

# CROSSING OUR LINES

Working Together to Reform the U.S. Health System

HOWARD BAKER • TOM DASCHLE • BOB DOLE



BIPARTISAN POLICY CENTER





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Dear Fellow Americans:

I am pleased to join my friends Tom Daschle and Bob Dole in presenting this report of the Bipartisan Policy Center on the pillars of health care reform. It is the product of more than two years of work, including valuable contributions by our former colleague George Mitchell, and it reaches a level of policy detail that may seem unusual for an initiative undertaken by four former Majority Leaders of the United States Senate.

But we were determined to do more than present a general exhortation to the present generation of political leaders to deal with health care reform in a bipartisan way. Saying it is easy; doing it is hard, particularly when there are good arguments on several sides of important issues in this field. So we have labored to be as specific as possible in reaching for the political and policy consensus that underlies this report.

Frankly, the consensus is stronger in some parts of the report than in others. While we agree wholeheartedly on the need for universal health insurance coverage, the re-invention of the way we provide health care in this country, the need for more consistent quality in that care in rural and urban America, the need to maintain maximum consumer choice and a robust private insurance market, and much else, we are tethered more tenuously on some other important matters. These include such fundamental questions as how best to finance these reforms, contain costs without constraining quality, and deal with the inevitable unintended consequences of such a thorough-going revolution in the way medicine is practiced in America.

But we have found agreement wherever we could—consensus on large matters where possible and smaller points where necessary—because we deeply believe that a bipartisan approach to health care reform is much to be preferred to a party-line vote on an issue of such transcendent importance to the life of our country and the well-being of its people.

We do not envy the task before today's policymakers. But we have been there ourselves in earlier days of complex challenge and controversy, and we know that it is both possible and preferable to reach agreement among serious people of good will. We have every confidence that this generation of political leaders can succeed in health care reform where previous generations have fallen short. We offer this detailed plan, not without individual reservation over one proposal or another, but in the certainty that such reservations are the price of constructive compromise—and that such compromise is essential to the success of this endeavor.

I wish to thank my friends Tom Daschle and Bob Dole for their hard work and talented contributions to this report, and together we wish to thank the many experts whose perspectives have helped shape our work. The Congress, working closely with the new Administration, must now work its will on this issue. My colleagues and I agree most strongly that the time for action is now, and we wish our successors well in this most important enterprise.

Sincerely,



HOWARD BAKER

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*Senator Baker founded the Bipartisan Policy Center, along with Senators Dole, Daschle and Mitchell, in 2007, and he is a member of its Advisory Board. He served three terms as a United States Senator from Tennessee (1967 to 1985) and was Tennessee's first popularly elected Republican Senator. He is currently Senior Counsel at Baker, Donelson, Bearman, Caldwell, and Berkowitz, a law firm founded by his grandfather in 1888.*



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Dear Friends:

Health care reform is our most urgent domestic priority. Costs are skyrocketing and unsustainable. While we spend more on health care than any other country, the quality of care patients receive in return has been inconsistent. The United States is home to world renowned medical facilities, and yet we have repeatedly ranked lower in outcomes compared to other developed countries. Millions lack access to our health care system and must rely upon overburdened emergency rooms for routine

care. For those who do have health insurance, oftentimes their coverage is inadequate and they are prohibited from getting the care they need when they need it.

In the past, we have tinkered with the health care system with moderate success—most notably the CHIP program. Unfortunately, incremental solutions are no longer tenable. The problems associated with access, quality, and cost are interrelated and must be addressed simultaneously. Ultimately, the best way to achieve a high-value, high-performance health care system that provides greater quality at lower cost is to enact comprehensive reform.

That is why my colleagues and I at the Bipartisan Policy Center launched the Leaders' Project on the State of American Health Care. By working together across party lines, we hope we can provide policymakers, stakeholders, interest groups, and most importantly, the American people, with a constructive bipartisan solution to our health care crisis.

During the course of our deliberations we found common ground on a number of issues: promoting wellness and prevention and better value for care. However, there are some proposals in our report that would have been different if they had been crafted solely by Democrats or Republicans. If we had made the perfect the enemy of the good in our efforts to reach consensus, it is likely we would have been deeply divided along ideological lines and without a solution to the health care crisis.

President Obama has made it clear that health care reform is one of his highest priorities. Likewise, both the House of Representatives and the Senate are diligently working to draft comprehensive legislation. Stakeholders, who in previous years worked in opposition to each other, are now working together because they understand we have a historic opportunity to finally make health reform a reality.

These developments are a step in the right direction. It is my hope that our work at the Bipartisan Policy Center will contribute to the ongoing dialogue and help further the debate on health care reform.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom Daschle". The signature is stylized with overlapping loops and a horizontal line across the middle.

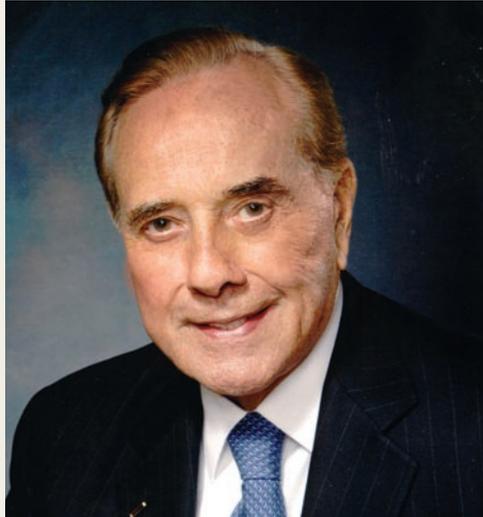
TOM DASCHLE

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*Senator Daschle founded the Bipartisan Policy Center, along with Senators Dole, Baker and Mitchell, in 2007, and he is a member of its Advisory Board. He is one of the longest serving Senate Democratic Leaders in history and the only one to serve twice as both Majority and Minority Leader. Today, Senator Daschle is a Special Policy Advisor to the law firm of Alston + Bird.*



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Dear Fellow Americans:

When it comes to the use of health care services, I have as much experience as almost anyone and have come to appreciate how lucky I am to have been able to avail myself of the finest health care system in the world. But I also recognize there are millions who for financial or other reasons cannot say the same.

Over the years we have attempted to address the problems of cost, quality and access. We have expanded our public

programs, Medicare and Medicaid; we have patched up problems as they arose; but we have not made the kind of fundamental changes necessary to give all Americans access to better care. We continue to treat illness, not patients or families. We continue to pay for volume and not value and we continue to leave the most vulnerable of our people without the security of knowing that their families will be cared for when most in need. Most recognize the time has come to reform our system. Without good health care, the American dream eludes too many of our fellow citizens.

When I look back on my 35 <sup>1</sup>/<sub>2</sub> years in Congress it is evident to me that anything that has really lasted, any legislation that has stood the test of time, has been truly bipartisan. The public has more confidence in the final product when the vote represents a serious compromise.

Senator Baker, Senator Daschle, Senator Mitchell—before he left us in March to work for the president in the Middle East—and I all believe we have an opportunity to improve our health care system and the lives of millions of Americans. Working together, this report represents our honest, best effort to reach common ground and perhaps provide a model for the current leadership in Congress as they do the same.

Let's not kid ourselves about the enormity of the health care problems we are confronting and the options being considered. Most importantly, we should be open with the American people when it comes to cost. Based on my long experience the estimated costs are always less than actual costs. That is why my colleagues and I provide a number of options for Congress to consider to ensure that health reform is truly deficit-neutral. Secondly, even though our goal is to provide care for everyone, we need to recognize that this will be a difficult feat to accomplish. The often-cited figure of 46 million uninsured provides a confusing and perhaps inaccurate picture of the problem. We should keep that in mind when we make policy choices. Our goal should be to get more people who can afford coverage to take it up, and provide support to those who might not have the means to purchase it on their own.

I wish to thank my colleagues as well as the outstanding staff of the Bipartisan Policy Center and the many others who participated in our work, as well as the Robert Wood Johnson Foundation, whose financial support was critical.

God Bless America,



BOB DOLE

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*Senator Dole founded the Bipartisan Policy Center, along with Senators Daschle, Baker and Mitchell, in 2007, and he is a member of its Advisory Board. He was elected to Congress from his home state of Kansas in 1960 and to the U.S. Senate in 1968, until he resigned in 1996 to pursue his campaign for President of the United States. Senator Dole currently serves as Special Counsel to Alston + Bird.*

## 01

## Introduction and Summary of Recommendations

At the founding of the Bipartisan Policy Center (BPC) in March 2007, its Advisory Board, former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole and George Mitchell, decided to devote significant time to a specific policy project that would exemplify their commitment to bipartisan action. Recognizing the current flaws in the nation's health care system, as well as the existing political stalemate in the federal reform debate, they selected health care as their signature issue. Collectively, the Senators believe there are too many gaps between what medical science and health professionals are capable of doing, and what the nation's health system is actually achieving. The American people deserve better than the status quo of uneven quality of care, growing numbers of uninsured, and rapidly increasing costs.

This report presents key findings from the Leaders' Project on the State of American

Health Care—an inclusive, year-and-a-half-long effort to develop consensus on bipartisan policy recommendations for health care reform. The goal of the Project was to develop a comprehensive but achievable set of policies to ensure that all Americans have quality, affordable health insurance coverage, while constraining cost growth, promoting innovative delivery of care, and focusing treatments more on the patient, and not just the illness. These changes are necessary to achieve a higher return on the nation's health care spending, which now exceeds \$2 trillion per year.

Developing these recommendations required exploring solutions to the problems facing the U.S. health care system, and making the same very tough, politically sensitive decisions that Congress and key stakeholder groups will inevitably have to confront in order to enact comprehensive health reform. Both sides

*“The American people deserve better than the status quo of uneven quality of care, growing numbers of uninsured, and rapidly increasing costs.”*

conceded positions that they feel strongly about, but did so recognizing that negotiations often require making tough choices. Since they are no longer sitting members of Congress, Senators Baker, Daschle and Dole do not have any direct purview over the efforts that will be required to enact broad, bipartisan health reform legislation. Rather, they hope to contribute the policy and political expertise they have built over decades of working across party lines to achieve progress on critical policy issues.

As part of the Leaders' Project, advice and input was sought from a broad range of stakeholders, including health care providers, businesses, labor representatives, state and local policymakers, health plans, academics, and consumer advocates, through a series of public policy forums and targeted outreach activities. Ultimately, this

report seeks to establish a constructive center in the often polarized health reform debate, and to advance a coherent strategy for modernizing the health care system so that every American has stable, quality health coverage.

### **Core Problems in the Health System**

The problems policymakers seek to resolve through comprehensive health reform are significant. Today, the nation's health care system focuses primarily on treating illness and not improving population health. Additionally, health care spending and premiums are rising at a rate that is unsustainable for families, businesses, and government. Growth in health care costs is much higher than growth in wages and gross domestic product (GDP). Consequently, despite a wider range of better medical treatments becoming

available, more and more people are struggling to afford even the most basic levels of care.

Particularly in the face of the recent economic downturn, growing numbers of people are losing their jobs and the health benefits those jobs provide. Many others are finding that they can no longer afford to pay monthly insurance premiums and out-of-pocket costs for needed medical services. The trend of rising costs also extends to public health care programs. In fact, states have been forced to cut other services, including education, to maintain their Medicaid programs. The federal government's long-term fiscal problem is largely related to cost and demographic trends that are causing unsustainable growth in Medicare and Medicaid spending, as well as rising levels of "tax expenditures" for employer-provided health insurance.

While the U.S. health system features some of the best physicians and facilities in the world, many Americans do not consistently receive high-quality care or achieve good health outcomes. Even those with meaningful health benefits often do not receive preventive services that could delay the onset of chronic diseases and related complications. Chronic diseases account for three-quarters of all health care costs, but unfortunately, those who develop them frequently receive care that is neither well coordinated nor proven to be effective. These gaps in quality often occur despite the best efforts of health professionals. Because of

provider payment mechanisms and health benefit designs, the current health care system is largely focused on the quantity and intensity of services delivered, and not on improving quality and health outcomes. Efforts to control costs in the short term by lowering provider payments or broadly restricting access to coverage or services have only exacerbated existing problems with health care quality.

Finally, U.S. health outcomes are significantly worse than those in many other countries, not just because of the system's problems with health care delivery and coverage, but also because of unhealthy personal behavior, as evidenced by the growing number of Americans who are obese. These problems are all reflected in alarming health disparities across racial, ethnic, and socioeconomic groups. To reduce the growth of health care spending while simultaneously achieving better health outcomes, reforms must be implemented in a way that makes fundamental improvements in health care delivery, and supports Americans in their efforts to stay healthy.

An unprecedented combination of political and policy consensus is emerging around the need for comprehensive health reform that accomplishes the complementary goals of affordable coverage and high-value, innovative health care. The policy recommendations put forward in this report recognize that efforts to achieve these goals must be made concurrently, and that neither can be accomplished without the other.

### The Four “Pillars” of Health Reform

The Project’s specific policy recommendations are organized around four substantive “pillars” of health reform. Pillar One includes a package of bold measures to *achieve greater health care quality and value*, building on recent efforts to identify and support more personalized, reliably high-quality, well-coordinated care. Pillar Two sets forth policies to *make health insurance available, meaningful and affordable* by stabilizing insurance markets, offering subsidies to help individuals and employers purchase coverage, and promoting effective

*to health care financing* in a manner that is budget neutral and credibly slows growth in health care spending.

### Promoting a Bipartisan Process

The Leaders’ Project was motivated by a strong belief in the importance of acting now to find a real, bipartisan solution to the nation’s health care crisis. This requires members of both parties to engage in a collaborative, constructive debate with the goal of achieving a compromise that can be broadly supported. Truly bipartisan efforts are needed in Congress, along with a commitment

“ TRULY BIPARTISAN EFFORTS ARE NEEDED IN CONGRESS, ALONG WITH A COMMITMENT TO INCLUSIVENESS AND TRANSPARENCY ACROSS ALL STAGES OF THE PROCESS—FROM POLICY DEVELOPMENT TO FINAL PASSAGE. ”

competition to achieve better value. Pillar Three includes proposals to *emphasize and support personal responsibility and healthy choices* by providing better support to develop a culture of prevention and healthy lifestyles, and creating the expectation that individuals will purchase at least basic insurance coverage that promotes wellness and protects against very high expenses. Finally, Pillar Four outlines proposals to *develop a workable, sustainable approach*

to inclusiveness and transparency across all stages of the process—from policy development to final passage. Addressing an issue as complex and personal as health reform through the budget reconciliation process may impede the ability of lawmakers to pass durable, lasting legislation that achieves meaningful results for all Americans. Similarly, because timing is so critical, bipartisan legislation should be considered without extended floor debate or filibuster.

### Policies That Work Together

It is important to emphasize that the recommendations in this report are designed to be mutually reinforcing, and they function as a package. Each component is the product of extensive discussions and rigorous analysis, informed by many of the nation's top health care experts.

### A Principled Approach to Compromise

Reaching agreement on the policy recommendations put forward in this report required a willingness to move beyond many of the key tension points that have contributed to the impasse in the current reform debate. For instance, some policymakers and advocates argue

“ THESE POLICIES ARE INEXTRICABLY INTERTWINED; IMPLEMENTED TOGETHER THEY CAN ACHIEVE MORE SIGNIFICANT IMPROVEMENTS IN THE HEALTH CARE SYSTEM THAN COULD BE ACHIEVED IF THEY WERE CONSIDERED SEPARATELY. ”

These policies are inextricably intertwined; implemented together they can achieve more significant improvements in the health care system than could be achieved if they were considered separately. There is no one policy in this report, such as a requirement that individuals purchase health coverage, or any single improvement in the way health care is delivered, that will—by itself—resolve the problems currently facing the system. Further, it is the full package of recommendations that constitutes the Leaders' Project approach to bipartisan health reform. As such, extracting any one policy could easily undermine the consensus that has been achieved through this project, as well as the structural soundness of the overall policy recommendations it has generated.

for a system managed exclusively by the government and public entities, while others advocate with equal vigor for a privately-administered system. Likewise, many supporters of health care reform call for a national approach, while others note the country's longstanding tradition of federalism, and endorse a stronger role for states in administering and overseeing the health system. Personal responsibility is often touted as a key health reform priority, but is tempered with concerns that vulnerable individuals, including those who suffer from chronic illnesses, may need additional protections.

Recognizing that these principles have great significance for different lawmakers,

stakeholders, and political constituencies—the Leaders’ Project nonetheless reflects a belief that successful health reform must incorporate ideas from both ends of the political spectrum. Accordingly, the policy recommendations presented here envision a strong partnership between the public and private sectors, with government providing a consistent regulatory framework within which the private health care industry operates. They also call for a partnership between the federal government and the states in managing the health system, with the federal government providing minimum standards for states to implement and oversee. Finally, the approach outlined in these recommendations empowers individuals to take greater responsibility for

its long tradition of allowing consumers to choose their own physicians and health professionals, hospitals, and health insurers. The policy framework proposed here preserves and enhances that level of choice, and ensures that Americans can keep their current providers and source of coverage if they so choose. While resolving the current cost, coverage, and delivery challenges facing the health care system will require a significant effort, it can and should be done with the least possible amount of disruption.

