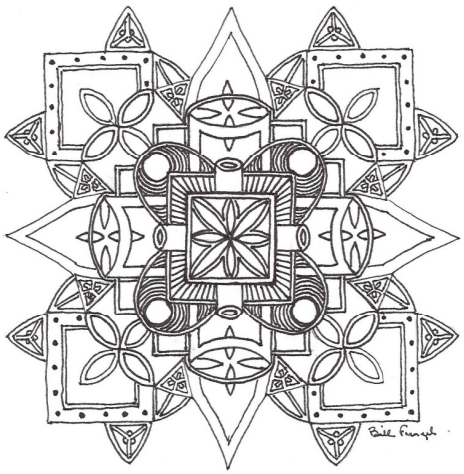
A COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET PROJECT

USBUDGETWATCH

Evaluating Health Care Plans:

An Analysis of the Short- and Long-Term Fiscal Implications of Reform Plans



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USBUDGETWATCH

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SUMMARY TABLE 1: SUMMARY OF MAJOR METRICS

Metric	House Tri-Committee	HELP Committee	Finance Committee
Cost of Coverage Provisions			
10-year Gross Cost of Coverage Provisions	$1,264	$779 / $1,279*	$829
10-year Net Cost of Coverage Provisions[#]	$1,027	$691 / $1,191	$802
Gross Cost of Coverage Provisions in 2019	$254	$148 / $244*	$180
Net Cost of Coverage Provisions in 2019[#]	$205	$133 / $229*	$174
Deficit Projections			
Ten Year Budgetary Impact	-$239	-$611 / -$1,111*	$81
Surplus/Deficit in the Tenth Year	-$65	-$120 / -$216*	$12
Beyond the Ten Year Window			
Expected Impact on 2020-2029 Deficits	Substantial Increases in Deficits	X	Deficit Reduction of Around ¼ to ½ a Percent of GDP
% of Offsets Growing Much Faster than Costs[+]	42%	X	76%
% of Offsets Growing Much Slower than Costs[+]	36%	X	11%
Curve Benders and Game Changers[&]			
Tax Measure to Reduce Costs	No Major Provisions	X	Excise Tax on High-Cost Insurance Plans
Comparative Effectiveness	Establishes Center for Effectiveness Research	X	Establishes Patient-Centered Outcomes Research Institute
Insurance Market Reforms	Health Exchange; Guarantee Issue Rules with Strong Mandate	Health Exchange; Guarantee Issue Rules with Mandate	Health Exchange; Guarantee Issue Rules with Weak Mandate; Rules Allowing Some Purchase of Insurance Across State Lines
Direct Payment Reforms	Pilots for Payment Bundling and Accountable Care Orgs; Strong Penalties to Reduce Preventable Hospital Readmissions.	X	Pilot for Payment Bundling; Broader Program for Accountable Care Orgs; Penalties to Reduce Preventable Hospital Readmissions
Indirect Payment Reforms	No Major Provisions	X	Commission to Automatically Cut Costs; Innovation Center to Experiment with New Payment Models.
Other Metrics			
Decrease in Number of Uninsured in 2019	37 million	21 million / 36-41 million*	29 million
Decrease in Percent of Uninsured in 2019	69%	39% / 67%-76%*	54%
Gimmicks	Timing Gimmick: Early Surpluses Followed by Growing Deficits	Bogus Offset: Up-front Long-Term Care Insurance Premiums	Omission Gimmick: No Updated Medicare Physician Payments Beyond 2010

Notes: Estimates in billions. Estimates describing America's Affordable Health Choices Act as introduced in the House on July 14th, Affordable Health Choices Act as reported out of the Senate HELP Committee on July 14th, and America's Healthy Future Act as Amended in the Senate Finance Committee on October 13th.
Sources: CBO, JCT, OMB, Library of Congress (legislation via Thomas) and US Budget Watch calculations.
X = Not addressed in the proposal, but expected in the final bill.
*Assumes inclusion of $500 billion Medicaid expansion; [+]Measures which reduce Medicare/Medicaid spending or tax health insurance are assumed to grow faster than costs, non-health related taxes are assumed to grow slower; [&]Categories and measures listed with categories are non-exhaustive; [#]Excluding interaction effects.

