



**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.

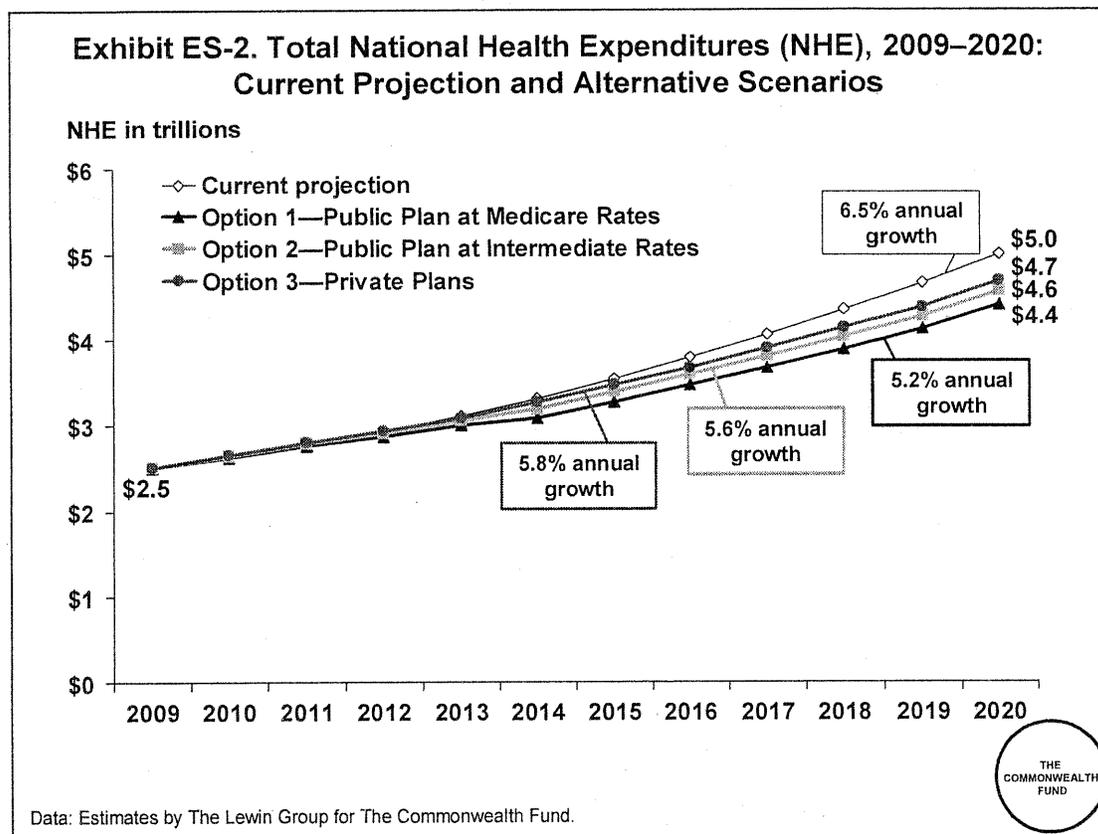
	Public Plan at Medicare Rates	Public Plan at Intermediate Rates	Private Plans
<b>Requirements for Coverage</b>			
Individual mandate	X	X	X
Employer shared responsibility	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings
<b>Insurance Exchange</b>			
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
<b>Provider Payment Reform</b>			
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
<b>Changes to Current Public Programs</b>			
Retain current Medicare benefit structure	X	X	X
End Medicare disability waiting period	X	X	X
Expand Medicaid/CHIP	X	X	X
<b>System Reform</b>			
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:

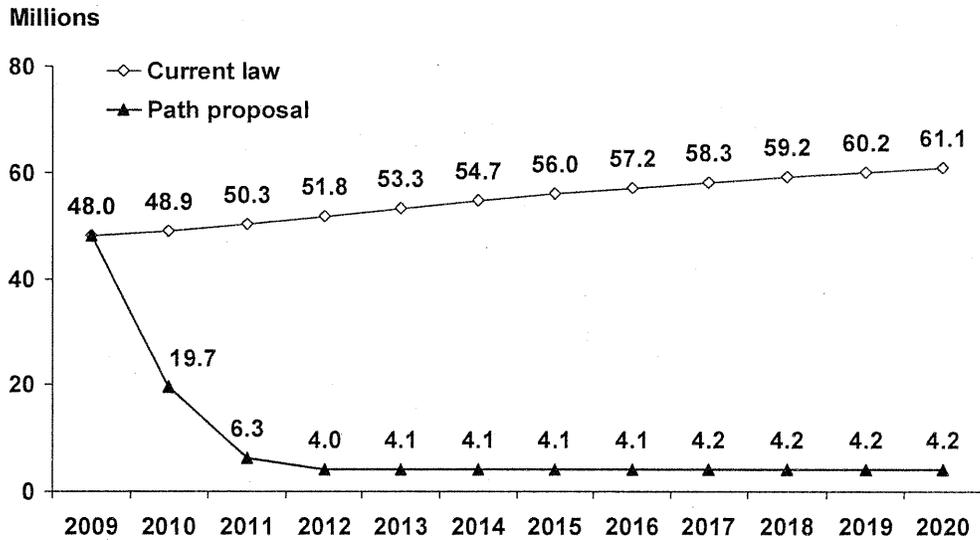
- **Health system savings.** All three paths would produce substantial health system savings over the 11-year period from 2010 through 2020, with cumulative savings of \$3.0 trillion under the Public Plan with Medicare Payment Rates scenario, \$2.0 trillion under the Public Plan with Intermediate Payment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



- 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**



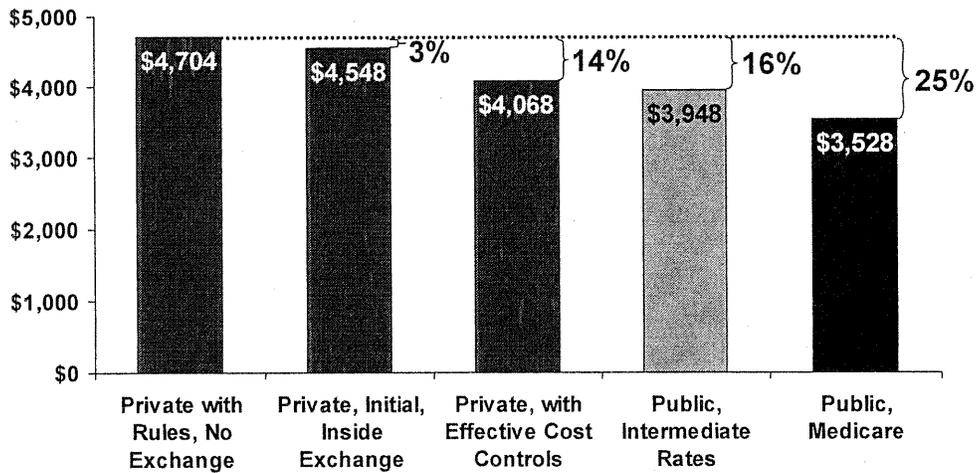
Note: Assumes insurance exchange opens in 2010 and take-up by uninsured occurs over two years.  
 Remaining uninsured are mainly non-tax-filers.  
 Data: Estimates by The Lewin Group for The Commonwealth Fund.



