The $3 Trillion Question:

What Health Care Reform Can Save For Families, Businesses and Taxpayers.

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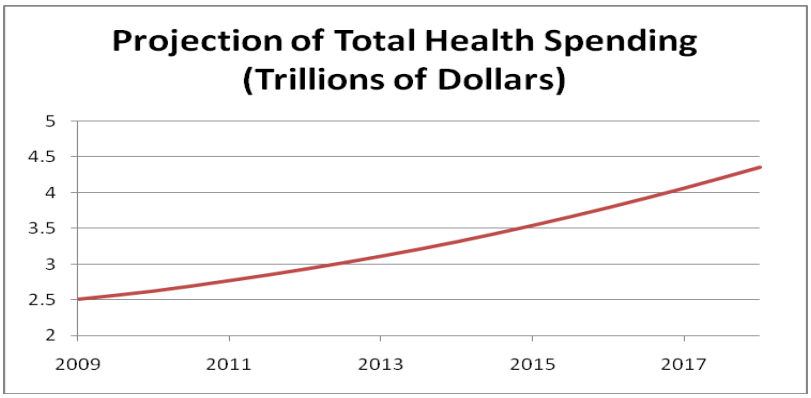
EXECUTIVE SUMMARY

Without health care reform, the United States is projected to spend over $40 trillion on health care in the next decade. Experts estimate that thirty percent of that spending – up to $12 trillion dollars – will be wasted on ineffective care, pointless red tape, and counterproductive treatments that can actually harm patients.



As a result, American families and businesses are weighed down by high premiums that continue to increase twice as fast as inflation. Meanwhile, cost-benefit analyses performed by the Business Roundtable show that, dollar for dollar, we get less for our health care spending than the rest of the industrialized.

Health care reform holds out the golden promise of addressing both of these problems at once. By aligning incentives within the health care system in favor of quality treatment, by investing in health information technology, and by conducting better research on which treatments work for which kinds of patients, we can make health care both more affordable and higher quality.

I. Streamlined Billing

Replacing the profusion of different forms and codes with a single, uniform process, and connecting providers and payers in an electronic network that does not rely on paper-based records, has been proven to increase efficiency and decrease costs.

Net ten-year savings: up to $350 billion.

II. Health IT

Almost alone among American industries, for the most part health care has failed to integrate productivity-enhancing information technology systems. Well-designed information technology systems can help close information gaps and allow data sharing for better coordination.

Net ten-year savings: $180 billion.

III. Insurer Efficiency

Currently, insurers are not required to devote any fixed portion of the premium dollars consumers pay to medical care. Requiring insurers to spend at least 85 percent of premium dollars on actual health benefits would create a firm incentive for insurers to prioritize quality care and reduce wasteful inefficiencies.

Net ten-year savings: $100 billion, as a very rough estimate.

IV. Comparative Effectiveness Research and Evidence-based Medicine

Due to a lack of easily available research on which drugs, devices, and treatments are most effective for particular patients, unsuspecting doctors sometimes prescribe ineffective or counterproductive treatments. Adoption of the findings in evidence-based treatment protocols and guidelines can help ensure we are paying for the most effective treatments.

Net ten-year savings: up to $480 billion.

V. Prescription Drug Advertising

Heavy marketing of prescription drugs raises health care costs and fails to improve patient health. Pharmaceutical marketing encourages patients to take drugs that cost them more and that often are riskier than alternative medications. Restricting this marketing would allow more prescriptions to be written based on unbiased science, reducing costs and improving care.

Net ten-year savings: Savings on the very rough order of $210 billion appear possible.

VI. Payment Reform and Prevention

Too often patients do not receive the most effective care for their illnesses. We systematically under invest in the primary and preventive care – including early treatment and screenings – that keep people well, and when a patient enters a hospital or gets sick, many doctors may treat him or her without strong coordination, leading to duplicative tests, miscommunication, and needed care slipping through the cracks. Creating financial incentives for proven treatment strategies, including managing chronic diseases, would lead to more primary care and better coordination – and lowered costs.

Net ten-year savings: ~$1.1 trillion

VII. Health Insurance Option

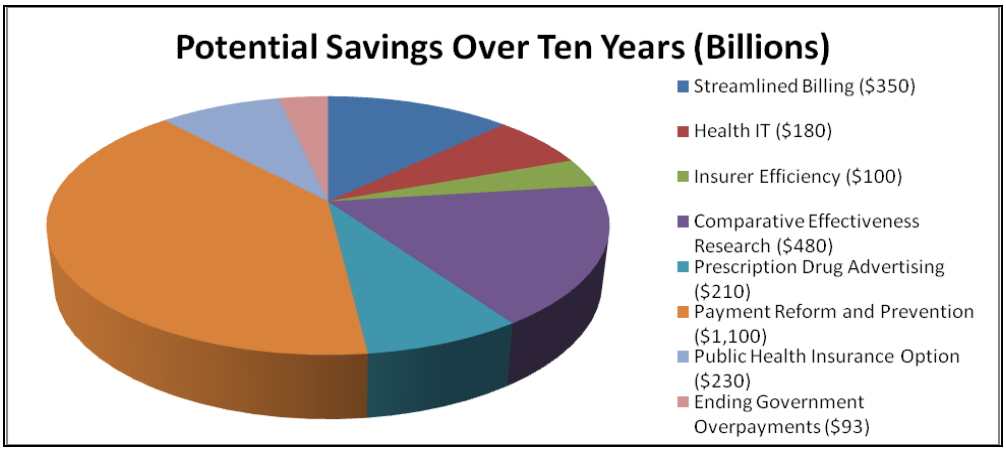
One of the most high-profile elements of proposed health care reform is the establishment of a new public health insurance option, open to those who are unhappy with their private coverage. This option would expand consumer choice, but it would also help bring down costs by forcing private insurers to be more competitive.