SUMMARY TABLE 2: HEALTH CARE COSTS AND SAVINGS

Provision	House Tri-Committee	HELP Committee	Finance Committee	President's Reserve Fund
Mandate Provisions	**$237**	**$88**	**$27**	**X**
Individual Mandate Penalties	$29	$36	$4	X
Employer Play-or-Pay Provision	$208	$52	$23	X
Coverage Expansion	**-$1,264**	**-$779 / -$1,279***	**-$829**	**X**
Insurance Subsidies	-$773	-$723	-$461[α]	X
Medicaid Expansion	-$438	X / -$500*	-$345	X
Small Business Tax Credit	-$53	-$56	-$23	X
Other Spending	**-$292**	**$34**	**-$58**	**X**
Physician Payment Updates	-$229	X	-$11	X
Long-Term Care Insurance	n/a	$58^	n/a	X
Medicare Prescription Drug Coverage	n/a[+]	X	-$21	X
Other Spending	-$63	-$24	-$26	X
Spending Offsets	**$491**	**X**	**$510**	**$645**
Prescription Drug Cost Reductions	$47[+]	X	$28	$105
Medicare Advantage Cuts	$162	X	$114	$176
Provider Payment Updates	$196	X	$185	$110
Medicare Premium Increase	n/a	X	$33	$8
Medicare Payment Commission	n/a	X	$22	$2[#]
Measures to Slow Health Cost Growth	$5	X	$15	$47
Measures to Reduce Federal Health Care Spending	$81	X	$113	$197
Tax Increases	**$589**	**X**	**$382**	**$296**
Surtax on High Earners	$544	X	n/a	n/a
Limits to Itemized Deductions	n/a	X	n/a	$269
Excise Tax on High Cost Insurance	n/a	X	$202	n/a
Limits to Corporate Tax Benefits	$37	X	$17	$27
Limits to Health Care Tax Benefits	$8	X	$42	n/a
Fees on Health Care Companies	n/a	X	$121	n/a
Interaction and Other Effects	**$0**	**$46**	**$49**	**-$33**
Ten Year Deficit Impact	**-$239**	**-$611 / -$1,111***	**$81**	**$908**

Notes: Estimates in billions. Positive numbers represent a decrease in the deficit. Estimates describing America's Affordable Health Choices Act as introduced in the House on July 14th, Affordable Health Choices Act as reported out of the Senate HELP Committee on July 14th, and America's Healthy Future Act as reported out of the Senate Finance Committee on October 13th.
Sources: CBO, JCT, OMB, and US Budget Watch calculations.
X = Not addressed in the proposal, but expected in the final bill.
[α]Includes $3 billion to fund CO-OP startup and $5 billion for high risk pools; *Assumes the addition of the Medicaid expansion as per CBO's rough estimate; ^Decreases deficit in short-run due to 5-year vesting period (see gimmicks box); [β]$25 billion in costs net of $20 billion in fees; [+]Costs of expanding prescription drug coverage incorporated into savings estimate for reducing payments; [#]Actual savings from establishing a commission to propose or enact payment changes are highly uncertain.

EVALUATING HEALTH CARE PLANS:
AN ANALYSIS OF SHORT- AND LONG-TERM FISCAL IMPLICATIONS OF REFORM PLANS

Background

Currently, Congress is working on a number of bills to reform the U.S. health care system. Each of the five relevant Committees has reported out their own preferred reform bills, and though more similar than different, the bills will have to be reconciled with each other and with President Obama's priorities before being enacted into law.

A reform of this magnitude will have major fiscal and economic implications. Done wisely, health care reform could considerably slow economy-wide health care cost growth and help to move Medicare and Medicaid toward more sustainable paths. Done poorly, however, reform could exacerbate both public and overall costs, worsening an already untenable long-term fiscal picture. In their current forms, none of the bills go far enough to reduce health care costs given the tremendous fiscal problems facing the country and the major role health care plays as a driver.

Recently, US Budget Watch released *Comparing Health Care Plans: A Guide to Reform Proposals* (http://usbudgetwatch.org/document/comparing-health-care-plans-guide-reform-proposals), which detailed the key provisions in the three major bills under consideration – the House Tri-Committee bill as originally introduced, the Senate Health, Education, Labor and Pensions (HELP) Committee bill, and the "Chairman's Mark" introduced by Senator Baucus in the Senate Finance Committee**.** An updated chart comparing the bills is available on the page above.

In this companion paper, we have gone beyond simply describing the bills to offer detailed analysis of their key costs, deficit impacts, and long-term fiscal implications.

We looked at the bill passed by the Senate HELP Committee on July 14th (the "Senate HELP bill"), the original version of the House Tri-Committee bill[1] (the "House bill") as introduced on July 14th, and the legislation recently reported out of by Senate Finance Committee (the "Senate Finance bill") on October 13th. We rely largely on the work of the Congressional Budget Office (CBO) and Joint Committee on Taxation for cost and savings estimates. As health reform moves forward and new cost estimates are advanced, we will provide additional analysis.