- 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

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

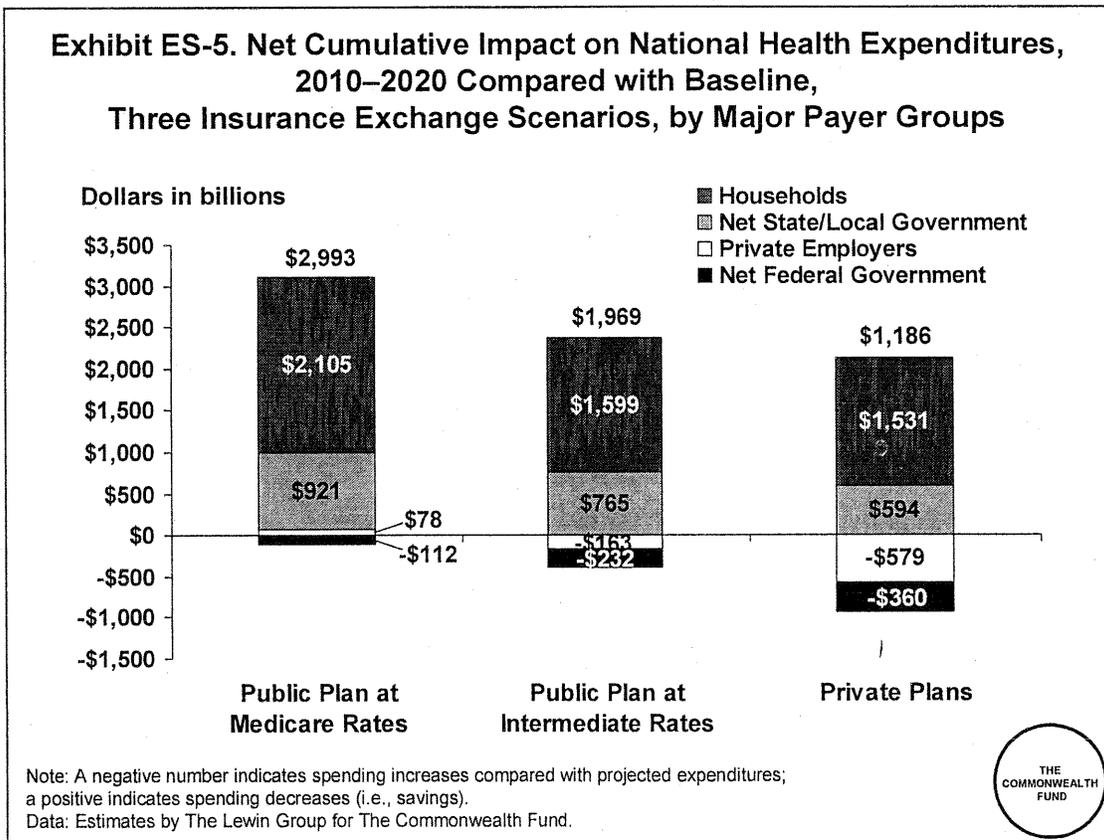


\* Premiums for same benefits and population. Benefits used to model: full scope of acute care medical benefits; \$250 individual/\$500 family deductible; 10% coinsurance physicians services; 25% coinsurance, no deductible prescription drugs; full coverage preventive care. \$5,000 individual/\$7,000 family out-of-pocket cost limit. Data: Estimates by The Lewin Group for The Commonwealth Fund.

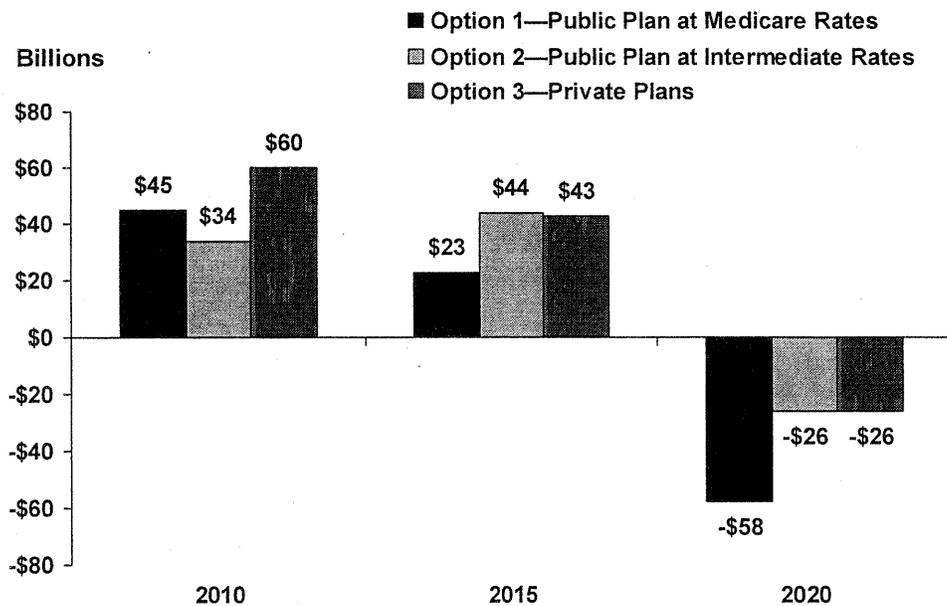


- Effective private-sector cost containment.** Offering a public health insurance plan as an alternative choice should be a catalyst for private plans to innovate in the way they operate and pay for care. It would help them reduce their administrative costs and implement payment and system reforms that 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-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.



- 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.<sup>6</sup> 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.

## **HEALTH REFORM: SIDE-BY-SIDE COMPARISON OF SENATE AND HOUSE PROPOSALS**

**Background:** The following table provides a side-by-side comparison of proposals from the Senate Finance and the Health, Education, Labor and Pensions (HELP) committees, and the joint version of health reform legislation released by the chairmen of the House Energy and Commerce, Ways and Means, and Education and Labor committees. The information about the Finance Committee proposals is drawn from the committee's three "options" papers discussing possible proposals for delivery system reform, coverage, and financing reforms and a June 18<sup>th</sup> slide presentation shared by committee staff. To date, the Finance Committee has not released legislative text. The Senate HELP and House drafts currently do not include several key provisions, including financing. In addition, some provisions will need clarification to determine the committees' intent. Analysis is ongoing and the chart will be updated as more information becomes available or is further clarified.