### **Rejecting the Status Quo**

The work of this project was guided by a shared belief that the status quo, with its large gaps in health care quality, skyrocketing costs, and growing numbers

“ CONGRESS AND THE ADMINISTRATION FACE A UNIQUE OPPORTUNITY THIS YEAR TO TAKE CRITICAL STEPS TOWARD SYSTEMATIC REFORMS THAT WILL PROTECT PATIENTS, PRESERVE AND EXPAND HEALTH INSURANCE COVERAGE, REDUCE SPENDING GROWTH, AND IMPROVE QUALITY OF CARE AND HEALTH OUTCOMES. ”

their health and health care, but also provides extra support to those who need it.

Ultimately it will be critical to assess the strengths as well as the weaknesses of the health system. One of the most notable and unique features of the U.S. system is

of uninsured, is both unsustainable and unacceptable. Senators Baker, Daschle and Dole strongly believe that the time for meaningful, lasting health reform has arrived. Congress and the Administration face a unique opportunity this year to take critical steps toward systematic reforms that will

protect patients, preserve and expand health insurance coverage, reduce spending growth, and improve quality of care and health outcomes. The American people deserve nothing less than decisive, timely action.

### **Promoting Fiscal Responsibility**

When considering reforms of this magnitude, it is essential to apply principles of fiscal responsibility. Therefore, while the coverage reforms and other federal infrastructure investments called for in these recommendations are expected to have a gross cost of approximately \$1.2 trillion over the 10-year budget window, the recommendations also include policies that would completely offset this amount. To place the \$1.2 trillion figure in appropriate context, it is important to consider that the nation's projected health expenditures for the next 10 years are expected to total \$35.2 trillion. Moreover, the strong incentives being recommended to improve health care delivery—when combined with coverage and financing reforms—will accrue additional private and public sector savings in the long term.

To pay for this health reform proposal, the Leaders' Project recommends over \$1 trillion

in specified financing, divided between federal health-system savings and health-related revenues. The remaining cost, approximately \$200 billion, should be offset through one of three possible options:

First, Congress could choose to enact a set of specific health-savings and revenue-generating policies that would more than cover the remaining cost. Second, Congress could create an explicit budget “trigger” that would be designed to measure targeted expenditures and automatically implement specified policies that would achieve more savings if needed. Third, if Congress chooses to create an entity like the Independent Health Care Council (an issue discussed later in this report), it could be charged with submitting specific proposals to Congress and the president to reduce any remaining financing shortfalls. The Council's recommendations could be reviewed by the president and submitted to Congress under expedited procedures, with limited opportunity for amendment. These three approaches to ensure budget neutrality are not mutually exclusive and could be reinforcing if implemented together.

## Summary of Recommendations

### ■ PILLAR ONE

#### Preserving and Improving Quality and Value of Care

- Invest in the Meaningful, Effective Use of Health Information Technology (HIT)
  - > Define “meaningful” HIT use
  - > Align provider incentives with new payments to achieve higher-value care
  - > Promote patient-centered care by providing patients useful information about treatments and conditions
- Develop a Quality Measurement Infrastructure to Support Patient-Centered Care
  - > Fund the development of consensus-based quality measures
  - > Move to electronic, patient-centered quality reporting
  - > Improve the capacity of the Department of Health and Human Services (HHS) to facilitate systematic use of measurements for care improvement
  - > Improve data collection on health disparities
- Reform Provider Payments in Federal Health Programs to Pay for Patient-Centered, High-Value Care
  - > Expand targeted pay-for-reporting and pay-for-performance initiatives
  - > Reduce payments for low-value services
  - > Phase in bundled payments for providers once proven effective
- Guarantee Patient-Centered Care for Chronically-Ill Beneficiaries
  - > Create community health teams to provide comprehensive support to prevent chronic illnesses and their complications
  - > Establish a joint program for care coordination for individuals who are eligible for both Medicare and Medicaid (also known as “dual eligibles”)
  - > Ensure new care coordination programs improve outcomes for the chronically ill
  - > Improve quality of palliative care
- Develop a Health Care System That is Accountable for Value
  - > Establish Accountable Care Organizations
  - > Share savings with Accountable Care Organizations that meet or exceed quality benchmarks and reduce overall cost trends

- Expand Comparative Effectiveness Research Relevant to Patient Decisions and Effective Health Care Policy Reforms
  - > Develop infrastructure to support comparative assessments of the effectiveness of medical treatments and practices
  - > Prioritize comparative effectiveness research topics
  
- Invest in Health Care Workforce
  - > Offer funding for providers in underserved areas
  - > Integrate delivery reforms into graduate medical education
  - > Provide funding for the education of nurses and allied health professionals
  - > Revise scope-of-practice laws that discourage use of advanced practice nurses, pharmacists, and other allied health professionals
  
- Address Racial and Cultural Disparities
  - > Guarantee that patients are treated with best practices, regardless of race or ethnicity
  - > Realign reimbursement in federal programs to improve patient outcomes and care coordination based on a patient's specific circumstances
  - > Ensure adequate provider capacity in medically underserved areas
  - > Invest in workforce to increase the number of minorities entering the medical and allied health professions
  - > Implement standard collection of patient race and ethnicity information
  
- Establish an Independent Health Care Council
  - > Analyze and report on health care quality and cost trends in federal health programs and in the overall health care system
  - > Promote coordination among federal health programs
  - > Issue an annual report to the president with recommendations to improve quality of care and avoid unnecessary costs
  
- Reform Medical Liability Laws

## ■ PILLAR TWO

### Making Health Insurance Available, Meaningful and Affordable

- Reform Health Insurance Markets
  - > Guarantee access to coverage regardless of health status
  - > Limit variation in premiums
  - > Ensure a high level of participation by expecting individuals to purchase basic health coverage
  - > Achieve lower administrative costs via standardized electronic claims processing, public reporting of medical loss ratios, and administrative simplification
  - > Establish a federal fallback if states do not implement market reforms
  
- Create a Network of State- or Regional-Level Health Insurance Exchanges
  - > Establish minimum operating guidelines for exchanges
  - > Provide startup funding for states to establish insurance exchanges
  - > Permit all individuals and small groups to purchase in the exchanges
  - > Ensure coverage is affordable and meaningful
  - > Make available enrollee support tools and adopt strategies to improve plan choice
  - > Risk adjust the premiums paid to plans that participate in exchanges
  - > Implement a federal fallback if states or regions do not create exchanges in a timely manner
  - > Require states to report on progress toward implementing reforms
  - > Provide for competing state plan options
  - > Require further action if coverage affordability and accessibility goals are not met
  
- Ensure Meaningful Health Insurance Benefits
  - > Establish minimum creditable coverage standards for health insurance
  - > Set additional standards for plan options available through insurance exchanges
  
- Guarantee Affordable Coverage for All
  - > Limit out-of-pocket premiums to no more than 15 percent of income for a minimum benefit package
  - > Offer enhanced protections for Americans with incomes under 400 percent of the federal poverty level
  - > Provide additional protections for retirees
  - > Create new tax credits for small businesses to purchase coverage for their employees
  - > Ensure low-income families have coverage through the Medicaid program

## ■ PILLAR THREE

### Emphasizing and Supporting Personal Responsibility and Healthy Choices

- Expect Individual Responsibility for Obtaining Basic Health Insurance
  - > Establish a personal responsibility requirement for all Americans
  
- Empower Individuals to Make Better Health Care Choices
  - > Expand the Centers of Excellence program within Medicare
  - > Offer reduced premiums for healthy behaviors
  - > Support the development of educational materials to improve health literacy
  
- Create a Public Health and Wellness Fund to Provide Support for Evidence-Based Wellness, Prevention, and Care Coordination Programs
  - > Eliminate cost-sharing for A- and B-rated services by the U.S. Preventive Services Task Force in both Medicare and health insurance exchanges
  - > Extend new authority to the Secretary of HHS to eliminate coverage for D-rated services by the U.S. Preventive Services Task Force, at the Secretary's discretion
  - > Allow Medicare coverage for health risk assessments and personalized prevention plans within routine wellness visits
  - > Provide tax credits for certain worksite wellness programs
  - > Fund the community health teams initiative to help coordinate care for Medicare beneficiaries, including dual eligibles
  - > Invest in grants to schools and community-based prevention and wellness programs

## ■ PILLAR FOUR

### Developing a Workable and Sustainable Approach to Health Care Financing

- Reform Delivery and Payment Systems to Achieve Higher-Value Health Care (Pillar One)
- Implement a Balanced Set of Medicare and Medicaid Payment Reforms in Support of Delivery Reforms
  - > Align Medicare Advantage payments more closely with fee-for-service Medicare
  - > Adjust Medicare market basket updates to account for expected savings from delivery reforms
  - > Adjust funding for uncompensated care to account for coverage expansions
  - > Reduce payments to home health and skilled nursing facilities
  - > Create an approval pathway for competing biologic products
  - > Reform prescription drug payments in Medicare and Medicaid
  - > Restructure Medicare and Medigap cost-sharing
  - > Reallocate Medicare and Medicaid improvement funds
- Raise Additional Revenue from Coverage-Related Reforms
  - > Link the tax exclusion to the value of benefits received by Members of Congress
  - > Institute a fee for certain employers not offering or paying for health benefits
- Ensure Budget Neutrality Through One of the Following Options:
  - > Enact additional, specified savings and revenue-generating policies
  - > Implement pre-specified targets for spending growth and establish a “trigger” mechanism that automatically enforces reductions
  - > Empower the Independent Health Care Council to develop policy recommendations that would be expected to achieve federal spending growth targets, and authorize the president to submit the recommendations for consideration under expedited procedures with limited opportunity for amendment
- Address Medicare’s Sustainable Growth Rate Formula for Physicians

## 02

## Project Overview

The last several years have witnessed a convergence of political, economic, and policy-related factors suggesting that now is the time for action on health care reform in America. Monumental domestic policy accomplishments, such as social security, civil rights, and environmental protection, have been achieved during critical periods in the past, and there is growing agreement that the country is now facing such a moment with health reform. This report intends to serve as an example of how, by working together across party lines and varying points of view, the health system can be reformed.

The mission of the Leaders' Project is two-fold: (1) to create a bipartisan plan for health reform that can transform our nation's health care system and (2) to demonstrate that comprehensive reform is politically achievable. Supported by solid

research, analysis, and strategic outreach, the Project takes a broad-based approach to tackling the key delivery, cost, coverage, and financing challenges facing our nation's health system. Its primary policy goal is simple, yet nonetheless ambitious: to ensure that all Americans have quality, affordable health coverage. Toward that end, the Project and this final report are focused on four principles, or "pillars" of health reform:

### ■ PILLAR 1

***Promoting High-Quality, High-Value Care***

### ■ PILLAR 2

***Making Health Insurance Available, Meaningful and Affordable***

### ■ PILLAR 3

***Emphasizing and Supporting Personal Responsibility and Healthy Choices***

*“Any successful health care reform effort must have the input and support of not only citizens and lawmakers, but also key health care constituencies.”*

#### ■ PILLAR 4

##### ***Developing a Workable and Sustainable Approach to Health Care Financing***

While Senators Baker, Daschle and Dole personally spearheaded the development of this report, they were guided by two of the nation’s top health policy experts who served as project co-directors: Chris Jennings and Dr. Mark McClellan. Mr. Jennings is a health policy veteran of the White House, Congress, and the private sector and currently serves as President of Jennings Policy Strategies. Dr. McClellan is Director of the Engelberg Center for Health Care Reform at the Brookings Institution, a former senior health care policy advisor to President George W. Bush, and a former administrator for the Centers for Medicare and Medicaid Services. The Project also relied on support from current and former staff members, as well

as the expertise of key health care scholars. Working together, this network of policy experts, thought leaders, and staff sought to develop a bipartisan policy framework that can make a constructive contribution to the current health reform debate.

##### **A Broad-Based Outreach Strategy**

Any successful health care reform effort must have the input and support of not only citizens and lawmakers, but also key health care constituencies. Accordingly, the Leaders’ Project sought practical input and supportable ideas from employers, labor advocates, health care providers, state officials, health plans, and health reform coalitions. Understanding now more than ever that the current health system is unsustainable, these groups have begun a productive dialogue to define real solutions for change. Successful health reform requires

an inclusive process, and the Leaders' Project made it a priority to give all voices an opportunity to contribute.

The work of the Leaders' Project coincided with a renewed national emphasis on

to announce their goal of developing a bipartisan policy framework for health care reform. They reflected on their personal experiences working across the aisle to restore Social Security's solvency, improve veterans' health care, and support disabled

***“In order for us to be successful, we need input and support of all those with a stake in our nation’s health care system. We are pleased that so many diverse groups and organizations are represented here today—it’s a real sign of engagement that the time is right for charting the path forward to reform.”***

– Senator Bob Dole

comprehensive health reform. Throughout the 2008 presidential election, voters consistently ranked health care as a top domestic policy priority and, not surprisingly, this issue dominated the candidates' platforms. Congress has focused its attention on health care with numerous hearings and proposals introduced by both Republicans and Democrats. To ensure that their work accounted for the views of current Members and government officials, Senators Baker, Daschle and Dole, along with the project co-directors, maintained a continuous dialogue with Congress and both the Bush and Obama Administrations over the course of the project.

The Leaders' Project was formally launched in April 2008. Senators Dole and Mitchell joined well over 100 members of the health care community at a press conference

Americans, and expressed hope that Congress would follow in that tradition with health reform. While the process of writing this report would be inclusive, Senators Dole and Mitchell made clear that they, along with their colleagues, would personally develop and approve its policy recommendations. In doing so, they hoped to demonstrate that achieving consensus on a comprehensive health reform plan is something that Republicans and Democrats can and should do.

## **THE POLICY FORUMS**

### **Learning From Those on the Front Lines of Health Reform**

To bolster the Project's outreach efforts, and further explore policy issues identified in each of the four pillars, Senators Baker, Daschle, Dole, and Mitchell hosted a series of public policy forums. These events brought together key stakeholders in the debate and

provided an opportunity to hear firsthand how current flaws in the health system were harming businesses, states, the federal government, and, most importantly, American families. They also helped to establish a two-way dialogue with the health care community to solicit ideas for practical, effective solutions that could be considered part of a national health reform effort.

Senator Daschle hosted the first of these policy forums in Washington, DC on April 24, 2008. The event focused on the first pillar of the Leaders' Project: promoting high-quality, high-value care. A group of health care



experts discussed a wide range of practical ideas for delivering the highest quality, most effective medical treatments possible, while at the same time controlling costs. Several specific themes were highlighted at the forum, including (1) designing provider payment mechanisms that support accountability and improved health outcomes; (2) integrating and coordinating

health care delivery; (3) developing and disseminating better evidence; (4) developing standards for safer, higher quality care; and (5) increasing transparency. Senator Daschle made clear that creating an efficient, high-performing health system was not only a function of improving quality, but of ensuring that all Americans have health coverage and reducing overall health care costs.

The Leaders' Project was designed from the outset to take the health reform debate outside the Washington beltway. State and local health care communities have long

***“I’m always amazed at the irony between the 21st century ability to deliver health care and our ability to manage health care with 19th century administrative practices today.”***

– Senator Tom Daschle

been at the forefront of innovative reform efforts, and many lessons can be learned from their experiences. Senator Dole hosted the Project's first state-based policy forum on August 4, 2008, at the Dole Institute for Politics in Lawrence, Kansas. Speakers highlighted effective ways to help individuals make better health care decisions, such as providing them with cost and quality



***“I really believe the American people are ready for health reform. I believe the medical community is ready. And hopefully, we can find enough people in each party who are willing to make some hard choices to get the job done.”***

– Senator Bob Dole

information, advice from health coaches and benefit counselors, and access to online decision-support tools. Panelists also presented ideas to engage consumers in prevention and wellness via community-based efforts and better-designed health benefits. Senator Dole expressed his desire to see the nation’s “sick system” transformed into one that instead focused on keeping individuals healthier, so they might lead fuller, more active lives.

Additionally, a special panel of rural health care advocates discussed the unique challenges that confront providers in isolated and underserved areas in terms of recruiting and retaining a qualified workforce, providing a consistent point of access to health care, and adopting health information technology. A successful reform effort is one that supports all providers and patients, regardless of their specific circumstances.

Senator Mitchell hosted the third Leaders’ Project forum on September 10, 2008, in Portland, Maine. This forum focused on the challenge of reforming health benefits and insurance markets to improve access to health coverage. The discussion featured an overview of recent reform efforts in Maine, Vermont, and Massachusetts, with speakers emphasizing that while their states have done much to innovate, the federal government has a clear and important role in helping to complete that work. Participants also focused on ways to improve access to health coverage through effective market reforms, particularly highlighting options that promote fairness and reduce adverse selection. Senator Mitchell reflected upon his decades of work trying to resolve these issues, motivated by Jack Wennberg’s groundbreaking studies on poor health care quality and the absence of evidence about the effectiveness of specific health care treatments. Findings

from those studies ultimately led Senator Mitchell to introduce legislation that created the Agency for Healthcare Research and Quality. He expressed hope that the current health reform effort will not only resolve longstanding disparities in the health system, but also achieve coverage for all.

