CROSSING OUR LINES

Working Together to Reform the U.S. Health System

HOWARD BAKER • TOM DASCHLE • BOB DOLE

BIPARTISAN POLICY CENTER

THE LEADERS' PROJECT
On the State of American Health Care

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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 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.

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, Senator 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 1981-1985. 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 Council to Alston + Bird in Washington DC. 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 for heroic achievement two Purple Hearts and a Bronze Star with Oak Leaf Cluster for heroic achievement.

01 INTRODUCTION AND SUMMARY OF KEY 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, they believe that there are too many gaps between what medical science and our health professionals are capable of doing, and what the 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' sustained effort to develop consensus on bipartisan policy recommendations for health care reform. Their goal 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. Together, these changes are necessary to achieve a higher return on our health care spending, which now exceeds $2 trillion per year.

In developing their recommendations, the Leaders deliberated solutions to the challenges facing the nation's health care system, and ultimately made 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 conceded positions that they feel strongly about, but did so recognizing that negotiations often require making tough choices. The Leaders acknowledge that they are no longer sitting members, and therefore 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 garnered over decades of working across party lines to achieve progress on critical policy issues facing the nation.

To support the development of their recommendations, the Leaders sought advice and input from a broad range of 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, the Leaders' 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 to create a consistent source of health coverage for every American.

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 our nation's families, businesses, and governments. 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 cost sharing for needed medical services. Rising cost trends also extend to public health care programs, with states 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 spending growth in Medicare, Medicaid, and the "tax expenditure" for employer-provided health insurance.

While the U.S. health system features some of the best medical capabilities 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. And, unfortunately, those who develop chronic diseases – which account for three quarters of all health care costs – 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. The current health care system, through provider payment mechanisms and health benefit designs, 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 many other countries, not just because of our 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 complimentary goals of affordable coverage and high-value, innovative health care. The Leaders' policy recommendations 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 Leaders set forth specific policy recommendations 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 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 health care financing*** in a manner that is budget neutral and credibly slows the growth in health care spending.

These policies are inextricably intertwined, and consequently work together to achieve more significant improvements in the health care system than could be achieved if they were considered in an isolated manner.

Promoting a Bipartisan Process

The Leaders believe strongly in the importance of finding a real, bipartisan solution to the nation's health care crisis right now. This requires members of both parties to engage in a collaborative, constructive debate with the goal of achieving true compromise. The Leaders encourage truly bipartisan efforts in Congress, and support 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 legislation that is durable, lasting, and meaningful to all Americans. In similar regard, 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 Leaders' recommendations are designed to be mutually reinforcing and are intended to 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. These policies are inextricably intertwined, and consequently work together to 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 personal responsibility requirement to purchase health coverage or improvements to the way that health care is delivered, that will singularly resolve the problems currently facing the system. Further, it is the Leaders' collective set of recommendations that amounts to bipartisan health reform. As such, extracting any one policy could very well undermine the carefully crafted consensus that has been achieved, as well as the structural soundness of the overall policy recommendations.

A Principled Approach to Compromise

In achieving their historic policy agreement, the Leaders moved 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 for a system managed exclusively by the government and public entities, while others advocate equally 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.

The Leaders encourage truly bipartisan efforts in Congress, and support inclusiveness and transparency across all stages of the process – from policy development to final passage.

The Leaders recognize the significance these varying principles represent to lawmakers, stakeholders, and political constituencies, and believe that successful health reform can incorporate ideas from both ends of the political spectrum. Accordingly, their policy recommendations envision a strong partnership between the public and private sectors, with the government providing a consistent regulatory framework by which the health care industry operates. They also call for a national and state approach to managing the health system, with the federal government providing minimum standards for states to implement and oversee. And, individuals are empowered to take greater responsibility for their health and health care, but extra support is provided to those who need it.

The 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.

Additionally, the Leaders believe, it is critical to assess the strengths as well as weaknesses of the health system. One of the most notable and unique features of the U.S. health care system is its long tradition of allowing consumers to choose their own physicians and health professionals, hospitals, and health insurers. The Leaders' policy framework 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, the Leaders believe it can and should be done with the least amount of disruption possible.

Rejecting the Status Quo

Guiding the Leaders' work is their shared belief that the status quo of large gaps in health care quality, skyrocketing costs, and growing numbers of uninsured is both unsustainable and unacceptable. The Leaders 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, the Leaders believe that it is essential to apply principles of fiscal responsibility. Therefore, while the coverage reforms and other federal infrastructure investments in these recommendations are expected to have a gross cost of approximately $1.2 trillion over the 10-year budget window, they also propose policies that would completely offset this amount. To place this in appropriate context, it is important to consider that projected national health expenditures for the next 10 years are expected to total $35.2 trillion. Moreover, the Leaders believe the strong incentives they are recommending 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 their health reform proposal, the Leaders recommend over $1 trillion in specified financing, divided between federal health system savings and health-related revenues. The Leaders believe that 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 policies and revenue enhancements 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 explicit policies that would achieve more savings if needed. Of

course, this approach would be unnecessary if the comprehensive set of delivery system reforms and infrastructure investments produce long-term savings beyond what is scored by the Congressional Budget Office (CBO). 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: PROMOTING HIGH-QUALITY, HIGH-VALUE 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 development of consensus-based quality measures
  - ◊ Move to electronic, patient-centered quality reporting
  - ◊ Improve the Department of Health and Human Services' (HHS) capacity 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 (CHTs) to provide comprehensive support to prevent chronic illnesses and their complications
  - ◊ Establish a joint program for care coordination for 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 (ACOs)
  - ◊ Share savings with ACOs meeting or exceeding quality benchmarks and reduce overall cost trends

- **Expand Comparative Effectiveness Research (CER) Relevant to Patient Decisions and Effective Health Care Policy Reforms**
  - ◊ Develop infrastructure to support comparing 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 (GME)
  - ◊ Provide funding for 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/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 (IHCC) that would:**

  - ◊ 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
  - ◊ Require state reporting on implementation progress
  - ◊ 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 enrollee support tools and adopt strategies to improve plan choice
- ◊ Risk-adjust premiums paid to plans participating in exchanges
- ◊ Implement a federal fallback if states or regions do not create exchanges in a timely manner
- ◊ 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 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 under 400 percent of the federal poverty level (FPL)
  - ◊ 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 premium reductions 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, including, but not limited to:

  - ◊ Eliminate cost-sharing for A and B-rated services by the U.S. Preventive Services Task Force (USPSTF) in both Medicare and in the health insurance exchanges
  - ◊ Extend new authority to the Secretary of HHS to eliminate coverage for D-rated services by the USPSTF, at her 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 (CHT) 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 enact a "trigger" mechanism that automatically enforces reductions
  - ◊ Empower the IHCC 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 (SGR) Formula for Physicians

02 PROJECT OVERVIEW

Over the last several years, the Leaders have witnessed a convergence of political, economic, and policy-related factors suggesting that now is the time for action. The nation has achieved monumental domestic policy accomplishments, such as social security, civil rights, and environmental protection, during critical periods in the past, and the Leaders believe that the country is now facing such a moment with health reform. They hope their report serves 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 be used to transform our nation's health care system, and (2) to demonstrate that health reform is an achievable political reality. 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. In order to accomplish that end, the project and its final report are centered upon four principles, or "pillars" of health reform:

1. Promoting High-Quality, High-Value Care

2. Making Health Insurance Available, Meaningful and Affordable

3. Emphasizing and Supporting Personal Responsibility and Healthy Choices

4. Developing a Workable and Sustainable Approach to Health Care Financing

While the Leaders personally spearheaded the development of this report, they were guided by two of the nation's top health care 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 Leaders also relied upon the support of their current and former staffs, as well as the expertise of key health care scholars. Together, this network of policy experts, thought leaders, and staff supported the Leaders as they worked to achieve the ambitious goal of developing a bipartisan policy framework that makes a relevant, constructive contribution to the current health reform debate.

A Broad-Based Outreach Strategy

The Leaders believe that any successful health care reform effort must have the input and support of not only citizens and lawmakers, but also key health care constituencies. The Leaders sought to identify practical and supportable ideas to resolve the challenges facing the health system from employers, labor advocates, health care providers, state officials, health plans, and health reform coalitions. Now more than ever, these groups understand that the current health system is unsustainable, and they have begun a productive dialogue to define real solutions for change. Successful health reform requires an inclusive process, and the Leaders made it a priority to give all voices an opportunity to contribute to the process.

The work of the Leaders' Project coincided with a renewed national emphasis on comprehensive health reform. Throughout the 2008 presidential election, voters consistently ranked health care as a top domestic policy priority, and it dominated the candidates' platforms. Congress has focused its attention on the issue with numerous hearings and proposals introduced by both Republicans and Democrats. To ensure that their work accounted for the views and positions of current Members and government officials, the Leaders, along with the project co-directors, maintained a continuous dialogue with Congress and the Administration over the course of the project.