Net ten-year savings:$230 to $320 billion.

VII. Ending Government Overpayments to Insurers and Drug Companies

Currently, a pair of federal government policies enrich insurance and drug companies at taxpayer expense, overpaying insurance middlemen and drug manufacturers. Eliminating these backdoor subsidies would save taxpayer dollars and make government programs more efficient

Net ten-year savings: $93 billion



Conclusion

Ultimately, the reforms discussed above can save roughly $3 trillion over the next decade. And health care reform can also save billions of dollars in every state of the union, opening up the possibility of increased private and public investment, higher job growth, and increased savings.

The question, critical to the health and economic well-being of all Americans, is whether Congress will push for strong measures to bring down costs, or will instead settle for more modest reforms. So far, the impact on the federal balance sheet is front and center in the current health care debate. But just as most health care spending falls on the backs of families, businesses, and state governments, so too do the benefits of potential savings. Leveraging federal investment into system-wide savings is the best way to get unsustainable premium hikes under control – by fostering investment in health IT, by reorienting perverse payment policies within public programs, by funding all-important medical research.

Further, one of the clearest lessons of the last few years is that the rise of health care costs is not a once-per-decade problem; additional policies will need to be adopted as technological breakthroughs occur and new research points the way to better modes of treatment. To truly deliver on the promise of reducing health care costs, Congress should adopt proposals that would foster continual innovations to make care more affordable and effective, starting with Medicare.

INTRODUCTION

Without health care reform, the United States is projected to spend over $40 trillion on health care in the next decade.[1] Experts estimate that thirty percent of that spending – up to $12 trillion dollars – will be wasted on ineffective care, pointless red tape, and counterproductive treatments that can actually harm patients.[2]

As a result, American families and businesses are weighed down by high premiums that continue to increase twice as fast as inflation.[3] Meanwhile, cost-benefit analyses performed by the Business Roundtable show that, dollar for dollar, we get less for our health care spending than the rest of the industrialized.[4]

The problems of cost and quality are two sides of the same coin. We pay so much because our system provides too much ineffective care. Similarly, sometimes we spend so much that it leads to lower quality care, for example when multiple specialists fail to coordinate with each other and order duplicative tests or contradictory treatments for the same patient.

Health care reform holds out the golden promise of addressing both of these problems at once. By aligning incentives within the health care system in favor of quality treatment, by investing in health information technology, and by conducting better research on which treatments work for which kinds of patients, we can make health care both more affordable and higher quality.

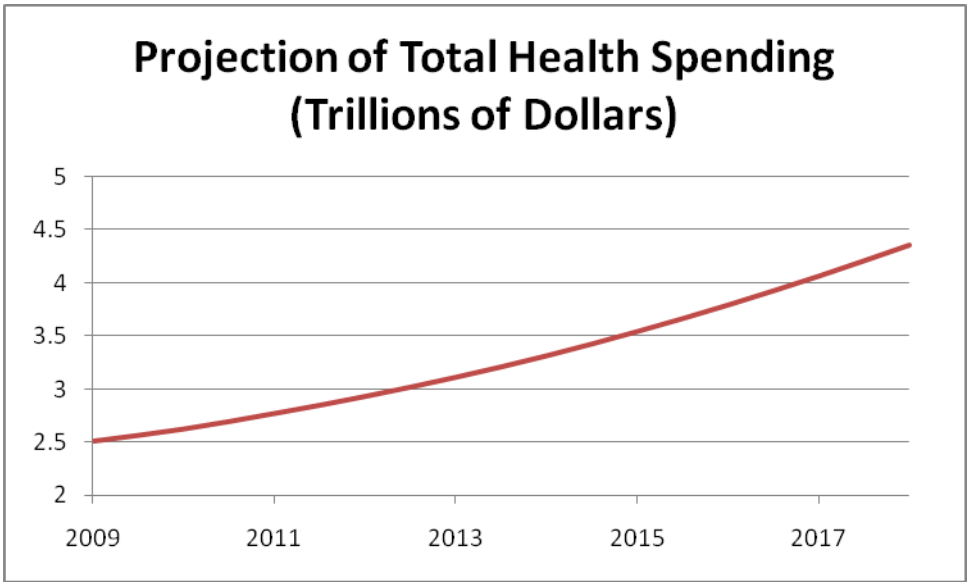
It is encouraging that many of the policies discussed above are included, in one form or another, in the health care bills currently before Congress. But one of the clearest lessons of the last few years is that the rise of health care costs is not a once-per-decade problem; additional policies will need to be adopted as technological innovations occur and new research points the way to better treatments. That means that focusing only on policies adopted in a single legislative package will forego many potential savings over the next decade.

To truly deliver on the promise of reducing health care costs, Congress should adopt proposals that would foster continual innovations to make care more affordable and effective. A critical opportunity to do so is to enact legislation that would strengthen the committee that advises Medicare on its payment policies. This proposal, supported by the White House and many lawmakers, would fast-track cost-saving recommendations made by the advisory committee, opening up the possibility of continual quality and affordability improvements throughout the health care system. And since many private payers take their cues from Medicare, all Americans, not simply the federal government, will benefit from such a policy.

[1] Uwe Reinhardt, "Is Health Care Reform Worth $1.6 Trillion?", *New York Times Economix Blog*, June 26, 2009, *at* http://economix.blogs.nytimes.com/2009/06/26/is-health-care-reform-worth-16-trillion/.
[2] Peter Orszag, Testimony before House Budget Committee, *Increasing the Value of Federal Spending on Health Care*, July 16, 2008, *at* http://www.cbo.gov/ftpdocs/95xx/doc9563/07-16-HealthReform.1.2.shtml#64.
[3] California Health Care Foundation. Health Care Costs 101 (2009 edition), *at* http://www.chcf.org/documents/insurance/HealthCareCosts09.pdf.
[4] Arnold Milstein and Carrie Hoverman Colla, Mercer Health & Benefits, Prepared for Business Roundtable, *Tracking the Contribution of U.S. Health Care to the Global Competitiveness of American Employers and Workers: 2009 Business Roundtable Health Care Value Comparability Study*, 28 February 2009.

However they are implemented, the key reforms discussed in this report are necessary to get rising costs under control. We draw on existing research and our own analysis to estimate how much can be saved over the next decade. While it is not possible to completely eliminate all 12 trillion wasted dollars, the U.S. now has a generational opportunity to put our health care system on a path of stability and free our economy from the crippling burden of high costs – all while improving our health.

Figure 1: Projections of Total Health Spending 2009-2018, in Trillions of Dollars.[5]



[5] *See* Centers for Medicare and Medicaid Studies, *National Health Expenditures Historical and Projections, 1965-2018, available at* http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage.

I - Streamlined Billing

In our fractured, Balkanized health care system, administrative inefficiencies abound. One of the most pointless of these is the array of different forms, codes, and billing procedures insurers require doctors to use. These systems are different for each insurer, and often reliant on paper records. As a result, some doctors can spend up to 45 minutes on paperwork for every hour of care they provide. Nationally, we spend roughly $82 billion every year just on billing, claims processing, and other insurance industry red tape.[6]

Replacing the profusion of different forms and codes with a single, uniform process, and connecting providers and payers in an electronic network that does not rely on paper-based records, has been proven to increase efficiency and decrease costs. As discussed in more detail in the CALPIRG report *Cutting the Red Tape in Health Care*, nation-leading networks in Utah and New England have proven that streamlined billing systems can increase efficiency and decrease costs.[7]

Cost Estimate

No previous national estimates for the potential impact of streamlined billing have been made. National expenditures on billing are estimated at $82 billion per year.[8] The New England network saves on the order of $5 per transaction relative to non-streamlined, paper-based processing.[9] There are an estimated 7 billion non-electronic health care billing and payment transactions per year.[10]

A very rough estimate for the potential value of streamlined billing would thus be $35 billion per year ($5 saved for each of 7 billion transactions). However, the dollars saved per transaction is likely to differ from region to region, due to the high variation in health care and labor costs. Since New England is a high-cost region, this estimate represents an upper bound on likely potential savings.

> *Net ten-year savings: up to $350 billion. *[*: See Appendix for state-specific savings from this policy]*

[6] CALPIRG Education Fund, *Cutting Red Tape in Health Care*, July 2009, *available at* http://www.calpirg.org/home/reports/report-archives/health-care/health-care/cutting-red-tape-in-health-care; CALPIRG Education Fund, *Diagnosing the High Cost of Health Care*, July 2008, *available at* http://www.calpirg.org/home/reports/report-archives/health-care/health-care/diagnosing-the-high-cost-of-health-care-how-spending-on-unnecessary-treatments-administrative-waste-and-overpriced-drugs-inflates-the-cost-of-health-care-in-california#H3RqrB44jHOQv168WAlccQ.

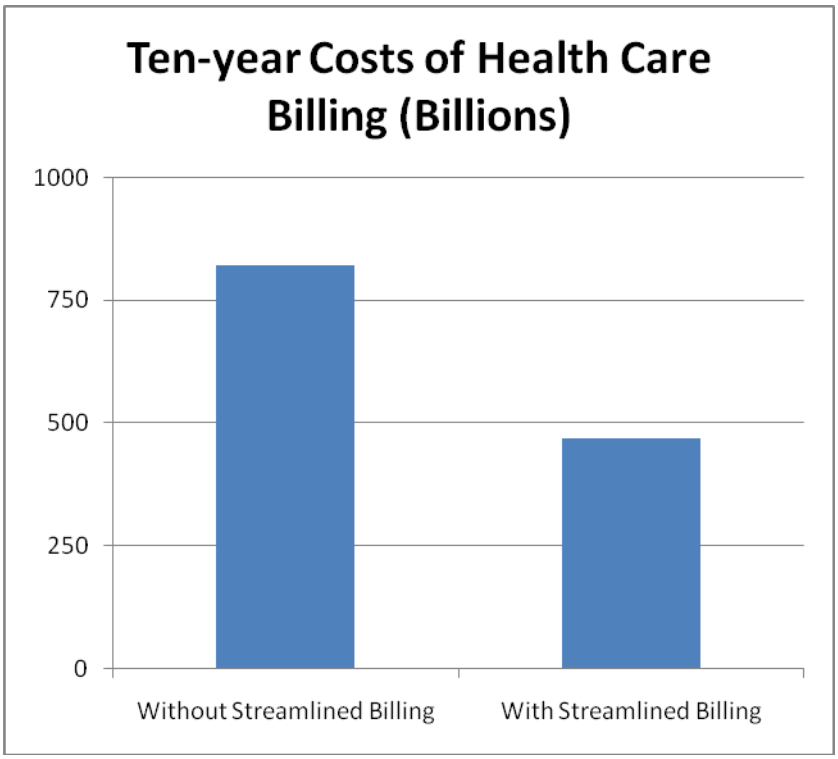
[7] *Id.*

[8] CALPIRG Education Fund, *Diagnosing the High Cost of Health Care*, *see* p. 28 – performing the calculation explained in FN 75 without adjusting to CA-only expenditures, results in an estimate of $82.17 billion per year.

[9] John D. Halamka, MD, New England Healthcare EDI Network, *The New England Approach to HIPAA* [PowerPoint presentation], *at* http://www.ehcca.com/presentations/HIPAA2/106.PDF.

[10] *See* sources cited at http://www.ushealthcareindex.com/howitworks.php. Note that this source suggests total cost savings (provider and payer) per electronic transaction as $4.50, even without the additional streamlining and centralization made possible by the Utah and New England style networks.

Figure 2: Ten Year Costs of Health Care Billing (in Billions of Dollars)



II – Health IT

The health care system is far behind virtually every other American industry in integrating productivity-enhancing information technology systems. Electronic storage and sharing of clinical, administrative and financial health information not can only streamline administration – they also can assist doctors in providing better care.

Increased use of computerized systems integrating all of a patient's health care data into one system along with supporting information reduces medical errors. For example, when a physician writes a prescription, the system can flag potential negative interactions with other medicines the patient has been prescribed, remind the physician about the patient's history of allergic reactions, and ask a physician to confirm that an unusually high or low dose is indeed correct.

Similarly, patients typically receive care from multiple physicians. Frequently, physicians must see a patient whose test results or other relevant records are missing. If doctors' notes and test results are recorded in a single electronic file, coordinating care between different providers becomes much easier. And automatic reminders to screen for potential diseases can also make care more effective and efficient.

Cost Estimate

A Commonwealth Fund study assuming a robust program of investment in health IT showed the program could lead to $180 billion in ten-year savings.[11] Other estimates have been more optimistic, assessing the potential benefits at roughly $80 billion per year, or $800 billion over a decade.[12] The savings depend greatly on how aggressively health IT is phased in, and whether health IT is simply used to replace paper systems or whether it is also used to enable new approaches to care management and coordination.[13]

As an example of these follow-on benefits, health IT can reduce adverse drug events by alerting doctors to potential errors in prescribing or dosage. This would help doctors avoid 2 million adverse drug results each year, saving $3.5 billion annually.[14] Using health IT to help patients with chronic diseases better manage their conditions via lifestyle changes and medication could lead to annual national savings of as much as $147 billion.[15]

Thus, while it is safest to assume savings on the lower end, increased adoption of health IT can help drive significantly larger health care savings.

Note that some of the efficiency gains here estimated for health IT might overlap those discussed in the streamlined billing estimate above. Similarly, to the extent health IT aids the increased use of preventive care, there may be overlap with those sets of estimates, found below.

> *Net ten-year savings: $180 billion, and use of health IT can leverage savings in other areas, such as coordinated care and disease management, potentially leading to savings of $800 billion. *[*: See Appendix for state-specific savings from this policy]*

III – Insurer Efficiency

Currently, insurers are not required to devote any fixed portion of the premium dollars consumers pay to medical care. As a result, insurers spend unnecessarily large amounts on inefficient administrative practices and untold layers of red tape.

Requiring insurers to spend 85% of premium dollars on actual health benefits would reorient the current system, creating a strong incentive for insurers to prioritize quality care, and reduce wasteful inefficiencies. CALPIRG research has shown that an efficiency standard requiring 85

[11] Commonwealth Fund, *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, July 2009, *available at* http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jun/Finding-Resources-for-Health-Reform.aspx.
[12] Richard Hillestad, et al., "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, 24 (5): 1103-1117, September/October 2005.
[13] Anna Wilde Matthews, *CBO Questions Savings from Digital Health-Care Records*, Wall Street Journal, May 22, 2008, at A12 (http://www.pnhp.org/news/2008/may/cbo_questions_saving.php).
[14] Richard Hillestad, et al., "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, 24 (5): 1103-1117, September/October 2005.
[15] *Id.*

percent of premiums to be spent on care is achievable, as many insurers presently meet such a requirement – the requirement would bring less efficient companies up to the standard of their more-efficient peers.[16]

Cost Estimate

No comprehensive estimates of the potential savings from an 85 percent insurer efficiency standard have been made. Complicating matters, the insurer efficiency standard can either lead to administrative savings or increased insurer spending on health care rather than administrative costs, or a mixture of the two.

The California Medical Association has estimated that the 85% standard would save California $1.1 billion annually (or lead to the equivalent amount being spent on care rather than administration).[17]

A very rough scaling may be attempted by noting that California's health expenditures are roughly 11% of national health expenditures.[18] Assuming that California's savings from an insurer efficiency standard are similarly 11% of potential nationwide benefits, the policy could be expected to save roughly $10 billion per year, or $100 billion over a decade.[19]

Note that the efficiency gains prompted by this policy might in some circumstances overlap with those calculated as part of the streamlined billing and health IT discussions, above – which both offer savings greater than simply the $100 billion estimated here. Thus, the greatest impact of the efficiency standard would be to spur the adoption of even greater health care savings.

> *Net ten-year savings: $100 billion, as a very rough estimate. *[*: See Appendix for state-specific savings from this policy]*

IV – Comparative Effectiveness Research and Evidence-based Medicine

Today, health care leaders like the Mayo Clinic and Intermountain Healthcare in Utah are saving lives and millions of dollars by finding the best ways to treat their patients. At Intermountain, for example, changes to Caesarian section policies mean that pregnant women have spent 45,000 fewer hours in labor, saving over $10 million per year.[20]

But while individual efforts are laudable, the country's ailing health care system lacks a coordinated, national effort to support comparative effectiveness research aimed at discovering

[16] CALPIRG Education Fund, *More Bang for the Health Care Buck*, May 2009, *available at* http://www.calpirg.org/home/reports/report-archives/health-care/health-care/more-bang-for-the-health-care-buck.
[17] California Medical Association, *15th Annual Knox-Keene Health Plan Expenditures Report*, http://www.cmanet.org/upload/knox_keene_08.pdf, June 2008, p. 22.
[18] Center for Medicare and Medicaid Services, *National Health Expenditures – State Estimates*, Feb. 2007, *at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatesummary2004.pdf.
[19] See *More Bang for the Health Care Buck*.
[20] U.S. PIRG Education Fund, *The Facts About Comparative Effectiveness Research*, July 2009, *available at* http://www.uspirg.org/uploads/J9/3N/J93NSwEOiNeQ3BZhwfwQtg/The-Facts-About-CER-PRINTvUS.pdf.

which treatments work best. Some studies do exist, but many of them, produced by the companies whose products are being tested, have been found to be biased in favor of the products.[21]

Due to the lack of impartial information, much of the time doctors are unable to provide the most effective care. This dearth of reliable research also means that doctors are less informed about which treatments work best on which kinds of patients. Unnecessary treatments increase costs without improving health while ineffective treatments endanger patients and drive up health care costs by leading to lengthier hospital stays and expensive follow-up treatments.

Investment in unbiased medical research – and adoption of the findings in evidence-based treatment protocols and guidelines to help doctors provide the best care – can cut the skyrocketing costs of health care by ensuring we know what works.

Cost Estimate

Identifying the best drugs, treatments, and procedures will give doctors the best tools to care for their patients, and establishing incentives to encourage them to follow guidelines incorporating the results will further increase the research's impact.

A Commonwealth Fund estimated the potential benefits of such an approach as $480 billion over the next decade – so long as reform also adopts incentives that would encourage doctors to follow the results of the research.[22]

> *Net ten-year savings: up to $480 billion, with savings very dependent on the extent to which the research is used and incentivized.*[*: See Appendix for state-specific savings from this policy]*

V - Prescription Drug Advertising

Heavy marketing of prescription drugs raises health care costs and fails to improve patient health. Pharmaceutical marketing encourages patients to take drugs that cost them more and that often are riskier than alternative medications. In some cases, it encourages use of drugs that patients just don't need.[23]

Television and magazine ads promoting prescription drugs haves a significant effect on prescription drug purchases, with the Government Accountability Office estimating that between 2 and 7 percent of consumers who view such ads ultimately request and receive the advertised drug.[24] Studies have shown that physicians' prescribing habits are even more significantly affected by visits from drug company representatives (called "detailing"), ads in medical journals, and other approaches that directly target doctors. Overall, drug companies spend $8,000 to $15,000 annually on marketing for every doctor in the United States.[25]

[21] *Id.*
[22] Commonwealth Fund, *Finding Resources for Health Reform*.
[23] CALPIRG Education Fund, *Diagnosing the High Cost of Health Care.*
[24] *Id.*
[25] *Id.*

Where lower-cost, generic alternatives are available, it is drug company marketing that pushes the latest, most expensive drugs and drives up costs. And where the product they are peddling is actively harmful, as was the case with Vioxx, the toll is obviously much greater. Limiting this advertising would lead to more prescriptions being written on scientific merit, rather than marketing muscle. When doctors and patients rely on unbiased science rather than salesmen's patter, prescriptions will be more effective and more affordable.

Cost Estimate

In 2000, the industry spent $2.5 billion on direct to consumer advertising; advertising to physicians came in at $13.2 billion.[26] Estimates on the return on investment the drug companies realize on their advertising found a ratio of 1:11 for physician-directed marketing, and 1:1.3 for direct to consumer ads. That is, for every dollar spent by drug companies on advertising, they got back $1.30 in the case of direct-to-consumer (DTC) ads, and $11 in the case of physician-targeted detailing.[27]

Turning these figures into a cost estimate is necessarily speculative, as the impact of marketing restrictions on drug company and prescriber behavior is hard to assess.

As a very rough estimate, it is likely that sufficiently strong marketing restrictions can reduce drug company marketing expenditures by 10%, both in the detailing and DTC fields. Ordinary inflation would bring the $2.5 billion spent on DTC in 2000 to $3.1 billion in 2009, with the $13.2 billion spent on physician advertising in 2000 equivalent to $16.5 billion in 2009 dollars.[28]

Reducing these expenditures by 10% would reduce DTC spending by ~$300 million annually, and detailing spending by $1.7 billion. These reductions will lead to larger savings, however, in decreasing the number of prescriptions written, and shifting prescriber behavior to favor non-marketed generic and older drugs that are equally effective and significantly less expensive. Using the returns on investment cited above suggests that the DTC reduction will leverage $400 million in additional savings, while reducing detailing spending by 10% will reduce overall drug spending by roughly $19 billion.

Summing these together yields a very rough estimate of $21 billion per year, $210 billion over the decade.

> *Net ten-year savings: Savings on the very rough order of $210 billion appear possible. *[*: See Appendix for state-specific savings from this policy]*

[26] Kaiser Family Foundation, *Trends in Direct-to-consumer Advertising of Prescription Drugs*, Feb. 2002, *available at* http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14881.
[27] Wittink, Dick R., "Analysis of ROI for Pharmaceutical Promotion," Presentation to Association of Medical Publications, Sept. 18, 2002, *available at* http://www.vioworks.com/clients/amp.
[28] Calculation performed using the Inflation Calculator tool offered by the Bureau of Labor Statistics, *available at*, http://data.bls.gov/cgi-bin/cpicalc.pl.

VI – Paying for What Works

Perhaps the single factor that is most responsible for runaway health care costs is the fact that high-quality, cost-effective treatments are not incentivized – instead, most doctors and hospitals are paid according to the quantity, not the quality of care that they provide. A doctor who provides counseling to patients that helps them avoid costly surgery will have a harder time keeping his doors open than a similar doctor who simply performs the surgeries.

The result of these perverse incentives is that too often, patients do not receive the most effective care for their illnesses. We systematically underinvest in the primary and preventive care – including early treatment and screenings – that keep people well and reduce the need for later acute care. When a patient enters a hospital or gets sick, many doctors may treat him or her without strong coordination, leading to duplicative tests and miscommunication – too many cooks spoiling the broth.

Along the same lines, not enough is done to help sufferers of chronic diseases to manage their illnesses. Without sufficient monitoring, they experience frequent, and costly, flare-ups of their conditions. One study has found that the chronically ill receive only 56% of the recommended care for keeping their diseases under control – and this foregone care eventually leads to more expensive acute care.[29] Initiatives to address this problem by giving patients increased access to care in their homes have realized savings of 24% or more.[30]

All of this leads to increased utilization of health care: more specialist visits, more days in the hospital, more of everything. But study after study has shown that incentivizing doctors to better coordinate care and prioritize effective prevention allows them to treat their patients better, improve health outcomes, realize lower costs – and have more satisfied patients.[31]

Research into treatment patterns in different parts of the U.S. has shown that in some areas, medical culture has learned these lessons. But in other areas, patient satisfaction is low as high-spending regions fail to provide the most effective care and instead rely on high-intensity interventions that drive up costs without improving patient health. For example, the use of lumbar fusion surgery is 23 times higher in Idaho Falls, ID, compared to Bangor, Maine – but the

[29] McGlynn, E., Asch, S., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26, June 26, 2003.
[30] "Veteran's Affairs Home Based Primary Care," J. Beales, T. Edes, Clinics in Geriatric Medicine, vol. 25, no. 1 (Feb. 2009); "Geriatric Care Management for Low Income Seniors, A Randomized Control Trial," S. Counsell, et al. JAMA (Dec. 12, 2007); "Consider Medical Care At Home," R. Meyer, Geriatrics (June 2009); "Home Delivery: Bringing Primary Care to the Housebound Elderly," S. Okie, New England Journal of Medicine (Dec. 4, 2008); "Programs Bring Care To Homebound Seniors," M. Friedrich, JAMA (June 11, 2008); "Elderpact: A Housecall Program Teamed With An Area Agency on Aging to Provide Coordinated Chronic Care," B. Kinosian, et al., Journal of the American Geriatric Society (2004).
[31] CALPIRG Education Fund, *Diagnosing the High Cost of Health Care*.

increased use of this expensive surgery led to no improvement in patient outcomes.[32] These regional variations are vivid proof that costs can be lowered while improving patient care – and provide compelling examples of the scale of the problems within our current system.[33]

Changing the way we pay for and deliver care is the one policy change most likely to improve care while lowering costs. World-leading health centers, like the Mayo Clinic and Intermountain Health System, have proven that these innovations can make care less expensive and more effective, both at the same time.[34]

Creating financial incentives for these proven treatment strategies, rather than just more tests and procedures, would lead to more primary care and better coordination – and lowered costs. Similarly, focusing our efforts on reducing and managing chronic disease will increase patients' health and bring down costs at every stage along the way.

Cost Estimate

The Commonwealth Fund and the Lewin Group have produced estimates for 10-year-savings from a variety of payment and delivery system reforms. Moving towards a system that reimburses based not only on the amount of care provided, but instead on rewarding high performance, can save up to $263 billion over ten years.[35] Setting up medical homes that coordinate care and support primary care could achieve $208 billion in savings.[36] Chronic care management initiatives could bring down costs by $418 billion.[37] Finally, reforming payment structures so that high-cost areas are encouraged to take lessons from their more effective neighbors could generate $177 billion in savings over the next decade.[38]

Taken together, this category of savings is by far the largest potential contributor to lowered health care costs.

> *Net ten-year savings: Roughly $1.1 trillion *[*: See Appendix for state-specific savings from this policy]*

[32] Institute of Medicine, *Learning What Works Best: The Nation's Need for Evidence on Comparative Effectiveness in Health Care*, September 2007, *available at* http://www.iom.edu/Object.File/Master/57/395/Comparative%20Effectiveness%20White%20Paper%20-%20ES%20(F).pdf.
[33] CALPIRG Education Fund, *Diagnosing the High Cost of Health Care*.
[34] U.S. PIRG, *Paying for What Works*, April 2009, *available at* http://www.uspirg.org/home/reports/report-archives/health-care/health-care/paying-for-what-works-a-u.s.-pirg-policy-primer-on-health-care.
[35] This is the pay for performance expansion to hospitals ($34 billion), and blending an episodic care system into the FFS status quo ($229). Commonwealth Fund, *Bending the Curve*.
[36] Primary care case management and medical homes ($194), and mandating prevention in state programs ($19). *Id.*
[37] Lewin Group, *A Path to a High Performance U.S. Health System: Technical Documentation*, Feb. 2009, *available at* http://www.lewin.com/content/publications/LewinPATHTechnicalDocumentation.pdf.
[38] Commonwealth Fund, *Finding the Resources*.

VII – Public Health Insurance Option

One of the most high-profile elements of health care reform is a proposed new public health insurance option, available to small businesses, the self-employed, and others without affordable, job-based coverage. This public plan would expand consumer choice, and would also help bring down costs.

The negotiating power of a large, nationwide plan would allow the public plan to leverage significant savings. Further, it would employ the cost-saving, quality-improving policies discussed under payment and delivery reform, above.

Additional savings come from the effect that such a plan would have on the private insurance industry. By offering a low cost alternative to private insurance, private insurers would have to innovate to bring their own costs down and so compete with the public plan. Such innovation would result in cost savings even for those who keep their existing coverage.

Cost Estimate

In 2007 the Lewin Group modeled a public plan proposal which served as the blueprint for President Obama's plan as a presidential candidate. They found it would save, per year: $7 billion due to reimbursing providers at lower rates; $25 billion due to decreased administrative costs; and $20 billion due to the types of payment and delivery system reforms discussed earlier. Leaving aside this last category to avoid double-counting them, this is a net savings of $32 billion per year, $320 billion over the decade.[39]

A second Lewin Group analysis of a different version of a public plan along the lines currently being considered by Congress updated this analysis found $23 billion in yearly savings due to administrative economies of scale and savings due to increased bargaining power ($230 billion over ten years).[40]

These two studies provide the best estimate for savings traceable solely to incorporation of a public plan. However, the public plan acts as a multiplier for the savings discussed under payment reform and prevention, above. The public plan will directly implement the reforms for those covered through the public plan, and its competition will spur private insurers to also adopt these proven cost-saving policies.

Thus, the Lewin group found that combining the above policies could lead to savings between $800 billion and $1.8 trillion, as synergies between the policies produces greatly increased

[39] Lewin Group, *Cost Impact Analysis for the "Health Care for America" Proposal*, Feb. 2008, *available at* http://www.sharedprosperity.org/hcfa/lewin.pdf, pp. 28-29.
[40] Lewin Group, *The Cost and Coverage Implications of a Public Plan*, June 2009, *available at* http://www.lewin.com/content/publications/June12HealthLawConference.pdf, p. 12.

benefits.[41] The federal government would be a major beneficiary of this approach, seeing its deficits decrease by $130 to $250 billion over the next decade.[42] (A similar Urban Institute study found comparable federal savings, ranging from $224 billion to $400 billion over ten years).[43]

*Net ten-year savings: The savings traceable to the public plan alone are estimated at $230 to $320 billion. *[*: See Appendix for state-specific savings from this policy]*

VIII – Ending Government Overpayments to Insurers and Drug Companies

Currently, a pair of federal government policies enrich insurance and drug companies at taxpayer expense. The Medicare Advantage program allows private companies to provide coverage to Medicare beneficiaries. The government pays these private middlemen 12% more than it costs to provide coverage to seniors directly through Medicare, but this extra money does not improve health outcomes – it simply acts as a windfall for the insurance companies.[44]

In an analogous scheme of government underwriting, under the Medicare Part D prescription drug benefit the government does not currently negotiate directly with the drug manufacturers, contracting instead with a myriad of smaller plans. As a result, none are able to leverage the purchasing power or economies of scale that could allow all Medicare beneficiaries to see lower costs, increasing drug company profits while taxpayers pick up the tab.

Cost Estimate

The Commonwealth Fund has estimated the ten-year impact of reducing or eliminating these subsidies. Recalibrating Medicare Advantage reimbursement rates could save $50 billion; allowing Medicare to directly negotiate with drug companies to get higher discounts would save $43 billion.[45]

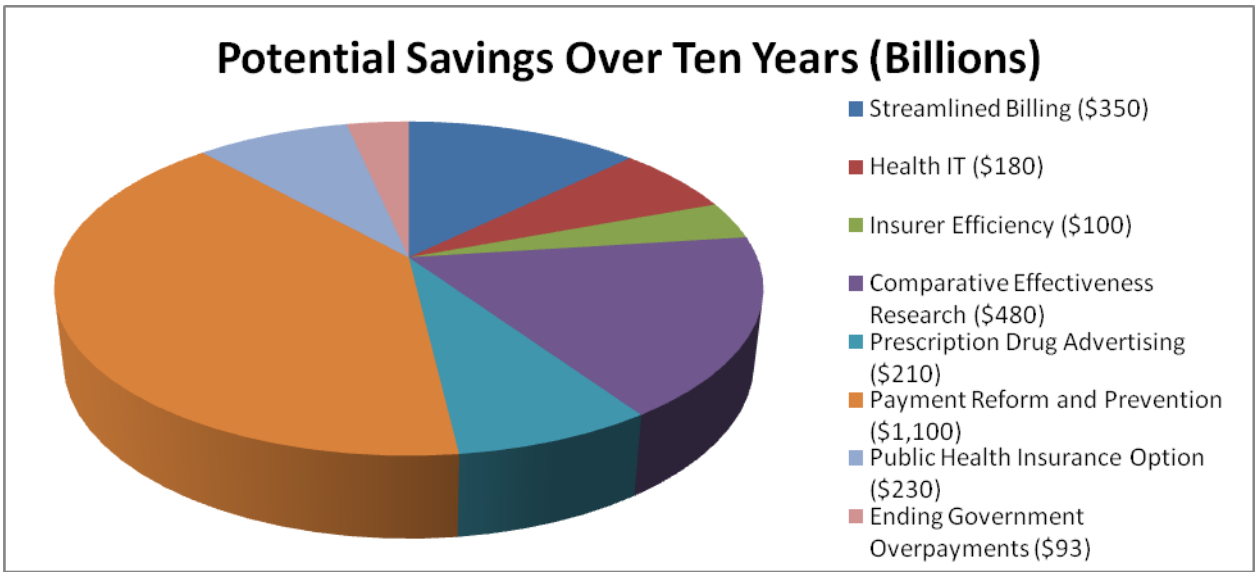
*Net ten-year savings: $93 billion *[*: See Appendix for state-specific savings from this policy]*

[41] Commonwealth Fund, *Fork in the Road: Alternative Paths to a High-Performance U.S. Health System*, June 2009, *available at* http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jun/Fork-in-the-Road.aspx.
[42] *Id.*
[43] The Urban Institute, *Is the Public Plan Option a Necessary Piece of Health Reform?*, *available at* http://www.urban.org/UploadedPDF/411915_public_plan_option.pdf.
[44] Peter Orszag, "The Medicare Advantage Program: Enrollment Trends and Budgetary Effects," Testimony before Senate Finance Committee, Congressional Budget Office, April 11, 2007, *available at* http://www.cbo.gov/ftpdocs/79xx/doc7994/04-11-MedicareAdvantage.pdf.
[45] Commonwealth Fund, *Bending the Curve*.