Senator Baker hosted the Project's final policy forum on December 1, 2008, in Nashville, Tennessee. The discussion explored how targeted quality improvement initiatives, combined with efforts to expand health insurance coverage, can increase overall value in the health system. Speakers highlighted practical ways to improve care coordination, effectively use health information technology, and better prepare physicians, nurses, and other health care personnel to deliver high-value care. Other discussants noted that in order to maximize the effectiveness of new tools

for delivering health care, individuals must have health insurance and vulnerable populations like early retirees, low income families, and individuals with pre-existing health conditions need extra assistance to obtain coverage. Senator Baker emphasized that the time for health reform had arrived, and that current efforts to resolve the weaknesses in the nation's health system would be successful as long as all parties came together to work in a common direction.

### **Advancing the Project's Substantive Agenda**

In addition to hosting policy forums, the Leaders' Project commissioned a series of technical papers to advance its substantive agenda. The Project collaborated with several prominent think tanks, including the Center for American Progress, the American Enterprise Institute, and the Brookings Institution, to produce these papers. They are intended to provide policymakers with



an objective resource on the key issues and policy options that underlie the four pillars of health reform described in this report. Each one discusses a wide range of topics such as effective health benefit design, sustainable health care financing, and improving the quality and value of health care, and also describes the impact different policy options would have on consumers, providers, the health industry, and the economy. In the spirit of the overall project, the BPC developed these papers with academics and experts from both ends of the political spectrum to ensure that all views were appropriately reflected in its substantive work.

### **CROSSING THEIR LINES**

#### **Reaching a Bipartisan Agreement for Health Reform**

With the successful completion of the policy forums, the former Senate Majority Leaders began meeting and communicating regularly as a group to consider policies to include in their framework for comprehensive health reform. As Senators Dole and Mitchell made clear at the Project's launch, the final report would not be a staff-developed product on which they merely "signed off." While the project co-directors and staff provided broad substantive guidance, the Senators personally negotiated and approved a set of policy recommendations they believe can win support from both political parties, and from the American people. Their work was guided by the premise that, beneath the ideological differences that garner so much public attention in the health reform debate, a great deal of consensus exists on how to resolve the problems in the health care system.

Senators Baker, Daschle, Dole, and Mitchell began their deliberations by drawing upon ideas and concerns presented at the policy forums, stakeholder meetings, and discussions with Members of Congress and staff. They placed no preconceived limits on the scope or breadth of policies they considered—all options were on the negotiating table. While their goal was to be as prescriptive as possible, they did not want to encroach on the role of Congress in developing, negotiating, and enacting legislation. They set out not to write a bill, but to offer enough substantive direction in their policy recommendations to support their colleagues' efforts to break the longstanding stalemate in the debate—and to demonstrate that bipartisan health reform is possible.

Throughout their respective careers, the Senators have been able to resolve tough policy issues when they crossed their own personal, political, and ideological lines. As former Members now removed from the day-to-day political and ideological pressures of Congress, they had the ability to delve beneath the surface of the problems facing our health system, and offer clear and credible policy-based solutions. Working together, they made very difficult, politically sensitive decisions—the same decisions that lawmakers and stakeholders must make in order to enact meaningful health reform.

Earlier this year, President Obama called upon Senator Mitchell to serve as his Special Envoy to the Middle East. As the chief arbiter

of the Good Friday Accords that ushered in a new era of peace in Northern Ireland, Senator Mitchell is an ideal choice to work for resolution to the longstanding unrest in the Middle East. Unfortunately, his new responsibilities limited his ability to stay engaged in the work of the Leaders' Project. His colleagues support his new venture, and have wished him every success. Fortunately, Senator Mitchell was able to contribute to the substantive work of the Project through the end of March 2009.

After months of deliberations, Senators Baker, Daschle and Dole agreed to a meaningful package of health reforms that both Republicans and Democrats can support. Their policy recommendations represent the

culmination of a sustained effort to actively engage the American people, solicit ideas and input from key health care stakeholders, and hold frank, yet constructive discussions about possible solutions to the problems currently facing the U.S. health care system. Taken as a whole, the Project's final report ensures that all Americans have quality, affordable health coverage. It should be emphasized that Senators Baker, Daschle and Dole reached consensus on this package of recommendations through a process that consistently embodied the ideals of civility and cooperation. In the end, they hope this effort can serve as proof that, despite differing political and substantive views, reform is possible when people come together with resolve to find viable solutions.

## 03

## Diagnosing the U.S. Health System

Although widely recognized as the most technically advanced in the world, our nation's health care system is falling short on many levels. Costs are rising at unsustainable rates for individuals, families, businesses, states, and the federal government. Despite having the highest per-capita health care spending of any industrialized nation, Americans have among the worst health outcomes. More than 46 million Americans have no health insurance coverage. These individuals and families frequently go without necessary preventive services that could avoid long-term chronic illnesses, and instead rely on the safety net system for urgent care. Taken together, these conditions make clear the health care system is in need of broad-scale reform.

For too long, the political and legislative process has largely addressed the well-

documented challenges facing our health care system in an incremental fashion. Policy solutions often attempt to tackle cost, quality, and coverage problems as independent issues. They also take a siloed approach to expanding or making improvements to insurance coverage, through the Medicaid program, for example, or new tax credits for private health coverage. Without universal coverage and a comprehensive approach to containing costs, poor health outcomes, cost shifting and delivery of fragmented care will persist. Only by addressing all of these issues together will it be possible to bend the long-term health care spending curve and achieve better value.

Major, systemic policy changes are not only necessary but—for the first time in over a decade—politically feasible. Businesses,

*“Total U.S. spending on health care is rising at a rate of almost 7 percent per year—rapidly outstripping projected growth in GDP (4 percent) and wages (3 percent).”*

labor unions, consumer groups, health care providers, health plans, and manufacturers have come together to urge action on a national scale. This report advances achievable, bipartisan recommendations that, if enacted, will address the following problems in an integrated, coordinated, and comprehensive fashion:

***Rising health care costs that make health insurance increasingly unaffordable, placing pressure on businesses that struggle to continue offering coverage to their workers, and significant financial strain on family and government budgets***

Total U.S. spending on health care is rising at a rate of almost 7 percent per year—rapidly outstripping projected growth in GDP (4 percent) and wages (3 percent).<sup>1</sup> As a nation, the United States spends over

16 percent of total GDP on health care, and that portion is expected to rise to nearly 20 percent over the next 10 years. These costs are placing financial pressure on private industry, state and federal governments, and individual families.

Employers now spend almost 11 percent of payroll on health care, with premiums continuing to rise each year.<sup>2</sup> From 2000 to 2006, workers' monthly health insurance premiums grew 73.8 percent, but U.S. median income during the same period grew just 11.6 percent.<sup>3</sup> While many companies are increasing workers' cost-sharing responsibilities to offset some of this cost growth, some are electing to forego coverage for their employees altogether. In 2000, 69 percent of employers offered insurance; by 2008, the figure had dropped to 63 percent, with the smallest employers

accounting for the bulk of this decline. As fewer employers offer coverage, and as more and more workers find themselves unable to afford their premiums, the number of uninsured individuals will continue to rise.<sup>4</sup>

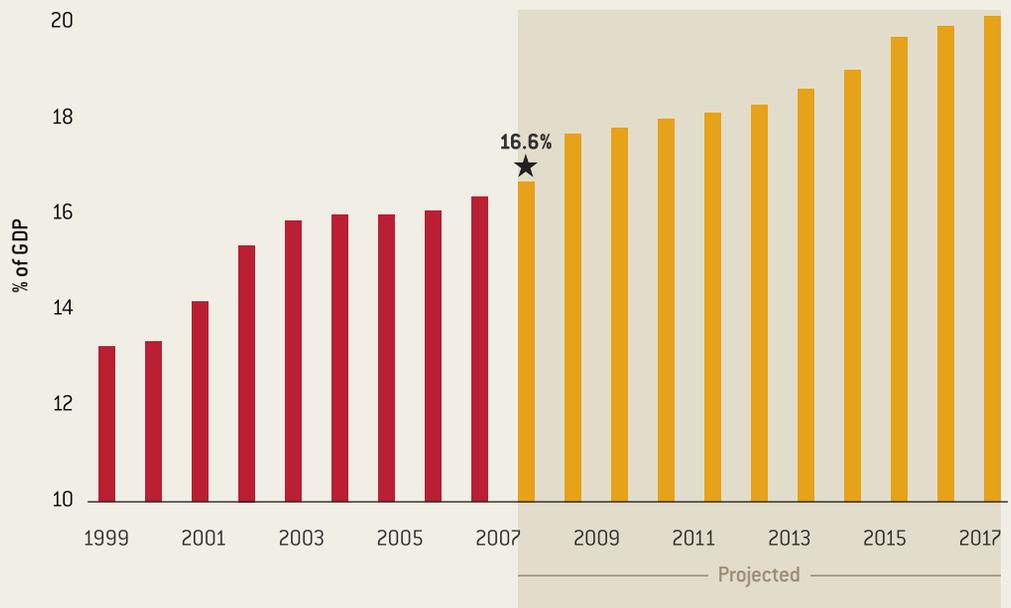
Costs are also becoming a growing burden for governments that fund public health care programs. At the federal level, Medicare costs are rising rapidly, with the Medicare trust fund projected to become insolvent by 2017 or earlier. Meanwhile, in the current economic downturn, state governments are grappling with controlling cost growth as more residents become eligible for Medicaid and the Children's Health Insurance Program. Because almost all states are required to

balance their budgets, growing costs for these programs often mean lower payments to health care providers, reduced eligibility guidelines, or cutbacks in other vital areas such as education.

### *Cost-shifting and excessive administrative costs due to lack of universal coverage*

Uninsured individuals and poorly functioning non-group insurance markets contribute to costs being shifted to public and private payers, thereby distorting true per-capita health care spending. For those who lack adequate insurance, the nation's safety net providers, including hospital emergency rooms, are too often the primary source

### U.S. Health Care Spending as a Percent of GDP



Source: Centers for Medicare and Medicaid Services. National Health Expenditure Projections.

of health care. As a result, significant uncompensated care costs must be absorbed by providers or passed through

some researchers maintain that it may account for as much as 8 percent of premiums.<sup>7</sup> Another study finds that in

**“ IN 2008, THE UNINSURED RECEIVED OVER \$56 BILLION IN UNCOMPENSATED CARE.<sup>5</sup> THE FEDERAL GOVERNMENT IS ESTIMATED TO HAVE FUNDED ABOUT 75 PERCENT (OR \$42 BILLION) OF THIS THROUGH DISPROPORTIONATE-SHARE HOSPITAL (DSH) PAYMENTS, MEDICAID SUPPLEMENTAL PAYMENT PROGRAMS, MEDICARE INDIRECT MEDICAL EDUCATION FUNDING, AND OTHER PUBLIC ASSISTANCE PROGRAMS.<sup>6</sup> ”**

to the government and the privately insured. In 2008, the uninsured received over \$56 billion in uncompensated care.<sup>5</sup> The federal government is estimated to have funded about 75 percent (or \$42 billion) of this amount through disproportionate-share hospital (DSH) payments, Medicaid supplemental payment programs, Medicare indirect medical education funding, and other public assistance programs.<sup>6</sup>

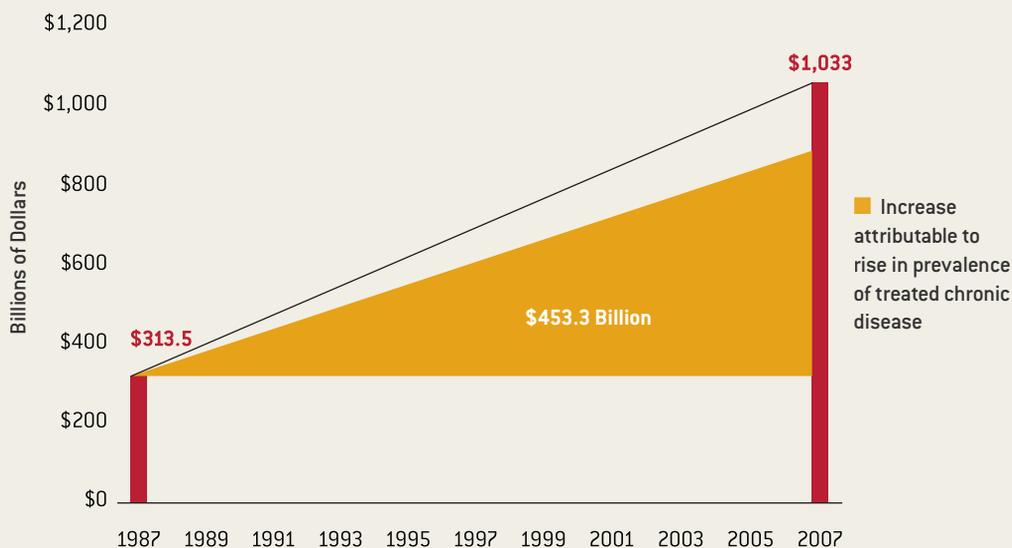
Providers also offset some of their uncompensated care costs by raising the price of care for insured patients, thereby increasing their premiums. While estimates of this cost shift vary,

2008, average premiums for family coverage were inflated by \$1,017 per year due to uncompensated care.<sup>8</sup>

In today's non-group market, insurers compete by trying to maximize the number of low-risk individuals enrolled in their plans, which has the effect of excluding those who represent a higher risk—typically individuals with pre-existing health conditions. Additionally, the lack of a central marketplace (like an insurance exchange) to purchase non-group coverage means that plans spend quite a bit of money on marketing efforts. On average, administrative costs for plans in the non-group market are about 40 percent of premiums compared

## Increase in Health Spending Attributed to Preventable Chronic Diseases

Level of health spending among the U.S. population, 1987–2007



Source: Partnership to Fight Chronic Disease, "2009 Almanac of Chronic Disease."

to just 10 percent in the employer market.<sup>9</sup> Marketing and underwriting efforts that help plans sell to targeted enrollees to protect themselves from risk largely account for these much larger administrative costs.<sup>10</sup>

### *Fragmented, uncoordinated delivery of care with weak financial incentives for accountability*

The health care system suffers from fragmentation and a lack of accountability that limits the effectiveness of care. For example, the Agency for Healthcare Research and Quality (AHRQ) estimates that preventable medical errors account for over 7,000 deaths per year. Such adverse events are not only tragic, they are also

expensive for the health care system, further underscoring the need for reforms that both improve quality and ultimately reduce costs.

Moreover, the current health care system is inherently biased toward the volume of services provided, rather than improving health outcomes. Because most fee-for-service (FFS) systems pay providers for each service rendered, they create incentives to provide more care, even if the patient would benefit from fewer services and less intensive treatment. The overuse or misuse of care is evident from regional variations in Medicare spending. Regions with lower per-beneficiary spending in Medicare have been shown to provide similar-quality care, on average, and to

achieve equal or better health outcomes and patient satisfaction than higher spending regions.<sup>11</sup>

*High rates of preventable medical conditions that are partially the result of poor behavioral choices and lack of primary care*

Chronic diseases, such as obesity, hypertension, and diabetes, are responsible for a high percentage of health care costs in this country. Patients with chronic diseases account for 75 percent of national health

prevent acute medical events in the future, and (3) more likely to encounter problems with care coordination. For insured and uninsured populations alike, health reform must promote wellness initiatives that encourage healthy lifestyle choices and use of preventive care services.

Health reform also must invest in both primary and secondary preventive interventions to reduce the incidence of chronic disease. Primary interventions focus on disease prevention through outreach

**“ UNINSURED INDIVIDUALS ARE ALSO AT HIGHER RISK FOR DEVELOPING PREVENTABLE DISEASES BECAUSE THEY ARE (1) MORE LIKELY TO FOREGO NEEDED MEDICAL CARE, (2) LESS LIKELY TO RECEIVE PREVENTIVE SERVICES THAT MIGHT PREVENT ACUTE MEDICAL EVENTS IN THE FUTURE, AND (3) MORE LIKELY TO ENCOUNTER PROBLEMS WITH CARE COORDINATION. ”**

spending and even higher rates in Medicare (96 percent) and Medicaid (83 percent). Uninsured individuals are also at higher risk for developing preventable diseases because they are (1) more likely to forego needed medical care, (2) less likely to receive preventive services that might

in schools, communities, and workplaces to discourage behavioral choices that can lead to disease. Secondary interventions emphasize early screening and detection of diseases to avoid unnecessary and costly health care treatments. Health care reform should focus on implementing strategically-

designed, evidence-based prevention programs that can both demonstrate cost savings, and improve health outcomes.