*Sources:*

- Senate Finance Committee: <http://finance.senate.gov/sitepages/legislation.htm> (see publications from 4/28/09, 5/11/09, 5/18/09)
- Senate HELP Committee: [http://help.senate.gov/BAI09A84\\_xml.pdf](http://help.senate.gov/BAI09A84_xml.pdf)
- House "Tri-Committee" draft as posted by the Energy and Commerce Committee: [http://energycommerce.house.gov/Press\\_111/20090619/healthcarereform\\_discussiondraft.pdf](http://energycommerce.house.gov/Press_111/20090619/healthcarereform_discussiondraft.pdf)

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Issue	SENATE FINANCE COMMITTEE (Based on Committee's "options" papers and 6/18 committee handout)	SENATE HELP COMMITTEE DRAFT (“Affordable Health Choices,” 6/9/2009)	HOUSE “TRI-COMMITTEE” DRAFT (“Affordable Health Care Choices,” 6/19/2009)
<b>INSURANCE MARKET REFORMS</b>			
<b>Individual and Small Group Health Insurance Markets</b>	<ul style="list-style-type: none"> <li>• Guaranteed issue and guaranteed renewability</li> <li>• No exclusions for preexisting conditions</li> <li>• Adjusted community rating with variation capped at 7.5:1. Draft versions indicate variation permitted in exchange plans based on age, geography, tobacco use, and family size in the non-group, micro-group (2-10 employees), and small group markets</li> <li>• Highest rate cannot be more than 7.5 times the lowest rate for all factors combined</li> <li>• Risk adjustments: insurers with large share of low-risk enrollees would be required to transfer money to those with large share of high-risk enrollees to establish level playing field and reduce “cherry-picking”</li> </ul>	<ul style="list-style-type: none"> <li>• Guaranteed issue and guaranteed renewability</li> <li>• No exclusions for preexisting conditions</li> <li>• Insurers can vary premiums on age (by a ratio of up to 2:1), family size, community rating area in the individual and small group</li> <li>• Insurers must rebate to enrollees a share of the amount premiums exceed expenditures for health care quality activities</li> <li>• Dependent coverage available for children 26 or younger</li> <li>• No lifetime or annual limits</li> <li>• Effective date for rating rules no later than 4 years after enactment of federal legislation</li> </ul>	<ul style="list-style-type: none"> <li>• Guaranteed issue and guaranteed renewability</li> <li>• No exclusions for preexisting conditions</li> <li>• Insurers can vary premiums on age (by a ratio of up to 2:1), family size, premium rating area in the small group and the Exchange</li> <li>• Medical loss ratio limited to 85%; insurer provides rebate to enrollees if fail to meet standard</li> </ul>
<b>Options for Health Insurance Exchange</b>	<ul style="list-style-type: none"> <li>• State option to establish an Exchange to facilitate enrollment, provide standardized enrollment application, format for</li> </ul>	<ul style="list-style-type: none"> <li>• State option to establish a “gateway”; choose to have the federal government operate a gateway for a minimum of 5 years, or neither</li> </ul>	<ul style="list-style-type: none"> <li>• Create a new national health Exchange, operational in 2013</li> <li>• Phases in participation for individuals and employers</li> <li>• State option to develop state</li> </ul>

Issue	SENATE FINANCE COMMITTEE (Based on Committee's "options" papers and 6/18 committee handout)	SENATE HELP COMMITTEE DRAFT ("Affordable Health Choices," 6/9/2009)	HOUSE "TRI-COMMITTEE" DRAFT ("Affordable Health Care Choices," 6/19/2009)
	<ul style="list-style-type: none"> <li>insurance options and marketing, call center and customer support</li> <li>State option to create multiple, competing exchanges after 5 years</li> </ul>	<ul style="list-style-type: none"> <li>Gateway may operate in more than one state, if permitted by state</li> <li>State may establish more than one subsidiary gateway that is geographically unique and based on community rating area</li> <li>Planning grants to states to establish gateway, based on HHS Secretary-developed formula and funding for no more than 2 years</li> </ul>	<ul style="list-style-type: none"> <li>or regional level exchange, with HHS approval, in lieu of national Exchange. Must contract with QHBP, enroll individuals and employers, establish local offices</li> <li>Commissioner may specify functions that state Exchange cannot perform or can be performed by either state or federal Exchange</li> <li>Exchange may operate in more than one state but only one Exchange per state</li> <li>Assistance to states for operation of Exchange</li> </ul>
<b>Health Insurance Exchange</b>	<ul style="list-style-type: none"> <li>Serve as a clearinghouse for sale of insurance for at least individuals and small business (could be organized at federal and state level)</li> <li>States would provide seal of approval for health benefit plans, with a federal benefit floor</li> </ul>	<ul style="list-style-type: none"> <li>"Gateway" intended to facilitate purchase of health coverage, either by a state or by HHS Secretary</li> <li>Functions: establish procedures for certification and related processes, utilize administrative simplification measures and standards, provide tools for consumers to compare plans</li> <li>Have agreements with "navigators," facilitate purchase of coverage for LTSS, and handle consumer complaints</li> </ul>	<ul style="list-style-type: none"> <li>Create new federal Health Choices Administration under the direction of a Commissioner that will operate/direct the Exchange</li> <li>Establish Exchange to facilitate access of individuals and employers to health coverage, including public option</li> <li>Commissioner duties include: establishes standards for bids, negotiates and contracts with qualified health benefits plans,</li> </ul>

Issue	SENATE FINANCE COMMITTEE (Based on Committee's "options" papers and 6/18 committee handout)	SENATE HELP COMMITTEE DRAFT ("Affordable Health Choices," 6/9/2009)	HOUSE "TRI-COMMITTEE" DRAFT ("Affordable Health Care Choices," 6/19/2009)
	<ul style="list-style-type: none"> <li>Identify individuals who lack qualifying coverage and assist them in enrolling in qualified health plan or public insurance program</li> <li>Requires states assess risk adjustment charge</li> <li>States/federal government may assess surcharge on qualified health plans not more than 3% of premiums collected</li> <li>ONC with HHS to develop standards to facilitate enrollment in state and federal programs and provides grants to states to develop enrollment technology, education campaigns, and training programs</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid eligible individuals covered through state Medicaid programs and would not eligible for credits/subsidy to purchase coverage through Gateway</li> <li>Option for CHIP eligible individuals to enroll in CHIP or a qualified health plan through Gateway</li> </ul>	<ul style="list-style-type: none"> <li>facilitate outreach and enrollment in plans, conduct, operate risk pooling mechanism and consumer protections</li> <li>Create Health Insurance Exchange Trust Fund for payments to operate exchange</li> </ul>
<p><b>Exchange Relation to Medicaid/CHIP</b></p>	<p>Several options proposed:</p> <ul style="list-style-type: none"> <li>Medicaid eligible individuals enrolled in existing Medicaid program or enroll children, pregnant women, parents, and childless adults in Exchange</li> <li>Enroll all expansion populations except childless adults in Medicaid. Childless adults would be given tax credits to purchase coverage through the</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid eligible individuals covered through state Medicaid programs and would not eligible for credits/subsidy to purchase coverage through Gateway</li> <li>Option for CHIP eligible individuals to enroll in CHIP or a qualified health plan through Gateway</li> </ul>	<ul style="list-style-type: none"> <li>Childless adults newly eligible for Medicaid may enroll in Exchange plan if they had qualified coverage in previous 6 months</li> <li>Individuals at or below 133% FPL who lose health coverage in the previous 6 months can enroll in Medicaid or receive a premium subsidy to enroll in Exchange QHBP</li> </ul>

