policy Provisions Under Three Reform Scenarios

	Public Plan at Medicare Rates	Public Plan at Intermediate Rates	Private Plans
Requirements for Coverage			
Individual mandate	X	X	X
Employer shared responsibility	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings
Insurance Exchange			
Plans offered	Public and private	Public and private	Private
Replaces individual insurance market	X	X	X
Income-related premium assistance in exchange	X	X	X
Community rating	X	X	X
Guaranteed access and renewal	X	X	X
Minimum benefit standard	X	X	X
Provider Payment Reform			
Payment on value, not volume	Required for public plan; voluntary for private plans	Required for public plan; voluntary for private plans	Voluntary for private plans
Cost restraints on provider prices	Medicare level for public plan; commercial level for private plans	Midpoint between Medicare and commercial level for public plan; commercial levels in private plans	Unchanged
Medicaid at Medicare rates	X	X	X
Coverage of the uninsured	Bought in at Medicare level	Most bought in at midpoint level	Bought in at commercial level
Changes to Current Public Programs			
Retain current Medicare benefit structure	X	X	X
End Medicare disability waiting period	X	X	X
Expand Medicaid/CHIP	X	X	X
System Reform			
Comparative effectiveness	X	X	X
Health information technology	X	X	X
Public Health	X	X	X

Market Rules and Payment Rates

Because of the urgency of the country's health care, economic, and financial crises, the Public Plan with Medicare Payment Rates path contains provisions for achieving rapid transformation of the health insurance market as well as the organization and delivery of health care services. Most importantly, it offers a public health insurance plan with much lower premiums than current plans—as a consequence of lower administrative overhead and provider payment at Medicare rates which fall below those of commercial insurers (but above Medicaid payment rates and above the limited payment for the uninsured).

Some experts and stakeholders are concerned that a public plan paying at Medicare rates would make it difficult for private insurers and providers to transform their operations quickly enough to compete effectively.[3] Various compromise proposals have been suggested that could "level the playing field" for competing private plans and the public plan, increase payment rates to providers under the public plan above Medicare levels, and apply uniform rules to private plans and the public plan.[4]

In the two scenarios that offer a public plan, the same insurance standards and rules would apply to the public plan and competing private plans. Key elements include:

- *Premiums:* Like private plans, the public plan would be financially self-sustaining, with premiums set to cover projected medical outlays and administrative overhead.
- *Premium reserves:* The public plan would set premiums to enable a premium reserve fund, as the federal government now does with the Blue Cross Blue Shield (BCBS) standard option in the Federal Employees Health Benefits Program (which is administered by BCBS for an administrative fee paid by the federal government).
- *Premium assistance:* Premium support to low-to-moderate-income enrollees would be available for both private plans and a public plan offered through the exchange. The assistance would be benchmarked to the most efficient plan (based on cost and quality).
- *Standards:* Both public and private plans would be required to meet minimum benefit standards and reporting in order to ensure adequate financial protection for enrollees and facilitate comparison of plans in the insurance exchange.
- *Governance:* The government agency or board overseeing the public plan (e.g., the Centers for Medicare and Medicaid Services or a new agency within the U.S. Department of Health and Human Services) would be separate and distinct from the public or quasi-public authority that sets the rules and runs the insurance exchange.
- *Regulations:* The public plan would be subject to the same laws and regulations as self-insured private plans. National standards for consumer protections, public

reporting, essential benefits, and market rules on nondiscrimination against the sick (e.g., guaranteed issue and community rating) would apply equally to private plans and the public plan. Self-insured plans typically offered by large employers now are not subject to state premium taxes; the public health insurance plan would be similarly exempt. In addition, neither nonprofit private insurers nor public plans would be subject to corporate income taxes.

- *Payment reforms:* The public plan would incorporate innovative payment reforms that reward value not volume, as would Medicare and Medicaid; private insurers could, if they choose, adopt similar payment reforms that reward results rather than volume of services provided. The goal should be to institute multipayer reforms that apply to both public and private payment for providers, but these have not yet been modeled.
- *Payment level:* The public health insurance plan would pay providers at Medicare rates in the first scenario and at rates intermediate between Medicare and commercial rates in the second scenario. For modeling purposes, payment rates are set at the midpoint between Medicare and commercial payment rates. Future policy would be to establish a process (e.g., payment council or commission similar to MedPAC) to determine a "fair payment rate sufficient for efficient operations."[5] Medicaid payments would be raised to Medicare levels and incorporate payment reforms.
- *Quality standards:* Providers in private plans and the public plan would be required to meet the same standards for quality of care.
- *Enforcement:* Physicians choosing to be out-of-network and not participate in public and private plans could do so, but physicians charging in excess of a given threshold (e.g., 10% to 15% above the approved intermediate plan rates) would be at risk of losing Medicare participation. Unified federal policies would ensure quality and efficiency, and all payers would use their purchasing leverage to effectively bend the curve in health spending and promote more integrated, coordinated care delivery.

Establishing a level playing field on standards and rules for all insurers would enable competition among them on "value added" services, such as their ability to achieve efficiencies in insurance operations and to develop and implement innovative payment arrangements. Obviously, it makes little sense to continue payment incentives that reward increased volume and complexity of services rather than more efficient care with better outcomes. Accordingly, each Path scenario would include new payment methods that apply to Medicare, Medicaid, and any other public plan. Private plans could also adopt the public plan payment rules or innovate in other ways.

Currently, it is argued that prices charged to private insurers, especially hospital charges, should cover the costs of providing care to the uninsured and bad debt/charity for the underinsured. All three Path scenarios would provide affordable coverage to everyone and would raise Medicaid payments to Medicare levels. These reforms would earn hospitals and physicians an estimated $60 billion or more in new revenues per year and eliminate the need for implicit cross-subsidies that are built into current charges to private insurers. This infusion of funds and reduction of provider bad debts would enable private plans to adopt new payment rules that are incorporated in Medicare and the public health insurance plan, with incentives for more effective and efficient integrated care. Community health plans that partner with integrated delivery systems and accountable-care organizations would be particularly well positioned to respond to the new competitive dynamic by offering a competing public coverage plan that would redesign care procedures, adopt optimal practices and health information technology, and employ team approaches to care of patients with chronic conditions.

Recently, health insurers, providers, and labor organizations have committed to an effort to eventually slow the growth in health expenditures by 1.5 percentage points annually.[6] However, since no enforcement mechanisms or specific policies were proposed at the time that estimates of the three Path scenarios were made, the impact of that pledge could not be modeled here.

The private health insurance sector has offered to abide by new regulations governing the sale of private insurance, and these market rules are assumed in all three scenarios. The rules include a commitment to community rating, with the same premium charged to enrollees regardless of health status or gender.[7] Open enrollment would permit anyone to qualify for coverage, and renewal would be guaranteed even if enrollees incurred health problems. A national insurance exchange with market rules governing risk-pooling applied broadly across plans sold inside and outside the exchange would pool risks more equitably but might not lower average premiums as more individuals with serious health conditions are covered.

The health insurance exchange would be open to individuals and employer groups, phased in over four years by size of firm, with community rating, guaranteed-access and renewal provisions, and a minimum benefit standard applying across all markets. In all three scenarios, the insurance exchange would be the source of all insurance sold on an individual basis, and all premium assistance would flow through the insurance exchange.

Need for Risk Adjustment: Focusing Competition on Adding Value

To promote competition based on better health outcomes, quality of care, and insurance efficiency, there would need to be a mechanism to make adjustments for health risks across plans. With 20 percent of the population accounting for 80 percent of total spending each year, any plan would be at a competitive disadvantage if it earned a reputation for providing excellent care and access for those with chronic or serious health conditions. A risk-adjustment mechanism that recalculated rates and protected plans if they enrolled a sicker mix of patients would focus competition on adding value of service rather than risk segmentation. Such a mechanism would also encourage plans to advertise their performance with seriously ill patients—a practice that could put plans at risk in current markets.

A scenario with a public insurance plan that accepts everyone also opens the door to the possibility that private insurers might "compete" by using network designs or targeted marketing that attracts a healthier mix of patients. This sort of experience within the current Medicare program has led to increasingly sophisticated methods of risk-adjustment rating and oversight. Although existing risk-adjustment approaches are less than perfect, they have improved over the last decade. It should be possible to devise a risk-adjustment mechanism that could protect the public insurance plan option as well as safeguard private insurers that attract a high proportion of sicker patients because of their reputations for high-quality and responsive care. Policy leaders could draw from international as well as U.S. experience to guide this effort.[8]

ESTIMATED IMPACTS

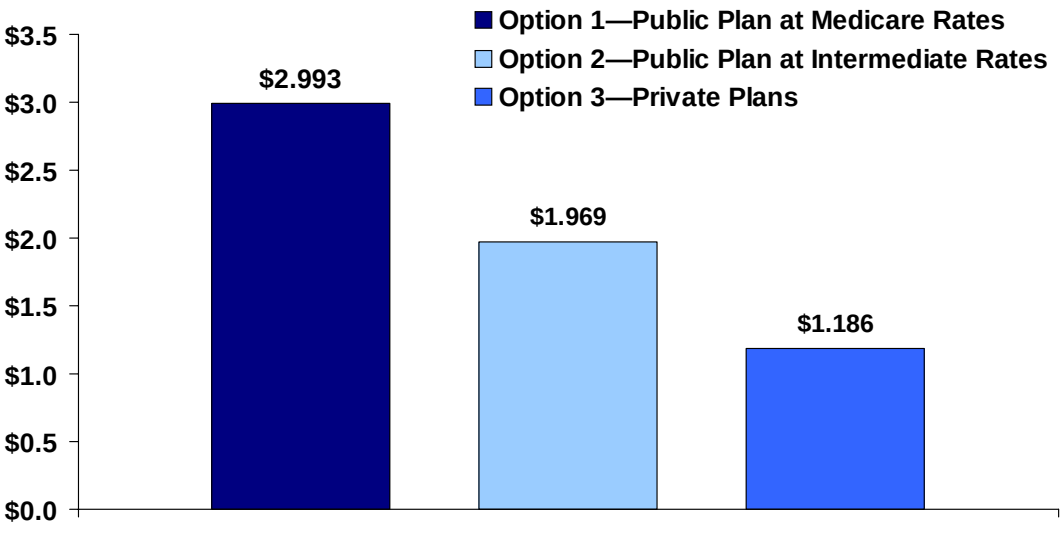
Estimates of the impacts of the three paths—Public Plan with Medicare Payment Rates, Public Plan with Intermediate Payment Rates, and Private Plans—are based on modeling by The Lewin Group using illustrative specifications provided by the authors and outlined in the Appendix (see page 37). The results based on those specifications were drawn from available evidence concerning their potential impact on the people who would be affected by the plans and their behavioral responses. The same parameters apply to all three scenarios.