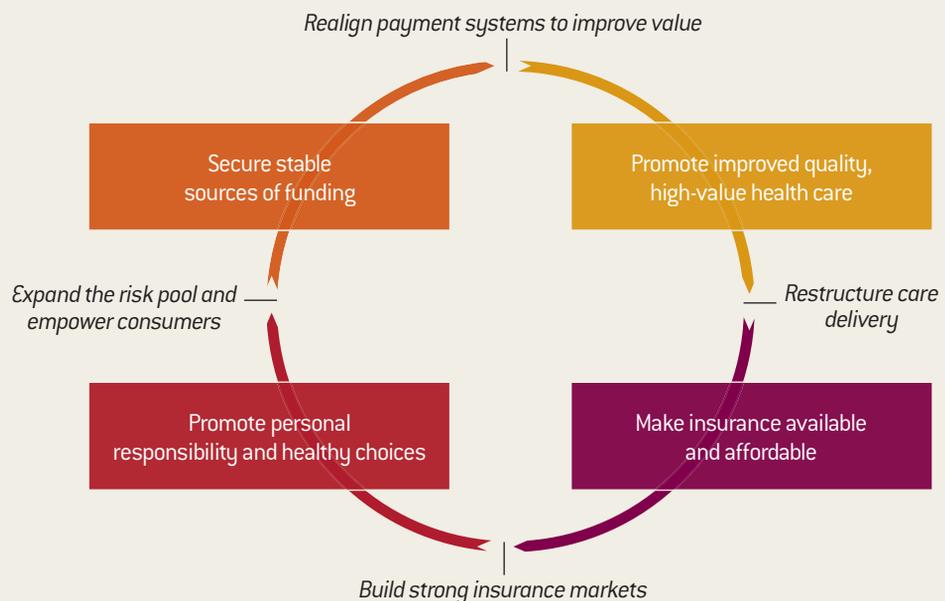
***Significant gaps in health care quality and access for racial and ethnic minorities***

In the United States, racial and ethnic minorities have worse health outcomes, receive lower quality health care, and have more difficulty accessing medical treatment than their white counterparts. For example, death rates for African American adults are 55 percent higher than they are for white adults.<sup>12</sup> When asked to rate their own health status, American Indians (17.2 percent), African Americans (14.6 percent)

and Latinos (12.9 percent) are more likely to report being in fair or poor health relative to whites (7.9 percent) and Asians (7.4 percent).<sup>13</sup>

These disparities stem from a number of challenges facing minority populations. First, minorities are more likely to have very low incomes, making them susceptible to a variety of environmental health risks associated with poverty. Second, minorities are much more likely to be uninsured or enrolled in Medicaid and other public programs that serve low-income individuals.<sup>14</sup> Third, there are a variety of structural barriers that prevent minority and underserved populations

**The Pillars of Health Reform Are Interrelated and Require Coordinated Policy Decisions**



**“ THE SIGNIFICANT CHALLENGES FACING THE NATION’S HEALTH CARE SYSTEM ARE OPPORTUNITIES TO USHER IN COMPREHENSIVE REFORM THAT IMPROVES QUALITY OF CARE, INCREASES EFFICIENCY, EXPANDS INSURANCE COVERAGE, AND PROMOTES HEALTH AND WELLNESS FOR ALL INDIVIDUALS. ”**

from accessing care. These include limited sources of after-hours medical care, transportation challenges, language barriers, lack of providers in underserved areas, and a shortage of racially and ethnically diverse providers who could deliver more culturally appropriate care.

The significant challenges facing the nation’s health care system are opportunities to usher in comprehensive reform that improves quality of care, increases efficiency, expands insurance coverage, and promotes health and

wellness for all individuals. Because these issues are so interrelated, the response must be a coordinated, system-wide package of reforms. Coverage expansions that are implemented before quality and value improvements will ultimately prove too expensive. Similarly, delivery reforms will have limited effect and only prolong a fragmented system of care if they are implemented without ensuring all Americans have health coverage. Taken together, system improvements need to be rolled-out as an integrated package that will address the health system’s uncertain future.

## 04

## Policy Recommendations

The time for achieving affordable, quality coverage for every American has arrived. It is essential not only for the nearly 46 million uninsured and millions more underinsured, but for the businesses and families who have coverage and are concerned about losing it or not being able to afford it any longer. It is also necessary for health care providers who try to deliver quality care in a dysfunctional and administratively burdensome system. And it is particularly important as a means to help Americans achieve better health. Reform is needed to ensure that when Americans need health care, they get the right services, at the right time, at the right cost.

Comprehensive reform can only be achieved by concurrently securing a much greater return on the country's \$2 trillion annual investment into the health system, expanding coverage for all Americans, and

ensuring the country maintains its role as an international medical innovator. Recognizing this, the Leaders' Project recommends a framework of interconnected policies, organized around the four pillars of health reform. Taken together, these policies provide the essential foundation to achieve the goal of ensuring all Americans have quality, affordable health coverage.

### ■ PILLAR ONE

#### *Promoting High-Quality, High-Value Care*

Despite having the highest spending and some of the most advanced technical capabilities in the world, the U.S. health system has large gaps in quality, and compelling evidence of unnecessary spending abounds. Those regions within the country that spend more on health care have no better outcomes than those with lower spending. Some analysts suggest

*“Reform is needed to ensure that when Americans need health care, they get the right services, at the right time, at the right cost.”*

that as much as 30 percent of spending on Medicare does not contribute meaningfully to patient outcomes.<sup>15</sup> At the same time, preventive care that is proven effective is often underutilized. For example, Americans receive evidence-based treatments for their chronic diseases only about half the time, even though these treatments are covered by Medicare and most insurers.<sup>16</sup> In addition, medical errors and misuse of treatments are common, threatening patient safety and resulting in thousands of deaths and many billions of dollars in medical complications.<sup>17</sup>

Many of these problems can be traced to the lack of support for interventions that prevent illnesses and their complications, like effective wellness programs, health information technology (HIT) that provides timely and complete information, care coordination programs, and provider efforts

to educate and support patients in taking steps to better manage chronic illnesses. This is perhaps not surprising, since the U.S. health care system does not consistently collect and report meaningful quality and cost data or track patients between different care settings. Without such data, it is difficult to implement provider reimbursement systems, benefit designs, and regulatory reforms that support well-coordinated, high-value care.

The challenges of cost and quality must be addressed together so that efforts to reduce costs do not lead to lower quality of care, and efforts to improve quality do not simply result in substantially increased spending with little to show for it. Rather, the goal must be to create accountability for improving the overall value of health care, which means achieving greater quality and lower cost

## Federal Budget Savings from Medicare, Medicaid and the Employer Tax Exclusion with Cost Growth Slowdown



Note: Cost growth slowdowns start in 2012 to account for lag in effectiveness of reforms.

growth. No one aspect of the system is at fault—the system itself needs to be changed. Marginal changes will result in only marginal improvements.

Achieving higher-value care will require progress on multiple fronts, including: (1) effective investments in health information infrastructure; (2) new investments in the development of sophisticated measures of quality and care experience; (3) payment reforms that support providers and patients in restructuring the delivery of care and that hold providers accountable for achieving better results; and (4) targeted investments in the health care workforce to ensure a highly-skilled provider population and an

appropriate mix of health care providers in communities across the country, especially in rural and medically underserved areas.

These policies will require a coordinated outreach process for educating and soliciting input from health care providers—particularly smaller providers—and other stakeholders to ensure there is a meaningful impact on quality of care. The Project's recommendations in these areas require a significant up-front investment. However, they are collectively expected to yield considerable improvements in the quality of care and to produce long-term reductions of 1 to 2 percent in the growth of health care spending. This would amount to

about \$2 trillion in reduced national health expenditures and hundreds of billions of federal savings over the next decade.

To ensure that our nation's health care system delivers higher-value care for all Americans in the future, the Leaders' Project recommends:

### ***Investing in the Meaningful, Effective Use of HIT***

Greater use of HIT has the potential over time to help improve the quality and efficiency of our health care system. Federal support for HIT investments must be designed to improve quality, and should be reinforced by the private sector. Over time, policies should “build in” accountability for both quality improvements and cost savings.

- **Define “Meaningful” HIT Use:** Building on the HIT investments in the American Recovery and Reinvestment Act of 2009 (ARRA), clarify that the definition of “meaningful” HIT use is based on having a direct, meaningful impact on patient care. Specifically, providers should qualify for ARRA's HIT “meaningful use” bonuses only if they use electronic systems for timely reporting and support the development of increasingly sophisticated cost and quality measures to improve care coordination and patient outcomes. These measures can then be used to demonstrate improvements in outcomes.
- **Align Provider Incentives:** Ensure that requirements relating to HIT bonus

payments for providers are coordinated with new payments to achieve better care. Such incentives include rewards for quality reporting or performance, payments for care coordination (such as medical home payments), and “accountable care” payments for improving outcomes and reducing costs. Aligning these payment reforms and regulatory changes will both increase their collective impact and reduce the administrative burden on providers. For example, a quality measure related to coordination of care is likely to require integrating data from multiple sources (including administrative, lab, and clinical data), which should be the goal of “meaningful use.” Alignment will also help ensure that products offered by IT vendors do not just meet inter-operability standards, but also can be used to help better coordinate care.

- **Promote Patient-Centered Care:** Patients should have access to information related to their medical conditions so that they can be confident they are receiving the best care for their particular needs. Patients should also have confidence that providers are aware of and have access to advance directives, durable powers of attorney, and similar documents—as appropriate—to ensure that their preferences are reflected in care transitions, in palliative and end-of-life care, and in other challenging settings where, despite the best efforts of providers, serious gaps in quality of care often

occur. This requires support for prompt development and reporting of meaningful quality of care measures in all of these areas, along with further steps, if needed, to ensure that standards of care are met.

***Developing a Quality Measurement Infrastructure to Support Patient-Centered Care***

The health care system needs a more robust infrastructure for measuring quality to (1) help providers deliver better-coordinated,

measures that can help guide the treatment of patients with multiple illnesses, not simply those with a single disease.

- **Fund the Development of Consensus-Based Quality Measures:** Expand funding to the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), and collaborative efforts by other organizations for the prioritization, development,

“ **THE HEALTH CARE SYSTEM NEEDS A MORE ROBUST INFRASTRUCTURE FOR MEASURING QUALITY TO (1) HELP PROVIDERS DELIVER BETTER-COORDINATED, HIGHER-QUALITY CARE AND (2) FACILITATE EFFORTS TO EVALUATE THE EFFECTIVENESS OF PARTICULAR PAYMENT AND DELIVERY SYSTEM REFORMS IN TERMS OF HEALTH OUTCOMES AND OVERALL COSTS.** ”

higher-quality care and (2) facilitate efforts to evaluate the effectiveness of particular payment and delivery system reforms in terms of health outcomes and overall costs. For these reasons, it is important to provide additional support to public-private processes for developing, endorsing, implementing, and updating reliable measures of health care quality, cost, and patient-level experience. Particular attention should be paid to the development of

endorsement, and implementation of consensus-based quality measures. These resources should ensure:

- > Special emphasis on person- and episode-level measures for overall health, care experience, and per capita costs for common types of health problems. Current measures related to coordination of care, patient compliance, care transitions, and end-of-life and palliative care show

particularly significant gaps in these areas and call for urgent attention.

> Consistent methods for summarizing patient care data in the public and private sectors (e.g., using consistent summary information from integrated electronic records and regional collaborations) can support measuring quality without compromising patient privacy.

- **Move to Electronic, Patient-Centered Quality Reporting:** Direct the Secretary of HHS to transition the Physician Quality Reporting Initiative (PQRI), Hospital Compare, and other pay-for-reporting bonus programs toward paying for the electronic reporting of increasingly sophisticated measures. Such measures should focus on quality and costs at the patient level and should be designed to be useful to providers for coordinating care. This will require CMS to have the resources to implement timely and accurate reporting to providers based on the data it collects. This policy also should reinforce incentives for the “meaningful use” of HIT outlined above. These measures should be extended to other federal agencies, including the Veterans Administration (VA) and the Department of Defense (DOD), to the extent that they are not already in place.
- **Improve HHS’ Capacity to Facilitate the Systematic Use of Measures for Care Improvement:** Quality measurement and related programs are not currently

structured to give practical support to providers in improving care because federal agencies do not have adequate capacity for large-scale, timely reporting and evaluation. Congress should expand funding to HHS and direct the Secretary to use these funds to improve the department’s capacity to collect and analyze data toward these ends. As a byproduct, these investments would enhance HHS’ capacity to evaluate new delivery and payment reform programs.

- **Improve Data Collection on Health Disparities:** Develop and adopt guidelines for the collection of racial and ethnic data in health care; create incentives and technical assistance for insurance plans to collect patient information; and provide feedback to health care providers on disparities in treatment and on strategies for eliminating those disparities.

### ***Reforming Provider Payments in Federal Health Programs to Pay for Patient-Centered, High-Value Care***

There is broad bipartisan recognition that providers need better support to deliver high-quality, efficient care, and this requires redirecting reimbursement incentives in federal health programs, for example, in Medicare. The goal is to move toward paying providers based on accountability for overall cost and quality using an increasingly sophisticated measurement and reporting infrastructure. Not only will these reforms improve quality and slow the growth of Medicare costs, they should also reduce

currently significant geographic variations in spending. These disparities are based in part on historical patterns of practice and Medicare reimbursement, which vary widely from one location to another—even within regions. While such changes must be applied systematically, however, they must be implemented in a way that avoids unintended disruptions in care. The following are initial steps that should be implemented as part of a coherent strategy to transition to value-based payments:

- **Expand Targeted Pay-for-Reporting and Pay-for-Performance Initiatives:** Move reporting payments from “process” measures toward patient-level measures that reflect overall quality and coordination of care; increasingly move from pay-for-reporting to pay-for-performance; and implement medical home payments that build in accountability for overall patient results over time.
- **Reduce Payments for Low-Value Services:** Limit public program payments for care that is unnecessary or inappropriate (e.g., hospital-acquired conditions and excessive hospital readmissions).
- **Phase In Bundled Payments for Providers:** The Secretary of HHS could develop and implement programs to expand the use of bundled payments once such payment structures are proven effective. Bundled payments would reimburse providers in a way that encourages improved coordination of care for patients with

chronic conditions. This in turn would help reduce the number of preventable readmissions. Such payments might initially be implemented through bonuses for providers who take the necessary steps to coordinate care effectively. Within several years, such payments would be expanded to levels that reflect expected gains in coordination, leading to both widespread use and significant savings over five years. Bundled payments would also be tied to an expanded Centers of Excellence program in which Medicare beneficiaries get savings from using providers that deliver whole episodes of care efficiently.

### ***Guaranteeing Patient-Centered Care for Chronically-Ill Beneficiaries***

Millions of Americans suffer from chronic diseases that affect their health and quality of life; in fact, people with chronic health conditions account for a significant portion of spending in our health care system. Steps to achieve significant and timely improvements in care for chronically-ill individuals are therefore greatly needed. These steps include reforms to pay providers more when they undertake preventive care to delay or eliminate the onset of chronic conditions and to avoid costly hospitalizations for related complications. Such reforms (an example would be greater use of bundled payments) will ensure that Medicare payments support—rather than penalize—valuable efforts aimed at preventing disease and coordinating care. But the problem of chronic illnesses is so urgent that additional steps

are needed to help people get more support for staying well. The proposals described in this section aim to improve the coordination of care and provide increased support to patients and their caregivers so they might better understand their conditions and treatment plans.

Value-based payment reforms would also give providers incentives to assist patients

eligible for both Medicare and Medicaid (also known as “dual eligibles”) promotes cost-shifting between providers as patients move from one care setting to another. The expansion of Medicaid for low-income, non-elderly Americans (discussed in Pillar Two) provides an opportunity to stabilize states’ financing responsibilities and provide better coordinated care for dual eligible individuals at the same time.

“ **MILLIONS OF AMERICANS SUFFER FROM CHRONIC DISEASES THAT AFFECT THEIR HEALTH AND QUALITY OF LIFE; IN FACT, PEOPLE WITH CHRONIC HEALTH CONDITIONS ACCOUNT FOR A SIGNIFICANT PORTION OF SPENDING IN OUR HEALTH CARE SYSTEM.** ”

in navigating the health care system. In fact, the intervention that may have the greatest potential to improve care and reduce costs is enhanced transition care services, which could help overcome the well-documented challenge of preventing hospital readmissions. Moreover, through the use of basic preventive care and wellness interventions, individuals with chronic illnesses could be targeted to avoid hospitalizations in the first place.

In conjunction with these steps, the current system of care for individuals who are

- **Create Community Health Teams (CHTs):** CHTs are groups of providers who are organized, trained, and accountable for helping vulnerable, chronically-ill individuals navigate through the complex health care system and follow care plans. To provide more comprehensive support for preventing chronic diseases and their complications, community health initiatives should be better integrated with efforts to achieve well-coordinated, prevention-oriented care for patients who are chronically ill or who are transitioning from the hospital to another care setting.

CHTs can help support these activities more comprehensively than is possible through traditional approaches.

Programs operated by Area Agencies on Aging and Aging and Disability Resource Centers provide successful examples of CHTs, as do some regional initiatives to provide transitional care and execute care plans (including programs in Vermont and North Carolina). CHTs can consist of care coordinators, nurse practitioners, social and mental health workers, nutritionists, community volunteers, pharmacists, and prescription drug care and cost coordinators. Federal support for these programs would be provided by building on existing authority under the Medicare Modernization Act to distribute mandatory funds to the states for qualifying programs.

States could work on a statewide or regional basis to establish care teams, and they would ensure that the functions and staffing of the teams build on and integrate existing prevention and care management resources. CHT programs would be required to report on how they are affecting the quality of care, including health outcomes for the populations they serve, on an ongoing basis. Programs that do not demonstrate a significant impact on health and health care costs within five years would be discontinued.

- **Establish a Joint Program to Coordinate Care for Dual Eligibles:** Direct the Secretary of HHS to establish a program or template

for states and the federal government to provide joint financial support for the delivery of integrated Medicare and Medicaid services to dual eligible beneficiaries, consistent with established patient protections in those programs. States would be allowed to share in a portion of any savings that accrue to Medicare and Medicaid programs as a result of these efforts. To further promote the expansion of coordinated care for dual eligibles, states would receive additional funding to offset their costs for covering newly eligible non-elderly Medicaid beneficiaries (discussed in Pillar Two). These integrated services would build on other recommended payment and delivery reforms and could include prescription drug management and coordination, specialized Accountable Care Organizations (described later in this section), medical homes, chronic disease management programs, or integrated health plans that demonstrate high performance.