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	Exchange or to buy-in to Medicaid <ul style="list-style-type: none"> <li>• After September 30, 2013, expand CHIP eligibility to 275% FPL. After Exchange operational, CHIP enrollees obtain coverage through the Exchange and states required continue to provide wrap-around services, including EPSDT services</li> <li>• No income disregards would be permitted for any Medicaid eligible population. Income would be measured based on modified adjusted gross income (MAGI), the same definition used by Exchange to determine eligibility for the tax credit in order to align eligibility for Medicaid and eligibility for credits to purchase coverage through Exchange</li> </ul>		<ul style="list-style-type: none"> <li>• State Medicaid programs must continue cover individuals with incomes above 133% FPL using the eligibility rules in place (6/16/09)</li> <li>• Starting year 4 of Exchange operation, all Medicaid eligible individuals can choose to enroll in Exchange QHBP or remain in Medicaid</li> <li>• States must offer wrap around services for Medicaid eligible individuals (based on 6/16/09 income eligibility policy) who choose Exchange plan</li> <li>• Starting year 5, state option to request some or all Medicaid populations enroll in Exchange plan, but state must provide for wrap-around coverage and Exchange plans must be approved to serve this population</li> <li>• State share of wrap-around reduced for above-average reductions in uninsured</li> <li>• CHIP eligible child eligible for Exchange QHBP, unless traditional Medicaid eligible Medicaid eligible who is also</li> </ul>

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	<ul style="list-style-type: none"> <li>All insurers selling individual and small-group insurance would be required to participate but could offer coverage outside</li> <li>Insurers selling both within and outside the exchange would have to charge the same price in both places for the same coverage and be subject to the same rules</li> </ul>	<ul style="list-style-type: none"> <li>Gateway must include a public health insurance option</li> <li>Coverage must be a "qualified health plan"</li> </ul>	<ul style="list-style-type: none"> <li>Exchange-eligible but has not elected QHBP is auto-enrolled in plan</li> <li>Each state must have MOU with Commissioner for coordinating enrollment of individuals into Exchange QHBP and relating to Medicaid program provisions</li> </ul>
<p><b>Insurance Plan Guidelines for Health Insurance Exchange</b></p>	<ul style="list-style-type: none"> <li>All insurers selling individual and small-group insurance would be required to participate but could offer coverage outside</li> <li>Insurers selling both within and outside the exchange would have to charge the same price in both places for the same coverage and be subject to the same rules</li> </ul>	<ul style="list-style-type: none"> <li>Gateway must include a public health insurance option</li> <li>Coverage must be a "qualified health plan"</li> </ul>	<ul style="list-style-type: none"> <li>Qualifying health benefits plan (QHBP) must offer at least one basic plan in service area; may offer enhanced, premium, and premium-plus plans</li> <li>Exchange QHBP plans must be: licensed under state law, provide for implementation of affordability credits for enrollees, beginning in year 5 provide Medicaid wrap-around benefits (to be reimbursed by Medicaid), QHBP basic plans must contract with community providers</li> </ul>
<p><b>Benefit plans</b></p>	<ul style="list-style-type: none"> <li>Four benefit categories: bronze, silver, gold and platinum</li> <li>No non-group or small group</li> </ul>	<ul style="list-style-type: none"> <li>Plans may operate outside a gateway</li> <li>No state law preemption of insurance mandates or law</li> </ul>	<ul style="list-style-type: none"> <li>Commissioner specifies benefits under qualifying health benefits plans (QHBP) each year</li> </ul>

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<b>Oversight</b>	<ul style="list-style-type: none"> <li>• policies (except grandfathered plans) that do not comply</li> <li>• Actuarial value adjusted to reflect plans offered in market today</li> <li>• Insurers must offer at least silver and gold coverage</li> <li>• Pediatric services, including dental and vision, must be provided</li> <li>• Out of pocket limits to all benefit categories consistent with current HSA standard</li> <li>• Allows "value-based insurance design"</li> </ul>	<ul style="list-style-type: none"> <li>• regarding market conduct or related consumer protections</li> <li>• HHS Secretary to establish criteria for a qualified health plan</li> </ul>	<ul style="list-style-type: none"> <li>• Tiered cost-sharing for affordable credit eligible individuals and range of variation in cost-sharing</li> <li>• Maintains state benefit mandates beyond basic benefit package for Exchange plans ONLY IF state enters into Commissioner-approved arrangement to reimburse federal government for net increase in affordability premium credits due to increase in premium in basic plans</li> </ul>
<b>Medical Advisory Board</b>		<ul style="list-style-type: none"> <li>• State must submit annual report concerning all activities, expenditures</li> <li>• Gateway subject to annual audits by HHS Secretary</li> </ul>	<ul style="list-style-type: none"> <li>• Commissioner establishes oversight, monitoring and enforcement processes, including grievance/complaint (in coordination with state insurance regulators)</li> <li>• Create Special Inspector General</li> </ul>
		<ul style="list-style-type: none"> <li>• Establishes Medical Advisory Council to recommend essential health care benefits eligible to be considered minimum qualifying coverage and eligible</li> </ul>	<ul style="list-style-type: none"> <li>• Establishes Health Benefits Advisory Committee to recommend covered benefit and essential benefits package</li> </ul>

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		for credits	
<b>TRANSITION</b>			
	<ul style="list-style-type: none"> <li>Medicaid expansion soon after enactment</li> </ul>	<ul style="list-style-type: none"> <li>Planning grants to states to establish Exchange</li> <li>Rating rules effective 4 years after enactment</li> </ul>	<ul style="list-style-type: none"> <li>Federal Exchange operating by 2013</li> <li>Phase in Medicaid expansion and primary care provider reimbursement rate increase</li> <li>(Clarification needed on timeline for rating rules)</li> </ul>
<b>SUBSIDY/TAX CREDIT/ASSISTANCE FOR LOW INCOME FAMILIES</b>			
<b>Federal assistance</b>	<ul style="list-style-type: none"> <li>Tax credits for premiums for individuals between 133%-300% FPL, tied to "silver" plan</li> <li>Cost sharing subsidy</li> </ul>	<ul style="list-style-type: none"> <li>Sliding scale federal subsidy for individuals between 150%- 500% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Sliding scale credits for family income between 133% - 400% FPL (AGI) if individual does not have access to affordable ESI</li> <li>Create affordability credit to be applied to premium and cost-sharing for Exchange plan</li> <li>Commissioner may approve and reimburse state Medicaid program to make eligibility determination for credit</li> <li>Auto-enrollment into Exchange QHBP if determined eligible for and did not opt out or enroll in plan</li> <li>Studies: income disregards</li> </ul>