All three paths would achieve the goal of health insurance coverage for all, though each would do so with different mechanisms and with very different implications for major stakeholders. Most importantly, all three approaches would bend the cost curve, though the savings achieved would differ significantly among them. The following sections include estimates of the impacts of the three alternative paths to high performance as they relate to costs, sources of coverage, administrative complexity, and savings for businesses, families, and government.

Impact on Bending the Health Care Cost Curve

Findings indicate that, with all policies starting in 2010, it would be possible under each scenario to extend affordable coverage to all and improve population health while simultaneously bending the curve of projected national health spending. Compared with current trends projected over the 11-year period from 2010 through 2020, cumulative savings would amount to $3.0 trillion with the Public Plan with Medicare Payment Rates path; $2.0 trillion with the Public Plan with Intermediate Payment Rates path; and $1.2 trillion with the Private Plans path (Exhibit 2). These system savings would result from the additional utilization of services that can be expected if the uninsured are covered and benefits are improved for the underinsured.

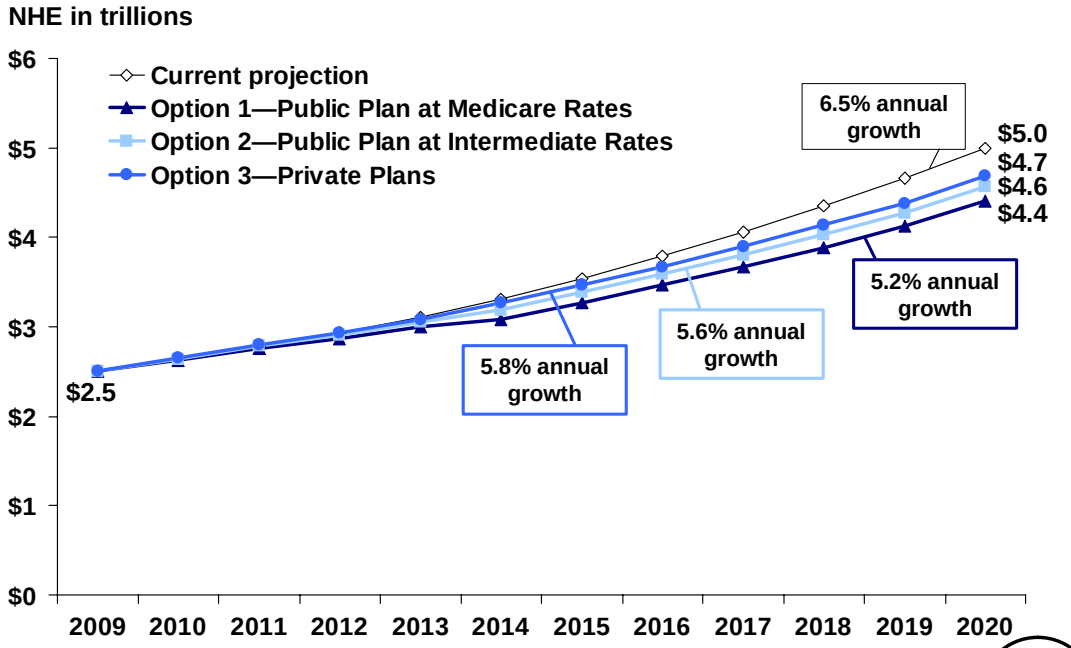
Exhibit 2. Three Insurance Exchange Scenarios: Cumulative 11-Year Savings in National Health Expenditures, 2010–2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.

Relative to current trends, the integrated approaches could reduce the projected annual rate of growth in national health expenditures from 6.5 percent per year to 5.2 percent under the Public Plan with Medicare Payment Rates path, 5.6 percent under the Public Plan with Intermediate Payment Rates path, and 5.8 percent under the Private Plans path (Exhibit 3).

Exhibit 3. Total National Health Expenditures (NHE), 2009–2020: Current Projection and Alternative Scenarios



Data: Estimates by The Lewin Group for The Commonwealth Fund.

Notably, even after these substantial reductions, national health spending would still continue to exceed the projected annual growth in GDP. Although the percentage of GDP spent on health care would be lower in 2020 under each scenario than the 21.3 percent currently projected—18.7 percent, 19.4 percent, and 19.9 percent, respectively—health spending under each would account for a higher share of the U.S. economy than in 2009 (17.6%).

Source of Savings

Differences in system savings under the three path scenarios derive from insurance administrative savings realized by the offer of a public plan in competition with private plans; from the tighter payment rates used by the public plan; and by the application of payment innovations and system reforms to a greater share of the insured population under the scenarios that have a public health insurance plan. Compared with trends projected for 2010 through 2020, the Public Plan with Medicare Payment Rates path would reduce insurance costs by a cumulative $425 billion, reflecting both lower administrative costs and the shift of some coverage from private insurance to a public plan paying at Medicare rates (Exhibit 4). By contrast, the net health system cost of

covering the uninsured under the Public Plan with Intermediate Payment Rates path would be $547 billion greater from 2010 through 2020 than currently projected trends. This net cost rather than net savings derives from the uninsured buying into coverage at intermediate provider payment rates rather than at lower Medicare payment rates and less of a shift of coverage to public health insurance from private coverage at still higher rates. As for the net insurance cost under the Private Plans path, it would add $1.2 trillion to national spending because the uninsured would be covered at the higher commercial provider payment rates, with no opportunity to save by switching from private to public insurance, and with no savings in insurance administrative costs.

Exhibit 4. Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020

Dollars in billions

	Public Plan at Medicare Rates	Public Plan at Intermediate Rates	Private Plans
Affordable Coverage for All: Coverage Expansion and National Health Insurance Exchange			
• **Net costs of coverage expansion**	**–$160**	**+$770**	**+$1,135**
• **Reduced administrative costs**	**–$265**	**–$223**	**+$32**
Total System Cost of Coverage Expansion and Improvement	***–$425***	***+$547***	***+$1,167***
Payment and System Reforms			
• **Payment Reforms**	**–$1,011**	**–$986**	**–$907**
• **Information Infrastructure and Public Health**	**–$1,557**	**–$1,530**	**–$1,446**
Total Savings from Payment and System Reforms	***–$2,568***	***–$2,516***	***–$2,353***
Total Net Impact on National Health Expenditures, 2010–2020	**–$2,993**	**–$1,969**	**–$1,186**

Data: Estimates by The Lewin Group for The Commonwealth Fund, April–May, 2009.

For each of the integrated approaches, the policies mentioned in the analysis interact and are mutually supporting. All contribute to the net cumulative effect on potential savings and improvement in value of services. These estimated impacts are contingent on their effectiveness in stimulating changes in the way that providers, patients, and insurers (both public and private) behave, and how they react to the new opportunities the proposed policies would create. Each set of policies is designed with a vision of potential dynamic change—a chain of events with effects that interact over time.

A central feature in each of the alternatives is the insurance exchange, which is structured to expand the choice of plans in the context of market rules prohibiting competition on the basis of risk selection. The goal of associated reforms is to promote competition based on value in order to drive innovation among insurers and to foster better organization of care.

The new public health insurance plan (in both the Public Plan with Medicare Payment Rates and the Public Plan with Intermediate Payment Rates paths) and Medicare and Medicaid would adopt innovative payment methods that reward results rather than volume of services. Private insurers could adopt such payment methods if they so chose. Public payers would share savings from the behavioral changes of providers, in for instance eliminating waste and ineffective care, which would result in a slowdown in public program spending over time. As indicated by the sharp differences across the three Path scenarios, the public plan plays a central role in harnessing market forces for positive change.

Offering a choice of a public plan makes it possible for payment reforms to spread more rapidly than at present and provides a less expensive means for expanding coverage to the uninsured. In essence, the public plan enables consolidated purchasing power on behalf of the population. A public plan also offers an avenue for lowering administrative costs. The public plan would operate with low or no marketing costs, with no costs for underwriting, and with premium margins invested in reserve funds. The public plan would thus serve as a catalyst for competing private plans to make their operations more efficient.

About $265 billion in insurance administrative savings are projected over 2010–2020 in the Public Plan with Medicare Payment Rates path, compared with $223 billion under the Public Plan with Intermediate Payment Rates path and an extra cost of $32 billion under the Private Plans path.

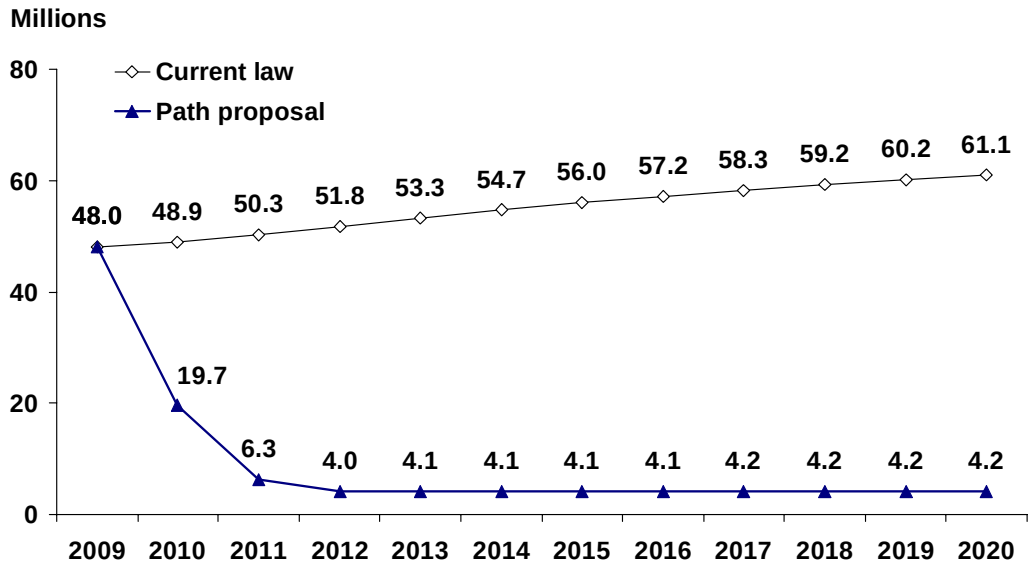
The great majority of savings in the three scenarios—ranging from $2.7 trillion to $1.2 trillion over the period 2010 to 2020—come from greater efficiencies in care delivery and reduced growth in health care spending. Revenues of providers would continue to grow throughout the period, albeit at a slower rate than at present and with differential effects across providers. In the absence of reform, national health expenditures will be $40 trillion over the 2010–2020 period.

Impact on Health Insurance Coverage

The insurance framework under all three scenarios includes the creation of a new national insurance exchange, expansion of existing public programs, market reforms, provisions for affordability, and requirements that coverage reach universal participation.

Under all three scenarios, the expansion of insurance would achieve near-universal coverage. The number of uninsured would drop from an estimated 48 million in 2009 (16% of the U.S. population) to 4 million by 2012 (1% of the population), with nearly everyone insured within the next decade (Exhibit 5). Absent new initiatives, the number of uninsured is projected to rise to 61 million or more by 2020, not counting the millions more who lose coverage or are underinsured.