- **Ensure That New Programs to Coordinate Care Improve Outcomes for the Chronically III:** The Project's recommendations emphasize new payment systems in Medicare to improve quality and value by requiring providers to better coordinate care, regardless of the model adopted. These programs should be evaluated based on patient outcomes, with a special emphasis on measures of patient and caregiver engagement and experience of care. Such measures should be incorporated at the start of health reform implementation.

However, appropriate consensus-based measures do not exist in all needed areas today. Until such measures are developed and implemented, the Secretary should establish a process to ensure quality and accountability in patient-centered efforts to coordinate care for chronically-ill Medicare beneficiaries through: (1) patient and caregiver assessment, planning, and monitoring; (2) ongoing care management; and (3) ongoing quality assessment and improvement. Programs to coordinate care would be required to demonstrate performance, either by meeting standards defined by HHS, through a third-party certification process, or by meeting standards on a sufficiently broad set of performance measures.

The intent of such standards or certification processes would be to ensure that care coordination programs are (1) reducing avoidable hospitalizations resulting from drug interactions or unsuccessful transitions between different care settings; (2) limiting disparities in care; and (3) maintaining or improving patients' maximum potential functional status. Organizations that provide these coordination services, provided they have a sufficient performance record (as demonstrated by the capacity to report on adequate measures of patient-centered care and by a track record of good performance on patient-centered metrics), could use that performance record to meet the requirements. Over time, all such organizations would be expected

to demonstrate their capacity to provide quality care for vulnerable beneficiaries with complex medical issues through meaningful performance measures.

### ***Improve the Quality of Palliative Care***

Quality measures for palliative care and for hospice programs—regardless of setting—should be developed by 2012 to facilitate the eventual implementation of accredited programs, as defined by the Secretary of HHS.

### ***Develop a Health Care System That Is Accountable for Value***

HHS, CMS, the VA, the DOD, and other federal health agencies should create pilot programs to identify financing reforms that could integrate payment incentives in a systematic way so as to provide better support for providers that deliver high-value health care. The secretary of the relevant agency would have the authority to implement pilot programs nationwide if they demonstrate success.

- **Establish Accountable Care Organizations (ACOs):** Establish ACOs as a new voluntary-enrollment payment model for Medicare providers. ACOs are provider collaborations that measure and report quality of care for their patient population, and take responsibility for coordinating their care across providers and settings.
- **Share Savings with Successful ACOs:** ACOs that meet or exceed quality-of-care benchmarks and also reduce overall costs for their patient population would receive “shared savings” bonuses, in addition to

their fee-for-service (FFS) payments.<sup>18</sup> In other words, they would be able to use the bonuses to pay for investments in improving care that normally are not covered by Medicare. Advanced ACOs that successfully demonstrate high-quality care could choose to receive less reimbursement based on FFS payments, and instead receive more of their payments based on achieving further

formulary designs and copayment structures, and information dissemination programs.

- **Develop Infrastructure to Support Comparing Effectiveness:** Ensure that the infrastructure being developed for measuring and improving quality of care can also be used to learn more about patterns of medical practices and their consequences for outcomes

***“We have to be providers as well as users of meaningful and valid quality and cost information, and we have to do our part in managing resources and controlling costs.”***

– Christine K. Cassel, M.D., President, American Board of Internal Medicine

improvements in quality and cost. CMS would be encouraged to coordinate with the private sector, using a wider array of consistent quality and cost measures, to provide increased support for these types of delivery reforms.

***Expand Comparative Effectiveness Research (CER) Relevant to Patient Decisions and Effective Health Care Policy Reforms***

There are considerable research gaps in what is known about the clinical and cost effectiveness of different health care treatments and practices. This is particularly true in the area of “personalized medicine,” which studies treatments for subsets of patients based on clinical history, genomics, and other factors. Similarly, there are significant gaps in knowledge about effective payment strategies, benefit features like

and costs, and about the health care policy reforms that can influence patterns of medical practice. This should begin by ensuring that the funding for CER in the ARRA emphasizes efforts to (1) compare the risks, benefits, and costs of different health care practices; (2) evaluate and revise policies that influence practices; and (3) identify strategies for targeting practices to specific groups of patients.

- **Prioritize CER Topics:** The highest priority questions relevant to improving outcomes for particular types of patients, as well as patient populations, must be addressed in a timely way, using appropriate methods. To that end, publicly-funded CER efforts should be better coordinated while recognizing that they may complement

privately-funded efforts. Forthcoming recommendations from the Institute of Medicine (IOM) should help provide a path toward this goal.

### ***Investing in Health Care Workforce***

The steps described above, which can begin immediately, will have a much greater impact over time if they are complemented by reforms to align the health care workforce, as quickly and effectively as possible, with the goal of creating a system of care that is well-coordinated and prevention-focused. Such reforms should reflect the best ideas and experiences from the nation's top health professional organizations and academic medical centers.

***“Rural communities face challenges in recruiting and retaining high-quality physicians, nurses and allied health professionals. Historically, there have been many creative ways to attract health care personnel to rural communities. But, new state-based and national innovations are needed.”***

– Michael L. Kennedy, M.D., FAAFP, McCann Professor in Rural Health, University of Kansas

Covering the uninsured and reorienting the health care system toward wellness and prevention will require additional doctors, nurses, and other health professionals to support the enhanced delivery of primary care. As the nation considers ways to ensure that our domestic health care work force is able to meet the needs of a reformed health care system, decision makers must be mindful that policies adopted at home could

also impact other countries. The United States is a destination country for tens of thousands of health care workers from across the globe. As such, the success of health care reform depends on policies to both recruit foreign-trained health care workers and effectively train domestic health care workers.

- **Offer Funding for Providers in Underserved Areas:** Consider additional financial incentives beyond the payment reforms outlined above, to ensure that there is an adequate capacity and distribution of health care professionals in medically underserved urban and rural areas. The availability of quality

coverage for lower-income Americans should help achieve this goal, and community-based interventions like CHTs can reinforce it. But, closing gaps in health care access and quality is an important enough goal that it deserves careful monitoring, and consideration of additional support, especially during the transition to a health care system that provides coverage to all Americans.

- **Integrate Delivery Reforms into Graduate Medical Education (GME):** Direct the IOM to develop a set of policy reforms designed to align GME with efforts to reform health care delivery systems. In addition, the Secretary of HHS should be given authority to implement the IOM recommendations. Policy reforms with respect to GME should:

- > Provide financial support for an appropriate mix of primary care providers and specialists.
- > Promote training in settings and geographic areas where providers will ultimately practice.
- > Encourage integrated systems of care that promote increased reliance on a highly qualified non-physician workforce.
- > Encourage participation in board certification programs for appropriate specialties, including hospice and palliative care.
- > Promote more effective applied research on implementing coordinated care initiatives.

In conjunction with these reforms, graduate schools for physicians, nurses, and other allied health professionals should ensure that their curricula reflect best practices for providing prevention-oriented, well-coordinated care.

- **Provide Funding for the Education of Nurses and Allied Health Professionals:** Redirect or enhance funding for grants to schools of nursing and other innovative educational sites to retain and recruit faculty qualified to train more nurses and to retrain other health care workers that may be less in demand as a consequence of health system reform (for example, workers interested in transitioning from administrative jobs that may become obsolete as a result of technological advances). These health professionals should be trained for a broader set of clinical responsibilities, and should learn skills to better serve specific patient needs. An expanded pool of nurses could help treat patients in rural and underserved areas, and conduct chronic disease management. Similar approaches should be taken to train additional allied health professionals.
- **Revise Scope of Practice Laws:** In conjunction with making meaningful quality-of-care and outcome measures more widely available, provide incentives for states to amend scope-of-practice laws that discourage the use of advanced practice nurses, pharmacists, and other allied health professionals.

### **Addressing Racial and Cultural Disparities**

The delivery and modernization reforms recommended in this report are critically important to address racial and cultural health disparities. The following policies will help ensure equitable access to and delivery of quality health care services:

- Enhancing investment in CER and consensus-based quality measures to ensure that patients are treated with best practices, regardless of race or ethnicity.
- Realigning reimbursement in federal programs to promote improved patient outcomes and better care coordination based on patients' specific circumstances.
- Ensuring adequate provider capacity in medically underserved areas, both urban and rural.
- Investing in the health care workforce to increase the number of minorities entering the medical and allied health professions.
- Working with the private sector to standardize the collection of information on patient race and ethnicity by health plans and to provide feedback to health care providers on disparities in treatment.

### ***Establishing an Independent Health Care Council (IHCC)***

The fragmentation of federal efforts to address gaps in the quality and coordination of care highlights the need for better assessments of the overall performance of the health care system and the challenges it faces.

This is not to suggest that federal health care programs should have unified decision making. Rather, all programs would benefit from better analysis of overall performance and from innovative, cross-cutting strategies for improvement. Accordingly, the Leaders' Project recommends that a permanent

IHCC be established and given the following responsibilities:

- Analyze and report health care quality and cost data in federal health programs and in the overall health care system.
- Promote better coordination among programs.
- Issue an annual report to the president that outlines specific administrative and legislative recommendations designed to improve quality, constrain cost growth, and better coordinate the delivery, reimbursement, and financing of federal health programs.

The purview of the IHCC's recommendations would include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, the Federal Employees' Health Benefit Program (FEHBP), Veterans' health programs, and the Indian Health Service. In addition, the IHCC could recommend strategic directions for federal investments that would improve these programs' performance. To avoid duplication of effort, its work would be coordinated with that of existing bodies, such as the Medicare Payment Advisory Commission (MedPAC) and the Agency for Healthcare Research and Quality (AHRQ).

### ***Reforming Medical Liability Laws***

Reforming medical liability is an important part of improving health care value and should be carefully considered in the context of broader reforms. Accordingly, policymakers should work to develop consensus proposals that more closely align

liability systems with other reforms proposed in this report and thereby reinforce efforts to achieve high-quality care.

## ■ PILLAR TWO

### ***Making Health Insurance Available, Meaningful and Affordable***

Today, approximately 46 million people in the United States have no health insurance and millions more have inadequate coverage.

Individual and small-group markets are often expensive, with high administrative costs. Additionally, they are limited or non-existent for individuals with pre-existing chronic illnesses, and are subject to large premium increases if a covered individual becomes sick. Those with costly pre-existing or chronic conditions may be denied coverage altogether, or face prohibitively high premiums, thereby having the same effect.

***“In a spirit of federalism, the national government must commit to a national policy, a clear roadmap, and sustainable funding to fully achieve affordable, quality health care for all of us.”***

– Trish Riley, Director, Maine Governor’s Office of Health Policy and Finance

Uninsured Americans are vulnerable to very high out-of-pocket costs that can result in the delay of medically necessary care, or can lead to personal bankruptcy as a consequence of excessive medical debt. They are also less likely to receive recommended preventive care that could avoid the onset of complicated chronic conditions. Furthermore, the health care that uninsured patients do receive often goes uncompensated; those costs are instead shifted to insured individuals through higher premiums and to public programs that subsidize providers who care for the uninsured.<sup>19</sup>

The approach to coverage reform proposed in this report starts from the principle that individuals and families who are happy with their current insurance should be able to keep it. Recognizing that a majority of Americans receive coverage through their employers, these recommendations are designed to preserve that coverage. They are also designed to strengthen existing group-coverage in some important ways—for example, by building on innovative worksite wellness initiatives and, in particular, by helping small businesses access affordable insurance through new tax credits.

Finally, millions more Americans who are currently covered fear losing their employer-sponsored insurance if they lose their job or switch to an employer that does not offer insurance. Coverage options in the

Individuals who are not satisfied with their employer-based coverage options, as well as small businesses, would be able to purchase coverage through state- or regional-level insurance exchanges. Regulatory changes

will promote the availability of a range of coverage options for everyone in these markets and will limit plans' ability to deny coverage and vary premiums based on health status. As a result, insurers will be competing on quality and cost, instead of cherry-picking the healthiest enrollees.

These protections will require a functional marketplace, which can be achieved with a personal requirement to buy basic health insurance coverage, consistent, equitable market regulations, and risk-adjusted payments to health insurers. Furthermore, a personal responsibility requirement to purchase health insurance must be accompanied by income-related subsidies to ensure that premiums are affordable, and user-friendly information to help individuals and families compare and choose appropriate health plans.

To ensure that all Americans have access to meaningful, affordable health insurance, the Leaders' Project recommends:

### **Reforming Health Insurance Markets**

Minimum insurance market guidelines, defined by the federal government and enforced by states, will improve stability and access in the non-group and small-group markets. States would be afforded discretion to enact stricter standards relative to those established at the federal level.

- **Guarantee Access to Coverage Regardless of Health Status:** Establish federal guaranteed issue requirements, prohibit

exclusions for pre-existing conditions, and prohibit premium rating based on health status for people who are continuously enrolled in coverage. These regulations would apply to all new non-group and small-group policies, including all policies purchased through the newly-established exchanges, starting from the implementation date of the exchange. Over time, existing non-group and small-group plans purchased outside exchanges would be required to meet the same requirements. However, initially, existing plans serving these markets would be grandfathered, meaning that they would not have to comply with insurance market reforms until their contracts are renegotiated. Enrollees in grandfathered plans could continue to renew their current coverage for a period of up to five years.

- **Limit Variation in Premiums:** Establish modified community rating requirements, to be overseen by states, that provide rate “bands” for all non-group and small-group plans (defined as plans with fewer than 50 workers). Premiums for the same plan should only be allowed to vary based on region,<sup>20</sup> wellness incentives (including smoking), whether it is an individual or family policy, and age (within limit).

Accordingly, a federal five-to-one age-rating ratio limit should be established. That is, premiums can vary by no more than five to one to reflect differences in utilization across age groups. This will help ensure that there is not excessive

cross-subsidization by age, and that younger populations are not priced out of the market.

Recognizing that a five-to-one age-rating ratio would permit higher premiums for older Americans, these recommendations call for limiting premium costs through refundable tax credits (an issue discussed later in this report), which should provide an effective way to ensure access and affordability for all Americans regardless of age. In addition, states could implement their own insurance reform requirements, including tighter age-rating ratios.

- **Ensure a High Level of Participation:** Establish a legal expectation that all individuals obtain basic health coverage, because insurance market reforms will only be effective with very broad participation in the market.
- **Achieve Lower Administrative Costs:** Use a public-private process to implement reforms (including standardized electronic claims processing) to promote administrative simplification of payment systems and to collect and publish information on the medical loss ratios of plans in non-group and small-group markets.
- **Establish a Federal Fallback If States Do Not Implement Market Reforms:** Direct the Secretary of HHS to implement minimum federal insurance reforms if any state fails to implement such reforms before 2013,

when coverage and personal responsibility provisions become effective. Additional resources should be provided to HHS to conduct this work.

# 15%

## FACTS ON EMPLOYER-SPONSORED HEALTH PLAN CHOICES

- 15 % of small firms (3–199) offer two or more health plan types
- 44% of large firms (200+) offer two or more plan types
- 51% of people with employer-sponsored coverage have access to more than one plan type

### *Creating State or Regional-Level Insurance Exchanges*

Health insurance options can be dauntingly complex and difficult to compare for the typical individual or small business. But as several recent examples<sup>21</sup> have shown, insurance markets with “exchange-like” features—such as greater transparency, comparable information on quality and cost, more plan options for small employers, and the ability to provide promised benefits—can make choices easier for beneficiaries while also promoting competition and reducing costs.

- **Establish Minimum Operating Guidelines for Exchanges:** The federal government would provide minimum guidelines for states—or, at their discretion, regional groupings of states—to establish, operate, and regulate exchanges. Allowing state or regional oversight will ensure that coverage options account for market conditions and population preferences. This in turn will help guarantee that all eligible Americans have access to quality, affordable health insurance.
- **Provide Startup Funding for States to Establish Insurance Exchanges:** The federal government would provide time-limited grants to states to help establish insurance exchanges. These grants could cover the initial administrative costs of developing systems for determining eligibility, structuring health plan competition, and implementing initial outreach efforts. States would then fund ongoing exchange expenses, like administering subsidies and coordinating plan participation, through a method of their choice (including through assessments on insurers participating in the exchange).
- **Permit All Individuals and Small Groups to Purchase through the Exchange:** Exchanges would be open to all individuals, regardless of whether they have coverage, and to small businesses with 50 or fewer employees, as soon as health status rating has been phased out.<sup>22</sup> To limit market disruption and avoid large changes in premiums, states or

regions would have the option to maintain separate pools within the exchange for individuals, micro-groups (2–10), and small groups (11–50). States that set up separate pools would have a three to five year transition period before unifying the risk pools. In addition, as discussed below, administrators of retiree health plans could opt into the exchange on behalf of their retirees.