[1] It is important to note that each committee passed its own version of the bill, with the Energy and Commerce Committee version including a number of fiscally important changes. In addition, Speaker Pelosi has submitted several alternative versions to the CBO for scoring. While we relied on the original version – which has been scored by the CBO in its entirety – it is worth pointing out that amendments from the Energy and Commerce Committee are expected to significantly reduce net costs. According to an estimate from the Lewin Group, this amended version would increase the ten-year deficit by $39 billion, compared to the $100 billion they estimate for the original legislation. The version submitted by Speaker Pelosi has been reported in the press to cost of around $900 billion for coverage provisions, compared to over $1 trillion for original bill.

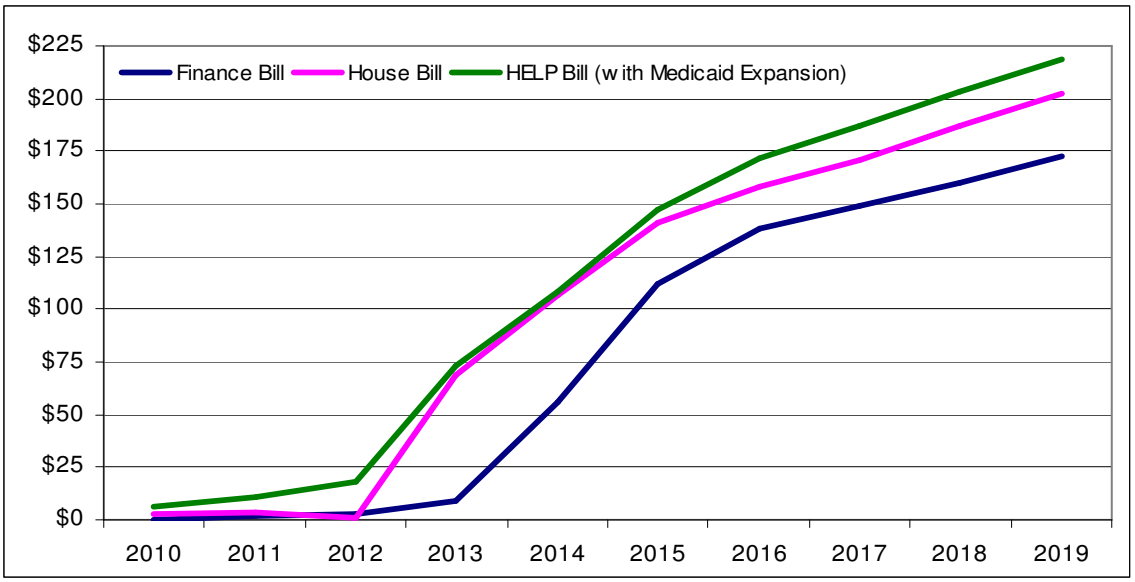
Cost of Coverage Provisions

Although the House Tri-Committee, Senate HELP, and Senate Finance bills all use a combination of mandates, subsidies, and Medicaid expansions to increase the number of uninsured covered, their actual effects differ – as do their costs.

The total coverage provisions in the House bill, for instance, would cost over $1 trillion, on net, over the next ten years.[2] Most of these costs would begin in 2013, fully phase-in during 2015, and continue to grow rapidly thereafter. In 2019 alone, coverage provisions would cost a net of more than $200 billion. These provisions include $160 billion in exchange subsidies, more than $80 billion in new Medicaid costs, and $10 billion in small business tax credits. They also include offsets of $45 billion in fees for employers who don't provide insurance coverage and $5 billion in penalties for individuals who are not covered.

The Senate Finance bill scores significantly cheaper, with net coverage costs of around $800 billion over ten years. The lower costs occur mainly because the bill provides smaller subsidies, subsidizes fewer people, and phases in later than the other bills. At the same time, however, the bill also includes significantly smaller penalties on uninsured individuals and employers who do not provide their workers with health insurance. All told, the Senate Finance bill would cost around $175 billion in 2019, including nearly $100 billion in exchange subsidies, $80 billion in Medicaid costs, and $2 billion in small business tax credits which are then offset by $6 billion from employer and individual payments.

Fig. 1: Net Cost of Coverage Provisions by Year (billions)



Sources: Congressional Budget Office and US Budget Watch Calculations

[2] The two versions of the bill submitted to the CBO by House Speaker Nancy Pelosi are reported to cost $859 billion and $905 billion, respectively.