The formal launch of the Leaders' Project took place in April 2008. Sens. Dole and Mitchell joined well over 100 members of the health care community at a press conference to announce their goal of developing a bipartisan policy framework for health care reform. They reflected upon their personal triumphs of working across the aisle to restore Social Security's solvency, improve veterans' health care, and support disabled Americans, and expressed hope that Congress would follow in that tradition by taking a bipartisan approach to health reform. While the Leaders recognized that the process to complete the project's final report would be inclusive, they made clear that their policy recommendations would be developed and approved by them personally, so that they could demonstrate that achieving consensus on a comprehensive health reform plan is something that Republicans and Democrats can and should do.

> ***In order for us to be successful, we need the 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 encouragement that the time is right such as ours that is charting the path forward to reform.***
>
> ***—Senator Bob Dole***

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 outlined in the four pillars, the Leaders hosted a series of public policy forums. These events brought together key stakeholders in the debate so that the Leaders could hear firsthand how the current flaws in the health system were harming businesses, states, the federal government, and, most importantly, American families. They also enabled the Leaders 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.

Sen. Daschle hosted the first of these policy forums in Washington, DC on April 24, 2008. The discussion focused on the first pillar of the Leaders' Project, improving the quality and value of health care. A group of health care experts discussed a wide range of practical ideas to deliver the highest quality, most effective medical treatments possible, while at the same time controlling costs. Specific

themes highlighted at the forum included designing provider payment mechanisms that support accountability and improved health outcomes; integrating and coordinating health care delivery; developing and disseminating better evidence; developing standards for safer, higher quality care; increasing transparency; and fostering the use of value-based benefit design. Sen. Daschle made clear that creating an efficient, high-performing health system was not only a function of improving quality, but of ensuring health coverage for all Americans and reducing overall health care costs.

When designing the project's agenda, the Leaders wanted to take the health reform debate outside the Washington beltway. State and local health care communities have long been at the forefront of innovative reform efforts, and many lessons can be learned from their experiences. Sen. 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 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. Sen. 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, active lives.

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

Sen. Mitchell hosted the third Leaders' Project forum on September 10, 2008, in Portland, Maine. His event focused on the challenging topic 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 complete that work. Participants also focused on ways to improve access to health coverage through effective

> ***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***

market reforms, particularly highlighting options that promote fairness and reduce adverse selection. Sen. 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, which ultimately led him 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.

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

Sen. 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 workforce personnel to deliver high-value health care. Other discussants noted that in order to maximize the effectiveness of delivery reform tools, individuals must have health insurance, and vulnerable populations like early retirees, low income families, and individuals with pre-existing health conditions will need extra assistance to obtain coverage. Sen. 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 their policy forums, the Leaders commissioned a series of technical papers to advance the project's substantive agenda. The BPC 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 policies underlying the four "pillars" of health reform. Each paper contains a wide range of detailed policy options on topics such as effective health benefit design, sustainable health care financing, and improving the quality and value of health care. They also describe the impact policy options would have on consumers, providers, the health industry, and the economy more broadly. 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 An Historic Agreement for Health Reform

With the successful completion of the policy forums, the Leaders began meeting and communicating regularly as a group to consider polices to include in their bipartisan policy framework for health reform. As Sens. 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 Leaders personally negotiated and approved a set of policy recommendations they believe could be successfully supported by both political parties, as well as 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.

The Leaders began their deliberations by drawing upon ideas and concerns presented at the policy forums, stakeholder meetings, and discussions with Members of Congress and staff. There were no preconceived limitations placed on the scope or breadth of policy options 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 Congress' role of 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, demonstrating that bipartisan health reform is possible.

Throughout their respective careers, the Leaders have been able to resolve tough policy issues when they crossed their own personal, political, and ideological lines. As former Members now comfortably 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. They worked together to make 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 Sen. 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, Sen. Mitchell is an ideal choice to work for resolution to the longstanding unrest in the Middle East. Unfortunately, his new responsibilities would limit his ability to continue engaging in the work of the Leaders' Project. His colleagues support his new venture, and wish him every success as he undertook the challenging work ahead of him. Fortunately, Sen. Mitchell was able to contribute to the report's substantive content through the end of March 2009.

After months of deliberations about how best to construct a durable, meaningful package of policies that both Republicans and Democrats could support, the Leaders reached the agreement for comprehensive health reform presented in this report. Their achievement is the culmination of a sustained effort that involved actively engaging the American people in the debate, soliciting ideas and input from key health care stakeholders, and holding frank, yet constructive, deliberations about meaningful policy solutions to the problems currently facing the system. This thoughtful, inclusive process enabled them to accomplish their primary goal – to develop a slate of policies that, taken as a whole, ensure that all Americans have quality, affordable health coverage. It should be emphasized that they accomplished this goal while consistently embodying the ideals of civility and cooperation. In the end, the Leaders hope their achievement will serve as proof that, despite differing political and substantive views, reform is possible, when we come together with resolve to find viable solutions.

03 DIAGNOSING THE 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 lead many experts and health care professionals to describe the health care system as in need of comprehensive reform.

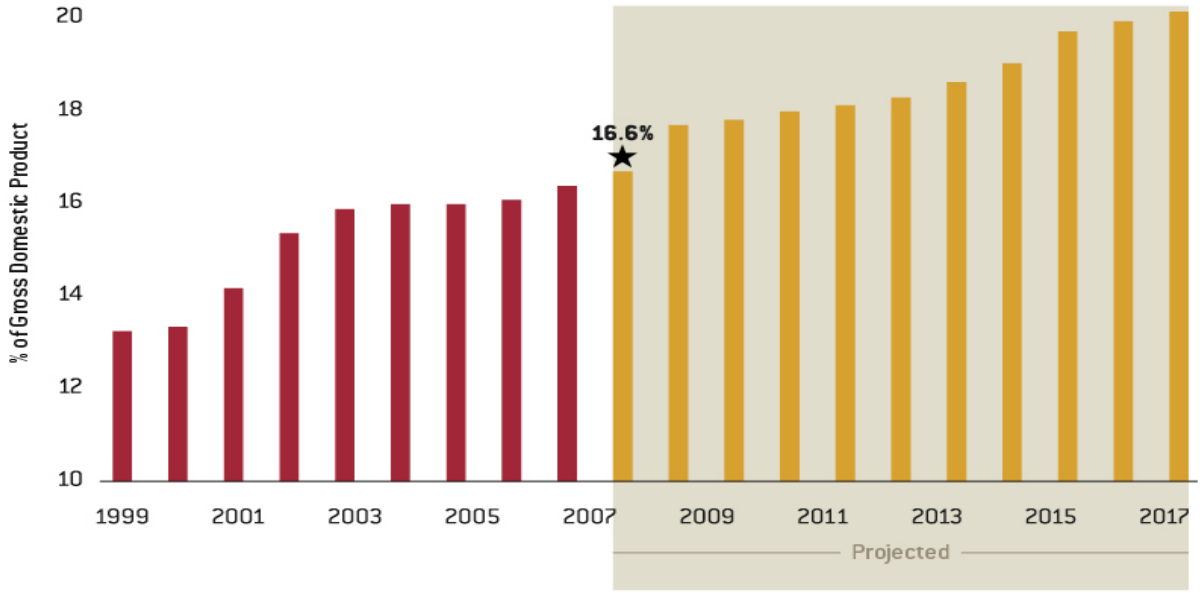
For too long, the political and legislative process has largely addressed the well-documented challenges facing our health care system in an incremental fashion. Policy solutions often attempt to tackle the cost, quality, and coverage problems as independent issues. They also take a siloed approach to expanding or making improvements to insurance coverage, through the Medicaid program, for example, or new tax credits for private health coverage, or state-based market reforms. Without universal coverage and a comprehensive approach to containing costs, policies will continue to lead to poor health outcomes, cost shifting, and fragmented care. Only by addressing all of these issues together will we be able to bend the long-term health care spending curve, and achieve better value.

Major, systematic policy changes are not only necessary but – for the first time in over a decade –politically feasible. Businesses, 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 fundamentally reform the nation's health care system in an integrated, coordinated, and comprehensive fashion. The problems that need to be solved include:

- ***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 almost 7 percent a year—rapidly outstripping projected growth in GDP (4 percent) and wages (3 percent).[1] As a nation, we spend over 16 percent of our 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.

Figure 1 • U.S. Health Care Spending as a Percent of GDP



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

Employers now spend almost 11 percent of payroll on health care, with premiums continuing to rise each year.[2] From 2000 to 2006, workers' monthly health insurance premiums grew 73.8 percent, but the U.S. median income grew just 11.6 percent during the same period.[3] While many companies are increasing workers' cost-sharing responsibilities to offset some of this cost growth, some are electing to forego coverage for their workers 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 more and more workers find themselves unable to afford their premiums, the number of uninsured individuals will continue to rise.[4]

Costs are also becoming a growing burden for governments that fund public health care programs. At the federal level, Medicare costs are rising rapidly, and the Medicare trust fund is 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 (CHIP). Because almost all states are required to balance their budgets, cost growth often means cuts to health care providers, reduced eligibility for programs, or reductions in other vital areas such as education.