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<b>MEDICAID</b>			
<b>Eligibility Expansion</b>	<ul style="list-style-type: none"> <li>Expansion to cover all children and pregnant women at or below 133% FPL</li> <li>Expansion to cover parents and childless adults at or below 100% FPL</li> <li>Phase in coverage for parents and adults: 50% by 2010, 75% by 2011, 100% by 2012</li> <li>MOE to maintain income eligibility for all previously eligible populations upon enactment. MOE expires HHS Secretary determines that the Exchange operational</li> <li>Add non-pregnant adults to the list of Medicaid beneficiaries for whom states would be permitted to waive the 5-year bar to extend Medicaid coverage</li> </ul>	<ul style="list-style-type: none"> <li>Assumes all currently eligible for Medicaid remain eligible and eligibility expanded to 150% FPL for all individuals</li> <li>Assumes improvements in enrollment process</li> <li>Assumes states required to “grandfather” individuals currently enrolled in Medicaid above 150% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Expansion to cover everyone under 133% FPL, based on state Medicaid plan rules as of June 16, 2009</li> <li>Studies to determine whether to vary standard FPL definition across geographic regions</li> <li>State MOE on Medicaid and CHIP eligibility, but CHIP eligible kids would become Exchange-eligible immediately (clarification needed)</li> <li>States must enter into MOU with Commissioner to coordinate enrollment and implementation of provisions for Medicaid enrollees and eligible individuals</li> <li>States must accept the Exchange’s determinations of Medicaid eligibility</li> <li>Optional coverage of low-income HIV infected individuals.</li> </ul>
<b>Medicaid Reimbursement</b>	<ul style="list-style-type: none"> <li>Require Medicaid</li> </ul>		<ul style="list-style-type: none"> <li>Medicaid must increase</li> </ul>

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<b>Rates</b>	reimbursement rates at 80% of Medicare		<ul style="list-style-type: none"> <li>payments to primary care physicians to 80% of Medicare in 2010, 90% in 2011, 100% in 2012</li> <li>Medicaid prohibited from paying extra for hospital acquired conditions</li> </ul>
<b>Medicaid Eligibility Expansion Financing</b>	<ul style="list-style-type: none"> <li>Temporary 5 year increase in federal funding for expansion populations</li> <li>Phase-down 20% per year over 5 years to regular state match</li> </ul>	<ul style="list-style-type: none"> <li>States receive 100% federal funding until 2015 for additional cost of enrolling expansion population, including in those states already covering newly mandated population.</li> <li>In 2015, begin FMAP phase-down to regular state match</li> </ul>	<ul style="list-style-type: none"> <li>Expansion increase 100% federally financed</li> <li>Reimbursement rate increase (compared to 6/16/09 rates) 100% federally financed</li> <li>Increases overall cap for territories by \$10 billion over 10 years</li> </ul>
<b>Benefits and Services</b>	<ul style="list-style-type: none"> <li>State option to offer additional services under 1915(i), and allow individuals to simultaneously enroll in more than one Medicaid waiver</li> <li>Eliminate existing institutional LOC requirement for eligibility for 1915(c) waivers. Require states replace it with less stringent criteria</li> <li>Eliminate prohibition against providing 1915(i) services to persons above 150% FPL.</li> </ul>		<ul style="list-style-type: none"> <li>Require wrap around benefits for “traditional eligible” individuals (under 133% FPL &amp; &lt;65 years old &amp;) Medicaid individuals and state financing responsibility, with reduction for certain states reducing number of uninsured</li> <li>Require coverage (no cost-sharing) preventive services and enhanced FMAP</li> <li>New coverage mandates for tobacco cessation counseling for pregnant women and</li> </ul>

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	<p>Create state option to confer eligibility for 1915(g) HCBS services as well as full Medicaid benefits to individuals with income up to state-specified level no greater than 300% of max SSI payment</p> <ul style="list-style-type: none"> <li>• Medicaid benefits through the special income rule eligibility pathway. Several options regarding HCBS: 1) Mandatory increase in cap; 2) prohibit states from using waiting lists to prevent eligible beneficiaries from accessing HCBS; 3) alternative under discussion</li> <li>• Increase FMAP for Medicaid HCBS by 1%</li> <li>• Require states to apply spousal impoverishment rules to applicants who would receive HCBS under 1915(c), (d), (e), (f), and (k), and section 1115 and persons applying for HCBS through medically needy pathway</li> <li>• Allow states treat applicants to Medicaid for HCBS</li> </ul>		<ul style="list-style-type: none"> <li>• translation services</li> <li>• New state options for : nurse home visitation services, with enhanced FMAP, family planning, freestanding birth centers</li> <li>• Inclusion of public health clinics under VFC program</li> <li>• Medical Home pilot project</li> </ul>

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	<ul style="list-style-type: none"> <li>• differently by allowing them to retain higher levels of assets</li> <li>• Require Medicaid coverage for tobacco cessation for pregnant women</li> </ul>		
<b>DSH</b>	<ul style="list-style-type: none"> <li>• State allotments designated as a pool for qualified hospitals within each state. Funds from pool would be dispersed directly by HHS Secretary to qualifying hospitals, based on claims data submitted by hospitals</li> <li>• Alternative proposal would reallocate DSH amongst states</li> </ul>		<ul style="list-style-type: none"> <li>• No DSH reductions</li> <li>• HHS report to Congress on appropriate targeting and distribution of Medicaid DSH and its coordination with Medicare DSH</li> </ul>
<b>Dual Eligibles</b>	<ul style="list-style-type: none"> <li>• Establish new Medicaid demonstration authority of five years for alternative approaches to coordinating care for dual eligibles</li> <li>• Modify Medicaid 1915(b) waiver authority to permit states to use savings from coordinating care for dual eligibles between Medicare and Medicaid in their waiver applications. Allow Medicaid 1915(b) waivers to recognize Medicare savings in 1915(b)</li> </ul>		<ul style="list-style-type: none"> <li>• Creates “Fully Integrated Dual Eligible Special Needs Plans” (FIDESNP) for duals and other Medicare special needs populations</li> <li>• Secretary would waive Medicare and Medicaid rules to align requirements re: marketing, enrollment, care coordination, auditing, reporting, quality assurance, and oversight</li> <li>• Create office (or program) within CMS for improved</li> </ul>

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	<ul style="list-style-type: none"> <li>cost effectiveness test. State option of using 1915(b) waivers to increase contracting with MCOs, such as MA-SNPs, to help coordinate care for duals</li> <li>Establish new office within CMS, the Office of Coordination for Dually Eligible Beneficiaries (OCDEB), responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles</li> </ul>		<ul style="list-style-type: none"> <li>coordination of duals</li> <li>Medicare Savings Programs (QMB, SLMB, etc) would use the higher assets test currently used by the Medicare Part D LIS program</li> </ul>
<b>Prescription Drugs</b>	<ul style="list-style-type: none"> <li>Increase Medicaid's flat rebate from 15.1% to as much as 23.1%. Medicaid best price unchanged.</li> <li>Another option: increase in basic Medicaid rebate for non-innovator, multisource drugs from 11% to 13% of AMP</li> <li>Extend rebates to MCOs</li> </ul>		<ul style="list-style-type: none"> <li>FUL pegged at 130% of AMP</li> <li>Additional rebate for new formulations of existing drugs</li> <li>Increase minimum rebate from 15.1% to 22.1%</li> <li>Extend rebates to MCOs</li> </ul>
<b>Miscellaneous</b>	<ul style="list-style-type: none"> <li>Clarifies optional preventive services for adults in Medicaid include those rated A and B</li> </ul>		<ul style="list-style-type: none"> <li>Extend TMA to 2012</li> <li>Expand outstationing of eligibility workers</li> </ul>