The Senate HELP bill is likely to be the most expensive of the three bills. Because the scored draft does not include a planned Medicaid expansion (which is outside of the Committee's jurisdiction), it is impossible to know exactly how much that provision would cost. By itself, the HELP Committee's plan to expand coverage would cost nearly $650 billion over ten years. This number, however, could rise to closer to $1.15 trillion once the Medicaid provisions were added in. By 2019, coverage provisions would cost over $120 billion without the Medicaid provisions, and likely closer to $220 billion if they were included. This accounts for $15 billion in offsets from individual and employer penalties.

Comparing Coverage Expansion

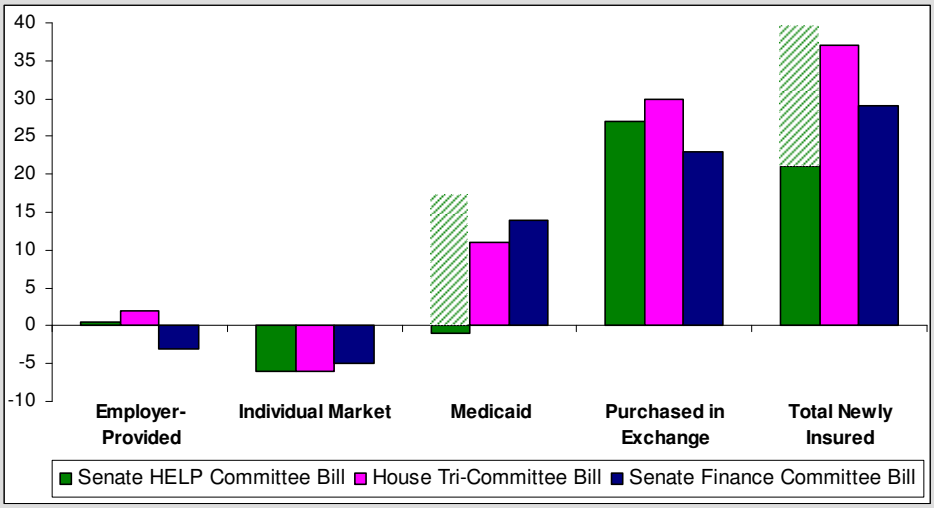
Cost is not the only relevant metric for evaluating a bill. Policymakers must ask whether the spending of a given initiative is valuable or worthwhile. In the case of health care reform, one way to evaluate this would be to look at how the bills impact health insurance coverage.

Not surprisingly, the least expensive plan – from the Senate Finance Committee – is also expected to provide insurance coverage to the fewest number of people. In this bill the CBO estimates that of the 54 million people projected to be uninsured in 2019, roughly 29 million would gain coverage. This includes 23 million buying through the exchange and 14 million new Medicaid recipients, but is offset by 8 million people leaving their current insurance.

The House bill would reduce the number of uninsured more significantly, by 37 million people in 2019. This includes 30 million in the exchange and 11 million in Medicaid. Because of the strong employer mandate, it also includes 2 million more with employer coverage.

If it incorporates the anticipated Medicaid expansion, the Senate HELP bill would likely increase coverage by between 36 and 41 million people. This includes 27 million people buying from the exchange, and 10 to 15 million in Medicaid (which would be available for those making over 150 percent of the federal poverty line, rather than 133 percent in the other bills).

Fig. 2: Impact of Legislation on Insurance Coverage in 2019 (millions of people)



Sources: Congressional Budget Office and US Budget Watch Calculation.
Note: Diagonal lines indicate rough estimated effect of including Medicaid expansion in bill.

Each bill also includes spending outside of the coverage provisions. Excluding new spending which is meant to slow health care cost growth and interaction effects, the Senate Finance bill includes $58 billion in non-coverage spending, the House bill includes $292 billion (the major difference is that the House bill updates Medicare physician payments through the budget window, whereas the Finance bill does so only in 2010), and the Senate HELP bill includes $24 billion. This money funds everything from expanding Medicare Part D to updating Medicare physician payments to offering grants for public health initiatives to increasing certain Medicare and Medicaid reimbursement rates.

When we look holistically at the *gross* costs of each bill,[3] the House bill totals to around $1.5 trillion, the HELP bill's costs equal around $800 billion or $1.3 trillion (depending on whether or not we account for a Medicaid expansion), and the Finance bill's costs add to just under $900 billion.