♦ *Lack of universal coverage results in cost-shifting, and excessive administrative costs*

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 of health care. As a result, significant uncompensated care costs must be absorbed by providers or passed through to the government and to the privately insured. In 2008, the uninsured received over $56 billion in uncompensated care.[5] 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.[6]

Providers also offset some of their uncompensated care costs by raising the price of care for their insured patients, thereby increasing premium costs for insured individuals. While estimates of this cost shift vary, some researchers maintain that it may account for as much as 8 percent of health insurance premiums.[7] Others find that in 2008, average premiums for family coverage were inflated by $1,017 per year due to uncompensated care.

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, in the non-group market, administrative costs for plans are about 40 percent of premiums compared to just 10 percent in the employer market.[8] These expenses are largely consumed by marketing and underwriting efforts that help plans sell to targeted enrollees to protect themselves from risk. [9]

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

The health care system suffers from fragmentation and lack of accountability that limits the effectiveness of care. For example, The Agency for Healthcare Quality and Research (AHRQ) estimates that preventable medical errors account for over 7,000 deaths per year. Such adverse events are not only tragic, but also expensive for the health care system, and suggest the need for reforms that improve quality and ultimately reduce costs.

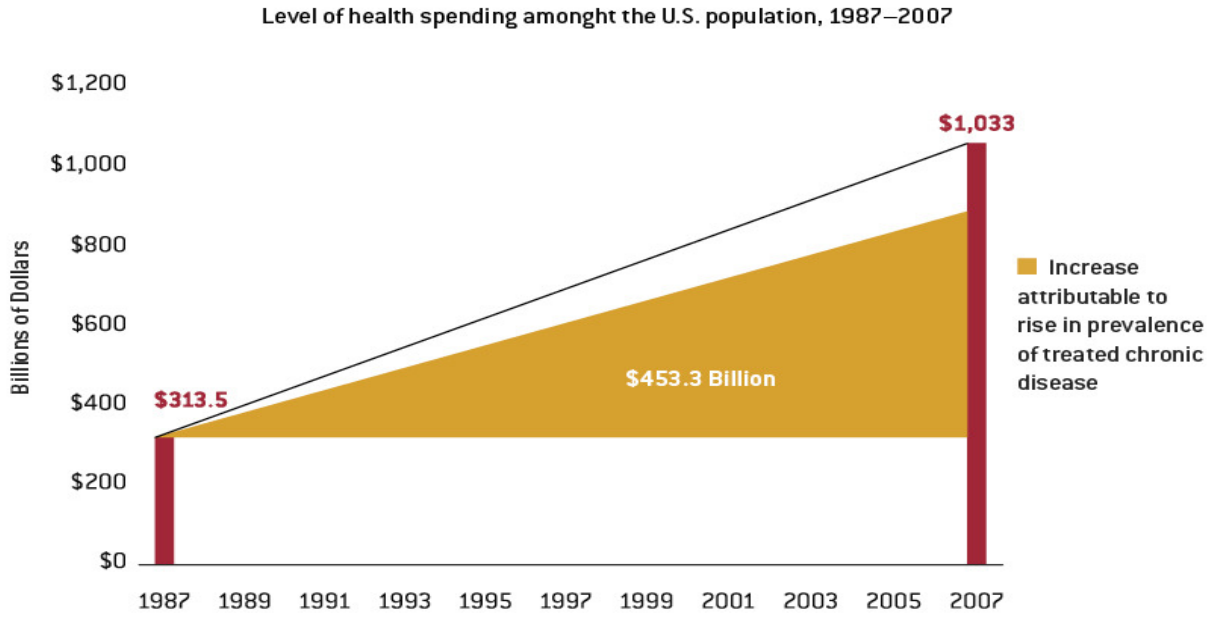
Moreover, the current health care system is inherently biased toward volume of services provided, rather than health outcomes. Because most fee-for-service (FFS) systems pay providers for each service rendered, they create incentives to provide more care, even if the patient would benefit from fewer services and less intensive treatment. The overuse or misuse of care is evident in regional variations in Medicare spending. Regions with lower per-beneficiary spending in Medicare have been shown on average to provide similar care quality, and achieve equal or better health outcomes and patient satisfaction than those in higher spending regions. [10]

- ***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, drive a high percentage of health care costs in this country. Patients with chronic diseases account for 75 percent of national health 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 more likely to forego needed medical care, are less likely to receive preventive services that might prevent acute medical events in the future, and are more likely to encounter problems with care coordination. For both insured and uninsured populations alike, health reform must promote prevention and wellness initiatives that encourage healthy lifestyle choices and use of preventive services.

Successful health reform must invest in both primary and secondary preventive interventions to reduce the incidence of chronic disease. Primary prevention focuses on disease prevention through outreach in

Figure 2 • Increase in Health Spending Attributed to Preventable Chronic Diseases



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

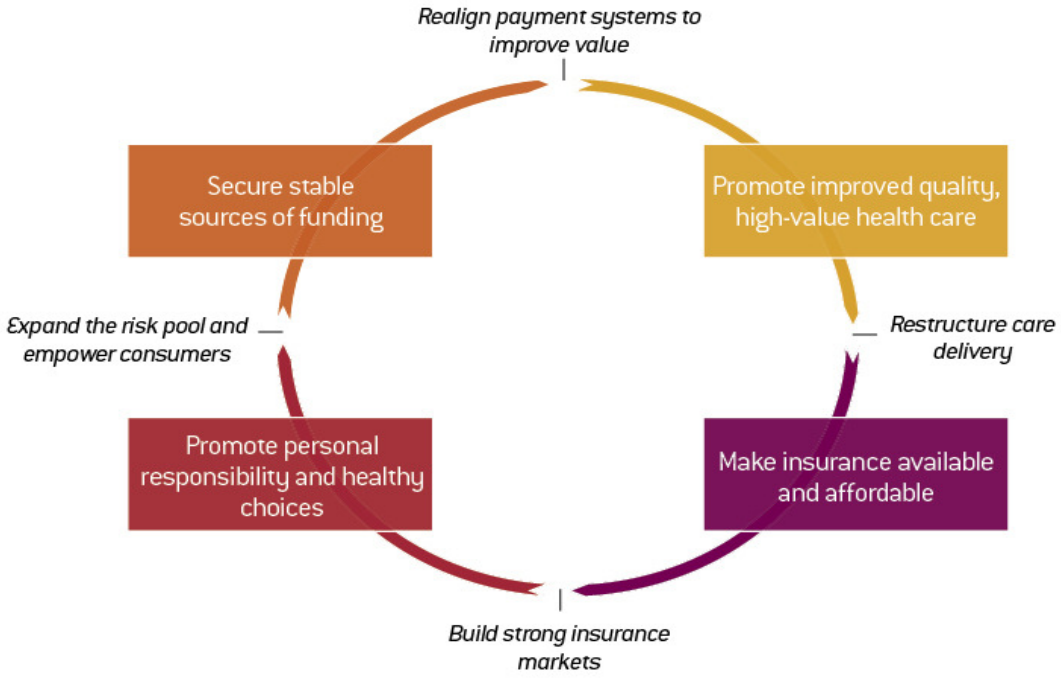
schools, communities, and workplaces to discourage behavioral choices that can lead to disease. Secondary prevention emphasizes early screening and detection of diseases to avoid unnecessary and costly health care treatments. Future health care interventions should focus on implementing strategically-designed, evidence-based prevention programs that can demonstrate cost savings, but also improve health for patients in public programs and private plans alike.

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

In the United States, racial and ethnic minorities have poorer health outcomes, receive lower quality health care, and have more difficulty accessing medical treatment than do their white counterparts. For example, death rates for African American adults are 55 percent higher than they are for whites adults.[11] When asked to rate their own health status, American Indians (17.2 percent), African Americans (14.6 percent), and Latinos (12.9 percent) are all more likely to report being in fair or poor health relative to whites (7.9 percent) and Asians (7.4 percent).[12]

These disparities stem from a number of systemic 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 serving low-income individuals.[13] Third, there are a variety of structural barriers that prevent minority and underserved populations 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 deliver more culturally appropriate care, and may be more accessible to minority populations.

Figure 3 • BPC's Pillars are Interrelated and Require Coordinated Policy Decisions



An Opportunity for Change

The Leaders view the significant challenges facing the nation's health care system as 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 together as an integrated package that will address the health system's uncertain future.