Exhibit 5. Trend in the Number of Uninsured, 2009–2020 Under Current Law and Three Path Scenarios



Note: Assumes insurance exchange opens in 2010 and take-up by uninsured occurs over two years. Remaining uninsured are mainly non-tax-filers.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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Insurance Exchange

All plans participating in the insurance exchange would be required to meet minimum benefit standards comparable to those included in the Federal Employees Health Benefits Program standard option (Exhibit 6). This requirement would improve financial protection for millions of people who now have difficulty paying medical bills because of gaps in coverage, limits on benefits, or high deductibles and cost-sharing relative to income. Targeted premium caps would ensure affordability for low-to-middle-income households (Exhibit 7).

Exhibit 6. Benefit Design for Public Health Insurance Plan Offered in Insurance Exchange

	Current Medicare Benefits*	New Public Health Insurance Plan in Exchange
Deductible	**Hospital: $1,024/benefit period Physician: $135/year Rx: $275/year****	**Hospital/Physician: $250/year for individuals; $500 for families Rx: $0**
Coinsurance	**Physician: 20% Rx: Depends on Part D plan**	**Physician: 10% Rx: 25% Reduce for high-value and chronic disease care/medical home Preventive services: 0%**
Ceiling on out-of-pocket	**No ceiling**	**$5,000 for individuals $7,000 for families**
Insurance-related premium subsidies	**Medicare Savings Programs Low-Income Subsidy**	**Premium cap ceiling of 5% of income for low-income beneficiary premiums or 10% if higher income**

* Basic benefits before Medigap.
** Part D coverage varies, often deductible. Most have "doughnut" hole and use tiered, flat-dollar copayments.
Note: Benefit design also would apply to Medicare Extra supplement option available to Medicare beneficiaries.
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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Exhibit 7. Premium Affordability: Insurance-Related Premium Subsidies

		Income Range	Premium as a Percentage of Income
Below 150% FPL	**Single**	**$16,245 or lower**	**0%**
	Family	**$27,465 or lower**	**0%**
15% tax bracket	**Single**	**$16,245–$33,949**	**5%**
	Family	**$27,465–$67,899**	**5%**
25% tax bracket	**Single**	**$33,950–$82,249**	**10%**
	Family	**$67,900–$137,049**	**10%**
28% tax bracket	**Single**	**$82,250–$171,549**	**12%**
	Family	**$137,050–$208,849**	**12%**
33% tax bracket	**Single**	**$171,550–$372,949**	**No cap**
	Family	**$208,850–$372,949**	**No cap**
35% tax bracket	**Single**	**$372,950 or higher**	**No cap**
	Family	**$372,950 of higher**	**No cap**

Note: Family income ranges based on family size of three.
Source: United States Department of Health and Human Services, "Annual Update of the HHS Poverty Guidelines," Federal Register: Jan. 23, 2009 (Vol. 74, No. 14), 4199-4201; United States Internal Revenue Service, 2009 Tax Rate Schedule X and Y-1.

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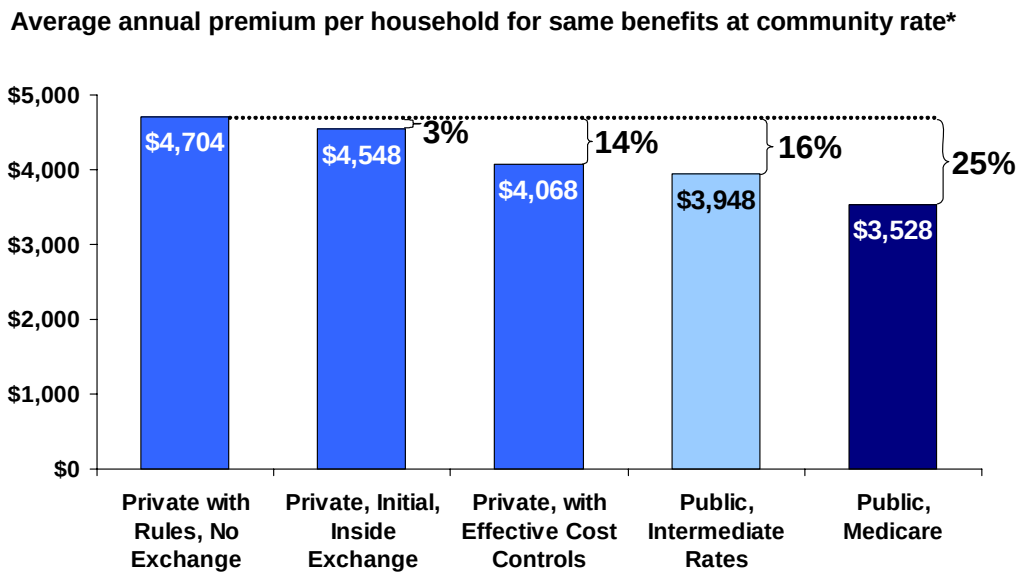
By building on existing insurance coverage, the Path framework would provide new choices through the insurance exchange yet permit all employer groups to keep their current coverage arrangements if those work well for them. Individuals would receive insurance through the exchange with its choice of multiple plans. Employers could purchase coverage directly from private insurers or self-insure as most large employers now do, or they could elect to bring their employees as a group into the insurance exchange and thus gain access to a menu of private national plans, local/regional plans, and, in the first two scenarios, a nationwide public plan.

Coverage through the exchange has the potential to increase the stability of coverage as well as to expand choice. All those enrolled through the exchange would be able to keep their coverage as jobs or circumstances changed. The insurance exchange could be opened in stages to allow reasonable setting-up time. The modeling assumes that the exchange starts out by opening to individuals and small firms with fewer than 100 employees, opens to mid-sized companies (under 500 employees) in two years, and opens to all employers by 2014.

Impact on Premiums

Estimates suggest that premiums for the public health insurance plan choice in the Public Plan with Medicare Payment Rates path would initially be 25 percent below premiums currently available for a comparable benefit package in the private individual/small-firm market in 2010 and 16 percent lower under the Public Plan with Intermediate Payment Rates scenario (Exhibit 8). Private plan premiums in all three scenarios would be 3 percent lower within the exchange than current individual and small-firm premiums, as the exchange facilitates the process of choosing plans and reduces administrative costs, especially for individuals and small businesses. The lower premiums reflect savings in insurance overhead for plans offered through the exchange with their more standardized products, lower marketing costs, reduced churning, and elimination of most underwriting costs.

Exhibit 8. Estimated Annual Premiums Under Different Scenarios, 2010



* 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.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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Effective Private-Sector Cost Containment

Including a public plan as an alternative choice should be a catalyst for private plans to innovate in the way they operate and pay for care, reducing their administrative costs and implementing payment and system reforms that lead to more appropriate utilization, better care, and slower cost growth, in the process contributing to greater premium savings. If private plans adopted effective cost-containment measures sufficient to slow premiums relative to trends in the public plan premium, public plan premiums and private plan premiums within the exchange would be roughly comparable (Exhibit 8). Or, private plans could be given the authority to adopt public plan provider payment methods. However, what such measures would entail and how they would be implemented to make refined estimates would require examination in greater detail.

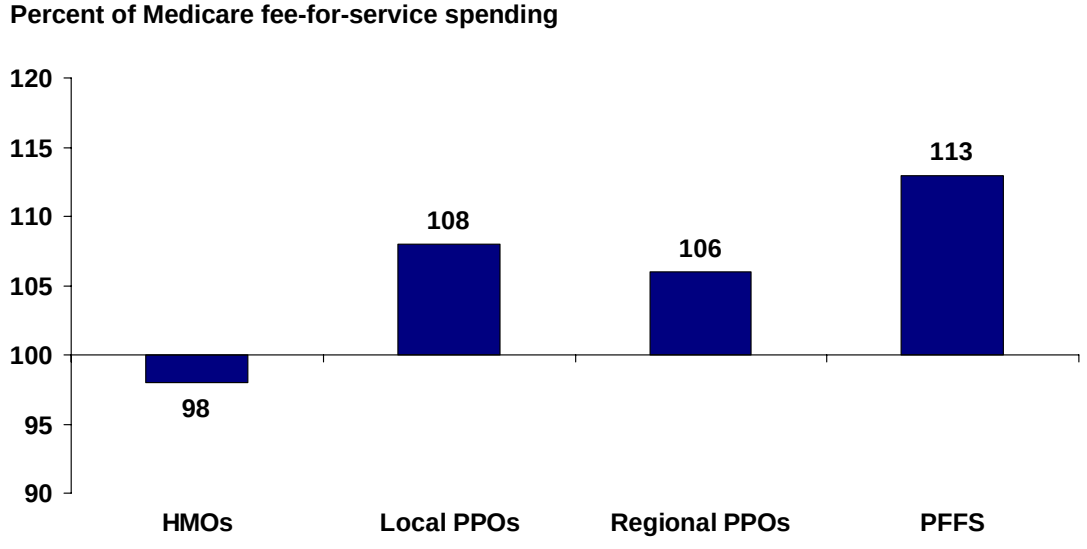
With the flexibility to establish more integrated-care networks and a variety of utilization management and payment policies, private plans could—by focusing on innovation and quality—compete with each other and outperform the public plan. Community health plans partnering with integrated delivery systems, in particular, have

considerable potential to achieve economies through redesign of care, control of chronic conditions, and prevention of avoidable hospitalizations.

Plan provisions could encourage multipayer synchronization to ensure coherent policies and reduce administrative complexity. The aim would be to encourage more vigorous, innovative, and value-driven competition, focused on outcomes and a more streamlined, efficient health insurance financing system.

Experience with Medicare Advantage private plan bids suggests that private health plans in many parts of the country will be able to compete effectively. Bids submitted by the most tightly organized private health maintenance organizations (HMOs) under the Medicare Advantage program have been consistently lower than Medicare fee-for-service spending.[9] Currently, the more integrated-plan bids average 98 percent of fee-for-service Medicare costs while the more loosely organized private fee-for-service-plan bids average 13 percent higher, which suggests that the latter may not be able to compete effectively in an insurance exchange against a public plan option (Exhibit 9).

Exhibit 9. Medicare Advantage Plans Bids as a Percent of Average Medicare Fee-for-Service Costs, by Plan Type, 2009



Note: HMOs = health maintenance organizations; PPOs = preferred provider organizations; PFFS = private fee-for-service plans.
Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2009).