Of course, it is important to weight costs against benefits – which, in the case of these bills, come mainly in the form of insurance coverage expansion (see the box above). The HELP bill would increase coverage by between 36 and 41 million people at a net cost of $1.1 to $1.2 trillion over ten years (about $220 billion in 2019). The House bill would increase coverage by 37 million people for around $1 trillion ($200 billion in 2019). And the Senate Finance Committee would increase coverage by 29 million for roughly $800 billion ($175 billion in 2019). Reasonable people can differ on which of these approaches is best.

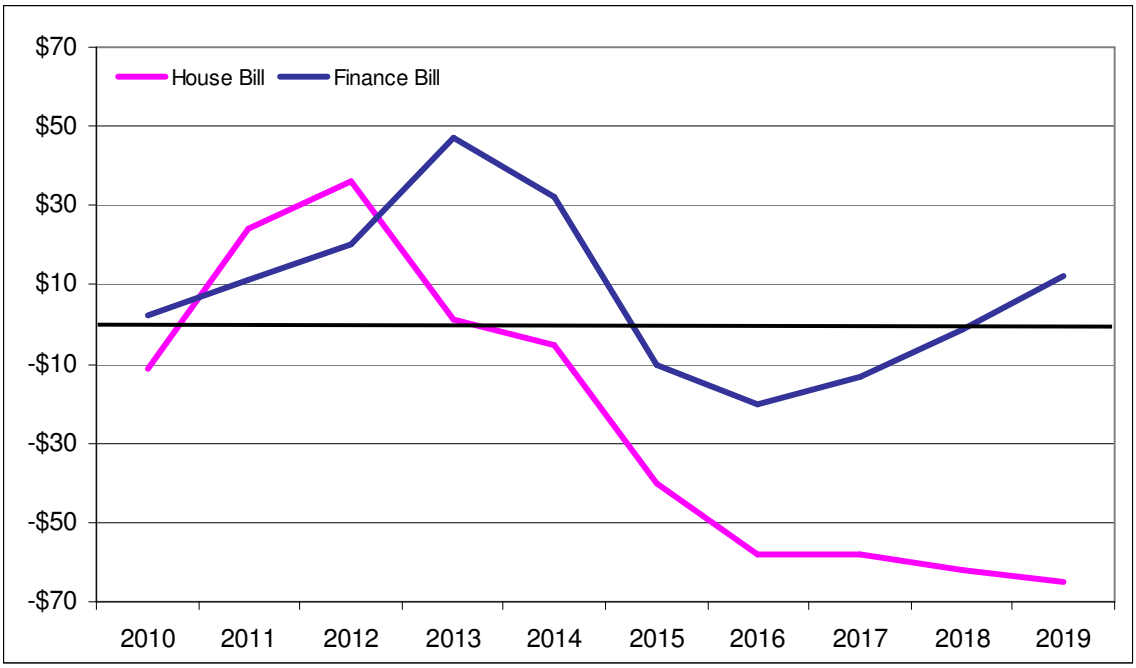
Deficit Projections

Costs should not be viewed in isolation. It is important if and how these costs are financed, especially from a fiscal and budgetary standpoint. Given the nation's current fiscal state, engaging in new borrowing to create new and permanent programs is economically dangerous. Federal health care spending is already projected to drive the national debt to unprecedented and untenable levels, suggesting that any effective health care reform bill should *reduce* overall deficits significantly.

The Senate Finance Committee meets the goal of deficit reduction over the next decade; the CBO projects it will reduce the deficit by $81 billion. The bill accomplishes this by combining its new spending with both spending cuts and tax increases. On the spending side, savings come largely from cutting Medicare Advantage, slowing updates to provider payments, reducing disproportionate share hospital (DSH) payments which help cover the private costs of uncompensated care, and increasing Medicare premiums for higher earners. New revenue comes mainly from fees on various health care companies and an excise tax on high-cost insurance plans.

[3] We calculate gross cost by adding the costs of exchange subsidies, Medicaid expansions, small business tax credits, and all additional spending except that which is meant to slow overall health care cost growth, or which is calculated as an interaction effect.

Fig. 3: Budgetary Impact by Year (billions)



Note: Positive numbers represent a decrease in the deficit.
Source: Congressional Budget Office.

The House bill does not meet the deficit reduction goal, rather it increases the deficit by $239 billion over the next decade (although the Energy and Commerce Committee believes their amended bill to be roughly budget-neutral). Like the Senate Finance bill, it cuts Medicare Advantage subsidies, slows updates to provider payments, and reduces DSH payments – although it cuts Medicare Advantage subsidies more significantly and does less to reduce DSH payments than the Finance bill. The House bill also implements measures to significantly reduce prescription drug costs. In addition, it relies on an income surtax on higher earners that would begin in 2011 and raise $544 billion in revenue over the next decade.