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	by U.S. Preventive Services Task Force; 1% increase in FMAP for states covering all preventive services <ul style="list-style-type: none"> <li>State option to develop medical homes and improve care coordination and transitional care for chronically ill enrollees</li> <li>Provides 4 options for phase-out of Medicare disability waiting period</li> <li>75 % matching rate for translation services to all Medicaid beneficiaries for whom English not primary language, and establish CLAS standards for private insurers in the Exchange</li> </ul>		<ul style="list-style-type: none"> <li>QI program made permanent</li> <li>Upgrades for electronic eligibility systems</li> <li>New reporting requirements for GME</li> </ul>
<b>INSURANCE RESPONSIBILITIES</b>			
<b>Individual</b>	<ul style="list-style-type: none"> <li>Individual mandate</li> <li>Fine for non-compliance based on percentage of average cost of lowest cost option available</li> <li>State option for auto-enrollment</li> <li>Mandatory auto enrollment for employers with 200+ employees</li> </ul>	<ul style="list-style-type: none"> <li>Individual mandate requiring purchase of "qualified" health insurance plan"</li> <li>Federal tax penalty if individual does not have "qualified" insurance</li> <li>Medical Advisory Council could exempt people</li> </ul>	<ul style="list-style-type: none"> <li>Once market reforms and affordability credits are in effect to ensure access and affordability, individuals responsible for having health insurance, with hardship exception</li> </ul>

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<b>Employer</b>	<ul style="list-style-type: none"> <li>• “Open Issue” options</li> <li>• “Free rider” or “anti-crowd out” approach:</li> <li>• No employer requirement provide health coverage but employers whose workers receive Medicaid or a tax credit in Exchange must contribute: 50% of national average Medicaid costs for enrolled workers and 100% of cost of the tax credit for workers receiving tax credit</li> <li>• Workers can only leave ESI and opt into Exchange if ESI unaffordable (12.5%+ income)</li> <li>• Medicaid eligible employee could leave ESI but employer not required to contribute unless ESI offered was unaffordable</li> <li>• Other alternatives under consideration</li> </ul>	<ul style="list-style-type: none"> <li>• Yes (provisions not yet released)</li> <li>• Provide qualifying small employers (requirements: &lt;50 FTE, average wage &lt;\$50K, and pay&gt;60%) with health options program credit</li> <li>• Create temporary reinsurance program for employers providing coverage to retirees (55 to 64). Ends when Gateway established</li> </ul>	<ul style="list-style-type: none"> <li>• Employers choose to provide coverage for workers or contribute funds on behalf of uncovered workers</li> <li>• Exempts small low-wage firms and provides new small business tax credit for firms providing health coverage</li> </ul>
<b>“PUBLIC PLAN”</b>			
<b>Public Plan Option</b>	<p>“Open Issue” options:</p> <ul style="list-style-type: none"> <li>• Establish Consumer owned and orientated (CO-OP), consumer governed non-profit corporation</li> </ul>	<p>Yes (provisions not released)</p>	<ul style="list-style-type: none"> <li>• Establish public plan option</li> <li>• Would have to operate under the same rules and restrictions as all other insurance products in the state, but would be a</li> </ul>

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	<ul style="list-style-type: none"> <li>Advisory board makes recommendations to HHS who makes final decisions about approvals of business plans and funds</li> <li>Business plans must meet governance standards and eligible applicants must meet standard for non-profit, participating mutual insurer</li> </ul>		<ul style="list-style-type: none"> <li>national plan</li> <li>Would pay providers at Medicare rates</li> </ul>
<b>PREVENTION AND WELLNESS</b>			
<b>Medicare and Medicaid</b>	<ul style="list-style-type: none"> <li>Establish "Personalized Prevention Plan" in Medicare</li> <li>Align Medicare coverage for preventive services with scientific evidence</li> <li>Medicare/Medicaid incentives to encourage health behavior</li> </ul>		<ul style="list-style-type: none"> <li>Eliminates cost-sharing for all preventive services.</li> </ul>
<b>Workplace</b>	<ul style="list-style-type: none"> <li>Tax incentives for workplace wellness programs for employers w/ &lt;math&gt;\leq 200&lt;/math&gt; employees</li> </ul>	<ul style="list-style-type: none"> <li>Workplace wellness marketing campaign to make employers, aware of the benefits of employer-based wellness programs</li> </ul>	
<b>Right Choices Program</b>	<ul style="list-style-type: none"> <li>"Right Choices" grant: annual, capped grants to states for 3-5 years – or until insurance options are available through Exchange – whichever is</li> </ul>	<ul style="list-style-type: none"> <li>Provide annual grant to each state to establish "Right Choices Programs."</li> <li>State Medicaid or comparable program may administer</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

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	<p>sooner. Grants would provide access to certain evidence-based primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening for uninsured adults and children</p>	<ul style="list-style-type: none"> <li>State must do outreach, risk assessment, care plan, and referrals for uninsured under 350% FPL not eligible for another federal program</li> <li>Grant based on percentage of uninsured in state and prevalence of costly chronic diseases</li> <li>Prospective payments to states until Gateway available</li> </ul>	<ul style="list-style-type: none"> <li>Create Public Health Investment Fund with funding for several public health purposes, including community health centers; health and public health workforce; and prevention and wellness programs</li> <li>Establish <i>National Prevention and Wellness Strategy</i> to identify specific goals and objectives in prevention and wellness; establish national priorities; and address disparities</li> </ul>
<p><b>Prevention and Wellness</b></p>	<ul style="list-style-type: none"> <li>Grant program to promote health and human services program integration, improve care coordination and access to preventive services and treatments; and better integrate delivery of health care services to improve health and wellness outcomes.</li> <li>Committee considering 3 approaches states may choose to implement: 1) states submit plan to HHS for locally integrated delivery systems including establishing multidisciplinary care teams; 2) allow states to implement service integration and delivery reform activities,</li> </ul>	<ul style="list-style-type: none"> <li>Establish the Community Transformation Grants program which includes grants to states and local agencies and CBOs, for implementation, evaluation, and dissemination of preventive health activities</li> <li>Establish National Prevention, Health, Promotion and Public Health Council</li> <li>Establish Prevention and Public Health Investment Fund</li> <li>Establish National Prevention and Health Promotion Strategy to set specific goals/objectives for improving the nation's health through</li> </ul>	<ul style="list-style-type: none"> <li>Establish <i>National Prevention and Wellness Strategy</i> to identify specific goals and objectives in prevention and wellness; establish national priorities; and address disparities</li> </ul>