04 THE LEADERS' POLICY RECOMMENDATIONS

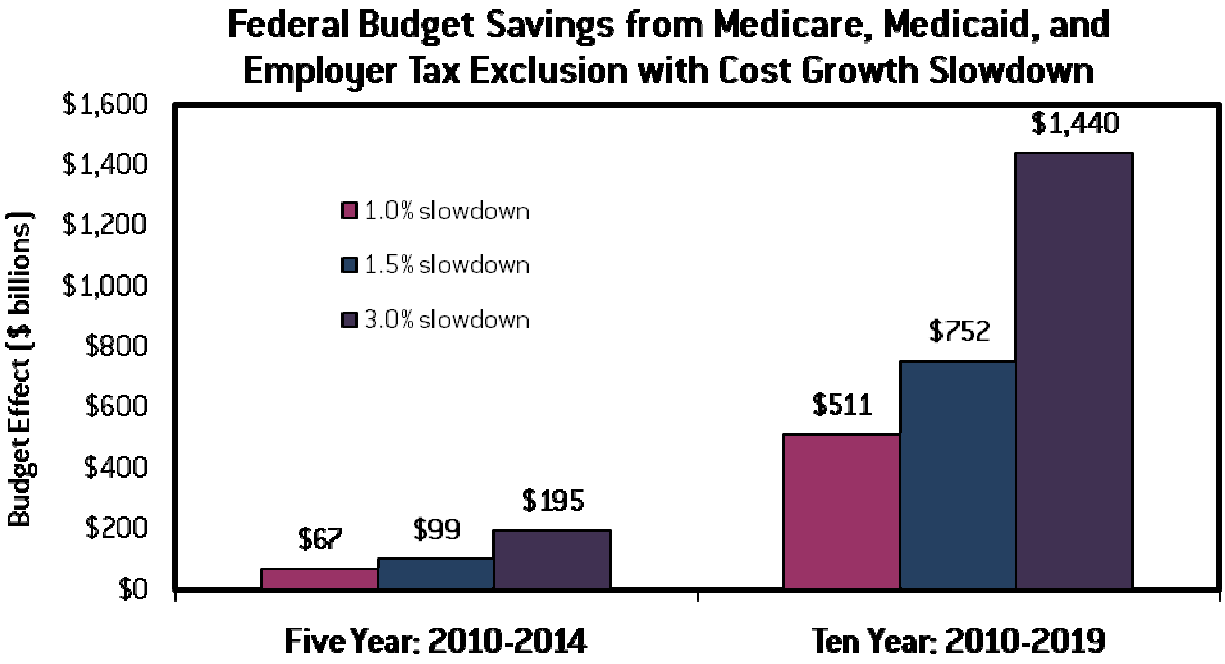
The time for achieving affordable, quality coverage for every American has arrived. It is essential not only for the nearly 46 million uninsured and millions more underinsured, but for the businesses and families who have coverage and are concerned about losing it, or not being able to afford it any longer. It is no less necessary for health care providers who try to deliver quality care in a dysfunctional and administratively burdensome system. And it is particularly important as 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. The nation can no longer afford to wait for meaningful improvements to the system, from the standpoint of our health, our economy, and our unsustainable health care entitlement spending.

The goal of reforming the health system can only be achieved by concurrently securing a much greater return on the more than $2 trillion per year investment the United States makes in the health care system, expanding coverage for all Americans, and ensuring the country maintains its role as an international medical innovator. The Leaders recognize this, and recommend a framework of interconnected policies that are organized around their four "pillars" of health reform, that, taken together, provide the essential foundation of comprehensive health reform.

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 low spending. Some analysts suggest that as much as 30 percent of spending on Medicare does not contribute meaningfully to patient outcomes.[14] Yet, at the same time, proven-effective preventive care 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.[15] 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.[16]

Many of these problems can be traced to the lack of support for interventions that prevent illnesses and their complications like effective wellness programs, HIT that provides timely and complete information to improve care, care coordination programs, and provider efforts to educate and support patients in taking steps to better manage chronic illnesses and stay healthy. This is perhaps not surprising, since



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

the U.S. health care system does not consistently collect and report meaningful quality and cost data or track patients between settings of care. 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 growth. Failure to realize improvements in both cost and quality together will render efforts to expand coverage neither feasible nor sustainable. 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 effective implementation of investments in health information infrastructure, new investments in the development of sophisticated quality and care experience measures, payment reforms that support providers and patients in restructuring how care is delivered and then holding them accountable for achieving better results, and targeted investments in the training and supply of 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 any strategy to bring about these changes has a meaningful impact on quality of care. The Leaders' recommendations in these areas require significant up-front investment; however, they are collectively expected to yield significant improvements in the quality of care

and produce long-term reductions of 1-2 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 future health care system delivers higher value care for all Americans, the Leaders recommend:

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 (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, in order to 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 payments include rewards for quality reporting or performance, care coordination, such as medical home payments, and "accountable care" payments for improving outcomes and reducing cost trends. Aligning these payment and regulatory reforms 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 electronic sources (administrative, lab, and clinical data), which is the goal of "meaningful use." Alignment will also help ensure that products offered by IT vendors do not just meet interoperability standards, but also can be used to coordinate care.

Promote Patient-Centered Care: Patients should have access to appropriate 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 assure their preferences are reflected in care transitions, palliative and end-of-life care, and 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, and further steps, if needed, to ensure that standards of care are met.

Developing a Quality Measurement Infrastructure to Support Patient-Centered Care—The health system needs a more robust quality measurement infrastructure that will help providers deliver better-coordinated, higher-quality care, and also facilitate evaluating the effectiveness of particular payment and delivery system reforms on 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 experiences with care. Particular attention should be paid to the development of measures that help guide the treatment of patients with co-morbidities, not simply those with single diseases.

Fund Development of Consensus-Based Quality Measures: Expand funding to the Department of Health and Human Services HHS or the CMS and broad-based collaborations of organizations for the prioritization, development,

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 and call for urgent attention.

- ◊ Consistent methods for summarizing patient care data in public and private sectors (e.g., using consistent summary information from integrated electronic records and regional collaborations) can support quality measurement 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 electronic reporting of increasingly sophisticated measures. Such measures should focus on quality and costs at the person level and should be designed to be useful to providers for coordinating care, which will require CMS to have the resources for timely and accurate reporting to providers based on its data. This policy should also reinforce the incentives for "meaningful use" of HIT outlined above. Such policies 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 taking place.

Improve the Department of HHS' Capacity to Facilitate 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 data and analytic capacity toward these ends. As a byproduct, these investments would improve HHS's 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 how to eliminate 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 that this requires redirecting reimbursement incentives in federal health programs. The goal is to move toward paying providers based on accountability for overall cost and quality using the increasingly sophisticated measurement and reporting infrastructure. Not only will these reforms improve quality and slow cost growth in Medicare, but they should also result in reducing the significant geographic variation in spending, which is based in part on historical Medicare reimbursement and variation in practice patterns from one location to another, even within regions. However, while such changes must be applied systematically, 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 person-level measures reflecting 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 readmission rates).

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 encourage and reimburse providers in a way that ensures care coordination for patients with chronic conditions in an effort to reduce the number of preventable readmissions. Such payments might initially be implemented through bonuses for coordinating care to help providers take the necessary steps to coordinate care effectively, but within several years they would be transitioned to levels that reflect expected gains in care 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.

Assuring Patient-Centered Care for Chronically-Ill Beneficiaries—Millions of Americans suffer from chronic diseases affecting their health and quality of life, and people with chronic health conditions account for a significant portion of spending in our health care system. Because of this, the Leaders believe that steps to achieve significant and timely improvements in care for chronically ill individuals are urgently needed. These steps include payment reforms that will pay providers more when they undertake efforts to improve prevention to delay or eliminate the onset of costly chronic conditions, and avoid costly hospitalizations arising from chronic disease complications. These payment reforms, like greater use of bundled payments, will ensure that Medicare payments support—rather than penalize—valuable prevention and care coordination. But the urgency of this problem means additional steps are necessary to ensure that people get more support for staying well and preventing the complications of chronic disease. The proposals described in this section will improve care coordination, and provide support to patients and their caregivers so they might better understand their conditions and treatment plans, thereby helping to ensure patient adherence.

Value-based payment reforms also would give providers greater support for assisting patients in navigating the health care system. 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 readmissions. Moreover, through the use of basic preventive and wellness interventions, individuals with chronic illnesses could be targeted to avoid hospitalization in the first place.

In conjunction with these steps, the current system of care for dual eligible individuals (those eligible for both Medicare and Medicaid) promotes cost-shifting between providers as patients move from one care setting to another. The expansion of Medicaid for low-income non-elderly Americans also provides an opportunity to make states' financing responsibilities more stable and to provide better coordinated care for dual eligible individuals at the same time.

Create Community Health Teams (CHTs): To provide more comprehensive support for preventing chronic diseases and their complications, community health initiatives should be better integrated into efforts that achieve well-coordinated, prevention-oriented care for the chronically ill, and patients who are transitioning from the hospital to a post-acute care facility or home. CHTs would support these activities more comprehensively than is possible through traditional approaches. CHTs are

organized, trained, and accountable for helping vulnerable chronically-ill populations navigate through the complex health care system and follow care plans designed by their physicians.

Some successful examples of CHTs include programs operated by Area Agencies on Aging, and Aging and Disability Resource Centers, and regional initiatives to provide transitional care and execute care plans (e.g. 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. The establishment of federal support would be achieved by building on existing authority provided in the Medicare Modernization Act to distribute mandatory funds to the states for qualifying programs.

States would work on a statewide or regional basis to establish care teams, and would ensure 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 impact on 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 for Care Coordination for Dual Eligibles*:** Direct the Secretary of HHS to establish a program that would include a mechanism or template for states and the federal government to provide joint financial support to deliver integrated Medicare and Medicaid services to dual eligible beneficiaries, consistent with established patient protections in those programs. States would be permitted 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 care coordination for dual eligibles, states would receive additional funding to offset the state cost of covering *newly* eligible non-elderly Medicaid beneficiaries (see 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 below), medical homes, chronic disease management programs, or integrated health plans that can demonstrate high performance.