Unlike the Senate Finance Bill, the House bill spends $245 billion, including interactions, to permanently update Medicare physician payments (which are otherwise scheduled to drop by 21 percent). These updates would likely occur anyway, as politicians have enacted them regularly. But they are only included in the Senate Finance bill for 2010.

Even setting that $245 billion aside, though, the House still fails to achieve anything more than token deficit neutrality. Although the bill would technically balance out over ten years – excluding the updates – this would largely be due to surpluses collected before the implementation of the coverage measures. As the bill is written, surpluses would turn to deficits by 2014 (or in 2015 if we exclude the cost of physician payment updates), and these deficits would grow every year, reaching $65 billion by 2019. Even excluding the cost of updating physician payments, the bill would still increase the deficit by around $25 billion in 2019.

Health Reform Gimmicks

In late July, the Committee for a Responsible Federal Budget warned of the possibility that "budget gimmicks" would be employed, either to make a bill appear fully paid for or to bring down its reported costs (http://crfb.org/document/beware-health-reform-budget-gimmicks). Unfortunately, each bill making its way through Congress has employed at least one of these gimmicks:

Timing Gimmicks – The House bill front-loads offsets, before the new spending begins, in order to make the bill seem more attractive. In fact, the bill begins running deficits in 2014 and continues to do so into the foreseeable future. The Senate Finance bill also uses timing gimmicks, delaying implementation six months in order to achieve on-budget (non-Social Security) budget neutrality; although it ultimately runs surpluses by the last year.

Loopholes – Many supporters of the House bill claim it is deficit neutral by not counting the ($245 billion) cost of updating Medicare physician payments. However, these updates are a part of the bill. Because of them, the bill would increase the 10-year deficit by $239 billion.

Omissions – Rather than failing to pay for Medicare physician payment updates, the Senate Finance bill does not update these payments at all beyond 2010. Based on the Senate Finance bill, payments would be reduced by 25% in 2011 – something policy makers will almost certainly not allow.

Bogus Offsets – The Senate HELP bill establishes a long-term care insurance program ("the CLASS Act"), which collects premiums for five years before beginning to pay out benefits. Using the money raised by the program through premiums in its first decade ($58 billion on net) would be improper, given that the same money will be needed to pay out benefits in the second decade of the program.

The Senate Finance bill also relies on early surpluses to fund several years of deficits. However, because the bill's costs grow slower than its offsets, it returns to surplus by 2019, reducing the federal budget deficit by a projected $13 billion that year. It also includes a "failsafe" mechanism designed to automatically scale back subsidies if the legislation is expected to increase the deficit in a given year.

The Senate HELP bill cannot be measured for its effect on the deficit, since the Committee does not have jurisdiction over Medicare, Medicaid, and revenues – where nearly all the offsets come from. However, the bill does include one offset – "the CLASS Act" – which we believe to be inappropriate (see the "Gimmicks" box above for details).

Beyond the Ten-Year Budget Window

It is important that health care reform not just avoid increasing the deficit in the first ten years, but reduce it substantially beyond that period. On their current courses, Medicare and Medicaid are expected to grow from 5 percent of GDP this year to around 6.5 percent by 2020, 10 percent by 2035, and 18 percent by 2080. Unchecked, this growth would likely lead to painful cuts in government spending, crippling tax increases, and unsustainable levels of national debt.

"Do no harm," therefore, is a woefully insufficient criterion for any health care reform bill, and "do no harm over the next decade" is especially inadequate. To provide a durable and sustainable financing framework, health care reform will also have to rein in Medicare and Medicaid's long-term costs – and if necessary find new sources to finance their growth.

Bringing Medicare and Medicaid under control will require both specific tangible changes in these programs and measures to slow economy-wide health care cost growth (discussed in the next section). None of the three major bills does as much as is ideal to address the growth of public or overall health care costs, although the Senate Finance bill represents a good start.