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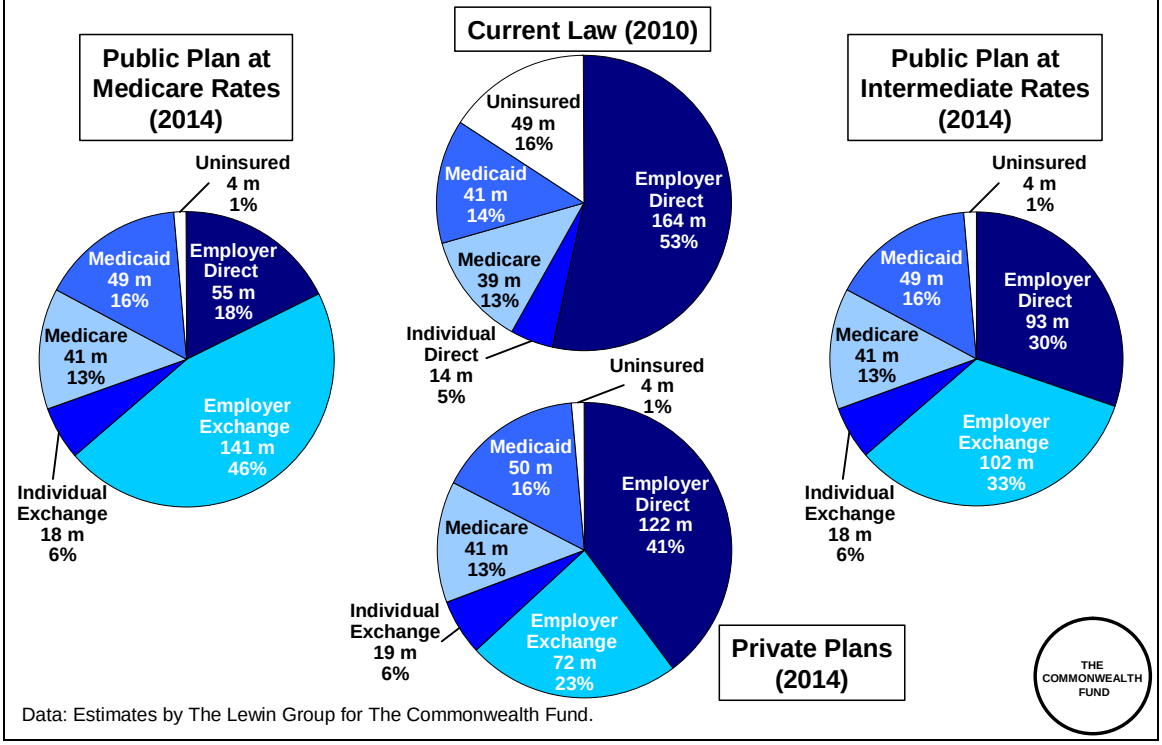
Coverage Through the Insurance Exchange

Employment-sponsored health insurance would continue to be the mainstay of health insurance coverage under all three scenarios. All three Path reforms do address many of the flaws in the current system, however. Each gives employers the option of purchasing coverage directly from private insurers, or self-insuring, or bringing their employees as a group into the national health insurance exchange. Each approach sets rules on insurance exchange plans, including ones relating to open enrollment, community premiums, and a standard benefit floor.

In all three scenarios, approximately 64 percent of the U.S. population (194 million–196 million people) would have employer-sponsored coverage by 2014, a substantial increase over the 53 percent (164 million people) that have employer coverage under the current system (Exhibit 10). This increased number would include those employer groups that opt to join the insurance exchange. If coverage is obtained through the exchange, employees could select from among a number of private health plans as well as the new public plan contained in two of the scenarios examined here.

Exhibit 10. Employers Remain Primary Sponsor of Coverage Under Three Reform Scenarios

Distribution of 307 Million People by Primary Source of Coverage



Data: Estimates by The Lewin Group for The Commonwealth Fund.

The modeling estimates that over time more than 70 percent of those covered by employer-based plans (141 million out of 196 million) would receive coverage through the exchange in the Public Plan with Medicare Payment Rates path, with its advantages of continuity, choice, and a new, affordable public plan option. Considering the smaller differences in provider payment rates between insurance plans offered inside and outside the insurance exchange in the Public Plan with Intermediate Payment Rates path, the modeling estimates that 52 percent of employer-based coverage (102 million people) would come through the exchange. With higher premiums under the Private Plans approach, fewer employers would switch to the insurance exchange—an estimated 37 percent of those with employer-based coverage (72 million people) would be covered through it (Exhibit 10). The insurance exchange would replace the individual insurance market—with 18 million to 19 million individuals obtaining coverage through the exchange.

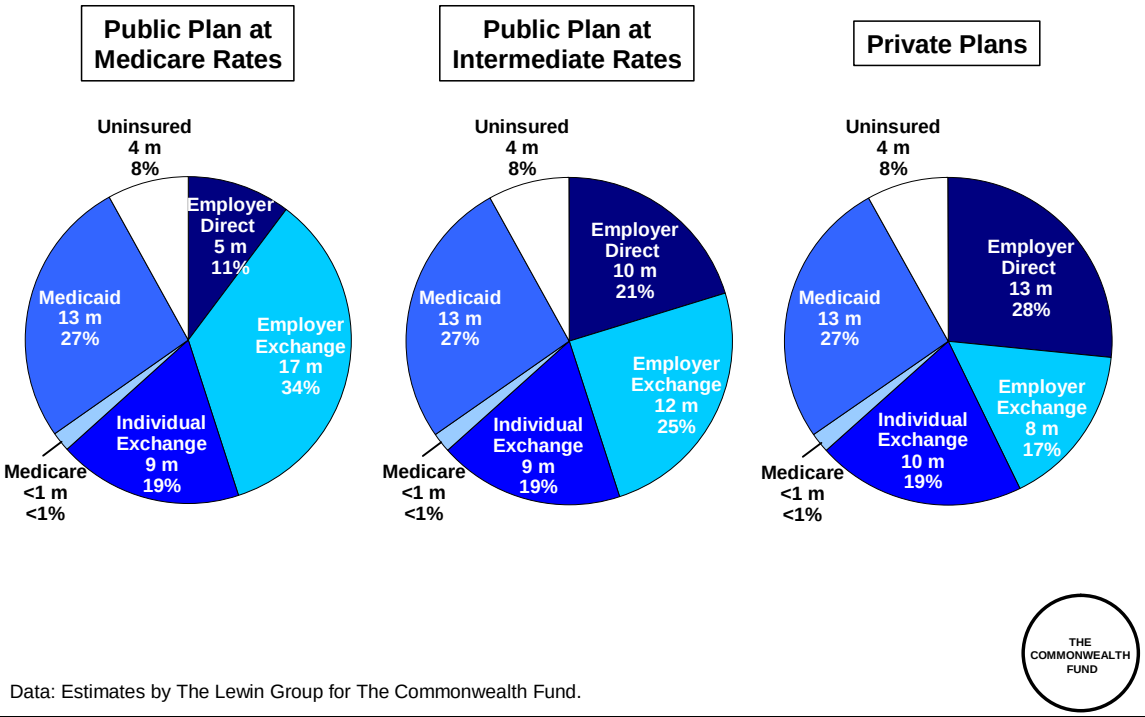
Under all three scenarios, most employees would have a considerably larger choice of plans than is now offered by their employers. Further, each path has the potential to reduce turnover in coverage. As more employers join the exchange, people could keep coverage as they change or lose jobs during a period of unemployment.

Source of New, Improved, or More-Affordable Coverage

The new public health insurance plan option in the first two scenarios would provide a less expensive alternative for the uninsured and underinsured than what is currently available in the individual and small-business insurance markets. Lower premiums would derive from significantly lower administrative costs and use of reformed provider payment methods at reasonable rates.

In the Public Plan with Medicare Payment Rates scenario, an estimated 26 million uninsured would be covered through the exchange (Exhibit 11). About 13 million would be covered by Medicaid. A few (5 million) would take up their employers' offer and be covered directly by employer plans outside the exchange. In the other scenarios, the numbers covered by Medicaid would be similar, but a higher proportion would be covered directly by employer plans outside the exchange.

Exhibit 11. Source of New Coverage for the Uninsured Under Three Reform Scenarios, 2014



Data: Estimates by The Lewin Group for The Commonwealth Fund.

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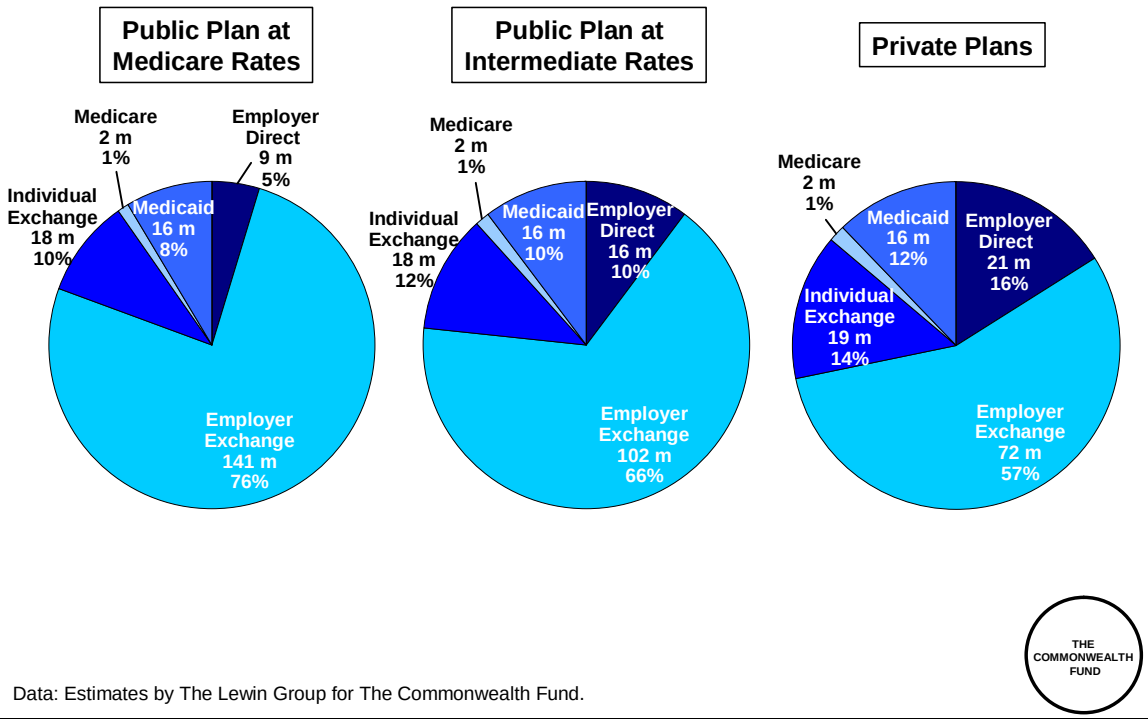
The exchange is not only attractive to the uninsured but is a major source of improved or more affordable coverage for those who are now insured. About 159 million insured people would move into the exchange under the Public Plan with Medicare Payment Rates scenario, 120 million under the Public Plan with Intermediate Payment Rates scenario, and 91 million under the Private Plans scenario (Exhibit 12).