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	<p>including developing an individualized plan for health and human service needs of low-income beneficiaries; 3) allow states submit a proposal that meets the goals and objectives of this grant</p>	<p>federally-supported prevention, health promotion, and public health programs; and establish measurable actions and timelines</p> <ul style="list-style-type: none"> <li>Establish independent Preventive Services Task Force and Community Prevention Services Task Force to review scientific evidence</li> <li>Establish oral healthcare prevention and education campaign</li> </ul>	
<b>WORKFORCE</b>			
		<ul style="list-style-type: none"> <li>Expands the National Health Service Corps;</li> <li>Expands training of primary care doctors and expands pipeline of individuals going into health professions, including primary care, nursing and public health;</li> <li>Supports workforce diversity efforts</li> <li>Expands scholarships and loans for individuals in needed professions and shortage areas.</li> </ul>	<ul style="list-style-type: none"> <li>Expands the National Health Service Corps;</li> <li>Expands training of primary care doctors and expands pipeline of individuals going into health professions, including primary care, nursing and public health;</li> <li>Supports workforce diversity efforts</li> <li>Expands scholarships and loans for individuals in needed professions and shortage areas.</li> </ul>

<b>Issue</b>	<b>SENATE FINANCE COMMITTEE</b> (Based on Committee's "options" papers and 6/18 committee handout)	<b>SENATE HELP COMMITTEE DRAFT</b> ("Affordable Health Choices," 6/9/2009)	<b>HOUSE "TRI-COMMITTEE" DRAFT</b> ("Affordable Health Care Choices," 6/19/2009)
<b>LONG TERM CARE</b>	<ul style="list-style-type: none"> <li>Grants to states to facilitate the delivery of HCBS by: (1) creating a Consumer Task Force to assist in the development of real choice systems change initiatives; (2) providing support for informal caregivers; (3) expanding prevention and health promotion education activities; (4) expanding the Green House Model; (5) implementing approved section 1915(i) Medicaid HCBS SPA amendments; and (6) other HHS-approved activities to facilitate the use of HCBS</li> <li>Continue funding ADRGs</li> <li>Extend Money Follows the Person Rebalancing Demonstration through September 30, 2016</li> </ul>	<p>CLASS Act provisions included [NGA to update ]</p>	





# Policy Points

June 2009

## Options for Financing Health Reform: Comparing the Impact of Selected Policy Options

### Synopsis

A number of policies have been proposed to expand health insurance coverage and improve health system performance in a financially sustainable way. To illustrate how the potential impact of such reforms depends heavily on the details and structure of the reforms, the authors examine estimates from three sources: a recent Commonwealth Fund report containing projections prepared by The Lewin Group; the Office of Management and Budget; and the Congressional Budget Office. Estimates from all three sources indicate that early investments in reform could yield significant reductions in total health care spending over time through gains in the quality and efficiency of care.

### Background

In President Obama's first budget to Congress, he outlined his administration's priorities for health reform: protecting families' financial health; ensuring that health coverage is affordable; aiming for universality in coverage; providing portability of coverage; guaranteeing consumer choice; investing in prevention and wellness; improving patient safety and the quality of care; and maintaining long-term fiscal sustainability.<sup>1</sup> Consistent with the president's belief that health reform should be financially sustainable and deficit-neutral, he included a \$634 billion reserve fund to advance reforms over the next decade and proposed \$313 billion in additional savings in a June 2009 addendum.<sup>2</sup> The budget proposal builds on the \$150 billion investment included in the economic stimulus package—the American Recovery and Reinvestment Act (ARRA), enacted in February.<sup>3</sup> In a departure from the past, the administration has left the details of the health reform legislation to Congress, looking primarily to the committees of jurisdiction to develop legislation consistent with its goals.

A wide range of policy options exist for achieving health system savings to help finance health reform. In the Commonwealth Fund report, *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, the authors compared impact estimates of selected options from three different sources: 1) The Commonwealth Fund report, *The Path to a<sup>1</sup> High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (Path), which included projections prepared by The Lewin Group; 2) the Office of Management and Budget (OMB), for the president's budget proposal and the economic stimulus bill; and 3) the Congressional Budget Office (CBO).<sup>4</sup> All estimates consider the potential impact over the 10-year period, 2010 to 2019. The OMB and CBO estimates focus only on the projected effect on federal spending and do not estimate the potential impact on total national health expenditures (NHE). The Path report, meanwhile, looked at potential savings in terms of both the federal budget and national health spending—in order to illustrate the impact on state revenues, employers, and households.

Estimates from all three sources indicate that early investments could yield significant reductions in total health care spending over time through gains in the quality and efficiency of care. The differences among the estimates reflect primarily the scope of the policies and their particular elements. The table below summarizes OMB/ARRA, CBO, and Path estimates for various policy options (refer to the [full report](#) for more detail on each of the selected policy options.)

In this *Policy Points* brief, we focus on two of the savings options: bundling hospital payments to include acute-care services and annual productivity adjustments, and comparative effectiveness research.

**Potential Sources of Federal Savings and Revenue  
Compared with Projected Trends, Cumulative, 2010–2019**

<i>Savings</i>	OMB: Budget and ARRA	CBO	Path (Federal)	Path (Total Health System)*
	\$ Billions	\$ Billions	\$ Billions	\$ Billions
Revision of Medicare Advantage Benchmarks	175	157/158	135	—
Reduction of Prescription Drug Costs	29 / 75	110	93	62
Hospital Payment Reform: Paying for Episodes of Care, Including Post-Acute Care and Incorporating Productivity Adjustments into Payment Updates	26/110	19/201	123	182
Modified Home Health Update Factor	37	50	—	—
Hospital Pay-for-Performance	12	3	43	55
Promotion of Patient-Centered Medical Homes	—	(6)	83	144
Primary Care Payment Reform	—	5	23	56
Adoption of Health Information Technology	13	4/61	70	180
Comparative Effectiveness Research and Use of Information	—	(1)	174	480
Modified High-Cost-Area Update	—	51	100	177
Reduced Subsidies to Hospitals for Treating Uninsured as Coverage Increases	106	—	9	—
Managed Physician Imaging	—	1/3	23	29
Modified Updates for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Long-Term Care Hospitals	—	24	—	—
Reduce Waste, Fraud, and Abuse	—	0.5	—	—
Select Population Health Options				
Tobacco Excise Tax	—	95	79	215
Alcohol Excise Tax	—	60	47	—
Sugar-Sweetened Beverage Excise Tax and Obesity Abatement	—	50	121	321

Notes: Savings are not additive and policies may have overlapping or synergistic effects. If Lewin did not provide any estimate for a policy or only provided an estimate of impact to the federal budget, the Total Health System column is left blank.