The House bill, unfortunately, is likely to make matters *worse* over the long-run. Although the CBO does not provide any formal analysis beyond the ten year window, it has shown that, as long as health care costs grow faster than the economy, the bill's cost will grow at a faster rate than its offsets. As a result, they determine that "the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window." The Lewin Group has aimed to quantify these effects, finding that even after the modifications made by the House Energy and Commerce Committee – which would bring the bill toward deficit neutrality in the first ten years – the House bill would add around $1 trillion to the deficit between 2020 and 2029.[4]

Whereas the House bill would worsen the long-term fiscal picture, the Senate Finance bill would likely improve it – although not by enough to address the unsustainable growth of Medicare and Medicaid. Because its offsets grow faster than its costs, the CBO estimates the Senate Finance bill has the potential to reduce the deficit by between 0.25 and 0.5 percent of GDP between 2020 and 2029 (roughly $35 billion to $70 billion a year in today's terms). For comparison, spending on Medicare and Medicaid is expected to increase by 2 percent of GDP over that time period.

The CBO evaluates long-term costs very roughly by estimating broad growth rates for various categories of spending and then extrapolating them forward. In the case of the House bill, much of the financing comes from income taxes, which tend to grow at a

[4] The Lewin Group, "Long-Term Cost of the American Affordable Health Choices Act of 2009; as Amended by the Energy and Commerce Committee In August 2009," September 9, 2009.

slower rate than would new health care spending. The Senate Finance bill, conversely, relies largely on offsets which grow at or above the rate of health care cost growth.

Fig. 4: Costs, Offsets, and Broad Growth Rates Beyond 2019 (dollars in billions)

	Broad Annual Growth Rate	Amount in 2019		% of bill in 2019	
		Finance	House	Finance	House
Costs					
Coverage Expansion	8 percent	$180	$254	92%	83%
Other Spending	8 to 15 percent	$15	$51	8%	17%
Offsets					
Mandates, Penalties, and Associated Effects	10 percent	$26	$53	13%	22%
Medicare and Medicaid Changes	8 to 15 percent	$112	$102	54%	42%
Excise Tax on Insurance	10 to 15 percent	$46	n/a	22%	n/a
Other Tax Policies	5 percent	$22	$87	11%	36%

Sources: Congressional Budget Office, Joint Committee on Taxation, and US Budget Watch Calculations.
Notes: Chart aims to break down spending and offsets within the House and Senate Finance bill as they would be divided by the Congressional Budget Office, but numbers may not match their methodology precisely. "Broad Annual Growth Rates" taken from CBO documents, but are meant to describe very rough averages – in reality each budget line grows at a different rate. Numbers cannot be summed to total costs of bills due to omission of certain budget lines.

Even setting this aside, the Senate Finance bill contains two provisions absent from the House bill which would very likely lead to deficit reduction beyond the first decade – an excise tax on high-cost insurance plans and a Medicare Commission.

The excise tax would work mainly by raising an increasing amount of revenue over time and, to a lesser extent, by lowering health care costs. Because the threshold to pay the tax (generally $8,000 for an individual plan and $21,000 for a family plan) would be indexed to one percent above inflation (CPI) – well below the historical rate of health insurance cost growth – an increasing number of health insurance dollars would be subject to the tax each year. Furthermore, to the extent it led employers to purchase cheaper insurance on behalf of their employees, the tax would lead to more compensation in the form of cash-wages, which, unlike health benefits, would be subject to the income tax. At the same time, the tax would create incentives for employers and workers to choose less expensive health insurance plans, which could help hold down the growth of health care costs and lower the costs of Medicare, Medicaid, and the new insurance subsidies offered under the bill.

The Medicare Commission, meanwhile, would work mainly by keeping Medicare costs from growing too rapidly. The legislation would establish an independent commission of experts and give them a mandate to propose direct reductions in Medicare spending. After 2019, the Commission would be required to make such recommendations whenever Medicare costs per capita were growing faster the one percentage point above GDP growth. These recommendations would be automatically adopted unless Congress either amended them (which they would be given time to do) or explicitly overruled them.

In addition to these two measures, the Senate Finance bill also includes a "failsafe" which would automatically reduce insurance subsidies if the legislation were expected to increase the deficit.

The House bill could be improved significantly by adding any of these three measures, by including more provisions which would reduce and slow the growth of health care costs, and/or by proposing offsets (such as limits on the employer health care exclusions) which are expected to grow as fast or faster than overall health care costs.

"Curve Benders" and "Game Changers"

While serious tangible tax and spending changes are necessary, they will not be enough to make public health care spending sustainable. Public costs cannot be held down forever as long as economy-wide health care costs – which currently consume a fifth of the economy and grow at an annual rate of about 2.5 percentage points above GDP growth – remain on their current path. Ultimately, controlling Medicare and Medicaid costs will require reducing and slowing the growth of overall health care costs, also referred to as "bending the curve."