Ensure New Care Coordination Programs Improve Outcomes for the Chronically Ill: The Leaders' recommendations emphasize new payment systems under Medicare to improve quality and value that require 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, which should be incorporated from the start.

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 care coordination 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. Care coordination programs would be required to demonstrate their performance of these activities, either through meeting standards defined by the Secretary, through a third-party certification process, or through meeting standards on a sufficiently broad set of performance measures.

The intent of these processes is to ensure that care coordination programs are reducing avoidable hospitalizations resulting from drug interactions or unsuccessful care transitions; are limiting disparities in care; and are maintaining or improving patients' maximum potential functional status. Care coordination organizations with a sufficient performance

record, as demonstrated by the capacity to report on adequate measures of such patient-centered care and by a track record of good performance on patient-centered metrics, could use such performance measurement and reporting to meet the requirements. Over time, all such organizations would be expected to demonstrate their capacity to provide quality care for complex and vulnerable beneficiaries through meaningful performance measures.

Improve Quality of Palliative Care – In addition to developing and reporting palliative care quality measures, quality measures 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.

Developing 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 integrate payment incentives into a systematic method to provide better support for providers that deliver high-value health care. The secretary of the relevant program would have the authority to implement pilots 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 cost trends for their patient population would receive "shared savings" bonuses, in addition to their fee-for-service payments.[17] 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 fee-for-service payments, instead receiving more of their payments based on achieving further improvements in quality and cost. CMS would be encouraged to coordinate with the private sector, using the increasing array of consistent quality and cost measures, to provide greater support for these types of delivery reforms.

Expanding Comparative Effectiveness Research (CER) Relevant to Patient Decisions and Effective Health Care Policy Reforms– There are considerable research gaps in what we know about the clinical and cost effectiveness of health care treatments and practices, particularly 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 the most effective approaches for payment strategies, benefit features like formulary designs and copayment structures, and information dissemination programs to improve care.

Develop Infrastructure to Support Comparing Effectiveness: Assure 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 and costs, as well as the health care policy reforms that can influence these practices. This should begin by ensuring that the CER funded in the ARRA emphasizes comparing risks, benefits, and costs of different health care practices, evaluating and revising policies that influence practices, and identifying strategies for targeting practices to specific groups of patients.

Prioritize Comparative Effectiveness Research Topics: To ensure that the highest priority questions for improving outcomes for particular types of patients, as well as patient populations, are being addressed in a timely way using appropriate methods, there should be

better coordination for publicly-funded CER efforts 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 help align the health care workforce as quickly and effectively as possible, with the goal of creating a system of well-coordinated, prevention-oriented, personalized care. Such reforms should reflect the best ideas and experiences from the nation's top health professional organizations and academic medical centers.

Covering the uninsured and reorienting the health care system to focus on wellness and prevention will require additional doctors, nurses, and other health professionals to support enhanced primary care delivery. As the nation considers ways to assure that our domestic health care work force is able to meet the needs of a reformed health care system, we must be mindful that the 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, and as such, the success of health care reform depends on policies to both recruit foreign-trained health care workers and to 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 adequate capacity and distribution of health care professionals in medically underserved urban and rural areas during the transition to cover all Americans. 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 the gaps in health care access and quality is an important enough goal that it deserves careful monitoring, and consideration of additional support.

Integrate Delivery Reforms into Graduate Medical Education (GME): Direct the IOM to develop a set of policy reforms designed to align GME with delivery system reform, and give the Secretary the authority to implement the IOM recommendations. The policy reforms affecting 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, including the Hospice and Palliative Care certification program, for appropriate specialties
- Promote more effective applied research on implementing coordinated care initiatives.

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

Provide Funding for 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 nurse faculty who can train more nurses and retrain health care workers who are transitioning from administrative jobs that may be in lesser demand as a consequence of applying technology to the health system. These health professionals should be trained for a broader set of clinical responsibilities, and should learn skills to better serve specific patient needs, including treating patients in rural and underserved areas, and conducting chronic disease management. Similar approaches

should be taken to train additional allied health professionals.

Revise Scope of Practice Laws: In conjunction with making meaningful measures of quality of care and outcomes 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 – It is important to explicitly recognize how important the Leaders' recommended delivery and modernization reforms are 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 a patient's 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 implement standard collection of patient race and ethnicity information by health plans and provide feedback to health care providers on disparities in treatment.

Establishing an Independent Health Care Council (IHCC)—The fragmentation of efforts within the federal government to address gaps in quality and care coordination highlights the need to better assess the overall performance and challenges facing our health care system. 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 health care system performance and innovative, cross-cutting strategies for improvement. Accordingly, the Leaders recommend that a permanent Independent Health Care Council (IHCC) be established and given the following responsibilities:

Analyzing and reporting health care quality and cost data in federal health programs and in the overall health care system.

Promoting better coordination among programs Issuing an annual report to the President outlining 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 Council'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, as well as any strategic directions for federal investments that can improve the performance of these programs. Its work would be coordinated with those of existing bodies, such as the Medicare Payment Advisory Commission (MedPAC) and the AHRQ to avoid duplication of effort.

Reforming Medical Liability Laws—The Leaders believe that medical liability reform is an important part of improving health care value, and should be carefully considered in the context of health reform. Accordingly, policymakers should work to develop consensus proposals that seek to more closely align liability systems with other reforms proposed in this report, thereby reinforcing 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. Many uninsured Americans are vulnerable to very high out-of-pocket costs that can result in the delay of medically necessary care, or lead to personal bankruptcy resulting from excessive medical debt. They are less likely to receive recommended preventive care that could avoid the onset of complicated chronic conditions. Furthermore, the health care uninsured patients receive often tends to go uncompensated, which shifts costs to insured individuals through higher premiums, and to public programs that subsidize providers who care for the uninsured through disproportionate share hospital payments.[18]

Additionally, millions more Americans 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 individual and small-group markets are often expensive, with high administrative costs. In particular, policies in the individual market 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 that would have the same effect.

For the Leaders, coverage reform starts with the principle that individuals and families who are happy with their current coverage should be able to keep it. Recognizing that a majority of Americans receive coverage through their employers, the Leaders' recommendations are designed to preserve existing group-coverage. They also strengthen it in some important ways, including building on innovative worksite wellness initiatives and, in particular, helping small businesses access affordable insurance through a new tax credit for offering coverage. Individuals who are not satisfied with their employer-based coverage options, as well as small businesses, will be able to purchase coverage through state-level or regional insurance exchanges. Regulatory changes will promote the availability of a range of coverage options for everyone in these markets and will limit plans' ability and incentive 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.

To obtain these protections, we must have a functional marketplace. In order to help create such a marketplace there needs to be a personal requirement to buy basic health insurance coverage and risk-adjusted payments to health insurers. This will address the problem of adverse selection in health insurance markets. Furthermore, an expectation of personal responsibility to purchase health insurance must be accompanied by income-related premium subsidies to ensure affordability, and user-friendly information to help Americans compare and choose appropriate health plans, including low-cost basic coverage options. To ensure that all Americans have access to meaningful, affordable health insurance, the Leaders recommend:

Reforming Health Insurance Markets — Insurance must be improved through minimum federally-defined and assured, state-enforced market reforms. Such reforms 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 on the date of implementation for the exchange to all new non-

group and small-group policies, including all policies purchased through the exchange. Over time, existing individual 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 revised 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 5 years.

Limit Variation in Premiums: Establish modified community rating requirements, to be overseen by states, providing rate bands for all non-group and small-group plans, defined as those with fewer than 50 workers. The Leaders recommend that premiums for the same plan be allowed to vary only based on region[19], individual versus family policies, wellness incentives (including smoking), and age within limit.

Establish a federal 5:1 age rating ratio limit. That is, premiums can vary by no more than 5:1 with age, reflecting age-related differences in utilization. This serves as an attempt to ensure that there is not excessive cross-subsidization by age, and that younger populations are not priced out of the market.

While the Leaders recognize that a 5:1 rate would permit higher premiums for older Americans, they believe that the financial assistance they are recommending, which limits premium costs through refundable tax credits, is an effective way to ensure access and affordability for all Americans regardless of age. Additionally, while the Leaders recommend a federal minimum age rating ratio, states could implement other 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 as 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 as well as collect and publish the medical loss ratios of plans in non-group and small-group markets.

Require States to Report on Implementation Progress: States would be required to report, as a condition of federal health reform funding, whether they intend to enforce minimum federal insurance market standards, and whether they intend to establish a purchasing exchange, either individually or in partnership with other states. States choosing to enforce the standards and establish an exchange would be required to have their exchanges provide annual reports to the Secretary of HHS. The reports would include the number of plans offered in each exchange, the range of premiums charged to enrollees, and the number of individuals covered through the exchange.

Establish a Federal FallBack If States Do Not Implement Market Reforms: Authorize and charge the Secretary of HHS to establish and implement minimum federal insurance reforms, if any state fails to implement them before 2013, when the coverage and personal responsibility provisions are implemented. Should this occur, additional resources should be provided to HHS in order to conduct this work.