Exhibit 12. Source of Improved or More Affordable Coverage Under Three Reform Scenarios, 2014



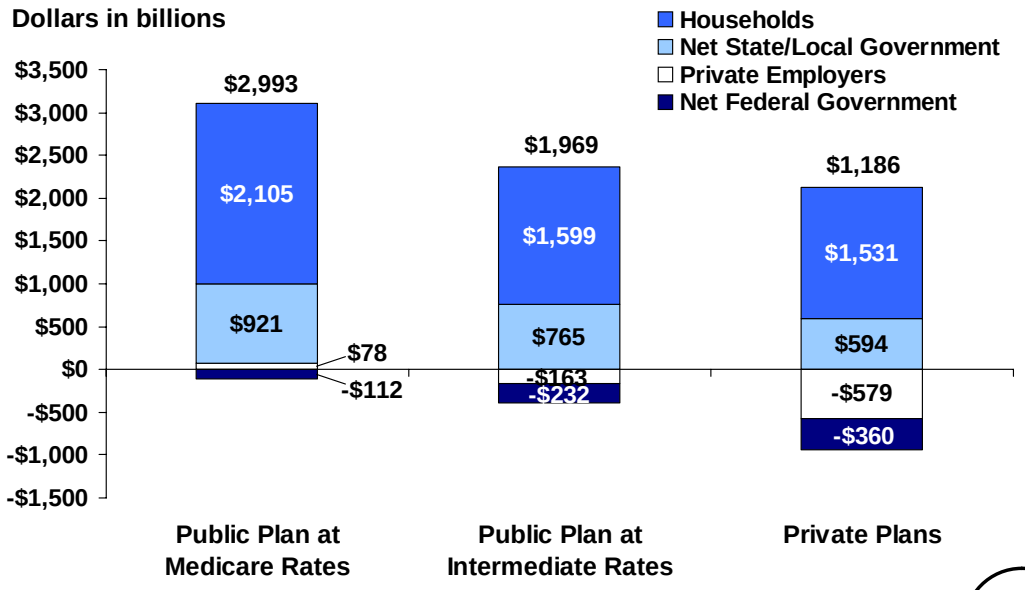
Data: Estimates by The Lewin Group for The Commonwealth Fund.

In both scenarios that include a choice of a public plan, families would have the security of an option that is always available. Unlike the situation in the late 1990s and early 2000s in the Medicare managed care market, or recent experience in some state Medicaid programs,[10] enrollees in the nationwide public plan could be sure that their plan would not be dropped from their geographic area. Notably, the decision to join the exchange or select private or public plans would be voluntary—decisions to switch would indicate moves to more affordable or higher-quality options.

Distribution of Impact Across Major Payer Groups

All major sectors would benefit from improved health and from bending the curve of future health spending, compared with projected trends. By 2020, the cumulative reduction in the growth of national health spending would be distributed across the major groups that pay for health care: the federal, state, and local governments; private employers; and households (Exhibit 13).

Exhibit 13. Net Cumulative Impact on National Health Expenditures, 2010–2020 Compared with Baseline, Three Insurance Exchange Scenarios, by Major Payer Groups



Note: A negative number indicates spending increases compared with projected expenditures; a positive indicates spending decreases (i.e., savings).
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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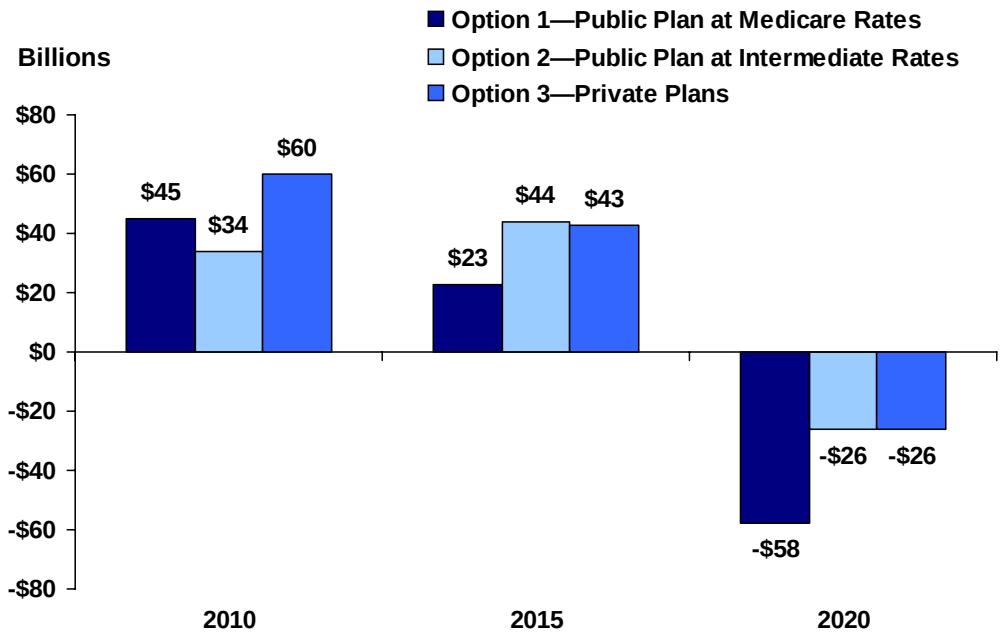
Impact on the federal budget. Over the period from 2010 through 2020, the cumulative net increase in federal budget outlays is estimated to be $112 billion with the Public Plan with Medicare Payment Rates path, $232 billion under the Public Plan with Intermediate Payment Rates path, and $360 billion with the Private Plans path (Exhibit 13). The federal budget costs of covering the uninsured and providing premium assistance to low-to-moderate-income working families are greatest when these groups are covered by private plans paying commercial provider payment rates and least when they are covered by a public plan paying at Medicare rates. Under each scenario, most of the federal budget costs are incurred in the first five years.

Costs to the federal government, as the central source of financing for coverage expansions, would increase during the early years as the government invests in system reform and extends affordable coverage to all. The insurance design specified for modeling also provides federal funding to offset state and local costs of expanding Medicaid and raising Medicaid payment rates to Medicare levels, thus increasing net federal government spending. With system reform policies in place, however, the net federal cost of insurance expansion and investing in the care system declines rapidly. By

2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections (Exhibit 14). In 2020, there would be a net reduction in federal government outlays under all three scenarios: $58 billion under the Public Plan with Medicare Payment Rates scenario, $26 billion under the Public Plan with Intermediate Payment Rates scenario, and $26 billion under the Private Plans scenario.

Exhibit 14. Change in Net Federal Spending Under Three Path Scenarios



Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
Data: Estimates by The Lewin Group for The Commonwealth Fund.

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Household savings. Most of the savings would accrue to individuals and families as a result of slower growth in premiums and out-of-pocket spending, federal premium assistance, and expansion of public programs to make insurance affordable. The savings would be realized by all income groups, including higher-income households (Exhibit 15). By 2020, these savings would average $2,228 per household with the Public Plan with Medicare Payment Rates path, $1,634 with the Public Plan with Intermediate Payment Rates path, and $1,576 with the Private Plans path. Total savings to households over the 2010–2020 period under the three scenarios are estimated to be $2.1 trillion, $1.6 trillion, and $1.5 trillion, respectively (Exhibit 13).

Exhibit 15. Average Annual Savings per Family Under Three Reform Scenarios, 2020

Family Income (thousands)	Option 1 Public Plan at Medicare Rates	Option 2 Public Plan at Intermediate Rates	Option 3 Private Plans
All	**$2,228**	**$1,634**	**$1,576**
<$10,000	**$1,542**	**$1,443**	**$1,395**
$10,000–$19,999	**$1,946**	**$1,781**	**$1,775**
$20,000–$29,999	**$1,928**	**$1,554**	**$1,587**
$30,000–$39,999	**$1,952**	**$1,482**	**$1,511**
$40,000–$49,999	**$2,324**	**$1,692**	**$1,665**
$50,000–$74,999	**$2,267**	**$1,551**	**$1,499**
$75,000–$99,999	**$2,558**	**$1,700**	**$1,580**
$100,000–$149,999	**$2,634**	**$1,675**	**$1,531**
$150,000+	**$2,948**	**$1,856**	**$1,656**

Data: Estimates by the Lewin Group for The Commonwealth Fund.

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Employers. Employers in all three scenarios are required to cover workers or contribute 7 percent of workers' earnings up to $1.25 an hour to a health insurance fund. As a result, employers that do not now cover their employees would bear added cost. However, employers that now cover their workers would benefit from insurance, payment, and system reforms that lower insurance premiums and slow future growth in health care costs. Employers would fare best when their employees have access to a public health insurance plan that provides value for the premium dollar. Over the period 2010–2020, payment and system savings under the Public Plan with Medicare Payment Rates scenario would offset any additional costs that health reform might produce for employers and workers, as slower premium growth results in net cumulative employer savings of $78 billion, although the effects on different employers would vary (Exhibit 13). Employers would incur $163 billion in increased costs under the Public Plan with Intermediate Payment Rates scenario and $579 billion under the Private Plans scenario over the 2010–2020 period.

Across the three Path scenarios, employers and workers would gain from having access to a public plan with provider payment rates comparable to Medicare levels or

even at a midpoint between Medicare and commercial rates. These savings greatly diminish without the public plan option.

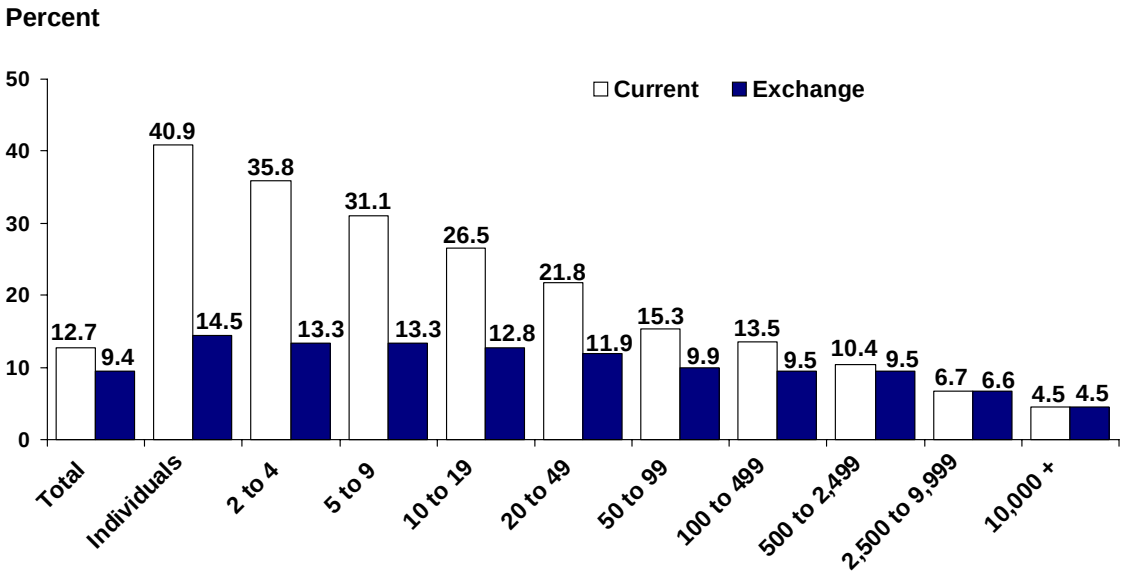
State and local governments. State and local governments would also realize substantial savings relative to current projections, ranging from $921 billion under the Public Plan with Medicare Payment Rates path and $765 billion under the Public Plan with Intermediate Payment Rates path to $594 billion under the Private Plans path (Exhibit 13). The savings accrue primarily from slower growth in national health costs as a result of payment and system reforms.