- **Ensure Coverage Is Affordable and Meaningful:** Tax credits and standardized coverage provisions would ensure meaningful insurance options so that all individuals can afford coverage. Plans participating in the exchanges would be required, by states, to demonstrate that they have adequate provider networks (both primary and specialty care, plus preventive and dental care, if offered) in medically underserved areas.
- **Make Available Consumer Support Tools and Adopt Strategies to Improve Plan Choice:** Exchanges would make available educational resources, would actuarially certify bids, and would be allowed to limit the number of participating plan options. They also would promote competition through innovative plan designs. The federal government would evaluate the impact of different exchange strategies to promote high-quality, low-cost coverage.
- **Implement Risk-Adjustment Among Participating Plans:** Plan premiums within each exchange would be risk-adjusted to

promote competition between insurers on cost and quality, not on selecting healthy enrollees. All enrollees would pay the same premium (subject to the allowed variation described above), and the total payments made to the plans would be risk adjusted.

- **Create a Federal Fallback for Exchanges:**

If any state or region fails to implement a qualifying exchange in a timely manner and if American citizens and legal residents are denied access to coverage as a consequence, the Secretary of HHS would be charged with establishing an exchange that offers a range of plan options for the state or region. In that case appropriate and necessary resources and technical support would be provided to

HHS to carry out these responsibilities. Any federally established exchanges would be expected to transition back to state management as qualifying criteria are met. Alternatively, a state could contract with the federal government, at its expense, to manage the exchange.

- **Require States to Report on**

**Implementation Progress:** As a condition for receiving federal health reform funding, states would be required to report on (1) whether they intend to enforce minimum federal insurance market standards and (2) whether they intend to establish an exchange, either individually or in partnership with other states. States that choose to enforce the standards and

### Coverage Options Available In The Exchange

HIGH COVERAGE	MEDIUM COVERAGE	STANDARD COVERAGE	BASIC COVERAGE
Similar to FEHBP Standard Option	Similar to a Typical Small Group Plan	Similar to a Typical Non-Group Market Plan	Minimum Creditable Coverage (\$5,000 deductible and out-of-pocket max for individual coverage/ \$10,000 for family)
Covers 90% of health care spending on average	Covers 84% of health care spending on average	Covers 75% of health care spending on average	All major service categories, including coverage of prevention and prescription drugs without a deductible
			Covers about 60% of health care spending on average

establish an exchange would be required to provide annual reports to the Secretary of HHS. The reports would include information on the number of plans offered in each exchange, the range of premiums charged to enrollees, and the number of individuals covered through the exchange.

- **Provide for Competing State Plan Options:** States would have the ability to establish a health insurance plan to provide another coverage option in the exchange. The state plan could be modeled after self-insured plans that many have created as part of their employee benefit programs, co-op plans with consumer boards, or other designs. The plan would compete on a level playing field with private insurers, meaning that it would need to (1) be actuarially sound; (2) could not be managed by the entity responsible for regulating the state's insurance markets; (3) could not leverage participation in public programs as a means to develop provider networks; and (4) could not be subject to special advantages in regard to risk-adjustment, premium rating, reserves criteria, marketing and automatic enrollment. The plan also would have to be self-sustaining over time without relying on government support (e.g. for administrative costs).

The federal government, drawing on its expertise administering TRICARE and FEHBP, could provide initial technical assistance to states that wish to create such plans. The federal government could also provide

adequate funding for plans to establish initial contingency reserves. However, states would be expected to pay back any depleted reserve funds over time, as they collect premiums from products sold.

- **Require Further Action if Coverage Affordability and Accessibility Goals are Not Met:** If, after five years from the time the exchanges are expected to be operational, HHS determines that states have been unsuccessful in implementing insurance market reforms and establishing exchanges to provide affordable insurance options, and as a result significant numbers of individuals still lack health coverage, the president would submit to Congress a proposal for a federal or state plan to be offered through the exchanges, alongside private plans. The proposal would be considered under expedited procedures, providing for limited amendments and a certainty of a final vote.

### ***Ensuring Meaningful Health Insurance Benefits***

Minimum standards for “creditable” insurance coverage in all markets, combined with special standards for exchanges, will help guarantee that those purchasing coverage have adequate protection from excessive medical costs. Setting these minimum standards requires a careful tradeoff among the goals of protecting individuals against high out-of-pocket expenses, avoiding disruption of existing coverage, and keeping costs sustainable.

- **Establish Minimum Creditable Coverage Standards for Health Insurance:** These standards should include:
  - > Protections against catastrophic medical problems, coverage of a comprehensive range of health care services, and coverage of preventive care and prescription drugs, before the deductible is reached.
  - > Benefits at least as generous as those offered by a federally-defined high-deductible plan.
  - > State flexibility to increase minimum benefit standards above this level, provided that states ensure everyone has access to affordable coverage options and do not increase federal costs.<sup>23</sup>
- **Setting Additional Standards for Options Available in the Exchange:** Require plans participating in the exchange to offer benefits that are at least actuarially equivalent to four established federal levels. Plans could have broad flexibility in their approach to benefit design, utilization controls, and cost-sharing—provided they satisfy all minimum creditable coverage requirements. The four standard plan levels would be: high (similar to the FEHBP Blue Cross Blue Shield Standard plan currently available to Members of Congress), medium (similar to a typical plan in the small-group market), standard (similar to the typical non-group market plan), and basic (equivalent to the federal

minimum creditable coverage standard]. All major service categories would be included in each level of coverage, but plans would have flexibility to vary cost sharing to keep expenses and inappropriate utilization down.

### ***Guaranteeing Affordable Coverage for All***

Health insurance is expensive, particularly for lower and middle-income families who need it the most. To promote coverage for all Americans, the federal government would provide direct financial support, in the form of tax credits, to citizens and legal residents so they could purchase non-group coverage in the exchanges. Additionally, further subsidies and other assistance will be needed to ensure special protections for retirees and small businesses.

In developing this health reform proposal, recommended benefit package levels and associated tax credits ultimately had to be constrained so that they would align with available offsets to meet the goal of achieving budget neutrality. As described in more detail in Pillar Four, benefit levels and subsidies should be increased if—after further refinement—estimates of program costs permit.

- **Limit Out-of-Pocket Premiums:** Limit out-of-pocket premiums for all individuals and families to no more than 15 percent of income for basic coverage. Increases in premium costs over time would be shared proportionally with the federal government by indexing the tax credits.

- **Offer Enhanced Protections for Americans Under 400 Percent of the Federal Poverty Level (FPL):** Individuals and families with incomes below 400 percent of the FPL (\$88,200 for family of four in 2009) would receive advanceable, refundable tax credits to cap premiums for more generous coverage at less than 15 percent of income. The subsidy schedule, described in the table below, bases the amount of the tax credit on the average premium for plans available in the same area in each relevant level of coverage. After five years, regional variation in subsidies would be phased down, to reflect the goal of narrowing geographic disparities unrelated to health or socio-economic status. Adults with incomes below 100 percent FPL would initially receive Medicaid coverage rather than tax credits to purchase coverage through the exchange. However, if the Secretary of HHS authorized low-income

adults to participate in the exchange, they would receive a tax credit to pay the full premium cost.

- **Provide Additional Protections for Retirees:** Retirees age 55 to 64 would receive extra protections against high premiums.<sup>24</sup> Voluntary Employees' Beneficiary Associations (VEBAs) and other employer-sponsored retiree health plans could obtain income-based subsidies for retirees by purchasing coverage through the exchange.
- **Create New Tax Credits for Coverage Provided by Small Businesses:** Small employers—defined as employers with fewer than 25 mostly low-wage workers—would receive a tax credit to help offer coverage to their employees.<sup>25</sup> Small non-profit associations and small municipal governments would likewise qualify for

Tax Credit (Subsidy) to Purchase Coverage Through the Exchange		
INCOME AS A PERCENT OF POVERTY (FPL)	MAXIMUM PREMIUM AS A % OF INCOME	GENEROSITY OF TAX CREDIT
< 100%	No Premium	Medicaid or Medicaid-Level
100–150%	2.0%	High Level
150–200%	5.0%	
200–250%	5.0%	Medium Level
250–300%	10.0%	
300–350%	10.0%	Standard Level
350–400%	12.5%	
>400%	15.0%	Basic Level

these subsidies to encourage them to purchase coverage for their employees.

- **Ensure Coverage for Low-Income Individuals and Families:** Individuals with incomes below 100 percent FPL would be eligible for Medicaid. To ensure that states do not incur additional cost for newly-eligible individuals (i.e. those who were not previously covered by Medicaid through state plan amendments or waivers), the federal government would provide full funding for this coverage. This support would be offered in conjunction with reforms to promote coordinated care for dual eligible beneficiaries (described in Pillar One).

Individuals and families that are over the poverty line and that are categorically eligible for Medicaid would continue to retain Medicaid coverage, as would children covered under CHIP. All individuals eligible for Medicaid would initially be ineligible for subsidized coverage in the exchange. After five years following implementation, however, Secretary of HHS could permit such individuals to enroll in subsidized private plans through state or regional exchanges—provided such coverage does not result in increased cost sharing or loss of benefits. For example, the Secretary could permit enrollment in private insurance plans with minimal out-of-pocket costs that reflect Medicaid benefits and protections. This would ensure that vulnerable populations, such as children and people with disabilities, do not lose benefits.

## ■ PILLAR THREE

### *Emphasizing and Supporting Personal Responsibility and Healthy Choices*

A key theme of the Leaders' Project is that everyone has a role in improving their own individual health and the overall performance of the health care system. However, better support for individuals and families to help lower the burden of health care costs is needed along with an increased emphasis on

# 45%

#### FAST FACTS ON CHRONIC DISEASE

- 45% (133 million) of Americans have a chronic disease
- Chronic disease accounts for 70% of all deaths in the U.S.
- Almost 17% of children 2 to 19 years old were overweight in 2004
- The incidence of cancer, mental disorders, and diabetes are expected to increase more than 50% by 2023.

personal responsibility. This section outlines two types of reforms designed to encourage individuals to make responsible choices about their health and health care.

First, a primary component of this report is a requirement that all Americans should

have, at minimum, basic health insurance coverage. Ensuring that all Americans have coverage in a reformed, accessible, and accountable health care system with large and balanced risk pools will help stabilize insurance markets. Additionally, it will create a much stronger force for expanding the availability of innovative and affordable health insurance options.

Second, the Leaders' Project strongly endorses efforts to focus on clinical and population-based prevention and wellness as a means of making Americans healthier. A large and growing proportion of the nation's overall health spending is currently going toward chronic diseases and the frequently preventable and costly complications associated with them.<sup>26</sup> While many factors contribute to chronic diseases, there are clear, changeable patient behaviors—like quitting smoking, following a nutritious diet, and exercising regularly—that can influence their likelihood of occurrence and severity. However, traditional approaches to health care, which pay more for treating illnesses after they develop, do not support these lifestyle changes. It is time to consider health more broadly and focus on changes that can impact people's wellbeing before they ever see a doctor.

Addressing the underlying causes of the nation's health problems requires a range of school, workplace, and community initiatives to target behavior changes that can lead to better health. At the same time, new government funds should not be

committed without ensuring a proper return on investment. Accordingly, the impact of these initiatives must be measured carefully, and only programs that prove to be effective should continue to receive funding.

Strategies to promote healthier lifestyle choices (through well-targeted methods that demonstrate health benefits, for example) should become regular components in both public and private health insurance coverage, and should be tied to achieving better health outcomes at a lower overall cost. Taken together, these strategies can help ensure that preventive services, like appropriate disease screenings and effective wellness programs, become a regular part of every person's health care.

To increase personal responsibility and promote lifestyle choices that benefit overall health, the Leaders' Project recommends:

### ***Expecting Individual Responsibility for Obtaining Basic Health Insurance***

With the availability of reliable health plan choices and new tax credits to help ensure their affordability, all Americans should be empowered and expected to obtain basic health insurance coverage.

- **Establish a Personal Responsibility Requirement for All Americans:** Individuals must demonstrate that they have health insurance that meets minimum creditable coverage standards. Almost every American who has any modest health insurance today already meets this requirement.

A legal requirement to obtain basic coverage is likely to produce the high levels of participation needed to make insurance markets work well. Most Americans are already insured, and most honor the law, so requiring them to self-attest that they have insurance on their income tax forms should not be

individuals who fail to obtain creditable coverage. Coverage could be verified through self-attestation and submission of documentation with tax forms.

- > A “fair share” fee added to income tax liability for individuals who choose not to obtain coverage. The fee could be

**“ COMPLEMENTARY REFORMS ON THE CONSUMER SIDE OF HEALTH CARE DELIVERY ARE JUST AS IMPORTANT AS GIVING PROVIDERS BETTER FINANCIAL SUPPORT FOR IMPROVING QUALITY AND LOWERING COSTS. ”**

an onerous requirement. Education and outreach programs would further increase awareness about the availability and affordability of new coverage options.

Appropriate enforcement mechanisms are critical to make the individual requirement effective. Such mechanisms could include, but are not limited to, the following options:

- > Default or simplified enrollment in basic coverage options, whether provided by the employer when starting a job, or through the state exchange.
- > Tax penalties, including the loss of federal deductions or exemptions, for

set at an explicit level, reflecting the cost of uncompensated care for example. Alternatively, it could be linked to the premium (or to a certain percentage of the premium) for the lowest-cost plan available through an exchange.

While provisions included in Pillar Two should protect Americans against excessive premiums, exceptions to the individual requirement may be appropriate in those limited and temporary circumstances where affordability cannot be guaranteed. The Leaders’ Project also supports religious exceptions to the individual requirement.

### ***Empowering Individuals to Make Better Health Care Choices***

Complementary reforms on the consumer side of health care delivery are just as important as giving providers better financial support for improving quality and lowering costs. These reforms would help people save money when they get high-quality care at a lower cost.

- **Expand the Centers of Excellence**

**Program:** Offer premium rebates and copayment reductions to individuals when they choose high-quality, low-cost providers who are receiving bundled payments as part of expanded Centers of Excellence programs in Medicare. These incentives are increasingly available in private health plans and could be reinforced by similar steps in Medicare.

- **Offer Premium Reductions for Healthy Behaviors:**

Allow employer-based health plans to offer rebates on premiums to individuals who participate in ongoing, evidence-based wellness programs. Such programs must be available to all employees, and demonstrate risk factor reductions and improvements in health outcomes (such as smoking cessation or blood pressure control). That is, they must be proven to work. Patient confidentiality would need to be protected and the opportunity to receive reduced premiums would need to be extended to all individuals, along with assurance that cost is not a barrier to participation.

- **Support the Development of Educational Materials to Improve Health Literacy:**

Develop a national strategy to foster health literacy by providing federal funding to support the availability of comparable, reliable information on the quality and cost of health care providers and coverage options, and on the risks and benefits of alternative treatments.

### ***Create a Public Health and Wellness Fund***

To support a sustained, nationwide focus on public health and wellness, a Public Health and Wellness Fund should be created with \$50 billion in funding over 10 years. The fund would be used to invest in evidence-based prevention and wellness programs, and initiatives to better coordinate care and manage chronic illnesses. These programs could be delivered through schools, community-based organizations, state and local government agencies, and employers. To continue receiving support they would be required to demonstrate an impact on risk factors for diseases and health outcomes. For example, the fund could be used to invest in the following reforms or initiatives:

- No copayments or nominal copayments for “A” and “B” rated preventive services that the U.S. Preventive Services Task Force (USPSTF) certifies as appropriate to cover by plans offered in the exchange and the Medicare program. Additionally, HHS would have discretionary authority to eliminate coverage for services rated “D” by the USPSTF.
- A covered wellness visit for Medicare beneficiaries to receive a health risk

assessment and a personalized prevention plan without incurring a copayment or deductible.

- A new 50 percent federal tax credit for certified employer-based wellness programs that meet accountability and health reporting requirements. This policy would be limited to small and mid-sized firms pending further recommendations by HHS and the Departments of Labor and Treasury with respect to the feasibility and advisability of expanding the policy. To be certified and continue to receive funding, wellness programs would need to demonstrate a positive impact on identified risk factors.
- A \$3 billion-per-year investment in wellness and prevention programs to promote individual and community health and to help reorient health care services to focus on prevention and wellness. Approximately \$2.5 billion of this amount would be used to support the work of CHTs (as described in Pillar One).
- At least a \$500 million investment in dedicated funding for innovative school and community-based programs that are designed to provide direct preventive and primary health care services, including educational programs on exercise, nutrition, and wellness.

Implementation of these proposals, along with related funding, would begin as quickly as possible once health reform is enacted, with the exception of new benefits

administered by exchanges. Future levels of funding would depend on success in improving health outcomes and reducing overall health care spending.

#### ■ PILLAR FOUR

##### *Developing a Workable and Sustainable Approach To Health Care Financing*

The United States spends over 16 percent of its GDP on health care, and employers who offer coverage spend almost 11 percent of payroll on health care.<sup>27</sup> As health care spending continues to grow faster than the economy and wages, solutions are needed to (1) ease the drivers of unnecessary or preventable increases in health care costs, (2) ensure that any health care spending increases reflect truly valuable services, and (3) address the unsustainable fiscal impacts of rising health care expenditures.

Reforming care delivery and payment systems is a critical component of the effort to stem spending growth. As outlined in Pillar One, delivery systems must be better integrated to promote care coordination and quality measurement, and dissemination of evidence that will inform the best methods of care delivery in the future. Reimbursement systems must be restructured to reward providers for improving health outcomes with the most efficient use of resources possible. Together, these reforms will spur true innovation for a modernized health system—one that improves value and reduces costs, rather than just increasing the volume and intensity of medical services provided.