Many believe that significant savings can be realized by ridding the system of inefficiencies. Some studies show that as much as one third of all health spending adds little or nothing to overall health.[5] Among the types of measures which could help boost the efficiency of health care spending include comparative effectiveness research, health IT, provider payment reforms, care coordination, certain types of prevention and wellness initiatives, insurance market reform, consumer cost-sharing, and tort reform, among others. Unfortunately, no one really knows which of these measures will succeed, nor by how much (for this reason, the CBO tends to score these "game changers" as generating very little savings). Therefore, it is necessary for health reform to take what OMB Director Peter Orszag describes as a "belt-and-suspenders approach" – relying on tangible offsets to reduce the deficit, while also enacting the potentially game-changing reforms whose impacts cannot be predicted.

All three bills make some inroads here – relying primarily on Medicaid and Medicare to set examples for the private system. But again, none goes far enough.

The excise tax and Medicare Commission in the Senate Finance bill, in addition to reducing long-term deficits on their own, certainly fall in the category of potential curve-benders. As explained above, the excise tax would increase the price of high-cost insurance, leading workers and employers to seek out more efficient and less generous insurance.

[5] National Academy of Engineering and Institute of Medicine, Building a Better Delivery System (Washington D.C.: National Academies Press, 2005).

Doing so would drive down both health care prices and utilization, slowing system-wide health care cost growth. Meanwhile, given the Medicare Commission's mandate to target its recommendations toward the drivers of health care cost growth and to improve the health care delivery system, it would likely make (automatically implemented) payment reforms which would increase the overall efficiency of health care delivery and would serve as an example to private insurers.

Beyond that, the Senate Finance and House bills are fairly similar. Both bills (along with the Senate HELP bill), for example, establish an insurance exchange designed to increase insurance competition in the individual market. All three also establish a number of new rules designed to decrease administrative costs and the costs associated with "adverse selection" for insurance companies[6] – although these rules are weakest in the Senate Finance bill.

In addition, both bills experiment with payment reforms in Medicare and Medicaid, including through bundling payments to pay for an episode of care rather than per health service, supporting Accountable Care Organizations which coordinate care, and establishing a large number of pilot and demonstration projects. They also both alter payment schemes in order to reduce preventable hospital readmissions, and they both institute measures designed to increase cost transparency. Furthermore, both bills encourage preventative care and wellness measures, and both increase payments to primary care practitioners. Finally, both provide new funding for, and reforms based upon, comparative effectiveness and quality research.

The bills do not enact these reforms in equal measure. The House bill establishes a small pilot program to support Accountable Care Organizations, for example, while the Senate Finance bill would support them more broadly. The House bill, conversely, includes stricter penalties for preventable hospital readmissions. The House bill also spends more on strengthening prevention, wellness, and primary care more generally. But the Senate Finance bill authorizes spending up to $10 billion on an Innovation Center charged with testing, evaluating, and expanding various payment models aimed in part at slowing Medicare cost growth (which the CBO estimates would generate $2.3 billion in direct *scoreable* savings in 2019 alone).

Despite these measures, neither bill will do enough to control costs. Payment reforms, while present, tend to be small in scale and scope, focusing on pilot programs and

[6] Adverse selection is an economic term which describes problems of asymmetric information. In the case of health care, potential customers know more about their health status (and therefore potential cost) than do insurers. Insurance companies, therefore, assume that healthier individuals will be less likely to purchase insurance than higher risk individuals, which means the companies need to increase rates to remain profitable; but higher rates result in an increasing number of potential customers not willing to purchase the insurance, setting off a vicious cycle of increasing prices and decreasing levels of coverage. To combat this problem, insurance companies attempt to acquire more information about their potential customers, and use this information to vary rates or exclude coverage altogether; however, this comes with considerable administrative costs, and leaves some individuals unable to afford or acquire health insurance at all.

demonstration projects. Comparative effectiveness research, especially in the House bill, is not used sufficiently to modify payments. Measures to increase consumer cost consciousness, reduce geographical cost disparities, and reform the medical malpractice system are small or absent. And many provisions within the bills – including those to expand insurance coverage and require insurance to meet minimum standards of coverage – would result in increases of overall health care costs.

Still, it is important to remember that the health care system is dynamic, complex, and filled with unknowns. Finding the right "game changers" may require continued experimentation and reform. The final piece of legislation should take the best ideas available, both from within the existing bills and from the expert community, and then revisit them regularly until public health care spending – as well as both the health care system and the federal budget more broadly – can be put on a sustainable path.