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, and this complexity can cause confusion and inhibit competition. But as several recent examples[20] have shown, insurance markets with "exchange-like" features, like greater transparency, comparable information on quality and cost, more plan options for small employers, and the ability to provide promised benefits, can make beneficiary choice easier, promote competition, and reduce costs.

Establish Minimum Operating Guidelines for Exchanges: The federal government would provide minimum guidelines for states or, at their discretion, regional groups of states, to establish, operate, and regulate exchanges. Allowing state or regional oversight ensures that the coverage accounts for market conditions and population preferences, which will help ensure that all eligible Americans have access to quality, affordable health insurance options.

Provide Startup Funding for States to Establish Insurance Exchanges: The federal government would provide time-limited grants to states to help establish insurance exchanges, which could include the initial administrative costs of developing systems for eligibility determination, structuring health plan competition, and initial outreach. States would then fund ongoing exchange expenses, like administering subsidies and coordinating plan participation, through whatever method they choose, including 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.[21] States or regions would have the option to maintain separate pools within the exchange for non-group, micro-groups (2-10), and small groups (11-50) in order to limit market disruption and avoid large premium changes. States that set up separate pools would have a 3 to 5 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. States would be required to ensure that participating plans demonstrate that they have adequate provider networks (both primary and specialty care, plus preventive and dental care if offered) in Medically Underserved Areas (MUAs).

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 plans participating or promote competition in 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: Premiums paid to the plans would be risk-adjusted among participating plans in each exchange to promote competition on cost and quality, not on selecting healthy enrollees. All enrollees would pay the same premium (subject to allowed variation described above), and risk adjustment would occur among the total payments made to the plans.

Create a Federal FallBack for Exchanges: If any state or region fails to implement a qualifying exchange in a timely manner, and consequently American citizens and legal residents are denied access to coverage, the Secretary of HHS would be authorized to, and charged with, establishing an exchange with a range of private plan options for the state or region. If this occurred, appropriate and necessary resources and technical support would be provided to HHS to carry out these responsibilities. The exchanges would be expected to transition back to state management, as qualifying exchange criteria are met. Alternatively, states could contract with the federal government, at the state's expense, to manage the exchange on its behalf.

Providing for Competing State Plan Options— States would have the ability to establish a health insurance plan, modeled after self-insured plans that many have created as part of

COVERAGE OPTIONS AVAILABLE IN THE EXCHANGE

High Coverage	Medium Coverage	Standard Coverage	Basic Coverage
Similar to FEHBP standard option Covers 90% of health care spending on average	Similar to a Typical Small Group Plan Covers 84% of health care spending on average	Similar to a Typical Non-Group Market Plan Covers 75% of health care spending on average	Minimum Creditable Coverage $5,000 single deductible and OOP max/ $10,000 for family coverage All major service categories, including prevention and drugs to prevent chronic disease complications without a deductible Covers about 60% of health care spending on average

their employee benefit programs, co-op plans with consumer boards, or other designs, to provide another choice of coverage in the exchange. The plan would compete on a level playing field with private insurers, meaning that it would need to be actuarially sound, could not be managed by the entity responsible for regulating the state's insurance markets, could not leverage participation in public programs as a means to develop provider networks, and could not be subject to special advantages in regard to risk-adjustment, premium rating, reserve rule, and 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 the Federal Employees Health Benefit Program, could provide initial technical assistance to states wishing to create such plans, and 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 being sold.

Requiring Further Action if Coverage Affordability and Accessibility Goals are Not Met—After five years from the time the exchanges are expected to be operational, if HHS determines that the states have been unsuccessful in implementing insurance market reforms and establishing exchanges that provide affordable insurance options, resulting in a significant number of individuals still lacking health coverage, the President would submit to Congress for its consideration a proposal for a federal or state plan to be offered through exchanges, alongside private plans. The proposal would be considered under expedited procedures providing for 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 in insurance exchanges, will help guarantee that those purchasing coverage will have adequate protection from excessive medical costs. Setting these minimum standards requires a careful tradeoff among the goals of protecting individuals against out-of-pocket expenses, avoiding disruption of existing coverage, and keeping costs sustainable.

Establish Minimum Creditable Coverage Standards for Health Insurance –
Creditable coverage should include:

- ◊ Catastrophic protections, coverage for a comprehensive range of health care services, and coverage of preventive care and prescription drugs before the deductible.

- ◊ Coverage at least as generous as a federal high-deductible plan.

- ◊ State flexibility to increase minimum benefit standards above this floor, provided that states ensure that everyone has access to affordable coverage options, without increasing federal costs.[22]

Setting Additional Standards for Options Available in the Exchange: Require plans participating in exchanges to offer benefits that are at least actuarially equivalent to four established federal standards, but with broad flexibility in 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 covering 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 other major service categories would be covered in each level of coverage, but plans would have flexibility to vary cost sharing to keep costs 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. In order to promote coverage for all Americans, the federal government would provide and limit direct financial support to citizens and legal residents through tax credits based on income for non-group coverage purchased in exchanges. In addition, further subsidies and other assistance are needed to ensure special protections for retirees and small businesses.

This issue challenging issues the Leaders discussed over the course of the project. The recommended benefit package levels and associated tax credit subsidies ultimately needed to be constrained to align with available offsets, in order to meet the goal of developing a budget-neutral health reform proposal. As described in more detail in Pillar Four, the Leaders believe benefit levels and subsidies should be increased if refined estimates of program costs permit.

Limit Out-of-Pocket Premiums: Limit premiums for all individuals and families to no more than 15 percent of their income for a minimum benefit package. The increases in premium costs over time would be shared proportionally by the federal government through indexing tax credits.

Offer Enhanced Protections for Americans Under 400 Percent of the Federal Poverty Level (FPL): Individuals and families below 400 percent FPL ($88,200 for family of four in 2009) would receive advanceable, refundable tax credits to cap premiums for more generous plans at lower percentages of income than 15 percent. The subsidy schedule, described in the table below, bases tax credit amounts on the average premium cost of plans available in each area in the relevant category of coverage generosity. Tax credits would be indexed to share premium cost increases proportionally with the federal government. After five years, the regional variation in subsidies would be phased down, to reflect the goal of narrowing geographic disparities in subsidies unrelated to health or socio-economic status. Adults with incomes below 100 percent of FPL would initially receive Medicaid coverage, rather than receiving subsidies for plans in the exchange. However, if the Secretary of HHS authorized their participation in the exchange (see below), they would receive credits to pay the full premiums.

Provide Additional Protections for Retirees: Retirees age 55-64 would receive extra protections against high premiums.[23] Voluntary Employees' Beneficiary Associations (VEBAs) and other employer-sponsored retiree health plans could obtain income-related and retiree subsidies by purchasing coverage through the exchange.

Create New Tax Credits for Coverage in Small Businesses: Small employers defined as those with fewer than 25 workers who are mostly low-wage, would receive a tax credit to help offer coverage to their workers.[24] Small businesses (with payroll less than $1 million) would also be exempt from any "play or pay" fees. Small non-profit associations and small municipal governments would also qualify for small business subsidies to encourage the purchase of coverage for their employees.

Ensure Coverage for Low-income Individuals and Families: Individuals with incomes below 100 percent FPL would be eligible for Medicaid. Those populations who are not currently eligible for Medicaid through a state plan amendment or waiver would be eligible for federal matching funds. To ensure that states do not incur a higher overall financial burden as a result of these reforms, the federal government would fully finance the newly eligible populations previously not covered by Medicaid, in conjunction with reforms to promote coordinated care for dual eligible beneficiaries (as described in Pillar One).

Populations over poverty that are categorically-eligible for Medicaid would continue to retain Medicaid coverage, as would children covered under the Child Health Insurance Program (CHIP). All individuals eligible for Medicaid would be ineligible for subsidized coverage in the exchange, but after five years of implementation, the HHS Secretary would be authorized to permit individuals to enroll in subsidized private coverage 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 coverage with minimal out-of-pocket costs reflecting Medicaid cost-sharing and benefits, to assure 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 health and the overall performance of the health care system. Along with personal responsibility to help lower the burden of health care costs is a need for better support for individuals and families to enable them to do so. This section outlines two types of reforms designed to encourage individuals to make responsible choices about their health and health care.

First, a key component of the Leaders' comprehensive health care reform package is a requirement that all Americans should have, at a minimum, basic health insurance coverage. Ensuring that all Americans are in the reformed, affordable, 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 to improve the availability of innovative and affordable health insurance plan designs.

Second, the Leaders strongly endorse efforts to increase the nation's focus on clinical and population-based prevention and wellness as a means to improve Americans' health. A large and growing proportion of our health spending is currently going toward chronic diseases, and the frequent occurrence of preventable and costly complications of these diseases[25] creates an imperative to take major steps toward both clinical and population-based prevention. While many factors contribute to obesity and other chronic diseases, there are clear, changeable patient behaviors, like quitting smoking, following a nutritious diet, and exercising regularly, that can influence their occurrence and severity. However, traditional approaches to

health care, which pay more for treating illnesses after they develop, does not support these lifestyle changes. We must consider health more broadly than just health care, and focus on changes that can impact people's health before they ever see a doctor.