**Bundling Payments for Hospitals: Inclusion of Post-Acute Care and Productivity Adjustments in Payment Updates**

The Medicare fee-for-service program currently pays hospitals fixed amounts for each hospital admission/discharge based on the diagnosis and adjustments for level of risk. Paying a bundled rate for the inpatient hospital stay up to the time of discharge creates an incentive for hospitals to provide efficient care over the course of the hospitalization. But this alone will not support incentives for hospitals to help patients during their transition to home or to post-acute care settings, nor will it ensure that patients receive follow-up care—essential for avoiding serious complications that can lead to costly rehospitalizations. One way to align incentives, provide better care for vulnerable patients, prevent readmissions, and lower health care costs would be to expand the scope of bundled payments to encompass acute hospital care and post-acute care and hold hospitals accountable for the costs of the initial hospitalization and readmissions.

- **OMB options:** 1) Bundle hospital payments for inpatient acute care and targeted post-acute care providers for 30 days after hospitalization, yielding \$8 billion from fewer readmissions and \$18 billion from increased efficiency in post-acute care (\$26 billion federal savings); 2) permanently adjust Medicare payment updates by half of the expected productivity gains, to encourage greater efficiency in the provision of care while better aligning Medicare payments with provider costs (\$110 billion federal savings).

- **CBO options:** 1) Bundle hospital payments for inpatient acute care, readmissions, and post-acute care within 30 days of discharge, allow hospitals to retain 20 percent of anticipated savings, and recapture the remaining savings through adjustments to annual update factors (\$19 billion federal savings); 2) reduce Medicare payment updates by the entire expected productivity gain to encourage greater efficiency and better align payments with provider costs (\$201 billion federal savings).
- **Path option:** Phase in bundled hospital payments for inpatient acute care to include readmissions, then post-acute care received within 30 days of discharge, and finally inpatient physician services; reduce annual update factors over time to reflect increased productivity (\$123 billion federal savings, \$182 billion total health system savings).

#### *Comparison*

The differences among the three estimates of savings stem from the scope of and approach to bundling, as well as from policies related to payment updates. The CBO estimate assumes the expanded bundled payment rate would be updated with the current update factors, less the savings adjustment, while The Lewin Group (Path option) estimate includes annual decreases to the update factors. Without this reduction, Lewin estimates that bundling would yield \$74 billion in federal savings. In addition, the Path option would be applied to the Medicare program and a new public health insurance plan option offered to the under-65 population through a national insurance exchange. In contrast, the Obama administration's budget option and the CBO option would only apply to Medicare. Of the net \$182 billion saved through this option, Lewin estimates \$115 billion would come from Medicare savings.

### **Comparative Effectiveness**

As medical science evolves, better information on the effectiveness and comparative effectiveness of available treatment options, medications, and devices is essential to support decision-making by providers and patients, as well as payers. Better evidence is important both for existing treatment alternatives and for new treatments and technology. An objective source of clinical information about what is likely to work well for particular patients would improve the quality of care, and approaches that synthesize information about treatments and outcomes also would help inform patients about their care options. Investments in generating better information for health care decision-making, combined with incentives to encourage more effective use of available information, could reduce unnecessary care, increase the provision of appropriate care, and improve the management of chronic conditions. Information about the relative costs of similarly effective care options could further inform decisions—and potentially control costs over time while improving health care quality and outcomes.

- **ARRA provision:** Appropriates \$1.1 billion for investment in comparative effectiveness activities, including \$400 million for the Secretary of Health and Human Services to conduct, support, or synthesize comparative effectiveness research and encourage the development and use of infrastructure and systems to generate or obtain outcomes data, and establishes an interagency advisory panel to coordinate and support such research (no estimate of savings available).
- **CBO option:** Fund comparative effectiveness activities, beginning with a \$100 million investment in 2010 and growing to \$400 million in 2014; funding would remain at that level through 2019 (\$1 billion increase in federal spending, \$8 billion total health system savings).
- **Path option:** Create a new Center for Comparative Effectiveness Research and Health Care Decision-Making responsible for conducting and synthesizing comparative effectiveness research and link research findings to public and private insurance payment and benefit design policies; also, support the use of decision aids designed to inform patients of alternative treatment options, including information about differential cost-sharing and relative pricing (\$174 billion federal savings, \$480 billion total health system savings).

#### *Comparison*

The ARRA provisions make an initial investment in comparative effectiveness research but do not provide ongoing funding or an advisory capacity to inform public or private health insurance policy decisions. Under the ARRA provisions, research

remains decentralized, conducted separately by the National Institutes of Health, the Agency for Healthcare Research and Quality, and the HHS secretary and evaluated by an advisory panel. The legislative language decouples the generation of information from payment policy.

Under the CBO option, comparative effectiveness research is funded entirely by the federal government, whereas the new center that would be established under the Path option receives both public and private funding for research and dissemination—an estimated \$12 billion investment over 10 years. The CBO estimates rely on voluntary use of new information by patients and providers and do not assume a mechanism to translate evidence-based information into incentives for patients or providers to apply the information.

Under the Path option, research would be centralized in a new, independent entity, responsible for generating information and making recommendations for payment and cost-sharing policies. In addition, the policy would spread use of decision aids to inform patients of the risks and benefits of alternative treatment choices. Both policies would accelerate the use of comparative effectiveness information to improve the quality of care. In addition, both would reduce the delivery of care that is of little or no benefit, as well as reduce the delivery of high-cost care when lower-cost alternatives exist. The incorporation of new information into payment and cost-sharing policies accounts for a great deal of the estimated savings from this option.

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## Conclusion

As the health care reform debate unfolds, it will be important to keep in mind that there are a number of options for financing the substantial federal investment that is necessary to ensure that all Americans have affordable health coverage and to address health care access, quality, and cost issues. Without bold initiatives, the U.S. faces a future in which millions more Americans are denied access to needed care, and in which health care consumes an ever-growing share of the nation's income without providing adequate value in return.

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## Notes

- <sup>1</sup> A New Era of Responsibility: Renewing America's Promise (Washington, D.C.: Office of Management and Budget, Feb. 2009); access at : [http://www.whitehouse.gov/omb/assets/fy2010\\_new\\_era/a\\_new\\_era\\_of\\_responsibility2.pdf](http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf).
- <sup>2</sup> White House Office of Management and Budget, *Paying for Health Care Reform: \$313 Billion in Additional Savings to Create a Deficit Neutral Plan*, June 2009. Accessed at: <http://www.whitehouse.gov/MedicareFactSheetFinal/>.
- <sup>3</sup> S. Rosenbaum, L. Cartwright-Smith, T. Burke et al., *An Overview of Major Health Provisions Contained in the American Recovery and Reinvestment Act of 2009* (Washington, D.C.: The George Washington University School of Public Health and Health Services Department of Health Policy, Feb. 18, 2009); accessed at: <http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/ARRA-Health-Care-Provision-Side-by-Side.cfm>.
- <sup>4</sup> 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); *Budget Options, Volume 1: Health Care, The Congress of the United States* (Washington, D.C.: Congressional Budget Office, Dec. 2008); accessed at: <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>; *A New Era of Responsibility: Renewing America's Promise* (Washington, D.C.: Office of Management and Budget, Feb. 2009); accessed at [http://www.whitehouse.gov/omb/assets/fy2010\\_new\\_era/a\\_new\\_era\\_of\\_responsibility2.pdf](http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf).