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Health Care Cost Containment and Coverage Expansion



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Health Care Cost Containment and Coverage Expansion

Introduction

Proposals to expand health insurance coverage are almost always accompanied by proposals to control the growth in health spending. Some people say that universal coverage cannot be achieved without cost containment, others that real cost savings will not be feasible without universal coverage. These arguments will be considered further below. Whether or not coverage expansion and cost controls are truly inseparable, it is likely that how the society goes about covering the uninsured may have implications for the feasibility of different possible approaches for controlling costs, and vice versa.

People who favor a particular approach to covering the uninsured may also tend to favor certain cost containment approaches. For example, people who believe that consumers would be more cost-conscious if they were enrolled in high-deductible health plans are also likely to believe that coverage expansion should take the form of tax subsidies for the purchase of health insurance in a largely unregulated individual market. However, it is possible to conceive of a single-payer plan whose benefit package included a high initial deductible. The two pieces are not inherently contradictory or even ideologically inconsistent, particularly if the deductible were progressively income-based. (France actually has a single-payer system with income-based coinsurance.) It just happens that, in the current political environment, the intersection between consumer-directed health care advocates and single-payer advocates is practically a null set.

This paper treats coverage expansion approaches and cost containment approaches as two distinct columns in the menu of health reform options: any choice from column A could theoretically be combined with any choice from column B. In practice, some combinations may work together better than others, and the interplay of different approaches to coverage and savings is the focus of this paper. There will be no attempt here to diagnose the sources of rapid health spending growth or to evaluate the likelihood that different proposed solutions can actually slow that growth. There is no shortage of analyses addressing these questions. Instead, the assumption is that every solution may offer at least some promise of savings – whether small or large, one-time or continuous. The question is what kind of insurance arrangements may make a preferred solution more or less workable.

The paper begins with a brief review of the question posed at the outset: whether coverage expansion and cost controls must go hand-in-hand. It then lays out the menus of commonly proposed coverage approaches and available savings measures before considering how the two might go together. Because the number of possible combinations is quite large, the discussion will focus on just a few of the savings

measures that have received the greatest attention from policymakers. In addition, this paper will not address measures intended to reduce the administrative costs of health insurance, as opposed to direct medical expenditures. Options for administrative simplification and their cost implications for insurers and providers are the subject of a separate paper for this project (Merlis 2008). It should be noted, however, that evaluating different coverage expansion approaches may require balancing their potential for medical spending restraint against their likely impact on administrative costs.

Coverage expansion and health spending

It is a commonplace that the United States cannot afford to provide universal coverage without first or simultaneously getting a handle on the cost problem. As one recent analysis has argued, this truism has been in circulation for at least forty years and may have been a major barrier to proposals to cover the uninsured (Feder and Moran)

In fact, the aggregate increase in national health expenditures (NHE) that could be expected to result from universal coverage might be relatively small. Recent estimates by the Lewin Group of the costs of some proposals that would reach near-universal coverage suggested a net increase in NHE of 2.1%-3.4% (Sheils and Haught).¹ Estimates in the early 1990s were in the same range; for example, a RAND Corporation study in 1994 projected a 1.8%-3.2% increase in NHE, with a “best estimate” of 2.2% (Long and Marquis).

There are two reasons that increases in health spending might not be proportionate to increases in the insured population. First, the uninsured might be healthier than the insured. The data used in the RAND estimates indicated that insured nonelderly adults were about 50% more likely than the uninsured to report that they were in fair or poor health. However, this difference may have diminished over time. Nonelderly adults with and without health insurance in 2005 were about equally likely to report fair or poor health.²

Second, the uninsured are already obtaining considerable amounts of care – paid for out-of-pocket, provided through public programs (such as the VA or community health centers), or subsidized through cost-shifting, as in the case of uncompensated hospital care. The RAND study found that uninsured adults had 61% as many ambulatory care contacts, and 67% as many inpatient hospital days, as comparable

¹ These were the estimates for the two proposals most nearly achieving universal coverage, reaching 40.3 million of a baseline 41.9 million uninsured; the remaining 1.6 million were undocumented or “hard to reach” people.

² Author’s analysis of 2006 Annual Social and Economic Supplement (ASEC) to the Current Population Survey.

insured adults. The size of the “access gap,” too, may have changed over time; for example, competition may have made providers less willing or able to cross-subsidize care for the uninsured. Despite these trends, much of the effect of universal coverage would be to shift existing spending from one set of pockets to another. (Some components of health spending, such as nursing home care, would not be affected at all.)

Whatever the size of any one-time increase in spending, the cost would be compounded if spending for the newly insured rose in tandem with those for the already insured. Suppose, for example, that universal coverage in 2008 would raise NHE by as much as 5%, from the projected \$2.4 trillion to \$2.5 trillion (Keehan et al.). If spending growth for both the currently and newly insured rose at the projected annual rate of 6.7%, NHE would reach 20.5% of GDP by 2017, compared to an estimated 19.5% without universal coverage. Of course, 1% of GDP is a lot of money, but perhaps not enough to affect people’s judgments about the level of health spending that society could “sustain.”

Some people claim that universal coverage would actually produce savings, because the newly insured would stop using emergency rooms and some serious conditions might be caught earlier, when they were less costly to treat. While this might be true, any such savings are already implicitly accounted for in the estimates. The basic method is, first, to estimate current annual spending by or on behalf of the uninsured, then to estimate their spending if their utilization resembled that of comparable currently insured people; the difference is the estimated aggregate spending increase.³ A newly insured person might substitute a physician office visit for a more costly emergency room visit, but she might also add three office visits, because she wouldn’t have to wait twelve hours to be seen at each encounter. The net effect is an aggregate increase. In addition to the increase in direct medical spending, there would also be the new administrative costs of insurance, which would be only partially offset by providers’ savings on billing and collection expenses for self-pay patients.

If the cost of covering the uninsured is comparatively small, why has it been such a concern? One obvious problem is that any measure to cover the uninsured will almost certainly also affect coverage and expenses for people who already have insurance. A small increase in total spending could entail very large shifts in spending from some payers to other payers. For example, a new tax credit for individual health insurance could help, not only the uninsured, but also people who are already buying coverage without assistance; private spending would be replaced by a federal tax expenditure. Politicians deal with specific programs, not with abstractions like the

³ The estimates might be affected by the one-year time frame. Some newly insured people will need catch-up services for some period, while some currently insured people might have high costs for conditions left untreated during a past period of uninsurance; these costs could be reduced in a universal coverage regime.

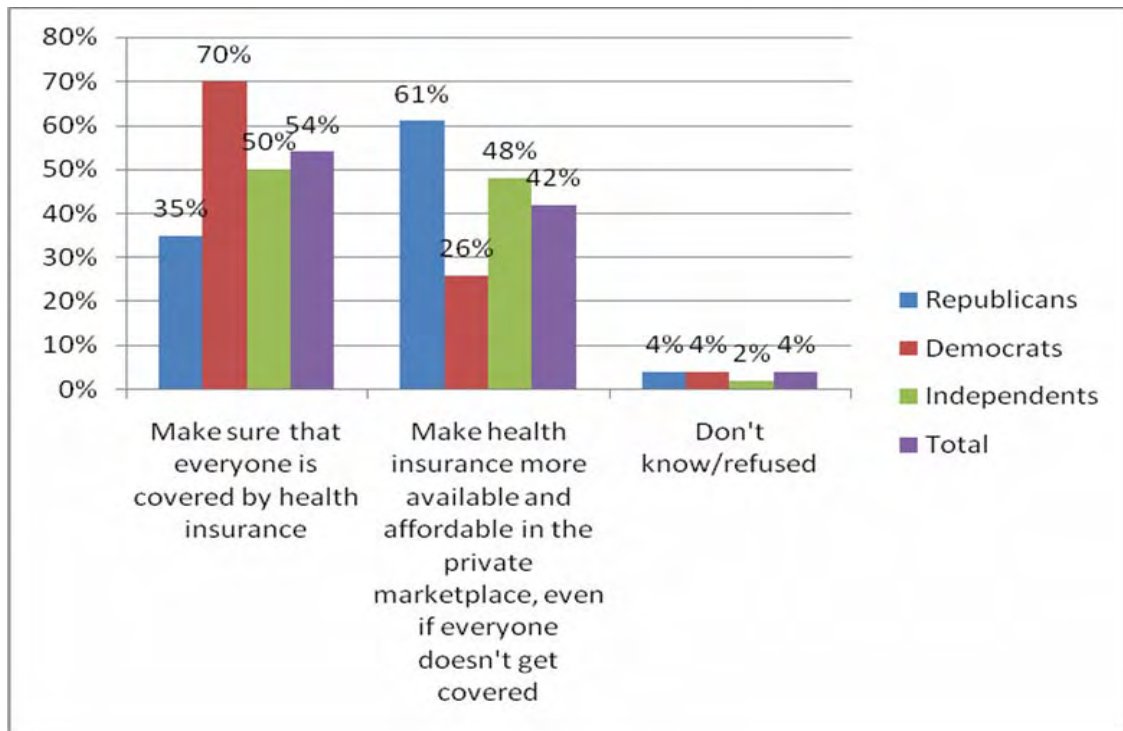
national health accounts, and the effect of coverage expansions on federal or state budgets could be much larger than the effect on aggregate spending. A second consequence, less frequently discussed, is that currently insured people with very poor coverage might gain better coverage and incur higher costs. In particular, it is hard to imagine how Medicaid programs could continue sometimes draconian benefit limits and low payment rates while categorically ineligible low-income people received more generous subsidized private coverage.

Whatever the effects of health coverage expansion on national health spending, it is certainly the case that high health care costs have contributed to the erosion of health insurance coverage, leading some employers to curtail health benefits and making nongroup coverage less affordable for people without access to employer or public plans. Continued unchecked growth in health costs could make the goal of universal coverage a moving target. While coverage expansion measures might be designed to reach people who do not have access to employer coverage today, rising premiums could mean that people who already have employer coverage might lose it in the future. Unless private sector costs can be brought under control, universal coverage through tax subsidies or public programs would mean, not just a one-time increase in public spending, but a steady shift from private to public spending.

Conversely, some people argue that cost containment even for the currently insured may not be achievable without universal coverage, for at least two reasons. First, certain approaches that some (by no means all) observers think could produce savings—such as health promotion and disease prevention—may not be workable if people are continually moving in and out of health coverage. Second, as Henry Aaron has pointed out, measures to reduce excess spending by the insured could squeeze out the fat in the system that is currently subsidizing essential services for the uninsured. This could mean that the access problems for the uninsured could eventually become too glaring for the society to continue to ignore (Aaron).

Whatever the practical arguments for linking cost containment and coverage expansion, there has also been a political linkage. Offering the prospect of ultimate cost savings could be a way of garnering support for the temporarily disruptive system or market changes needed to achieve universal coverage. Or the offer of universal coverage could be used to overcome resistance to potentially painful cost containment measures. The political calculus involved is beyond the scope of this paper, but polling data suggest that different Americans have very different ideas about what should be the major focus of health reform.

Figure 1. Registered Voters' View of the Main Goal for Improving the Health Care System in the U.S., April 2008



Source: Henry J. Kaiser Family Foundation, *Kaiser Health Tracking Poll, Election 2008*, available at <http://www.kff.org/kaiserpolls/upload/7771.pdf>.

Views of Republicans and Democrats about the key goal for health reform are almost mirror images, while independents are about equally divided: 50% for universal coverage and 48% for affordability. In this environment, it is hard to say which of the two goals is the sugar coating and which the pill. It should be noted, however, that the survey asks about making insurance “affordable.” The results might be quite different if voters were asked about measures to reduce the quantity and price of the services they themselves consume.

A matrix of coverage expansion and cost containment options

In order to clarify the interplay of coverage expansion and cost containment, this section describes a simple matrix of basic coverage models and cost containment approaches.

Coverage expansion models

The five models considered here represent an attempt at a basic typology of the options currently receiving the most discussion. Some of the models are often combined (for example, play-or-pay for workers and a public program expansion for

nonworkers). One key variable that is not considered here is whether a proposal includes an individual mandate. The presence or absence of a mandate obviously has implications for the size of the population that would be covered and for the workability of such possible program features as guaranteed issue or community rating. The cost implications are less clear. Presumably, without a mandate, the average risk level of the insured population would be higher than under full universal coverage. This would change the baseline against which insurers' or other actors' cost containment efforts would be measured, but would not necessarily affect the relative success of those efforts *for the covered population*.

In considering how the different models might affect cost containment options, the key issue is what kind of market would emerge under each model. Who would have the leverage to push for system change: consumers, insurers, employers, a connector administrator, or regulators? The answers given here are frankly speculative, and should be taken not as predictions but as illustrations of some of the possible dynamics.

1. **Subsidized nongroup coverage.** Consumers receive financial assistance, such as a tax credit or deduction or a voucher, to help cover the cost of health insurance premiums. The consumer may purchase coverage from any insurer, but benefits may be required to meet some minimum standards.

Proposals of this kind are often accompanied by a proposal to eliminate or place a dollar cap on the exclusion of employer-provided health benefits from workers' taxable income. In some variants, the employer exclusion is eliminated but workers can apply the tax credit to any required contribution for their employer coverage. Assuming a plan of this kind, workers in large firms that can offer favorable premiums might retain their current coverage, while those in smaller firms might shift to the subsidized nongroup market.

It is unclear how the insurance industry would evolve under this option—whether there would still be many small players or whether there would be continuing consolidation. It seems fair to say that there would be less consolidation under this option than under options 2 and 3. For the purpose of this paper, it will be posited that the option leaves in place many small commercial insurers with limited market power. These insurers would have to offer benefit packages and delivery models that were attractive to consumers; that is, they could not force a given benefit change in the way a large employer or a connector administrator could.

2. **Connector.** Consumers receive financial assistance, as in option 1, but may or must buy coverage through insurers participating in some form of connector or pooling arrangement.

Some connector proposals would effectively eliminate the nongroup and perhaps the small group market by providing that subsidies could be used only for connector coverage. Others – such as the proposals by several of the 2008 Democratic presidential candidates – would allow outside insurers to compete with the connector but subject them to guaranteed issue and community rating requirements. Some insurers would exit the market under these conditions, while others might find it difficult to compete with the connector plans – particularly if the connector plans could achieve significant administrative cost savings. (As is suggested in Merlis 2008, this is by no means certain.) It seems likely that, in this environment, the connector would capture the lion’s share of its target market. In the absence of the employer mandate provided in option 3, many small and medium-sized employers might offer their workers increased wages or other compensation in place of health benefits, shifting them into the subsidized connector market.

A key issue, in the context of this paper, is whether the connector would resemble the current Federal Employees Health Benefits Program (FEHBP) or whether it would come closer to the “pure” managed competition model represented, for example, by the health alliances in the 1993 Clinton plan. In a pure managed competition system, all insurers offer the same benefit package (although they may impose different levels of network restriction), consumers pay the entire difference between the cost of their selected plan and the least costly plan (or some other bid-based benchmark), and payments to plans are risk-adjusted. Plans compete solely on price and quality. FEHBP, on the other hand, has no standard benefit and no risk adjustment; there is price competition, but the formula for computing the federal contribution limits the reward for joining a low-cost plan or the penalty for joining a high-cost one. This paper will assume a sort of middle option, under which benefits are not fully standardized but the connector can issue occasional fiats in the form of, “All plans must cover procedure x,” or, “All plans must have a pay-for-performance system that rewards achievement of objective y.” The connector thus has some power to guide the system, but without the direct market power of a single-payer plan. (This power would be enhanced if the connector could select a limited number of plans through some form of bidding or competitive negotiation process, rather than accepting all qualified carriers.)

The market power of individual plans within the connector might also depend on how closely it resembled FEHBP. FEHBP has a few national PPO plans, with uniform national premiums, competing with local HMOs that charge local market prices. The national plans are more costly than the HMOs in some areas and less costly in others. While this oddity has been tolerated in FEHBP, it seems less tenable in a connector that would serve tens of millions of people. This paper will assume some geographic contribution adjustment, which would likely mean that competition would tilt toward national plans and regional plans with sizeable market power. (In practice, finding a fair way of compensating for geographic differences in medical care spending

has long been a difficult – and highly politicized – problem for the Medicare Advantage program and its precursor health plan contracting programs.⁴)

Note that some connector proposals include a public insurance plan that would be offered as an alternative to the available private plans. This variant is considered in another paper for this project; this paper will assume that all connector coverage is through private plans.

3. **Play-or-pay.** Employers may be required either to (a) offer health coverage to employees and contribute some share of the premium or to (b) pay into a public fund. If an employer chooses to offer coverage, it may self-insure or buy insurance; again, benefits may be required to meet some minimum standards, and a pooling arrangement may be made available for employers below some size threshold. If instead the employer contributes to a public fund, the proceeds may be used to finance option 2 or may be used to fund a public program expansion.

In terms of changes in the insurance market, this option might not play out very differently from option 2. It is included here simply to have one model in the matrix that emphasizes the employer's role as a purchaser of services, a designer of benefit packages, and possibly an influence on workers' health-related behaviors. There are differing views about whether large employers should continue to play a significant role in shaping health insurance options. Some people argue that employers have responded to cost pressures simply by shifting costs to workers, and that even some employers' attempts to address costs directly – for example, through wellness programs or value-based purchasing – are too fragmented and therefore unlikely to lead to fundamental changes in health care delivery (CED). Others contend that employers have been the major source of innovation in plan design in recent years, and that shifting workers out of employer-sponsored plans and into some form of connector arrangement might actually reduce the potential for innovation (Ginsburg 2008).

4. **Public program expansion.** A public program such as Medicaid or SCHIP would be expanded to reach a larger population.

Some proposals would allow people at all income levels to buy into public coverage by paying a premium. This would make the public program option very much like the connector approach, particularly as many Medicaid and SCHIP programs are already offering coverage through competing managed care plans. To distinguish this option from option 2, this paper will assume a fee-for-service program with some form of means testing but without the categorical eligibility restrictions (such as exclusion of single adults and childless couples) still imposed in most Medicaid and

⁴ For a discussion of the Medicare experience, see Merlis (2007).

SCHIP programs. The expanded program might have greater purchasing power than the public programs do now. One trade-off, suggested earlier, is that it might be less able to impose arbitrary benefit limits and low payment rates that arguably shift costs for program participants to other payers. Of course, one major cost problem currently facing Medicaid programs is the growing burden of financing long-term care and Medicare wrap-around benefits for the elderly and disabled. These issues are beyond the scope of this paper.

5. **Single-payer.** Everyone is enrolled in a public program.

There are several different single-payer models. In a Medicare-for-all plan, enrollees could choose between the public program and competing Medicare Advantage plans; the result might look very much like a connector option that included a public program component. In a “pure” plan, all enrollees would be in the public program, and supplemental coverage could be offered only for non-covered services (rather than, as under Medigap, for deductibles and coinsurance). This paper will assume a pure plan – able to exercise even more market power than Medicare but, like Medicare, subject to political and due process constraints that might not affect very large employers or private insurers. A second question is whether the program would operate nationally or at the state or regional level.⁵ A localized program would have considerable buying power, but variations in coverage rules, performance standards for providers, or other policies might influence the effectiveness of cost containment efforts. (If the goal is to change in some way the culture of medical practice, it is not clear whether national or local signaling would be more powerful.) This paper assumes a national program.

Cost containment options

Health care spending for a given population might be roughly defined as a function of five basic factors:

- Population needs or morbidity,
- Access to services,
- Propensity to seek services,
- Volume, nature, or intensity of services supplied or ordered, and
- Unit cost or price of services.

For the purpose of this paper, “cost containment” will be defined as any set of policies or measures intended to affect any one or more of these factors. Measures that

⁵ One example of a state-level single-payer proposal is Rep. Dingell’s national health insurance plan, H.R. 15 in the 110th Congress.

are designed only to shift costs for a given population from one payer to another, such as raising the eligibility age for Medicare or reducing an employer's percentage contribution to premiums, will not be considered here. (Note, however, that there are some measures that both shift and reduce costs, and therefore warrant inclusion; for example, increasing a health plan deductible both deters utilization and shifts some costs to the policyholder.) Again, measures to reduce the administrative costs of insurance are considered in another report for this project (Merlis 2008) and will also be omitted.

Table 1 lists a variety of measures that have been suggested as possible ways of reducing health spending or slowing spending growth. For each measure, the table indicates whether it is highly compatible (↑), less compatible (↔) or incompatible (↓) with each of the five coverage models. Because the focus of this paper is on the interaction of coverage models and cost containment options, the matrix omits some options that are entirely regulatory and whose implementation could be independent of the coverage system. Among these are malpractice reform, revived certificate of need programs for new facilities or major capital investments, stricter criteria for FDA approval of new drugs and devices, restrictions on direct-to-consumer advertising of drugs, and stronger (or, as some would prefer, weaker) enforcement in such areas as physician self-referral and antitrust. Some of these approaches might make one or another expansion model more workable, but none of them requires direct action by payers. Some other measures, identified (√) in the last column, might be advanced by both purchasers and regulators.

Table 1. Matrix of Coverage Expansion Models and Cost Containment Options

Key: model and option are-- ↑ = highly compatible ↔ = compatible ↓ = incompatible
 NA = option not applicable under expansion model

Cost containment options	Coverage expansion models					Regulatory or public health component
	Subsidized nongroup coverage	Connector or exchange	Play-or-pay (employer mandate)	Medicaid or other public coverage expansion	Single payer	
REDUCING NEED FOR SERVICES						
Primary and secondary prevention	↓	↑	↔	↑	↑	
Health promotion and education	↓	↑	↔	↑	↑	√
Health behavior-based premiums	↔	↔	↑	↓	↓	
Patient safety and reduced medical errors	↓	↑	↑	↑	↑	√
MODIFYING CONSUMER DEMAND						
High-deductible plans	↑	↔	↑	↓	↔	
Progressive cost-sharing	↓	↔	↓	↓	↑	
Tiered cost-sharing	↔	↑	↑	↓	↓	
Differential cost-sharing by service/procedure	↔	↑	↑	↓	↔	
MODIFYING PROVIDER BEHAVIOR						
Pay-for-performance	↓	↑	↔	↔	↑	
Bundled payment and capitation	↓	↑	↔	↑	↑	
Coverage rules and preauthorization	↑	↑	↑	↔	↔	
CONTROLLING PRICES						
Uniform pricing	↑	↔	↔	NA	NA	√
All-payer systems	↓	↔	↓	NA	NA	√
INSTRUMENTAL MEASURES						
Electronic health records and other IT	↔	↑	↔	↓	↑	
Clinical effectiveness and cost-effectiveness research	↑	↔	↑	↔	↔	
Price transparency	↑	↔	↔	NA	NA	√

Each cost containment measure has been grouped according to the health spending factor at which the measure is chiefly targeted. This grouping is necessarily

arbitrary, because some measures affect more than one factor. In addition, some measures directly targeted at one factor are also intended to have indirect effects on another. For example, high-deductible plans are meant to modify consumers' care-seeking behavior but might also, according to their proponents, induce price competition among providers.

The last set of options, labeled "instrumental measures" in the table, includes comparative effectiveness research, greater use of electronic health records and other health information technology, and measures to promote greater price and quality transparency. These are not in themselves cost containment measures but may instead be prerequisites for the success of other approaches. For example, knowing what medical practices are most effective is not the same as getting providers to adopt them, but may be essential for developing defensible coverage and payment rules. An electronic health record might alert a provider that a patient has already received a particular diagnostic test, but will not necessarily preclude a duplicate test if the provider will be rewarded for conducting it.

Reducing need for services

Preventive services. The familiar problem with preventive services in an insurance context is that the services cost money now but may produce savings only much later – if ever. If many people change insurers from year to year, Insurer A might be making an investment that produces savings for Insurer B. Possibly under the connector option, if it has a limited number of insurers and relatively stable enrollment, insurers would be willing to invest voluntarily in efforts to promote use of preventive services. (This is a question, perhaps, for game theorists.) In the play-or-pay environment, some employers with a very stable workforce might have similar incentives.

Under the nongroup option, basic policy standards to qualify for a subsidy could include coverage of specified preventive services and reduced cost-sharing for these services. Obviously similar standards could be imposed under the other options, but they might also afford opportunities to promote greater use of the services. These could be consumer-focused. For example, some Medicaid programs are experimenting with contracts with beneficiaries, under which full benefits are contingent on the beneficiaries' compliance with specified utilization rules. An employer might also require employees to obtain some preventive services as part of a behavior-based premium scheme, discussed later in this section. (Providers could be given incentives to promote use of preventive services through a pay-for-performance system, discussed below.)

Health promotion activities, such as smoking cessation or weight reduction

programs, are commonly either public health efforts or are conducted by employers. Because employers who offer these programs are often concerned as much with productivity as with potential health benefit savings, it seems unlikely that play-or-pay would induce many additional employers to undertake these activities. At least some insurers are also working on individualized health promotion programs, such as multidisciplinary efforts to combat childhood obesity (Dietz et al.). From the insurer perspective, the incentive problems are similar to those for preventive services. One way of furthering health promotion activities would be through an outcomes based pay-for-performance program. Because outcomes for health promotion may be extremely long-term, this approach might work best under the single-payer option.

One analyst has argued that current financing mechanisms are unlikely ever to place adequate emphasis on prevention and health promotion, and has suggested the establishment of a Wellness Trust (Lambrew). This would be an agency within Health and Human Services, funded by assessments on insurers, that would pay directly for preventive services for all consumers as well as fund health promotion programs. Possible concerns are that such a program would add complexity and inhibit coordination of preventive and curative services.

Behavior-based premiums. Insurers may offer different premiums, or employers may offer different premium contributions, to enrollees displaying approved or avoiding disapproved behaviors. At this time, insurers are simply offering smoking/nonsmoking rates, but employers are beginning to consider other factors, such as participation in wellness programs. It is possible to conceive of programs that would reward participants for bringing their blood pressure under control or losing thirty pounds. But it is hard to imagine how such programs would be conducted by a nongroup carrier, with limited monitoring ability, and they may not be politically feasible in a connector or single-payer arrangement. For this reason, the option is chiefly available to large employers (although it may raise concerns about hiring discrimination based on health behaviors). Again, Medicaid programs might achieve similar results through beneficiary contracts.

Patient safety and reduced medical errors. Improvements in patient safety are included in the category of need reduction because the victims of medical errors require additional services they would not otherwise need. Medicare has announced that it will not pay hospitals for services required as a result of certain preventable conditions or injuries that should never occur, and some other purchasers are adopting similar policies (Fuhrmans 2008). More broadly, patient safety could be considered in pay-for-performance systems. Both types of payment measures may be most effective under the connector and public program options; see the discussion of P4P systems, below. Regulators can also promote patient safety through licensure procedures.

Modifying consumer demand

High-deductible plans. High-deductible health plans (HDHPs) are intended to deter unnecessary utilization of services, lead consumers to consider costs and benefits in considering alternative treatment, and encourage price-shopping – which in turn, it is hoped, will promote price competition among providers. The plans may be combined with a tax-favored health savings account (HSA) or, in employer plans, with a health reimbursement arrangement (HRA). As was suggested at the start of this paper, a high-deductible plan design is hypothetically compatible with all of the coverage options except Medicaid expansion. If incorporated in a single-payer approach, it would need to be accompanied by some protection for low-income participants. It seems unlikely that an HDHP would be the sole option under a connector model. However, the connector could offer such plans among a range of other options, as the FEHBP has done.

A nongroup model could simply specify a minimum deductible for qualified plans. However, this would conflict with the consumer-choice orientation of these proposals. Notably, President Bush’s most recent tax credit proposal specified a maximum out-of-pocket limit, but not a minimum deductible. Although the HDHP concept seems to fit best with the subsidized nongroup option and has been incorporated in a number of these proposals, it might actually be of greater interest to employers than to consumers. Although HDHP plans had high initial penetration in the nongroup market, recent growth in HDHP enrollment has been much greater in employer plans.⁶ If a play-or-pay model specifies a minimum set of benefits to be offered by employers wishing to avoid the tax or assessment, the package is unlikely to be a high-deductible plan. However, employers could be allowed to offer an HDHP as a low-cost alternative for employees. And it might be possible to develop rules under which a combination of the HDHP and employer contributions to an HSA or HRA could be determined to be actuarially equivalent to the required minimum benefit.

One issue raised by HDHP plans is that they are likely to have limited effects on the behavior of higher-income participants. At least one analyst has suggested a **progressive cost-sharing** system, under which the family deductible would be a fixed percentage of family income (Furman). This is probably most workable retrospectively, through the tax system. (The author suggests a 7.5% threshold, making the option conceptually equivalent to replacing the current medical expense deduction for itemizers with a refundable medical expense credit.) This option is most compatible with a single-payer system, because everyone would have the same benefit package and the information needed could be readily assembled. The potential trade-off would be loss of political support for the system among middle and high income taxpayers.

⁶ Nongroup HDHP/HSA enrollment grew by 170% between 2005 and 2008, but employer group enrollment grew 1,060%, and the figure excludes employers adopting HDHP/HRA plans (AHIP).

Tiered cost-sharing offers enrollees in network plans reduced cost-sharing if they use a preferred subset of network providers, selected by the plan on the basis of efficiency, quality, or other criteria. Small insurers under the nongroup option would have too little data to make the selection, but might conceivably use this option if there were a public database on provider costs and quality (see the discussion of transparency). But it is not clear whether this benefit feature would be attractive to nongroup purchasers. Identifying the preferred providers would be politically very difficult under the single-payer option, and tiering would not be workable under a Medicaid expansion. This option is thus most compatible with the connector and play-or-pay options.⁷

Differential cost-sharing. Payers could require higher cost-sharing when a consumer obtains a treatment deemed to be less effective or less cost-effective than alternative treatments (Orszag ;Schoen et al.). This approach is less harsh than actual denial of payment (discussed under coverage policies, below); providers would still be paid for the service, but patients would have an incentive to consider other treatment options. This approach is compatible with all the coverage models except Medicaid expansion, but may be politically difficult under a single-payer model. This is especially true for procedures that offer some slight improvement in outcomes but only at a much higher cost than some other treatment. Private insurers may be in a better position than a public program to make the patients take cost into account. However, the marketability of this approach depends on effectiveness research that can actually quantify cost-outcome tradeoffs.

Modifying provider behavior

Pay-for-performance (P4P) programs reward providers either for achieving some target level of performance on selected process or outcome measures or for improving performance relative to some baseline measurement. P4P has received so much attention that this paper could easily be devoted solely to this option. The following discussion will consider how just a few key implementation issues might play out under the different coverage models.⁸

Uniform or varying systems. P4P may have a greater effect on provider behavior if all, or at least many, major payers adopt comparable systems. Otherwise providers would be expected to collect different data and meet different objectives for different

⁷ One paradox should be noted: if many insurers arrived at roughly similar assessments of preferred/nonpreferred providers, pushing all their enrollees toward the same doctors and hospitals, these providers could reach full capacity. This would mean that some unhappy consumers might not have access to them and would instead pay higher cost-sharing for providers deemed inferior.

⁸ For a useful overview of P4P issues, see Williams and Christianson.

payers, making it difficult to prioritize or make necessary investments or organizational changes. Uniformity can emerge from insurer/provider initiatives, as in the case of California Integrated Healthcare – although even this program has not been able to establish uniform payment incentives across insurers, partly because of antitrust concerns (Integrated Healthcare Association). Clearly a single payer or a connector administrator would be best positioned to develop uniform systems.

On the other hand, some people say that, because P4P is still in its infancy, it would be better to have continued experimentation with a variety of systems (Wilensky). This could be allowed by the connector and might occur naturally under the play-or-pay option. However, considerable resources may be needed to develop measures (including appropriate risk adjusters for outcome measures), test incentives, and monitor results. It is not clear how many individual insurers would make the investment to develop programs that could be adopted by others. The single payer model might be in a better position to experiment with different approaches through a demonstration authority comparable to Medicare's.

Form and amount of the incentive. P4P can just involve rewards for good performance or also include penalties for poor performance. CMS's proposal for a value-based purchasing system for Medicare inpatient services would fund incentive payments for high performers through an across-the-board reduction in base DRG payments (CMS 2007). This budget-neutral system effectively transfers funds from poor to high performers. Because it is hard to see how individual insurers could negotiate such an arrangement with providers, it is probably workable only in the single-payer and possibly the connector models. (Possibly some Medicaid programs could adopt this option, but not if their baseline payments to providers are already below cost.) A second issue is how big the incentives should be. A provider may not make system changes unless the amount of money in play for meeting a given objective is greater than the cost (Miller). Again, uniformity across payers may play a role here. A single insurer might have to pay a great deal to steer performance on a measure of its own devising, while multiple insurers using a common system might achieve results with smaller incentive payments.

Whose performance is measured and who is paid. P4P for process measures can be implemented at the level of individual providers. However, rewarding (or penalizing) outcomes is more difficult, because patients with chronic conditions or complex problems may be seen by multiple providers. One suggested option, that the payer somehow allocate bonuses among the treating providers – physician A gets x%, hospital B gets y%--seems impossibly complex (Schoen et al.). One alternative is simply to reward a single provider for the outcome. However, providers are unlikely to be willing to enter into P4P arrangements that depend on the performance of others over whom they have no control.

P4P for outcomes may be most practical if performance on a given measure is assessed and incentives provided for integrated groups of providers – such as for a hospital and its affiliated physicians, or for a primary care physician and some set of specialists he or she commonly works with. This in turn requires that providers come together and contract jointly to accept responsibility for care of certain kinds of patients: an ad hoc or formal network will contract with Acme Health Plan to guarantee some level of performance for the care of diabetics. Or – because some of the patients included in the diabetic P4P measure are also included in the cardiac P4P measure – an entire integrated delivery system would accept responsibility for overall care of a defined population. This fundamental reorganization of health care delivery is the ultimate direction in which P4P, as well as some of the other options to be discussed below, seems to point. Providers aren't likely to form integrated systems just to deal with Acme Health Plan. They might do so in order to deal with a single payer and possibly, in some communities, to contract with an expanded Medicaid program. How delivery system reorganization would fit under any of the options that retain multiple competing insurers will be considered at the end of this paper.

Bundled payments and capitation. Payers could make a single payment for an entire episode of care – for example, combining inpatient and physician payments into a comprehensive DRG payment for a hospital admission, or broadening this payment to include post-discharge care for some period, thus covering follow-up visits, home health, and so on (Schoen et al., Pham and Ginsburg). This approach, meant to encourage hospitals and their affiliated physicians to work together to improve efficiency, would clearly be possible under single payer or an expanded Medicaid program. But either might face political concerns about the possibility of underservice.⁹ Large insurers under the connector or play-for-pay options might have greater leeway to adopt bundled payments – if they have sufficient market power. But one observer notes that insurers have not tended to be very innovative in their payment methods; few have even reached the point of adopting DRG systems, instead paying hospitals a per diem rate or negotiating a fixed discount from billed charges (Ginsburg 2007).

Providers could also be capitated for providing the full range of services – or some subset, such as all ambulatory care or all care related to a specific condition) to a defined population for a fixed period. It is a little startling to see this option advanced by some analysts as a new concept. Capitation was widespread twenty years ago but has become less common, partly because of patient and regulator concerns, and perhaps partly because provider groups big enough to accept significant financial risk have enough market power to refuse it. One analysis has suggested that similar effects might be achieved through P4P systems that used overall spending for patients with a given

⁹ Medicare has long prohibited hospitals from sharing savings even on the base DRG payment with physicians. CMS is now conducting a “gainsharing” demonstration, under which incentive payments are permitted at selected sites (CMS 2006)

condition as one of the measures considered in calculating bonuses (Pham and Ginsburg). This would provide some incentive for efficiency without placing providers at excessive risk. These schemes, too, have been tried before (without the P4P label). They raise some of the same questions already discussed in the context of P4P: for which providers is efficiency measured, and who gets the payment? Again, the option may imply the emergence of integrated systems.

Coverage policies. Under any of the coverage models, payers would continue to make decisions about what services will not be covered or will be covered only under specified circumstances or with prior authorization. Of course, coverage decisions have been a source of friction between health plans, consumers, employers, and regulators for many years. In theory, some of this contention would be eased if research broadens the knowledge base about effective clinical practices. However, as will be discussed below, research may just shift the field of debate from effectiveness to cost-effectiveness, leading to even more painful disputes about the value of different treatments. It is not at all clear which of the models would promote more aggressive use of cost-effectiveness information. A single payer or connector might face more frequent political intervention in coverage decisions, while carriers under the nongroup or play-or-pay models might have greater freedom to restrict access to services deemed ineffective. Over the long term, however, coverage denials might lead once again to the backlash in the 1990s that produced patient bill of rights legislation and employer pressure to loosen managed care restrictions.

One alternative is to allow health plans to compete explicitly on the basis of the overall stringency of their evaluations and their price (Pauly). That is, Plan A might have a high premium but cover every new treatment that shows up in the newspapers, while Plan B might have a lower premium but more rigorous review of new services. Consumers could then sort themselves out on the basis of their price-sensitivity and their willingness to accept the plan rather than the physician as the arbiter of their care. There is a possible risk selection problem that would need to be addressed, and it is not clear that this consumer-choice model would take all the politics out of coverage decision-making: consumers who accept a hypothetically limited plan when they are well might not be stoical about the plan's limits once they become sick. Still, plan competition on this basis is not inherently less reasonable than competition on the basis of the tightness of network restrictions. It seems more likely that such a market would emerge under the nongroup and play-or-pay options than under the connector model.

Controlling prices

In the current system, health plans negotiate prices with providers, with the size of discounts theoretically dependent on the relative power of insurers and providers in a particular market. A single payer, of course, can ratchet down prices until quality and

access problems (or predictions of these problems) create political counter pressure. The reverse might be true under a large Medicaid or public program expansion; programs might have to bring their payment rates closer to market prices or at least to marginal costs. Among the private insurance options, assuming that the connector model is more likely to promote consolidation than the nongroup model, participating plans would have enhanced market power and might be able to squeeze down prices (possibly at the expense of whatever payers, such as self-insured employers, might be left out of the system). However, concentration in the insurance industry may be offset by consolidation of hospitals and other providers. And insurers' leverage in price negotiations may be affected, not only by their market share, but also by enrollees' demands for access to a wide selection of community providers (Ginsburg 2005). Advocates of a nongroup model with high-deductible plans contend that these plans would lead consumers to shop for better values and thus drive down prices. In practice, most of these plans give enrollees access to negotiated network prices before the deductible is met, dampening any incentive for shopping, and a plan that exposed enrollees to full provider charges would have difficulty competing.

Some people have suggested that the current pricing system is inherently inefficient and inhibits real competition among providers. At least two solutions have been suggested: uniform pricing by each provider and a return to the all-payer systems that proliferated in the early 1980s but have now largely vanished. Both of these are basically regulatory options but will be discussed here because they may have different effects in under different coverage models.

Under **uniform pricing**, each provider would set its own rates but would be required to charge the same rates to all payers (Porter and Teisberg).¹⁰ (An open question is whether individual payers' P4P programs would still be permitted under this option.) Under an **all-payer system**, rates for institutional services might vary by provider, but each provider's rates would be approved by a regulatory entity; rates for physicians would be set on some uniform basis.

Uniform pricing would somewhat reduce the competitive advantage of large insurers under all the private insurance models, although they would still have economies of scale and perhaps a greater ability than smaller competitors to use other cost-control techniques. All insurers would still be able to steer their enrollees to lower-priced providers, but there might be no rationale for formal insurer-provider network contracts. One risk, possibly greater under the nongroup model, is that insurance market segmentation would emerge, with some plans offering affluent enrollees access

¹⁰ A less sweeping proposal would allow providers to go on charging different prices to different payers, but would require all prices to be quoted in a standardized form. For example, all physicians would use Medicare's RBRVS, but Plan A would use one conversion factor and Plan B another (Reinhardt). This is really a transparency, rather than a price control, proposal.

to costly providers who were (or perceived to be) of higher quality, while cut-rate plans offered only the lower-priced providers. Another concern, that safety-net providers would be disadvantaged, would depend in part on the extent to which a coverage model achieved universal coverage.

All-payer systems, at least for the hospital sector, are effectively the same as the global budgets established, for example, by Canada's provincial health plans. The regulator determines the hospital's total revenue needs for its projected volume and mix of cases, and rates are set at the level needed to achieve this total.¹¹ In the physician sector, rate-setting might be designed to limit total growth in physician expenditures, using some target comparable to Medicare's sustainable growth (SGR), which is meant to link physician fee increases to growth in GDP.

While this kind of general health care budgeting is common in single-payer systems, it is not clear how well it can be made to fit with approaches that retain competing private health plans. In the 1993 Clinton plan, regional alliances (more or less comparable to connectors, but with control over all except the self-insured employer market) would have set the rates to be paid by fee-for-service health plans, leaving managed care plans the option of trying to negotiate lower rates. This set up a conundrum: providers granting discounts to the managed care plans would have sought to cost-shift to fee-for-service plans. If an alliance allowed the cost-shift in its rate-setting, the fee-for-service option would have become steadily less affordable, creating political problems. If it did not allow the cost-shift, managed care plans – especially in rural areas or other areas with limited provider competition – would have had difficulty obtaining discounts and would have had to compete solely on their ability actually to control utilization, also leading to potential political backlash.¹² In Germany, all competing insurers (sickness funds) pay the same rates, negotiated jointly by plans and providers, without discounting. This has left plans to compete largely on the basis of risk selection; a new risk-adjustment system in 2009 aims to force plans to compete instead on the basis of disease management and gatekeeping (Cheng and Reinhardt).

In both these cases, price controls and insurer competition are made to work together through an arrangement that oversees coverage for nearly the entire patient population and that uses risk adjustment to assure that competition is on the basis of care management. This suggests that price controls would be compatible with a near-monopsony connector scheme and less so under the subsidized nongroup or play-or-pay options.

¹¹ Assuming that the rates would include a capital component, the system would implicitly control hospital expansion and major technology adoption in somewhat the same way as a certificate of need program.

¹² Some of the trade-offs involved were discussed (before the Clinton proposal) by Ginsburg and Thorpe.

Instrumental measures

Health information technology. HIT can be said to consist of three main components: electronic health records (EHRs) maintained at the provider level; exchange of clinical data among providers using interoperable systems, and a personal health record (PHR) that ideally would include comprehensive information on an individual consumer's health conditions, medications, and past medical services and test results. Key differences between an EHR and a PHR are that the EHR includes only information entered by one provider or network of providers and is "owned" by those providers, while a PHR is theoretically owned by the consumer and includes information about services received from all the providers the consumer has used.

The role of payers in promoting use of EHRs and clinical data exchange is probably limited. In the US, the strategy for addressing the barriers to universal implementation of these components—standardization, capital, and technical assistance—relies basically on providers and government as regulator/facilitator rather than as purchaser. Public and private payers may play an indirect role, to the extent that their information requirements for P4P and other purposes may spur smaller providers to invest in technology or consolidate into larger groups.

Payers might play a larger role in the development of PHR systems, which offer the potential for savings by reducing duplicative services, drug interactions, and so on. There are currently a number of PHR models.¹³ Consumers can simply enter their own data—such as medication lists, known health conditions, records of recent visits, perhaps test results that the patient knows about—using software such as Microsoft's new HealthVault. "Tethered" PHRs are maintained for patients by providers, and can thus contain much more information, but only on services and findings at that provider or network of providers. Finally, insurers and employers are designing PHRs that can include data drawn from claims as well as data entered by the consumer. This information would be broader but less detailed than that in provider-developed PHRs and could be portable—allowing a lifelong record, regardless of whether the consumer changed providers, employers, or insurers.¹⁴ To address consumer concerns about confidentiality, several major employers are funding an independent system called Dossia that would maintain the record for the consumer without making it available to employers and insurers.¹⁵

The insurer/employer-based model might have the greatest long-range savings (and quality) potential, because it could give providers ready access to a patient's entire medical history. However, it might then raise the same issue as funding preventive

¹³ For an overview, see California Healthcare Foundation (2007).

¹⁴ AHIP and the BlueCross BlueShield Association (2007) are pilot-testing portability standards.

¹⁵ The Dossia initiative was delayed by contract problems and has not yet been implemented (Smerd).

services: why make the investment in something whose savings potential might be long-run and benefit the patient's next insurer? The investment seems to make more sense if enrollment is fairly stable, perhaps under the connector model. A single-payer plan, of course, could gain access to all of the data needed to assemble a comprehensive PHR, but for this reason may raise even greater concerns about protection of patient privacy.

Effectiveness research. Sound information about the comparative effectiveness of different treatment options is essential if public and private insurers are going to use coverage and payment policies to drive system performance. Although some insurers have conducted or sponsored studies of specific treatments or of multiple treatments for a specific condition, it seems unlikely that individual insurers would make a large investment in research whose results would benefit their competitors (CBO compare). A single payer or connector administrator might fund effectiveness research, but there is an emerging consensus that findings are more likely to be credible if the research is conducted by an entity independent of payers (see, for example, MedPAC).

Payers might play a larger role in assessing *cost-effectiveness*, as opposed to effectiveness per se. While an independent effectiveness research program might conclude that treatment A provides one more additional quality-adjusted life year (QALY) than treatment B at a cost of \$100,000, it might not be in a position to say whether treatment A should therefore be approved or disapproved (CBO compare). Someone has to decide what a QALY, or whatever the outcome is, is worth. In the near term, this is likely to be difficult for a single-payer or Medicaid program, because of political pressure to pay an infinite sum for a QALY.¹⁶ There might be somewhat more leeway under the connector and play-or-pay models, and considerably more under the nongroup model, for payers to deny services of small marginal value. Again, in all the models except Medicaid expansion, differential cost-sharing for cost-ineffective services might be more palatable than outright denial.

In a world of perfect knowledge by all parties, competition among insurers might depend in part, as the Pauly model cited earlier suggests, on how much different consumers were willing to pay in premiums for slightly improved outcomes. This would mean a shift from the implicit income-based rationing in the current system to explicit income-based rationing, and could lead to greater pressure for a single-payer system. (Even then, there would remain the question of whether a parallel private system, as in England, would be permitted.)

¹⁶ The Oregon Health Plan in the 1990s adopted a prioritization system for Medicaid benefits, ranking diagnosis/treatment pairs by probability of preventing death or disability and excluding low-ranking services. The threshold was set low enough that only clearly ineffective services were excluded, and the rules were not binding on the private health plans that served most Medicaid beneficiaries (Bodenheimer).

Price transparency. Improving information about provider prices is key to the high-deductible plan concept and is important even for enrollees in conventional network plans, who are seldom able to ascertain whether they would pay more at one network provider than another or what additional cost they would incur for an out-of-network service.

Many insurers are now providing at least some kind of price information to their enrollees, but few have reached the point of full transparency, including disclosure of negotiated network prices. A connector administrator or a large employer under the play-or-pay option might compel this disclosure. There is some debate about the possible effects of full transparency on competition among providers and/or health plans. Suppose that all hospitals and health plans in an area knew all the prices paid for a given procedure. If a hospital learned that a given insurer was paying other hospitals more for the procedure than it was receiving, it might demand the higher price. Conversely, if a health plan learned that a hospital had granted steeper discounts to competing insurers, it might ask for the same discount. Whether providers or health plans would prevail in this scenario would depend on which had the greater bargaining power.

Simply knowing prices would be insufficient for consumers to make fully informed choices, for two reasons. First, patients rarely know exactly what services they will receive during a given encounter. Second, Physician A will often order tests from Lab B and refer the patient to Specialist C. What the patient really needs to know is how the total out-of-pocket cost for an episode of care for a given condition will vary according to the patient's entry point into the system – and, ideally, how this total might change under alternative treatment options. Some insurers are now making estimates of this kind for internal purposes – for example, to select the preferred providers in a tiered cost-sharing system – but none are disclosing the results to enrollees. This is partly because providers would protest that the results were distorted by inadequate risk adjustment or other problems. At least one analyst has suggested that a fair system of cost transparency might require rules set by an independent arbiter, much as the Financial Accounting Standards Board sets rules for corporate financial statements (Galvin).

Conclusion

Many of the cost-containment approaches described in this paper are intended to induce changes in the health delivery system or will be more effective if these changes occur. Some people believe that steps should be taken to encourage the development of new kinds of providers. For example, Regina Herzlinger favors “focused factories,” which would be centers for the comprehensive treatment of a single condition such as diabetes or AIDS. This approach has a large regulatory component – or perhaps, more

properly, *deregulatory* – as it may involve relaxing various kinds of restrictions that might inhibit innovation. These might include licensure and scope of practice laws, which some people characterize as perpetuating a “guild system” in health care; laws against the corporate practice of medicine; and perhaps antitrust laws (Galvin).

While regulators may have a role in eliminating barriers to new types of care, payers will decide which are financially possible. Practitioners or entities (such as retail clinics) that can provide individual services at low cost may be more likely to thrive under high-deductible plans. New types of facilities can operate only if major insurers are willing to pay for them. (The biggest insurer, Medicare, can actually bring new categories into being, as in the case of medical assistance facilities – quasi-hospitals in isolated areas. The principle might be, “If you pay for it, they will build it.”) Innovation could be hastened if a connector or other regulator required insurers to cover new provider types, although this would be the equivalent of the much-derided state mandated benefit laws.

Whatever new types of specific providers may emerge, many possible measures to improve incentives for efficiency seem to point in the direction of integrated delivery systems that cross provider boundaries and that are able to bear bundled or capitated payment risk and to be held accountable for high performance, however defined. The systems that might be expected to emerge might closely resemble the integrated systems contemplated in classic managed competition proposals, with one critical difference. In the Enthoven model, the integrated system *was* the insurer, the “accountable health plan” competing for enrollment with other systems under the eye of the cooperative or alliance or connector that organized the competition (Enthoven). Under the models currently under discussion, the integrated system would be *paid* by the insurer, possibly with a transfer of some amount of the insurance risk.

This raises the question: why should the providers who have invested in the development of an integrated system sell their services on a risk basis to Acme Health Plan instead of offering themselves directly as Provider Health Plan? One possible answer is that past attempts to form Provider Health Plan have not been very successful, because of limited access to capital, conflicts of interest between the plan and its constituent providers, and other factors.¹⁷ The entry barriers would probably be even greater if consolidation in the insurance industry continues at its recent pace or is accelerated – as has been suggested might occur under a connector model. So what could emerge is what some observers have called a two-market model: provider systems competing for insurers and insurers competing for enrollees (Chernichovsky).

If the provider systems are competing on dimensions of cost-effectiveness, quality, patient satisfaction, or whatever other metrics are thought to be desirable, what

¹⁷ There have been occasional successes; see Ginsburg 2005.

is the basis of insurer competition? In the subsidized nongroup model, unless it included strict regulation of underwriting and rating practices, insurers might continue to compete through risk selection, perhaps rendering the relative efficiency of their provider networks moot. In an FEHBP-like connector arrangement, risk adjustment could deal with this problem, but insurers might still offer varying benefit packages—making it difficult for participating consumers or employer groups to assess whether price differences reflected benefits or efficiency. This problem, too, could be addressed through benefit standardization. There might be a little bit of competition on the basis of customer service or “amenities,” but essentially plans would be differentiated by the relative quality and (passed-through) prices of the provider systems with which they contracted.

This paper began with the premise that coverage expansion models and cost containment options were more or less independent, although some combinations might work better than others. However, increasing numbers of analysts contend that cost containment will require sweeping changes in the way health services are delivered. If it is expected that these changes will be driven by the way providers are paid, then the basis of competition among payers becomes central. Different coverage expansion models are often debated in terms of a preference for public or private funding sources, relative equity, ease of administration, degree of disruption of current arrangements, and so on. But different models also imply differences in the kind of insurance market that is created and the incentives that exist for insurers to drive change in the delivery system.

As was suggested at the outset, this paper’s assumptions about the kind of market that would emerge under each expansion model amount to speculation and not prediction. But each model will affect the market *somehow*. The point to be emphasized is that choices among models are not just about the simplest (or most readily enacted) way of getting some kind of health insurance card into every American’s hands, but about what those cards will buy and how they might be leveraged to improve the performance and value of the health system.

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Note: All URLs verified as of June 2008.

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