Implications for Complexity and Insurance Administrative Overhead

The insurance exchange reduces administrative complexity, making it easy for individuals to compare plans and premiums, select and enroll in a plan, and change or keep coverage. Use of the exchange and system reforms also reduce insurance-related administrative costs. Assuming the exchange would offer more standardized benefits to enable transparent, informed choices and provide a Web portal to help enrollees compare plans based on quality and price, it has the potential to reduce marketing as well as underwriting costs and costs related to churning. The public plan would also reduce overhead costs and provide a benchmark for competitors that includes low or no marketing costs, lower margins, and retention of premium surpluses as reserves.

In all three Path scenarios, small businesses and individuals stand to gain the most from greater efficiencies in insurance markets, as administrative costs now represent on average 41 percent of claims in the individual market and 15 percent to 36 percent of claims for small businesses with fewer than 100 employees (Exhibit 16). Under all scenarios, private plans offered through the exchange to individuals and small groups could have much lower administrative costs than they do now as a result of reduced churning, lower marketing costs, and elimination of the costs of underwriting for health risks (Exhibit 17).

Exhibit 16. Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size



Data: Estimates by The Lewin Group for The Commonwealth Fund.
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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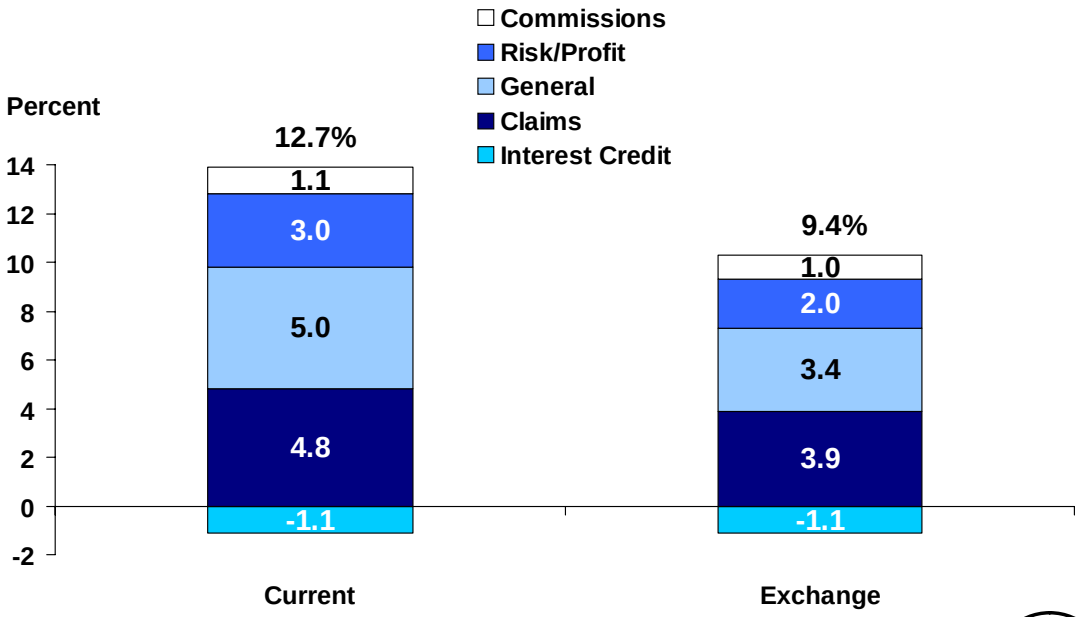
Exhibit 17. Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange



Data: Estimates by The Lewin Group for The Commonwealth Fund.
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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Overall, the exchange is expected to incur administrative expenses of 4.5 percent of average premiums in addition to administrative costs within health plans. Thus, it is essential that market reforms assure reduced costs within plans to hold the line on overhead expenses.

The public plan is estimated to have administrative expenses of 3.5 percent to 4 percent, similar to large-group risk pools. Including the costs of operating the exchange, the premium for the public plan would incur administrative costs of 8 percent. These costs would likely be lower than the average for private plans. Some of the advantages of the public plan include the absence of expenses for commissions, advertising, and markups for returns to investors. With a large risk pool, the public plan would hold its own reserves and earn the return on reserves similar to arrangements made for federal employees and large firms. The public plan would contract with private companies to administer claims.

About $265 billion in insurance administrative savings are projected over 2010–2020 in the Public Plan with Medicare Payment Rates path, compared with $223 billion in the Public Plan with Intermediate Payment Rates path and an extra cost of $32 billion in the Private Plans path. These figures reflect the added costs of operating the insurance exchange as well as the effect of the expansion of private plan enrollment in offsetting the reduction in administrative costs per person through the insurance exchange.

If the insurance market reforms included more standardized reporting, coding, and quality metrics plus electronic billing of claims and more standardized benefit designs, they have the potential to reduce insurance-related administrative costs for physicians and hospitals as well as health plans. Recent studies estimate physician practices spend $31 billion—the equivalent of 10 percent to 12 percent of total practice revenue—on billing and insurance-related administrative costs, which include 3 weeks a year of physician time per practitioner.[11] Hospitals spend 6 percent to 10 percent on just these two items of insurance-related administrative activities. If standardization could cut such insurance-related overhead in half, there would be $15 billion to $20 billion in savings per year for physicians and $25 billion to $40 billion in savings per year for hospitals.[12]

Implications for Providers

The modeling estimates that such integrated policies would slow expenditure growth from a projected 6.5 percent annually to 5.2 percent in the Public Plan with Medicare Payment Rates path, 5.6 percent in Public Plan with Intermediate Payment Rates path,

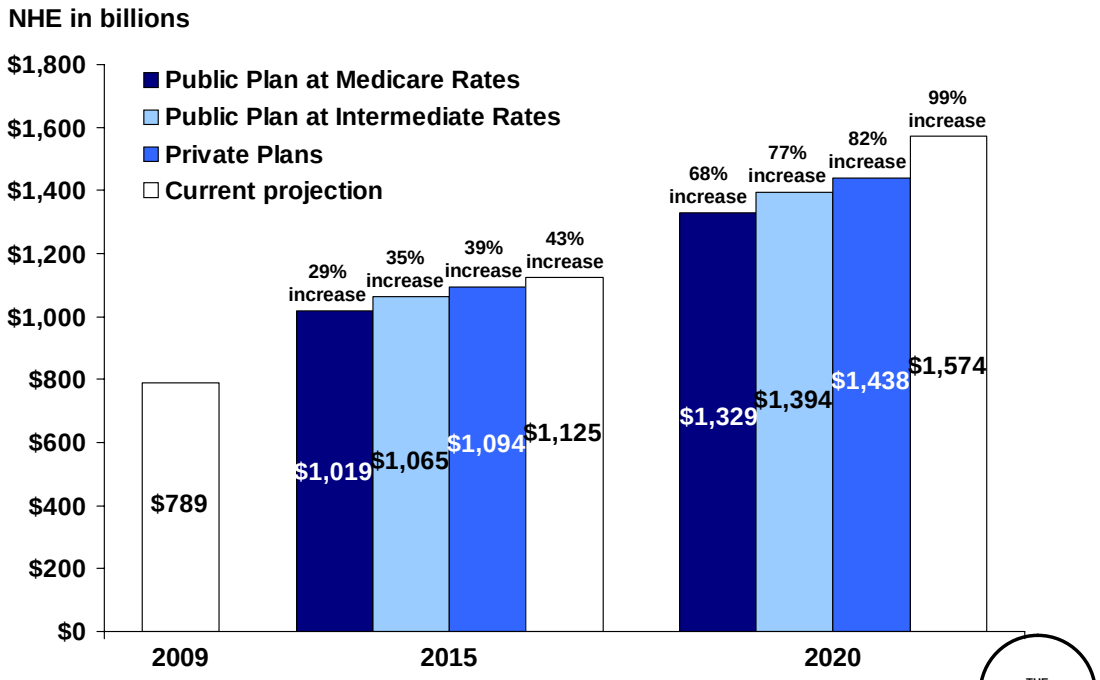
and 5.8 percent in the Private Plans path (Exhibit 3). All of these reductions are less than the 1.5-percentage-point growth-reduction goal endorsed by industry groups.

While significantly slower than projected growth, revenues for hospitals, physicians, and other providers would continue to grow each year. In early years, providers would be receiving substantial inflows of revenues for care of the uninsured and improved payment rates under Medicaid. Improved benefits for those currently underinsured would also reduce bad debts. Covering the uninsured and improving the coverage offered them is expected to generate $32 billion to $50 billion in new annual revenues as the uninsured gain access to needed care and can afford to pay for it. Raising Medicaid payment rates to Medicare rates would generate an additional $30 billion per year. As a result of upgrades in payments by public payers and coverage of the uninsured, most hospitals and physicians would see an increase in revenues in the early years. Increasing Medicaid payment rates to Medicare levels would enhance access for patients and provide direct support to safety-net hospitals and clinics and other providers who care for low-income families.

These increases provide enhanced revenues to most providers in the early years, and in the aggregate they offset any reduced revenue from enrollees switching their insurance from private to public plans that pay providers at reduced rates. In the early years, projected revenues are thus similar to ones predicted by current trends. Different providers will be affected differently, however, depending on the insurance status of the mix of patients.