To achieve budget neutrality, savings and revenue offsets are needed to pay for the proposed \$1.2 trillion 10-year federal investment that Project estimates suggest is necessary to secure a modernized health care delivery infrastructure, provide affordable coverage, and support better

package that is “paid for” within a 10-year budget window. Accordingly, the Leaders’ Project proposes—and commits to working toward—a specific package of delivery and reimbursement reforms in Medicare and Medicaid, health-related revenue policies, and financing and other budget reforms.

“**...THE POLICY RECOMMENDATIONS IN PILLAR FOUR SEEK TO ACHIEVE THE DUAL GOALS OF (1) IMPROVING THE NATION’S LONG-RUN FISCAL OUTLOOK THROUGH LOWER GROWTH IN HEALTH SPENDING AND (2) IMPLEMENTING A REFORM PACKAGE THAT IS “PAID FOR” WITHIN A 10-YEAR BUDGET WINDOW.**”

prevention and wellness. It is important, however, to consider this investment in the context of broader national health care spending, which is projected to total \$35.2 trillion over the next 10 years. It is also worth noting and commending the medical labor, provider, health plan, and manufacturer communities for committing to achieve some of the more than \$2 trillion in savings in the health system over the next 10 years.

With this in mind, the policy recommendations in Pillar Four seek to achieve the dual goals of (1) improving the nation’s long-run fiscal outlook through lower growth in health spending and (2) implementing a reform

The financing framework proposed here includes over \$1 trillion in specified savings and new revenues, roughly equally divided. About \$530 billion in expected federal health care savings comes primarily from reductions in Medicare and Medicaid spending growth, supported by a broad set of recommendations to improve the delivery of care. About \$510 billion would come from new revenues related to the tax treatment of, and enrollment in, employer-sponsored health insurance. The remaining one-sixth of required financing should be achieved through some combination of three complementary, viable methods to ensure that the proposed reform package is budget neutral. These three

methods include enacting additional savings provisions, creating enforceable budget “trigger” mechanisms to automatically slow spending and empowering the IHCC to make additional recommendations to the president and Congress. The specific components of the

have noted), implementing these reforms as part of a package has the potential to achieve a much larger impact. The proposals listed below are expected to produce between \$10 and \$50 billion in scoreable savings over 10 years, net of investments in delivery

“ **INFRASTRUCTURE INVESTMENTS, COMBINED WITH REDUCTIONS IN AVOIDABLE HOSPITAL READMISSIONS, SAVINGS FROM BUNDLED PAYMENTS, AND OTHER REFORMS, WILL PROMOTE GREATER EFFICIENCY IN THE HEALTH CARE SYSTEM.** ”

proposed financing package are discussed in further detail in this section:

***Reforming Delivery and Payment Systems to Achieve Higher-Value Health Care (Pillar One)***

The infrastructure investments and payment reforms described in Pillar One should significantly slow long-term health care cost growth. At the same time, it is understandable that experts have been reluctant to score such reforms as achieving more than modest budget savings within 5 to 10 years when implemented individually. Although it is obviously not possible to get clear empirical evidence on the issue (as the Congressional Budget Office (CBO) and others

reforms, with much higher savings anticipated in the long-term. Specific policies recommended as part of comprehensive reform include:

- Additional incentives for the adoption and meaningful use of HIT along with investments in CER.
- Targeted pay-for-performance and pay-for-reporting initiatives offset by assistance in establishing the necessary measurement infrastructure.
- Up-front incentives to reduce avoidable hospital readmission rates and a move toward bundled payments for hospital and post-acute care.

- Incentives for the expanded use of Centers of Excellence, which receive bundled payments for delivering high quality and lower costs over entire episodes of care.
- Incentives to begin implementing voluntary ACOs that share in savings achieved between providers and the government.
- New payments for primary care medical homes that are tied to accountability for quality and overall cost.
- Efforts to reduce overpayments and the overuse of some lower-value care (including advanced imaging) and investments in combating waste, fraud, and abuse.
- Administrative simplification to reduce the cost and burden of claims processing.

### ***Implementing a Balanced Set of Medicare and Medicaid Payment Reforms***

The following reforms to Medicare and Medicaid address opportunities for efficiency gains and reductions in overpayments that currently exist in the system. Improvements in the delivery of health care (as recommended in Pillar One) would facilitate efforts to achieve these savings. Taken together, these proposals are expected to save about \$500 billion over 10 years.

- **Align Medicare Advantage (MA) Payments More Closely with FFS Medicare:** MA plan payments should be brought closer to parity with FFS Medicare payments through reforms that align them with

the same kinds of incentives for quality reporting and improvement that are proposed for traditional Medicare and the private sector. In particular, payment reforms might include transitioning to a system of competitive bidding for an actuarially reasonable benefit package. At the same time, explicit quality enhancement bonus payments could be provided to reward plans that meet certain performance measures, aligned with those used to promote coordinated care in the FFS Medicare program. This change is expected to save up to \$110 billion over 10 years.

- **Adjust Market Basket Updates to Account for Expected Savings:** Infrastructure investments, combined with reductions in avoidable hospital readmissions, savings from bundled payments, and other reforms, will promote greater efficiency in the health care system. Such improved efficiency should eventually be reflected in the growth rates of bundled payments. Accordingly, market basket payment updates for hospitals and other providers (except physicians) would be reduced to reflect a little more than half of expected productivity gains, which will amount to far smaller reductions than would be achieved by a 1.5 percent slowdown in cost growth. Such changes are expected to save \$100 billion by 2019.
- **Adjust Funding for Uncompensated Care:** Funding for uncompensated care in the form of DSH payments should be reformed

to reflect expected coverage expansions. About two-thirds of projected funding should be maintained over the next 10 years. These funds should be directly tied to changes in uncompensated care and other public health burdens for which hospitals and other providers deliver services. In addition, providers should be accountable for the use of these funds. For example, funds could be tied to quality measures related to providing effective care for uninsured patients, and to the delivery of prevention-oriented care rather than hospital admissions. Such changes are expected to save \$80 billion over 10 years.

- **Reduce Payments to Home Health and Skilled Nursing Facilities:** Along the lines of recommendations from MedPAC, the growth of payments to home health and skilled nursing facilities would be reduced to address concerns about overpayment and inappropriate utilization of services. These reforms would occur in the context of the value-based payment reforms outlined in Pillar One that create opportunities for providers to get additional net revenues from effective steps to coordinate and improve care. Curbing these payments is expected to save \$75 billion over 10 years.
- **Create an Approval Pathway for Competing Biologic Products:** Congress should create a regulatory pathway for the approval of biosimilars and biologics. This would result in increased competition that could produce significant cost savings for individuals and for federal programs. The Leaders' Project is encouraged that a bipartisan, bicameral consensus exists between the two committees of jurisdiction and their chairmen concerning the need to establish a regulatory and patent process for reviewing and approving biosimilar and biogeneric products. Congress should resolve policy differences on the major outstanding issue of exclusivity in time to pass this legislation as a component of health care reform. This step, along with other reforms to promote better-coordinated and higher-quality care for beneficiaries with chronic illnesses, should help more seniors avoid the so-called "donut hole" in Medicare drug coverage. This proposal is expected to save \$9 billion over 10 years.
- **Reform Prescription Drug Payments in Medicare and Medicaid:** Medicaid brand drug rebate rates would be increased, while the "best price" provision would be removed. Limited increases in rebate amounts for generic drugs should be included but should be balanced against ensuring access to these products. States could provide for manufacturers to receive bonuses to offset part of the increase based on demonstrated improvements in outcomes, such as a lower incidence of complications from chronic disease or lower overall costs for Medicaid beneficiaries—provided such reforms ensure budget neutrality. Steps would be taken to encourage the use of high-value,

effective drugs, like supporting state adoption of best practices from the FEHBP and Medicare drug plans. These policies are expected to save up to \$80 billion over 10 years.

- **Restructure Medicare and Medigap Cost-Sharing:** Medicare beneficiary cost-sharing would be reformed to limit first-dollar coverage, provide protection against catastrophic costs, and ensure extra cost-sharing safeguards for low-income individuals. These reforms would generate some limited savings for the

budget, funds set aside for Medicare and Medicaid program improvements would be directed toward the extensive investments in higher-value health care proposed in this report. This would generate \$23 billion in offsets over 10 years.

### ***Raising Additional Revenue from Coverage-Related Reforms***

- **Linking the Tax Exclusion to the Value of Health Care Benefits Received by Members of Congress:** The income tax exclusion for employer-sponsored

“ ...BETTER COORDINATION OF CARE—PARTICULARLY AROUND POST-HOSPITAL TRANSITIONS—AND IMPROVED BENEFITS FOR THE CHRONICALLY ILL WOULD ENSURE THAT SENIORS RECEIVE HIGHER QUALITY CARE THAT IMPROVES HEALTH OUTCOMES AND MAKES IT EASIER TO NAVIGATE THE HEALTH CARE SYSTEM. ”

Medicare program and reduce average out-of-pocket costs for beneficiaries, while eliminating the risk of very high out-of-pocket expenses. Net savings associated with these reforms are estimated to total about \$20 billion over 10 years.

- **Reallocate Medicare and Medicaid Improvement Funds:** Consistent with the proposal in the president’s Fiscal Year 2010

insurance should be capped at the value of the FEHBP standard option, and that amount should be indexed to the rate of medical inflation over time.<sup>28</sup> The full exemption for payroll taxes should be maintained. To avoid unduly burdening certain groups, the tax exclusion cap should be set separately for single versus family premiums, and it should be adjusted for age and geography (though

the geographic adjustment should be phased down over time). Retirees would be exempted in recognition of the fact that they have, in many cases, traded

million. Small businesses with payrolls of less than \$1 million a year would be exempt—this threshold would exempt almost all firms with fewer than 25

“ TOGETHER, THESE FINANCING PROPOSALS WOULD PROMOTE SUSTAINED IMPROVEMENTS IN THE VALUE OF HEALTH CARE, AND WOULD PRODUCE OVER \$1 TRILLION IN FEDERAL SAVINGS WITHIN THE 10-YEAR BUDGET WINDOW. ”

wages for their retiree health benefits and will not benefit from wage increases that will accrue to the working population. Additionally, individuals covered by collectively bargained employment agreements would be exempted until those agreements expire. Implementation of the tax exclusion cap should be concurrent with the availability of new premium subsidies described in Pillar Two.

- **Instituting a Fee for Certain Employers Who Do Not Offer or Pay for Health Care Coverage:** Institute a “play or pay” assessment for the minority of firms not offering coverage. The fee would be 1 percent of payroll for firms with annual payrolls between \$1 million and \$2 million; 2 percent for firms with payrolls between \$2 million and \$3 million; and 3 percent for firms with payrolls above \$3

employees. Moreover, only about one-fourth of firms with 25 to 99 employees (weighted by number of workers) would end up paying the fee. New firms just starting up would be exempted from the fee for a two-year period.

- **Estimated Budget Effect:** Implementing these two coverage-related reforms, in conjunction with investments in affordable coverage as described in Pillar Two, is expected to increase federal revenues by about \$510 billion over 10 years. These revenues come from an interrelated combination of “play or pay” fees, income tax revenue on premiums above the exclusion cap, and “interaction effects” from reforms that result in changed patterns of coverage and higher taxable wages. The interaction effects are largely a

result of employee decisions to take advantage of less costly coverage options, including new affordable, portable coverage options offered through the exchanges. This will reduce the burden of health benefits on employers and raise wages. Additional payroll taxes collected as a result will have the benefit of strengthening the Medicare and Social Security Trust Funds.

Together, these financing proposals would promote sustained improvements in the value of health care, and would produce over \$1 trillion in federal savings within the 10-year budget window. The projected savings associated with these policies are calculated using traditional CBO scoring methods. Reduced Medicare spending would lower Part B premiums for Medicare beneficiaries and would extend the solvency of the Hospital Insurance Trust Fund significantly. At the same time, better coordination of care—particularly around post-hospital transitions—and improved benefits for the chronically ill would ensure that seniors receive higher-quality care that improves health outcomes and makes it easier to navigate the health care system. Finally, improved preventive care benefits will help seniors stay healthier.

While this roughly \$1 trillion down payment is substantial, Senators Baker, Daschle and Dole committed to producing a package that is fully financed even under strict budget rules.

### ***Ensuring Budget Neutrality***

To guarantee that the entire reform package is budget neutral, the remaining cost of approximately \$200 billion should be paid for through one or more of the following three options: (1) enacting additional savings provisions; (2) creating enforceable budget “trigger” mechanisms to automatically slow spending growth above a target level; or (3) empowering the IHCC to make additional recommendations to the president and Congress.

First, Congress could choose from among the following proposals, or others, to offset the remaining deficit:

- Further reduce payments to Medicare providers through market-basket reductions to fully reflect expected productivity gains (this could be done while still reducing market basket updates by less than 1.5 percent).
- Further reduce reimbursement to MA plans.
- Reform GME and Indirect Medical Education payments (in advance of the IOM report recommendations described in Pillar One).
- Increase Medicare cost-sharing.
- Reduce Medicare Part B and Part D premium subsidies for higher income individuals.
- Increase drug rebates for Medicaid or other federal programs.

- Take further steps to improve Medicaid value by implementing shared savings for states that lower cost growth and penalties for states with higher growth.
- Increase cigarette and alcohol taxes.

Second, Congress could establish targets for overall spending growth, or Medicare spending growth only, in conjunction with health care reforms, and enact a “trigger” mechanism that would automatically implement additional, pre-specified payment reforms if the targets are exceeded. For example, if a spending growth target equal to the medical portion of the Consumer Price Index (CPI) plus 1 percent is not achieved, one or more of the following steps could be implemented:

- Reduce Medicare market basket increases for providers in regions where spending growth has been consistently higher than 1.5 percent above the national average to achieve a growth rate equal to 1.5 percent above the national average (if spending growth slows in subsequent years, the reduction in the update could be reversed; if it does not slow, the reduction would be cumulative).
- Slow the growth of the new tax credits for health insurance—i.e., tax credits would be linked to plans with incrementally less generous actuarial value to limit growth in total spending to the target level.
- Medicaid match rates for states with relatively high growth in per capita Medicaid spending would be reduced incrementally.

Third, Congress could empower the new IHCC to develop policy recommendations for achieving federal spending targets. These recommendations would be provided to the president for submission to Congress under expedited procedures, with limited opportunity for amendment.

Projecting the future budget costs and savings that will result from various reforms is a process that is inherently uncertain. Thus, the numbers presented in this report are only estimates. They are calculated using methods similar to those used by the CBO, as CBO “scores” are ultimately what determines whether a package of reforms is “paid for” under Congressional budget rules. The cost of tax credits and Medicaid expansions, and revenues from changes in the tax treatment of employer-sponsored insurance were estimated by Professor Jonathan Gruber of MIT, using his reform simulation model. Medicare and Medicaid reform savings were estimated using published CBO scores. Nonetheless, CBO scores for a set of reforms like those recommended here may differ. Should any of these recommended reforms end up having substantially lower projected costs than the Project has estimated, Congress should use the difference to increase the generosity of the subsidized benefit package in a way that ensures greater cost-sharing protections for Americans, while still maintaining budget neutrality. Such increases should also be considered in the future, if actual health care spending growth is substantially lower than projected.

## Summary of Revenue and Expenditure Provisions

RECOMMENDED POLICY	Approximate Budget Effects	
	2013 Effects	Budget Window (2010-2019)
<b>INVESTMENTS</b>		
Ensuring Affordable Coverage: <ul style="list-style-type: none"> <li>• Tax Credits to Ensure Affordable Coverage for All Americans Through Exchanges, with Special Retiree Protections</li> <li>• Ensuring Adults with Incomes Below Poverty Have Access to Comprehensive Coverage through Medicaid</li> </ul>	[-\$131 billion]	[-\$1,135 billion]
Credits to Help Small Businesses Bear the Cost of Offering Employer-Sponsored Health Insurance	[-\$7 billion]	[-\$55 billion]
Public Health & Wellness Fund: New Benefits and Initiatives for Proven Approaches to Prevent Chronic Diseases and Their Complications	[-\$5 billion]	[-\$50 billion]
<b>Subtotal, Investments</b>	[-\$143 billion]	[-\$1,240 billion]
<b>SAVINGS/REVENUE OFFSETS</b>		
Modernization Initiatives to Reform Delivery and Payment Systems, Net of Initial Investment Costs	_____	\$30 billion
Slowing Growth of Medicare and Medicaid Spending through Balanced Reforms That Reflect Expected Savings from Delivery Reforms	\$40 billion	\$500 billion
New Revenues: <ul style="list-style-type: none"> <li>• Revenue from Capping Employer Coverage Income Tax Exclusion at the Value of Benefit Received by Members of Congress</li> <li>• Revenue from Fair Share Fee for Larger Employers Not Offering Coverage</li> <li>• Additional Savings from Changes in Decisions Resulting from These Reforms</li> </ul>	_____ \$54 billion _____	_____ \$510 billion _____
<b>Subtotal, Specified Offsets</b>	[\$94 billion]	\$1,040 billion
Ensuring Budget Neutrality: Further Savings from a Combination of Additional Reforms, Budget Triggers and/or Independent Health Care Council Recommendations	_____	\$200 billion
<b>FINAL BUDGET EFFECT</b>	[-\$49 billion]	Budget Neutral

Note: Coverage and health insurance tax reform impacts were estimated by Jonathan Gruber of MIT, using his reform simulation model. Estimates of Medicare, Medicaid, and other health system reform proposals reflect published estimates from CBO.