The Leaders believe we must act now to address the crucial underlying causes of the nation's health problems. This requires a focus on a range of school, workplace, and community initiatives to target behavior changes that can lead to better health. At the same time, new government should not be committed without ensuring a return on investment. Accordingly, the impact of these initiatives must be measured carefully, and only programs that prove to be effective should continue to be funded.

Strategies to promote healthier lifestyle choices, through well-targeted methods that demonstrate health benefits, should be more prominent in both public and private health insurance coverage. A range of school, workplace, and community-based programs can effectively encourage more responsible health choices. All of these strategies should be tied to achieving better health outcomes at a lower overall cost – the same kind of accountability central to the reformed health care system envisioned throughout this plan. 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 healthy lifestyle choices that impact overall health, the Leaders recommend:

Expecting Individual Responsibility for Obtaining Basic Health Insurance – With the availability of reliable health plan choices and new credits to help assure their affordability, all Americans should be empowered and expected to take responsibility for ensuring that they have basic health insurance coverage.

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

The high levels of participation needed to make insurance markets work well are likely to result from making basic coverage a legal requirement. Most Americans are already insured, and most honor the law, so requiring them to self-attest on their income tax forms that they have insurance will go a long way to ensuring coverage for all. There also would be education and outreach programs to help create awareness about the new availability and importance of affordable coverage options.

The Leaders are committed to appropriate enforcement mechanisms to make the individual requirement effective. Accordingly, they believe a number of mechanisms could be used to help ensure that the individual requirement is met. These could include, but are not limited to, the following options:

- Default and/or simplified enrollment into basic coverage options, either in employer coverage or the state exchange, when starting a job.
- Tax penalties, including the loss of federal deductions or exemptions, for individuals failing to obtain creditable coverage, verified through self-attestation and submission of documentation with tax forms.
- A "fair share" fee added to income tax liability for individuals choosing not to obtain coverage, reflecting the cost of uncompensated care. The fee could be set at an explicit level or could be linked to the premium (or a certain percentage thereof) of the lowest-cost plan available to an individual in the exchange.

While the affordability provisions included in Pillar Two should protect Americans against

excessive premiums, exceptions to the individual requirement may be appropriate in the limited and temporary circumstances where affordability cannot be assured. Moreover, the Leaders recommend religious exceptions.

Empowering Individuals to Make Better Health Care Choices – Just as important as giving providers better financial support for improving quality and lowering costs is the need for complementary reforms on the consumer side of health care delivery. 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 co-pay reductions to individuals for choosing high-quality, low-cost providers 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 private plans to offer premium rebates for ongoing participation in evidence-based wellness programs in which beneficiaries demonstrate risk factor reductions and improvements in health outcomes such as smoking cessation, blood pressure control, and other improvements in health. That is, wellness programs must be proven to work and must be available to all employees. Such targets would need to protect patient confidentiality and provide opportunities for all individuals to achieve premium-reducing improvements, including assuring that cost is not a barrier to participation.

Support the Development of Educational Materials to Improve Health Literacy: Provide 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 through a national strategy on health literacy.

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 as well as chronic care coordination initiatives that improve health outside of traditional health care. These programs could be delivered through schools, community-based organizations, state and local governmental agencies, and employers, and would be required to demonstrate an impact on risk factors for diseases and health outcomes for continued support. For example, the fund would be used to invest in the following provisions:

- No copayments or nominal copayments for "A" and "B" rated preventive services, which the U.S. Preventive Services Task Force (USPSTF) certifies as appropriate to coverage, in the exchange offerings and the Medicare program. Additionally, the Secretary of HHS would have authority, at her discretion, to eliminate coverage for services rated "D" by the USPSTF.

- A new no copayments/deductible wellness visit for Medicare beneficiaries to receive a health risk assessment and a personalized prevention plan.

- A new 50 percent federal tax credit incentive 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, about feasibility and advisability of expanding policy, and would require demonstrated impact on risk factors for continued funding.

- A $3 billion per year investment from the Fund into 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 Community Health Teams (CHTs). CHTs use care coordinators, nurses, nurse practitioners, social and mental health workers, nutritionists, pharmacists, community outreach workers coordinating with schools, community based resources, employers and others to provide preventive, wellness and coordinated care services.

◊ Supplementing this investment would be at least $500 million a year in dedicated funding for innovative school and community-based programs designed to provide direct preventive and primary health care services, including exercise, nutrition, and wellness education initiatives.

Implementation of these proposals, as well as related funding, would begin as close to the date of health reform enactment as possible, with the exception of new benefits administered by exchanges. Continued funding would be evaluated based on the proposals' success to improve health outcomes and reduce overall health care spending.

Pillar Four: Developing a Workable and Sustainable Approach to Health Care

The U.S. spends over 16 percent of its GDP on health care. [26] As health care spending growth rates continue to exceed growth in the economy and wages, solutions are needed to ease the drivers of unnecessary or preventable increases in health care costs, to assure that any health care spending increases reflect truly valuable services, and to address the unsustainable fiscal outlook associated with health care expenditures.

Delivery system and payment reforms are the critical components of efforts to stem spending growth. As outlined in Pillar One, delivery systems must be better integrated to promote care coordination, continual measurement, and better 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 lead to true health care innovation for a modernized health system, which will improve value and reduce costs, rather than just increasing volume and intensity.

To achieve budget neutrality, savings and revenue offsets are needed to pay for the proposed $1.2 trillion 10-year federal investment that the Leaders believe is necessary to secure a modernized health care delivery infrastructure, affordable coverage, and better prevention and wellness. It is important, however, to consider this investment in the context of broader national health care spending, which is projected to be $35.2 trillion over the next 10 years. It is also worth noting and commending the health care labor, provider, health plan, and manufacturer communities for affirming to the President that there are over $2 trillion in achievable savings over the next 10 years across the health system.

With these facts in mind, Pillar Four seeks to achieve the dual goals of (1) an improved long-run fiscal outlook through lower health spending growth and (2) a reform package that is "paid for" within a 10-year budget window. To achieve the goal of budget neutrality and sustainable financing, the Leaders propose and commit to a specific package of delivery and reimbursement reforms in Medicare and Medicaid, health-related revenue policies, and financing and other budget reforms.

The Leaders' financing framework 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 expected Medicare and Medicaid spending growth, supported by the broad set of recommendations

to help providers take the necessary steps 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 Leaders believe that the remaining one-sixth of required financing should be achieved through some combination of three complementary, viable methods outlined below to ensure their commitment to budget neutrality for their proposed reform package. The specific components of the financing package include:

Reforming Delivery and Payment Systems to Achieve Higher-Value Health Care (Pillar One)—The Leaders believe that the infrastructure investments and payment reforms described in Pillar One can significantly slow health care cost growth over time. The Leaders also understand 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 direct, clear empirical evidence on the issue (as the CBO and others have noted), implementing these reforms as part of a comprehensive package has the potential to achieve much larger impact. The proposals listed below are expected to achieve between $10 and $50 billion in scoreable savings over 10 years, net of investments in delivery reforms, with much higher savings anticipated in the long-term. Specific policies included in the Leaders' comprehensive recommendations include:

- Additional incentives for HIT adoption and meaningful use and investments in comparative effectiveness research.
- Targeted pay for performance and pay for reporting initiatives offset by assistance in establishing necessary measurement infrastructure.
- Up-front incentives to reduce avoidable hospital readmission rates and bundling 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 implementation of voluntary Accountable Care Organizations that share in savings between providers and government.
- New payments for primary care medical homes tied to accountability for quality and overall cost.
- Reduce overpayments and overuse of some lower-value care (including advanced imaging) and invest in reducing 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—These reforms would reflect efficiency improvements and reductions in overpayments that currently exist in the system. Achieving these savings would be facilitated by proposals described in Pillar One to improve the delivery of health care. The proposals below are expected to save about $500 billion over 10 years.

Align Medicare Advantage (MA) Payments More Closely with FFS Medicare: Move MA payments closer to parity with FFS Medicare payment rates, with reforms that align Medicare Advantage payments with the same kind of incentives for quality reporting and improvement as in the proposed reforms in traditional Medicare and in the private sector. In particular, the payment reforms might transition to a system of competitive bidding for an actuarially reasonable benefit package, while providing an explicit quality enhancement bonus payment to reward plans that meet certain performance measures that are aligned with the performance-based payment reforms 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

readmissions and savings from bundled payments and other reforms will promote greater efficiency, which should eventually be reflected in bundled payment growth rates. This productivity policy will reduce market basket payment updates for hospitals and other provider payments (except physicians) to reflect a little more than half of expected productivity gains, amounting 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: Disproportionate Share Hospital funding for uncompensated care 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, and providers should be accountable for the use of these funds. For example, use of funds could be tied to reporting on quality measures related to providing effective care for uninsured patients, and to the delivery of prevention-oriented care rather than 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 Med PAC, there would be reductions in payment growth rates to address overpayment and inappropriate utilization concerns. These reforms would occur in the context of the value-based payment reforms in Pillar One, to provide opportunities for providers to get additional net revenues from effective steps to coordinate and improve care. These payment reductions are 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 biogenerics, which could result in significant cost savings for individuals and for federal programs through the provision of competition where none exists today. The Leaders are pleased to note the bipartisan, bicameral consensus that exists between the two Committees of jurisdiction and their Chairmen on the establishment of a regulatory, scientific and patent pathway for review and approval of biosimilar and biogeneric products. However, on the major outstanding issue of exclusivity, the Leaders concluded that Congress should resolve policy differences on this issue 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 removing the "best price" provision. Limited rebate increases for generic drugs should be included but balanced against insuring access to these products. States could provide for manufacturers to receive bonuses offsetting part of the increase through demonstrated improvements in outcomes, such as lower chronic disease complications or lower overall costs for Medicaid beneficiaries – provided such reforms ensure budget neutrality. Reforms would include steps to encourage the use of high-value, effective drugs, such as supported state adoption of best practices from FEHBP and Medicare drug plans. These policies are expected to save up to $80 billion over 10 years.