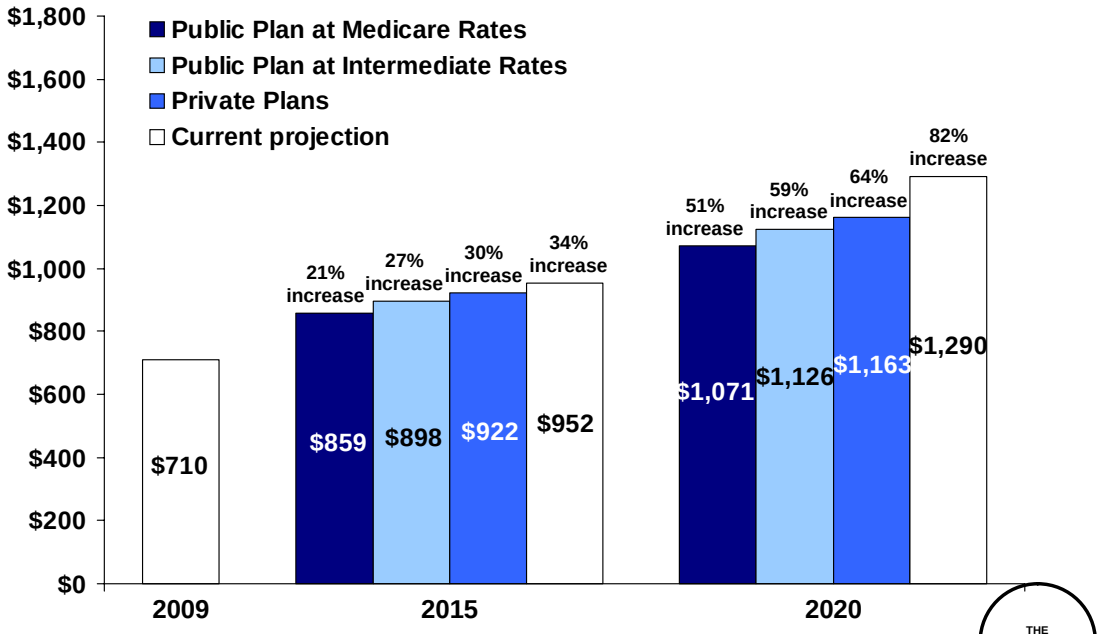
Most importantly, providers as a whole would experience growing revenues generated by continued medical advances and an aging population. Hospital revenues would increase from $789 billion in 2009 to between $1.33 trillion and $1.44 trillion in 2020, depending on the scenario—a growth of 68 percent to 82 percent over the baseline level (Exhibit 18). Similarly, physician revenues would increase from $710 billion in 2009 to between $1.07 trillion and $1.16 trillion in 2020—a growth of 51 percent to 64 percent over 2009 levels (Exhibit 19). Individual providers could experience greater or lesser growth, but nearly all should be able to adjust over time, given the underlying growth in demand for services.

Exhibit 18. Total National Health Expenditure Growth for Hospitals, Current Projections and with Policy Changes, 2009–2020



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

Exhibit 19. Total National Health Expenditure (NHE) Growth for Physicians, Current Projections and with Policy Changes, 2009–2020



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

Payment reforms would be intended to support and provide incentives for innovations in practices and more productive use of resources. The new public plan would include needed reforms in payment methods, as would Medicare. Critical areas for improvement include:

- Increasing payments for primary care services;
- Updating the relative value scale to adjust for overvalued services based on profit margins and rapid growth in volume;
- Introducing new options for payment of primary care practices serving as medical homes, with capacity to provide 24/7 access, coordinate care, and manage chronic conditions; and
- Developing more "bundled" payment approaches and shared savings arrangements with care systems to reward and support high-quality, efficient care.

In addition, fundamental payment reform that aligns incentives across all payers could eliminate many of the pricing complications that now exist and lend coherence to the incentives providers face. Currently, not only are there wide discrepancies in payment rates between public and private payers but private insurance rates vary widely for the same care within communities. One observer noted that a close look revealed "chaos" rather than any rational purchasing or payment policies.[13] Moreover, recent media accounts indicate that suppliers and medical care providers may be increasing prices now in anticipation of reforms.[14]

Implications for Population Health

Changing the way we pay for care to align incentives with value is critical. The payment reforms in the Path framework would enhance the value of primary care and change the way we pay to stimulate care delivery through patient-centered medical homes which have the capacity to provide access, coordinate care, and use information systems and teams in managing chronic conditions. Moving to more bundled payments, with provisions for accountability for outcomes, would align incentives with the value rather than the volume of care delivered and would support hospitals, physicians, and other clinicians working together to care for patients. Building a solid infrastructure of information systems and programs to enhance prevention of disease and promote population health would encourage innovation in the effort to meet current and future community health needs.

The health reform framework that underlies all of the paths examined here envisions a health system that provides patients with personal sources of care who know their medical history, that ensures timely access, that helps coordinate care, and that uses essential clinical information to provide the right care, with an emphasis on health and disease prevention. Payment and information systems would stimulate and support a patient-centered care system that is coordinated, accessible, and safe.

With a focus on prevention and improving outcomes for chronic disease, the nation could achieve substantial improvements in population health, relying on policies that align incentives with the provision of good care and prudent use of resources, provide clinicians with information system tools and decision support, and build and expand public health programs. We should aim for healthier, more productive lives through prevention of disease, earlier intervention, and effective management of chronic conditions, particularly for people with multiple comorbidities. In addition, more effective and humane care for those with late-stage diseases could address the huge variations in care.

All three paths described here include a major investment in population health. New federal taxes on tobacco, alcohol, and sugared soft drinks will generate $382 billion in revenues over the 11-year, 2010–2020 period under all three scenarios. Many of these revenues will be reinvested in state and local public health initiatives.

By setting targets and implementing policies that meet and raise benchmarks of top performance, we have the opportunity to save lives, improve the quality of life and care experience, lower safety risks to patients, and prevent the onset of disease and complications. As illustrated by key indicators from the Commonwealth Fund Commission's National Scorecard on U.S. Health System Performance, improving average performance by 2020 to targets or benchmarks set by current top performers would achieve substantial gains in population health and patient experiences (Exhibit 20).

Exhibit 20. Achieving Benchmarks: Potential People Impact if the United States Improved National Performance to the Level of the Benchmark

	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	**58%**	**99%**	**73 million increase**
Percent of adults (age 18 and older) receiving all recommended preventive care	**50%**	**80%**	**68 million increase**
Percent of adults (ages 19–64) with an accessible primary care provider	**65%**	**85%**	**37 million increase**
Percent of children (ages 0–17) with a medical home	**46%**	**60%**	**10 million increase**
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	**58%**	**70%**	**5 million increase**
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	**18%**	**14%**	**180,000 decrease**
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	**240**	**126**	**250,000 decrease**
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	**156**	**49**	**70,000 decrease**
Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)	**700**	**465**	**640,000 decrease**
Deaths before age 75 from conditions amenable to health care, per 100,000 population	**110**	**69**	**100,000 decrease**
Percent of primary care doctors with electronic medical records	**28%**	**98%**	**180,000 increase**

* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target.
Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008), with benchmarks from top performance.

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CONCLUSION

Though they are built on the same framework, the three alternatives examined here represent a three-pronged fork in the road, offering very different paths to a higher-performance, higher-value health system. Exhibit 21 compares their overall strengths to current markets and policies.

Exhibit 21. Net Impact of Insurance Exchange Options on Federal Budget and National Health Expenditures, 2010–2020

	Option 1 Public Plan at Medicare Rates	Option 2 Public Plan at Intermediate Rates	Option 3 Private Plans
Bending the Cost Curve			
Innovative payment reform	**+++**	**++**	**+**
Leveraging purchasing power	**+++**	**++**	**0**
Incentives to drive high-value care	**+++**	**++**	**+**
Reducing Administrative Waste			
Insurance	**+++**	**+**	**0**
Providers	**++**	**+**	**0**
Choices and Stability of Coverage	**+++**	**+**	**+**
Affordable Coverage and Care	**+++**	**++**	**+**
Federal Budget Cost, 2010–2020	**$112 billion**	**$232 billion**	**$360 billion**
Total Health System Savings, 2010–2020	**$2.993 trillion**	**$1.969 trillion**	**$1.186 trillion**

Note: 0 = no significant improvement; + slight improvement; ++ = moderate improvement; +++ = large improvement.
Data: Estimates by the Lewin Group for The Commonwealth Fund.

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The Public Plan with Medicare Payment Rates path envisions a rapid transformation of the payment system by establishing a strong public purchaser which could rapidly spread innovative provider payment reforms that reward value, not volume. This strong competitor could provide a catalyst for the private market to innovate—with competition based on beneficiary experiences with access, quality of care, and premium costs. Innovative payment methods would be incorporated in the public plan offered through the national health insurance exchange, Medicare, and Medicaid, representing substantial leverage of purchasing power on behalf of the population to transform the health system. Providers would have major incentives to drive high-value care and would

immediately be eligible for shared savings, if they are able to transform care to reduce avoidable hospitalization and hospital readmissions.

The public insurance plan could also provide a safeguard against undue use of market power in either insurance or provider markets. As a major efficient purchaser, it would have the leverage to trigger a new market dynamic. With standardization as well as more consolidated risk pools, the public plan options offer the potential for substantial reduction in administrative waste for both insurers and providers. With enriched choice in the insurance exchange, including a stable nationwide public plan, businesses, workers, and individuals would have substantially expanded choices of plans and the opportunity to stay with a plan if it works well for them.

The Public Plan with Intermediate Payment Rates path would also achieve significant savings and major reforms, although less rapidly. This "slower" start on cost containment and the decision to offer a new public plan with a premium based on provider payment above Medicare levels and midway toward commercial provider-payment levels results in smaller health system savings—$2.0 trillion—and smaller savings for employers and workers. At $232 billion, the net increase in federal budget costs is also greater than under the Public Plan with Medicare Payment Rates approach.

The Private Plans approach (with otherwise similar reforms) would cover nearly all of the uninsured while achieving total health system savings but at a much slower pace of cost reduction and with higher net federal budget costs. As modeled, this approach does not require incorporation of new innovative payment reforms in private plans, as payment reforms would be adopted by Medicare and Medicaid and already generate savings to government budgets. With private markets left to develop on their own and no benchmark or new competitor to stimulate change, and public programs continuing in a separate realm with different payment rates and methods, providers are unlikely to realize administrative savings. Further, administrative costs under private plans will remain high without the spur to compete against a public plan. Nonetheless, total health spending growth would slow to 5.8 percent per year, with cumulative health system savings of $1.2 trillion over 11 years, assuming implementation of coverage, payment, and system reforms. The costs of insurance expansion with lower system savings to offset federal outlays would result in a net increase in federal budget costs of $360 billion over the 2010–2020 period.

In any of the three approaches described here, both public payers (either with or without a public plan) and private insurers should be able to step up to the plate and

change the way that they operate and pay for care and so encourage and reward better performance within the health system. Public payers need to move away from fee-for-service toward more bundled payments which pay for coordinated patient care and better outcomes rather than for the volume and intensity of services provided. Among private insurers, the dominant carriers get price discounts and enjoy substantial purchasing power in some markets. Reforms could require that their operations become more transparent, with carriers disclosing prices paid and overhead costs, including medical loss ratios and margins. And private insurers could standardize and simplify coverage to reduce wasteful, complex administrative burdens for doctors, hospitals, and patients.[15] The nation urgently needs accountable insurance and insurers—whatever the sponsorship—that put patients' and families' health first, pool risks to provide financial protection, and serve as agents of the population in paying for care. A level playing field means raising, not lowering, standards.