### ***Addressing Medicare's Sustainable Growth Rate (SGR) Formula for Physicians***

The current Medicare physician payment formula, and the automatic cut in physician payments that looms each year, present a clear obstacle to health care reform and a more rational and accountable health care system that is focused on quality. This payment shortfall, which exceeds \$200 billion over the

the way of physicians assuming a leadership role in health reform efforts aimed at improving quality and reducing overall costs. Failure to act on this issue means physicians participating in Medicare will experience real payment cuts, and will be less able to implement prevention-oriented reforms, potentially threatening access to quality care. In sum, the current SGR formula impedes

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**THE LEADERS' PROJECT BELIEVES THAT THE LACK OF MEANINGFUL SGR PAYMENT REFORM STANDS IN THE WAY OF PHYSICIANS ASSUMING A LEADERSHIP ROLE IN HEALTH REFORM EFFORTS AIMED AT IMPROVING QUALITY AND REDUCING OVERALL COSTS.** ”

next 10 years under current utilization and price projections, results from the fact that spending growth has been exceeding actual spending targets under Medicare Part B “physician-related” services. Each year physicians face uncertainty in Medicare payments, and each year Congress enacts a temporary fix, but does not address the underlying drivers of the problem—largely because of the high cost of correcting the SGR formula, which promotes high-margin services over high-value services.

The Leaders' Project believes that the lack of meaningful SGR payment reform stands in

efforts to reform Medicare reimbursement to provide incentives for high-quality, high-value care.

Accordingly, the Leaders' Project concluded that the SGR issue should be addressed in the context of broad health reform. Indeed, the financing and delivery reforms outlined in this report suggest an array of legislative and administrative actions that can be taken, and a number of ways to budget for reform in this area. Other proposals could also provide additional savings or revenues to offset the current reimbursement shortfall.

The health reform package proposed here is budget neutral. While this is a critically important goal given the financing challenges facing the Medicare program, the sheer size, scope, and cost of physician payments will make it particularly difficult for policymakers to find support for sufficient offsets to pay for both health reform investments and a solution to the problems with the SGR formula. Therefore, in conjunction with identifying ways to offset the costs of fixing the SGR, serious consideration should be given to assuming

that a physician payment freeze will be included in the budget baseline. Such an approach has already been proposed by the Obama Administration and the U.S. House of Representatives. However, Senators Baker, Daschle and Dole would oppose such a policy if it took place outside the context of a broad reform effort to reduce overall growth in health care spending, including fundamental reforms in Medicare provider payments to ensure that the program's future physician reimbursement policy far more aggressively rewards value over quantity.



## PROJECT LEADERSHIP

### SENATOR HOWARD BAKER

Howard H. Baker, Jr. served three terms as a United States Senator from Tennessee (1967 to 1985) and was Tennessee's first popularly elected Republican Senator.

Senator Baker gained national recognition in 1973 as Vice Chairman of the Senate Watergate Committee. Three years later, he was the keynote speaker at the Republican National Convention and was a 1980 candidate for the Republican presidential nomination. He concluded his Senate career in 1985 after two terms as Majority Leader (1981 to 1985) and two terms as Minority Leader (1977 to 1981). He was President Reagan's Chief of Staff from February 1987 to July 1988.

A delegate to the United Nations in 1976, Senator Baker has extensive foreign policy experience. He served on the president's Foreign Intelligence Board from 1985 to 1987 and from 1988 to 1990, and is a member of the Council on Foreign Relations and the Washington Institute of Foreign

Affairs. He serves on the board of the Forum of International Policy and is an International Counselor for the Center for Strategic and International Studies.

In 2001, President George W. Bush appointed Senator Baker as 26th U.S. Ambassador to Japan. He currently serves as Senior Counsel at Baker, Donelson, Bearman, Caldwell, and Berkowitz, a law firm founded by his grandfather in 1888.

Among his many awards are the 1984 Presidential Medal of Freedom and the Jefferson Award for Greatest Public Service Performed by an Elected or Appointed Official, which he received in 1982.

Senator Baker is the author of four books: *No Margin for Error*; *Howard Baker's Washington*; *Big South Fork Country*; and *Scott's Gulf*.

### SENATOR TOM DASCHLE

Born in Aberdeen, South Dakota, Tom Daschle graduated from South Dakota State University in 1969. Upon graduation, he entered the United States Air Force where he served as an intelligence officer in the Strategic Air Command until mid-1972.

Following completion of his military service, Senator Daschle served on the staff of Senator James Abourezk. In 1978, he was elected to the U.S. House of Representatives where he served for eight years. In 1986, he was elected to the U.S. Senate and eight years later became the Democratic Leader. Senator Daschle is one of the longest serving Senate Democratic Leaders in history and the only one to serve twice as both Majority and Minority Leader. During his tenure, Senator Daschle navigated the Senate through some of its most historic economic and national security challenges. In 2003, he chronicled some of these experiences in his book, *Like No Other Time: The 107th Congress and the Two Years That Changed America Forever*.

Today, Senator Daschle is a Special Policy Advisor to the law firm of Alston + Bird. He has distinguished his expertise in health care through the publication of *Critical: What We Can Do About the Health-Care Crisis* and has emerged as a leading thinker on climate change and renewable energy policy.

In 2007, he joined with former Majority Leaders George Mitchell, Bob Dole, and Howard Baker to create the Bipartisan Policy Center, an organization dedicated to finding common ground on some of the pressing public policy challenges of our time. Senator Daschle serves on the board of the Center for American Progress and the National Democratic Institute.

He is married to Linda Hall Daschle and has three children and four grandchildren.

## SENATOR BOB DOLE

A renowned statesman, Bob Dole was elected to Congress from his home state of Kansas in 1960 and to the U.S. Senate in 1968. He gained national prominence as Chairman of the Republican National Committee from 1971 to 1972. In 1976, President Gerald Ford tapped him to be his vice presidential running mate. He served as Chairman of the Senate Finance Committee from 1981 to 1985. Elected Senate Majority Leader in 1984, Senator Dole holds the record as the nation's longest serving Republican Leader. He resigned from the Senate in 1996 to pursue his campaign for President of the United States.

Senator Dole currently serves as Special Counsel to Alston + Bird. Over the course of his distinguished career, he was National Chairman of the World War II Memorial Campaign and Chairman of the International Commission on Missing Persons. In 2007, Senator Dole was selected to co-chair the president's Commission on Care for America's Returning Wounded Warriors. Following September 11, he joined former President Bill Clinton as Co-Chair of the Families of Freedom Scholarship Fund, raising over \$120 million.

In 1997, Senator Dole received the Presidential Medal of Freedom for his many contributions to the nation. His other honors include the World Food Prize; the American Legion's prestigious Distinguished Service Medal; the Horatio Alger Award from The Horatio Alger Association of Distinguished Americans; the U.S. Defense Department's Distinguished Public Service Award; and the National Collegiate Athletic Association's Teddy Roosevelt Award.

The Robert Dole Scholarship Fund for Disabled Students was recently established in his honor at the United Negro College Fund. He also actively supports the Robert J. Dole Institute of Politics at the University of Kansas, which was dedicated in 2003. Senator Dole is a major spokesman on issues involving men's health, hunger and nutrition, veterans, and Americans with disabilities. His personal history of service includes active duty in World War II, during which he was gravely wounded and received two Purple Hearts and a Bronze Star with Oak Leaf Cluster for heroic achievement.

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The Leaders express their gratitude to project co-directors Chris Jennings and Mark McClellan for their time, service, and unparalleled health care expertise.

### CHRIS JENNINGS

Chris Jennings is a more than two decades-long health policy veteran of the White House, Congress, and the private sector. He currently serves as president of Jennings Policy Strategies (JPS), Inc., a nationally-respected health policy and advocacy consulting firm in Washington, DC. JPS, Inc. provides policy analysis, strategic guidance, and coalition building advice to clients who share a commitment to affordable, accessible, and accountable health care.

Prior to founding JPS, Inc., Mr. Jennings served in the White House as the Senior Health Care Advisor to President Bill Clinton at the Domestic Policy and National Economic Councils. During his tenure there, Mr. Jennings made significant contributions toward the enactment of major bipartisan health legislation including the Children's Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act, the Mental Health Parity Act, the Food and Drug Administration Modernization Act, the Work Incentives Improvement Act, and the tripling of funding for international AIDS programs for prevention, care, treatment, and health infrastructure.

In 1993 and 1994, he served as the Senior Advisor to Administrator of the then Health Care Financing Administration, and concurrently as the congressional liaison for



First Lady Hillary Rodham Clinton, providing assistance for her testimony before five committees and staffing her for hundreds of meetings with members of Congress as she advocated for affordable, quality health insurance for all Americans.

Prior to joining the Clinton Administration, Mr. Jennings served as Committee staff for three United States Senators over the course of almost 10 years on Capitol Hill. As Deputy Staff Director of the Senate Aging Committee for Chairman David Pryor, he staffed the Senator before the Finance Committee and the "Pepper Commission." He also coordinated Senator Pryor's legislative initiatives on health insurance affordability and access, long-term care, rural health, and prescription drug coverage and cost.

## MARK MCCLELLAN

Mark McClellan is the director of the Engelberg Center for Health Care Reform and Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution. Established in 2007, the Engelberg Center provides data-driven, practical policy solutions that will foster high-quality, innovative, and affordable health care in the United States.

A doctor and economist by training, McClellan has a highly distinguished record in public service and academic research. He is a former administrator of the Centers for Medicare & Medicaid Services (CMS) and former commissioner of the Food and Drug Administration (FDA). While at CMS and the FDA, McClellan developed and implemented major reforms in health policy, including the Medicare prescription drug benefit, the FDA's Critical Path Initiative, and public-private initiatives to develop better information on the quality and cost of care. In the Clinton administration, he was deputy assistant secretary of the Treasury for economic policy, where he supervised economic analysis and policy development on a range of domestic policy issues.

Previously, McClellan also served as an associate professor of economics and associate professor of medicine (with tenure) at Stanford University. He directed Stanford's Program on Health Outcomes Research, was



associate editor of the *Journal of Health Economics*, and co-principal investigator of the Health and Retirement Study (HRS), a longitudinal study of the health and economic status of older Americans. He has twice received the Kenneth J. Arrow Award for Outstanding Research in Health Economics.

McClellan is a member of the Institute of Medicine of the National Academy of Sciences, a research associate of the National Bureau of Economic Research, and a visiting scholar at the American Enterprise Institute. He holds an M.D. from the Harvard University-Massachusetts Institute of Technology (MIT) Division of Health Sciences and Technology, a PhD in economics from MIT, an MPA from Harvard University, and a BA from the University of Texas at Austin.

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Prior to his departure from the Bipartisan Policy Center to serve as President Obama's Special Envoy to the Middle East, Senator Mitchell participated regularly in Leaders' Project activities which led to the development of this report. Despite his extensive involvement, he is not a party to the final recommendations and he is not in the position to officially endorse them.

This report is dedicated to the memory of Jim Range, whose years of service and dedication will forever be appreciated by Senator Baker.

The BPC is honored to have the support of the Robert Wood Johnson Foundation (RWJF). RWJF is working to ensure that all Americans have stable, affordable health coverage.



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Greetings:

As the nation's largest philanthropy dedicated exclusively to improving health and health care, the Robert Wood Johnson Foundation strives to help Americans get and stay healthy and access the care they need. From our earliest days, one of the Foundation's core goals has been to ensure that all Americans have stable, affordable health insurance coverage. That is an essential pillar of comprehensive health reform, and today we stand at a defining moment in the long and difficult journey toward achieving that goal. And while coverage is critical, our health care system must also be high in quality and deliver value to those who give care, get care, and pay for care. We think health care needs to be safe, timely, efficient, and equitable, and we recognize that prevention must be a key driver of our nation's health strategy and an essential part of health reform.

The Foundation is honored to play a unique and important role in health reform. We're proud to provide rigorous, evidence-based, nonpartisan policy research and analysis to ensure that our leaders have the information they need to make informed decisions at the right time.

We do not take a position on specific legislative proposals or support any one approach to achieving health reform. We recognize that there are many approaches to transforming our health care system. It is essential that policymakers at the federal, state and local levels benefit from the best available evidence about both what creates the persistent and daunting challenges of America's health and health care systems, and about what we know about what does and doesn't work to address those challenges. That's why RWJF is committed to sharing the best knowledge and results from work conducted through our many grantees and partners. At any given time, Foundation projects are preparing objective policy research, testing pilot reforms in real communities, and bringing people with different perspectives together to discuss and attack big problems. So, in that spirit of bringing together those with expertise and distinct points-of-view, we are pleased to support the process that has produced this bipartisan report, and to work with the Bipartisan Policy Center and its leaders, who have great standing and experience in achieving consensus and compromise.

The recommendations presented here are an excellent example of what occurs when partnership rises above partisanship. This document is a direct result of the work of these

remarkable leaders who for many decades contributed so much of their lives to public service and to improving our nation's health and health care, and who continue their commitment to health reform by participating in this project. As they have done so many times in the past, these statesmen crafted a set of principles that are both realistic and well-reasoned from policy and political perspectives. Most importantly, the leaders have demonstrated what we are seeing inside the beltway and across the country: that health reform is both politically feasible and a wise investment in our nation's health.

I applaud the senators for leading this project and for their continued service to our country. We at the Robert Wood Johnson Foundation look forward to working with them again in the future and celebrating with them when all Americans have the health care insurance coverage they need, when they need it.



RISA LAVIZZO-MOUREY, MD, MBA

President and CEO, Robert Wood Johnson Foundation

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- 18 Over time, shared savings payments could be expanded to provide stronger incentives for coordinated-care steps that improve quality and reduce costs, such as "partial capitation," beneficiary copay reductions, and other models.

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- 20 As today, regional premium rating variation can occur within states, but the region cannot be so small as to, in effect, medically underwrite certain populations. For instance, such differences would not involve sub-dividing Metropolitan Statistical Areas (MSAs). Any regional rating variation must be based on actual differences in health care costs. Over time, as plans and providers move from a fee-for-service based system to a system of reimbursement that rewards quality and value, it is expected that variations in premiums from region to region will narrow, as at least some of these costs are due to variation in medical practice and historical costs under Medicare.
- 21 Recent examples of managed competition exchanges include the Massachusetts' Connector for nongroup and small-group insurance and Medicare Part D for seniors' prescription drug plans.
- 22 In order to discourage adverse selection, individuals offered coverage through an employer can only obtain low-income subsidies in the exchange after applying their employer's insurance contribution as a payment against the subsidy.
- 23 Federal tax credits would be tied to federal minimum creditable coverage standards to prevent subsidies from increasing if a state chose more generous requirements.
- 24 Early retirees would receive the lesser of a 25 percent premium credit or a credit sufficient to reduce premiums to 10 percent of income (for a plan at their income group's generosity level).
- 25 Businesses with fewer than 11 employees and average income less than \$20,000 would receive a 50 percent premium credit. The credit would phase out for larger firms up to size 25 and average income of \$40,000.
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- 28 Specifically, premiums would be capped in 2013 at the premium of the Federal Employees Health Benefit Program (FEHBP) Blue Cross standard option (separately for single and family coverage), indexed to the medical care Consumer Price Index over time. In 2013, the FEHBP standard premium is expected to be about \$7,400 for an individual and about \$17,000 for a family (assuming 6 percent annual growth from today's premium levels). The cap would first apply in 2013, the year coverage subsidies are implemented.

## ACRONYMS

<b>ACO</b>	<i>Accountable Care Organizations</i>	<b>IOM</b>	<i>Institute of Medicine</i>
<b>AHRQ</b>	<i>The Agency for Healthcare Research and Quality</i>	<b>MA</b>	<i>Medicare Advantage</i>
<b>ARRA</b>	<i>American Recovery and Reinvestment Act</i>	<b>PQRI</b>	<i>Physician Quality Reporting Initiative</i>
<b>CBO</b>	<i>Congressional Budget Office</i>	<b>SGR</b>	<i>Sustainable Growth Rate</i>
<b>CER</b>	<i>Comparative Effectiveness Research</i>	<b>VA</b>	<i>Veterans Administration</i>
<b>CHIP</b>	<i>Children's Health Insurance Program</i>	<b>VEBA</b>	<i>Voluntary Employees' Beneficiary Association</i>
<b>CHT</b>	<i>Community Health Team</i>	<b>USPSTF</b>	<i>United States Preventive Services Task Force</i>
<b>CMS</b>	<i>The Centers for Medicare and Medicaid Services</i>		
<b>CPI</b>	<i>Consumer Price Index</i>		
<b>DOD</b>	<i>Department of Defense</i>		
<b>DSH</b>	<i>Disproportionate-Share Hospital (Payments)</i>		
<b>FEHBP</b>	<i>Federal Employees Health Benefit Program</i>		
<b>FFS</b>	<i>Fee-for-Service</i>		
<b>FPL</b>	<i>Federal Poverty level</i>		
<b>GDP</b>	<i>Gross Domestic Product</i>		
<b>GME</b>	<i>Graduate Medical Education</i>		
<b>HHS</b>	<i>Department of Health and Human Services</i>		
<b>HIT</b>	<i>Health Information Technology</i>		
<b>IHHC</b>	<i>Independent Health Care Council</i>		





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