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

out-of-pocket costs for Medicare beneficiaries, while eliminating the risk of very high out-of-pocket expenses. The net savings associated with this policy is about $20 billion over 10 years.

Reallocate Medicare and Medicaid Improvement Funds: Consistent with the proposal in the President's budget, direct funds set aside for Medicare and Medicaid program improvements toward the extensive investments in higher-value health care proposed in this report. This proposal would generate $23 billion in offsets over 10 years.

Raising Additional Revenue from Coverage-Related Reforms—

Linking the Tax Exclusion to the Value of Benefits Received by Members of Congress: Cap the income tax exclusion for employer-sponsored insurance at the value of the FEHBP standard option, and index that amount by medical inflation over time.[27] Maintain the full exemption for payroll taxes. To prevent undue burden on certain groups, adjust the tax exclusion cap for single versus family premiums as well as for age and geography (though the geographic adjustment might be phased down over time) in order to ensure for equitable application of the policy. Exempt retirees to recognize that they have, in many cases, traded wages for their retiree health benefits and will not benefit from increases in wages that will happen for the working population. To avoid any unnecessary disruption, exempt individuals covered by collectively bargained employment agreements until they expire. Implement the tax exclusion cap concurrently with availability of new premium protections for coverage included in the reform recommendations.

Instituting a Fee for Certain Employers Not Offering or Paying for Health Care: 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 million. Small businesses with payrolls of less than $1 million a year would be exempt, which would exempt almost all firms with fewer than 25 employees who do not offer coverage. In addition, only about one-fourth of firms with 25-99 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 proposals, in conjunction with investments in affordable coverage 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" of reforms resulting in changes in coverage patterns and higher taxable wages. The interaction effects are largely a result of employee choices to take advantage of less costly coverage options, including new affordable, portable coverage options in the exchanges, thereby reducing the burden of health benefits on employers and raising wages. Additional payroll taxes collected as a result of the interaction effect will have the result of strengthening the Medicare, Social Security, and Disability Trust Funds.

Together, these financing proposals would promote sustained (and improving) improvements in the value of our nation's health care spending, and would produce over $1 trillion in federal budget savings within the 10 year budget window. The projected savings of these policies are based on 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 benefits will help seniors stay healthier.

While the roughly $1 trillion down payment is substantial, the Leaders are committed to producing a package that is fully financed even under strict budget rules. Recognizing the challenge of reaching consensus on further offsets, the Leaders recommend that Congress implement some combination of the following three options, and they are committed to supporting bipartisan Congressional efforts to do so. While each of these proposals could be implemented individually, they can also be implemented together so that they are mutually reinforcing to assure that savings are achieved.

Ensuring Budget Neutrality—Guarantee that the entire reform package is budget neutral by paying for the remaining cost of approximately $200 billion through one or more of the following three options: enacting additional savings provisions; creating enforceable budget "trigger" mechanisms to automatically slow spending growth above a target level; or empowering the Independent Health Care Council to make additional recommendations to the President and Congress. More specifically, the three options are:

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

- ◊ Enact Further payment reductions for Medicare providers (through further market-basket reductions to fully reflect expected productivity gains – which could be done while still reducing market basket updates by less than 1.5 percent)
- ◊ Further reduce Medicare Advantage reimbursement
- ◊ Reform GME and IME payments (in advance of the IOM report recommendations called for 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, with shared savings for states that lower cost growth and penalties for states with higher growth
- ◊ Increase cigarette and alcohol taxes

Second, Congress could implement pre-specified targets for overall or Medicare spending growth in conjunction with health care reforms, and enact a "trigger" mechanism that would automatically implement additional, pre-specified payment reforms if the spending growth target is 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:

- ◊ Medicare market basket increases for providers in regions where spending growth has been consistently higher than 1.5 percent above the national average would be reduced to achieve a growth rate equal to 1.5 percent above the national average (if spending growth slows in subsequent years, the update reduction could be reversed; if it does not slow, the reduction would be cumulative).

- ◊ Growth in the new tax credits for health insurance would be slowed, meaning they 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 Independent Health Care Council (IHCC) to develop policy recommendations that would be expected to achieve the federal spending growth targets, which would be provided to the

Summary of Revenue and Expenditure Provisions

Recommended Policy	Approximate Budget Effects	
	2013 Effects	Budget Window (2010-2019)
Investments		
Ensuring Affordable Coverage: • Tax Credits to Ensure Affordable Coverage for All Americans through Exchanges, with Special Retiree Protections • Ensuring Adults with Incomes Below Poverty Have Access to Comprehensive Coverage through Medicaid	(-$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)
Subtotal, Investments	(-$143 billion)	(-$1,240 billion)
Savings/Revenue Offsets		
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: • Revenue from Capping Employer Coverage Income Tax Exclusion at the Value of Benefit Received by Members of Congress • Revenue from Fair Share Fee for Larger Employers Not Offering Coverage • Additional Savings from Changes in Decisions Resulting from These Reforms	$54 billion	$510 billion
Subtotal, Specified Offsets	$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
Final Budget Effect	(-$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.

President to submit to Congress under expedited procedures, with limited opportunity for amendment.

Projections of future budget costs and savings from reforms are inherently uncertain, and thus, the numbers presented in this report are only estimates. They are based on methods similar to those used by the Congressional Budget office, as the "scores" it issues are ultimately what determine whether a package of reforms is "paid for" under Congressional budget rules. Costs 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's scores for a set of reforms like this one may differ. Should any of the recommended reforms end up having substantially lower projected costs than estimated here, the Leaders believe that Congress should increase the generosity of the subsidized benefit package to ensure greater cost-sharing protections for Americans, while still ensuring budget neutrality. Such increases should also be considered in the future, if actual health care spending growth is substantially lower than projected.

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, is a clear obstacle to sustainable 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 next 10 years under current utilization and price projections, is the result of spending growth exceeding actual spending targets under Medicare Part B "physician-related" services. Each year physicians face uncertainty in Medicare payments, and each year Congress steps in with temporary fixes, but does not address the underlying drivers of the problem—largely because of the high cost of correcting a formula that promotes high-margin services over high-value services.

The Leaders believe that lack of meaningful SGR payment reform stands in the way of physician leadership in reforming the delivery of health services to improve quality and reduce overall costs. Failure to act on the SGR reimbursement liability means physicians participating in Medicare will experience real payment cuts, and will be less able to implement prevention-oriented reforms in care, potentially threatening access to quality care. The SGR as implemented today impedes efforts to reform Medicare reimbursement to provide incentives for high-quality, high-value care.

With the above in mind, the Leaders conclude that the SGR policy challenge should be addressed in the context of broad health reform. Indeed, the financing and delivery reforms outlined in this report provide 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 Leaders have endorsed a health reform proposal that 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 the SGR payment challenge will make it particularly difficult for policymakers to find policy and political support for sufficient offsets to pay for both the necessary investments in health reform and a comprehensive fix to the SGR formula. Therefore, in conjunction with identifying ways to offset the costs of fixing the SGR, the Leaders believe serious consideration should also be given to assuming that the cost of a physician payment freeze be included in the budget baseline. Such an approach has already been proposed by the Administration and the House as well as suggested by the Senate Budget Committee Ranking Republican. However, the Leaders

would oppose such a policy if it took place outside the context of broad health reform that reduced overall health care spending growth, including fundamental reforms in Medicare provider payments to ensure that future Medicare reimbursement policy toward physicians far more aggressively rewards value over quantity.

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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, D.C. 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 William Jefferson 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 ten 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 MD 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 actively in the Leaders' outreach process and policy deliberations which led to the development of this report. Despite his year-long involvement in the project, 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.

Robert Wood Johnson Foundation

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 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
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[19] Recent examples of managed competition exchanges include the Massachusetts' Connector for non-group and small-group insurance and Medicare Part D for seniors' prescription drug plans.
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.

[20] Federal tax credits would be tied to federal minimum creditable coverage standards to prevent subsidies from increasing if a state chose more generous requirements.

[21] 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).
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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[23] 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).

[24] 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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[27] Specifically, premiums would be capped in 2013 at the premium of the 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.

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