In short, the presence of the public plan, and the payment policies that it adopts, account for most of the total health system savings and federal budget cost differences among the alternative scenarios. Differing results reflect the relative aggressiveness and effectiveness of cost-containment strategies and the creation of a new dynamic which can transform both health insurance and the provision of health care. The choice of a public plan provides a less expensive base for expanding coverage, because the public plan would, at least initially, be paying at lower rates than private plans currently pay (but at higher rates than most providers now receive for uninsured and Medicaid patients). The public plan would also enable more rapid spread of payment reforms, because more people would be covered under plans that adopt the reforms. And the public plan achieves economies through lower insurance administrative costs. Although difficult to predict, private plans, too, could be expected to respond to this new competitive dynamic by partnering with accountable-care organizations and integrated delivery systems to provide incentives and tools for more effective care and the elimination of ineffective, avoidable, or duplicative care, while achieving economies in insurance administration.

Although spending growth would slow, most providers would experience rising revenues and opportunities for shared savings as preventable hospitalization and greater efficiency of treatment are realized. Coverage of the uninsured and improved benefits would sharply reduce uncompensated care and infuse new revenues into the health system in the early years, benefiting in particular safety-net providers that now provide the bulk of care to people who cannot pay.

Having arrived at a critical fork in the road, the national reform debate has centered on which road to follow. At this moment, the label “public” or “private” has become a focal point, rather than the urgent goals of reform itself. However health care coverage is provided, reforms should ensure that everyone has the benefit of insurance plans that serve as agents for the public by pooling risk, paying for effective care, and being accountable for outcomes. The key issue should be how best to provide access to high-quality, affordable care for all, now and into the future.

Those are the goals of comprehensive health reform, and we should not lose sight of them. Achieving such goals requires bending the health care cost curve in a way that best improves quality, eliminates waste, and enhances value. All three paths described here, combined with an integrated set of Medicare payment and system reforms, would take major steps toward the goal of covering the uninsured. But with the nation’s economic and fiscal future at risk, health reform must pay particular attention to effective strategies for altering the future course of spending for health care and increasing the value obtained for the resources devoted to the health system.

NOTES

[1] 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).

[2] Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise* (Washington, D.C.: Government Printing Office, Feb. 2009).

[3] L. Nichols and J. Bertko, *A Modest Proposal for a Competing Public Health Plan* (Washington, D.C.: New America Foundation, March 2009).

[4] Ibid.; R. Pear, "Schumer Offers Middle Ground on Health Care," *New York Times*, May 5, 2009, page A20.

[5] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington, D.C.: CBO, Dec. 2008). The Congressional Budget Office estimates that Medicare pays hospitals 70 percent of what commercial insurers pay and 80 percent of what commercial insurers pay physicians. But providers will be getting a major influx of revenues from coverage of the uninsured and improved benefits for the underinsured, so bad debts will markedly decline, and these changes would also need to be taken into consideration in setting a "fair" rate.

[6] R. Pear, "Industry Pledges to Control Health Care Costs," *New York Times*, May 11, 2009, page A12.

[7] K. Ignagni, *Statement for Roundtable Discussion on Health Care Coverage* (Washington, D.C.: United States Senate Committee on Finance, May 2009).

[8] W. van de Ven and F. Schut, "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?" *Health Affairs*, May/June 2008 27(3):771–81; R. Leu, F. Rutten, W. Brouwer et al., *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets* (New York: The Commonwealth Fund, Jan. 2009).

[9] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2009). The bids submitted by Medicare Advantage plans represent the payment they would require to provide traditional Medicare benefits to their enrollees.

[10] For late 1990s and early 2000s, see A. Goldstein, "Managed-Care Medicaid Experiment Fails in Ohio; Plans Drop Out, Leaving Patients Unhappy," *Washington Post*, Aug. 14, 1999. For more recent evidence, see United States Securities and Exchange Commission, *Form 10-K, Wellpoint Inc.* (Washington, D.C.: Securities and Exchange Commission, Feb. 2008). Wellpoint recently exited from the Ohio Medicaid market.

[11] L. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009:w533–w543; J. A. Sakowski, J. G. Kahn, R. G. Kronick et al., "Peering into the Black Box: Billing and Insurance Activities in a Medical Group," *Health Affairs* Web Exclusive, May 14, 2009:w544–w554; and J. Kahn et al. "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians and Hospitals," *Health Affairs*, Nov./Dec. 2005 24(6):1629–39.

[12] Authors' estimate based on 2009 total hospital spending and physician practice estimates.

[13] U. E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, Jan./Feb. 2006 25(1):57–69.

[14] B. Martinez and A. Johnson, "Drug Makers, Hospitals Raise Prices," *Wall Street Journal*, April 15, 2009. The article reported: "Credit Suisse's Catherine Arnold said that drug companies have increased prices so aggressively in recent months to wring sales out of products before any healthcare cost-cutting efforts eat into profits. 'When the government is talking about more aggressive discounts, your start price is going to determine your end price,' she said. 'I don't think I have ever seen anything quite like this.'"

[15] America's Health Insurance Plans, *Now Is the Time for Health Care Reform: A Proposal to Achieve Universal Coverage, Affordability, Quality Improvement and Market Reform* (Washington, D.C.: America's Health Insurance Plans, Dec. 2008).

APPENDIX

Policies Included in the Three Insurance Scenarios: Modeling Specifications for Coverage and Cost Estimates

COVERAGE

- **Three Path Insurance Scenarios:**
    - *Public Plan with Medicare Payment Rates:* A new public insurance choice would be offered through the national health insurance exchange. It would include benefits similar to the standard-option Federal Employees Health Benefits Program (FEHBP). The public plan would use Medicare's private claims administrative organizations and reformed payment methods and rates.
    - *Public Plan with Intermediate Payment Rates:* This approach would include a new public health insurance plan with reformed payment methods and payment rates set between Medicare and commercial levels. The public plan and private plans would be subject to the same market rules governing choice of plans.
    - *Private Plans:* No public health insurance plan is offered in the exchange, but all other policies are the same. Private plans include insurance products that pay providers on a discounted fee-for-service basis as well as community health plans partnering with integrated delivery systems.

- **National Health Insurance Exchange.** Offers businesses and individuals a structured choice of plans, phased in by the size of the firm with all persons eligible by 2014. Premiums for all plans would be community-rated within broad age bands. National minimum standards for benefits are similar to the standard option in FEHBP. The exchange would replace individual insurance markets.*

- **Insurance Market Reforms.** Require community-rated premiums (age bands permitted up to a 2-to-1 ratio) and guarantee issue and renewal of policies. Establish a minimum national standard for benefits. Comparative premium and insurance-performance information would be publicly available on the Web.

- **Individual Mandate.** Everyone would be required to have coverage.

* Note that this is a change from the original Path framework.

- **Affordability.** Federal assistance to cap premiums at 5 percent of income for households in the two lowest income tax brackets; 10 percent of income for those in the 25 percent tax bracket; 12 percent for those in the 28 percent tax bracket, and no premium cap for those in the 33 percent and 35 percent tax brackets. Premium assistance is available only through the exchange. Premium assistance would be pegged to the most efficient plan.

- **Employer Shared Financial Responsibility.** Employers are required to provide coverage or contribute to a trust fund. The example used in the model included 7 percent of payroll, up to $1.25 an hour.

- **Medicaid/CHIP Expansion.** All individuals with incomes up to 150 percent of the federal poverty income level are eligible for Medicaid acute-care benefits. Medicaid provider payment rates are raised to Medicare levels. The federal matching rate is increased to offset state costs.

- **Medicare.** The two-year waiting period for coverage of the disabled is eliminated.

PAYMENT REFORM: ALIGNING INCENTIVES TO ENHANCE VALUE

- **Enhance Payment for Primary Care.** Increase Medicare payments for primary care by 5 percent and apply differential updates for primary and other care.
- **Encourage Development and Spread of Patient-Centered Medical Homes.** Provide $8 per month payment per patient in addition to fee-for-service to practices qualified to provide patient-centered care. Make reduced premiums and cost-sharing available to patients who designate a primary-care practice as their medical home. Shared savings would be distributed on the basis of provider performance.
- **Bundled Payments for Acute-Care Episodes.** Expand acute-care payment to include services during the hospital stay and 30 days post-discharge in a global fee. The policy would be phased in, starting with inpatient services in 2010, followed by post-acute care in 2013 and hospital inpatient and outpatient physician care in 2016. Over time, hospitals would be eligible for shared savings distributed on the basis of performance. Annual productivity gains of one percentage point would be incorporated.
- **Correcting Price Signals.** Modify payments by: 1) slowing the rate of Medicare payment updates in geographic areas with high costs; 2) reducing prescription drug costs by having Medicare pay Medicaid prices for drugs used by dually eligible beneficiaries as well as determining Medicare payments for unique drugs with effective monopolies based on prices paid in other countries; and 3) resetting

benchmarks for Medicare Advantage plans in each county to projected per capita spending under traditional Medicare.

INVESTING IN INFORMATION INFRASTRUCTURE

- **Accelerate the Adoption and Use of Health Information Technology.** Require all providers to report key health outcomes electronically by 2015 to qualify for payment updates. Provide funding to support health information networks and assistance for safety-net providers and small practices through a 1 percent assessment on insurance premiums and Medicare outlays.

- **Center for Medical Effectiveness and Health Care Decision-Making.** Create a mechanism to develop information on the clinical outcome and cost-effectiveness of alternative treatment options. Fund the Center with a .05 percent assessment on insurance premiums and Medicare and Medicaid spending. Use the information in benefit designs with higher out-of-pocket costs or differential pricing depending on comparative effectiveness and include physician–patient shared decision-making.

PROMOTING HEALTH AND DISEASE PREVENTION

- **Reduce Tobacco Use.** Increase federal taxes on tobacco products by $2 per pack of cigarettes. Use revenues to fund public health programs and insurance expansion.

- **Reduce Obesity and Alcohol Use.** Establish a new tax on sugar-sweetened soft drinks of 1 cent per 12 ounces to finance state obesity-prevention programs and increase the federal excise tax on alcohol by 5 cents per 12-ounce can of beer, with proportionate increases on other alcohol products. Use funds for prevention measures and insurance expansion.

Methodology Note

Modeling each option required detailed specifications for each policy. These specifications were prepared by the authors for illustrative purposes. Estimates are based on modeling by The Lewin Group, a health consulting firm with more than 35 years of experience serving organizations in the public, nonprofit, and private sectors. The Lewin Group is a wholly owned subsidiary of Ingenix, which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and is responsible for the integrity of data that it produces for the Fund. The Lewin Group technical report, *The Path to a High Performance U.S. Health System: Technical Documentation,* is available online at www.Lewin.com for parameters used in modeling.