Total Savings and State By State Breakdown

The problems in our health care system necessitate a fundamental shift in many aspects of how we pay for and provide care – a shift towards higher-quality, more affordable care. The benefits we can reap in improved health are hard to quantify. But as to the dollars we can save, this report shows that firmer estimates are possible – and even a conservative approach, summing the lower end of every range listed above, still leads to savings of nearly $3 trillion over the next decade.[46]

Figure 3: Potential Savings Over Ten Years (Billions of Dollars)



It is possible to estimate the state by state impact of such savings by allocating them according to each state's share of total national health expenditures. The picture that emerges shows billions of dollars in benefits to every state of the union – benefits that will allow for increased private and public investment, higher job growth, and increased savings.

[46] Summing the lowest estimates given in each category above leads to combined savings of $2.7 trillion. A more optimistic assessment increases the estimate to $3.4 trillion.

Table 1: Potential savings from health care reform over 10 years, state by state.[47]

State Name	Total Savings, Low End (Billions)	Total Savings, High End (Billions)	State Name	Total Savings, Low End (Billions)	Total Savings, High End (Billions)
Alabama	40	50	Missouri	57	71
Alaska	7	9	Montana	8	10
Arizona	43	53	Nebraska	17	22
Arkansas	23	28	Nevada	19	24
California	296	367	New Hampshire	12	15
Colorado	39	49	New Jersey	86	106
Connecticut	39	48	New Mexico	14	18
Delaware	9	11	New York	223	276
District of Columbia	11	14	North Carolina	79	98
Florida	168	209	North Dakota	7	9
Georgia	73	91	Ohio	116	144
Hawaii	11	14	Oklahoma	29	36
Idaho	10	12	Oregon	31	38
Illinois	115	142	Pennsylvania	132	163
Indiana	59	73	Rhode Island	12	15
Iowa	27	33	South Carolina	37	45
Kansas	25	31	South Dakota	8	9
Kentucky	40	49	Tennessee	60	74
Louisiana	40	50	Texas	187	231
Maine	15	18	Utah	18	22
Maryland	54	67	Vermont	6	8
Massachusetts	78	97	Virginia	63	78
Michigan	88	109	Washington	56	70
Minnesota	55	68	West Virginia	18	22
Mississippi	25	31	Wisconsin	55	68
			Wyoming	4	5

[47] Center for Medicare and Medicaid Services, National Health Expenditures by State of Provider, *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatesummary2004.pdf.

CONCLUSION

The stakes for the current health care reform debate could hardly be higher. Inaction would mean millions of Americans no longer able to afford insurance, heavily-burdened businesses dropping coverage, more lost jobs, higher premiums, and trillions of wasted dollars.[48] As this report has documented, there are proven ways to help prevent such an outcome. And the benefits to all of us, even in strictly economic terms, are significantly higher than the costs of the reforms currently being discussed in Congress, which hover around $1 trillion.[49]

In some respects, this may be because the plans in Congress are less ambitious than what is possible. But the larger point is that health care reform done right can more than pay for itself. The question, critical to the health and economic well-being of all Americans, is whether Congress will push for strong measures to bring down costs, or will instead settle for more modest reforms.

So far, the impact on the federal balance sheet is front and center in the current health care debate. But just as most health care spending falls on the backs of families, businesses, and state governments, so too do the benefits of potential savings.[50] Leveraging federal investment into system-wide savings is the best way to get rising premiums under control – by fostering investment in health IT, by reorienting perverse payment policies within public programs, by funding all-important medical research. We cannot allow a fear of greater federal outlays to limit the scope of cost-saving, quality-enhancing policies.

Winning the reforms that will help free America's families and businesses from the crippling burden of rising health care costs will not be easy. Savings to the system are lost profits to one interest group or another, and the losers will fight to protect those profits. Nevertheless, the way is there for an improvement in health care treatment that will reduce the costs for all of us. We must convince our leaders to stand up to the drug makers and insurers who benefit from the status quo, and work for the cost-saving reforms that can make our health care affordable.

[48] *See* U.S. PIRG Education Fund, *Health Care in Crisis*, Jan. 2009, *available at* http://www.uspirg.org/home/reports/report-archives/health-care/health-care/health-care-in-crisis-how-special-interests-could-double-health-costs-and-how-we-can-stop-it#hVipwl-QP7-wGchsXTYm6w; U.S. PIRG Education Fund, *The Small Business Dilemma*, July 2009, *available at* http://www.uspirg.org/home/reports/report-archives/health-care/health-care/the-small--business--dilemma----how-rising-health--care-costs-are-tough-on-small-business.

[49] *See* Congressional Budget Office Blog, House Democrats' Health Reform Proposal: Preliminary Analysis of Major Provisions Related to Insurance Coverage, July 14, 2009, *at* http://cboblog.cbo.gov/?p=324.

[50] Center for Medicare and Medicaid Services, *National Health Expenditure Web Tables*, *at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

Appendix: Total United States Estimates of Savings From Cost-Cutting Policies.

[In Billions]

	United States
Total Savings	2743
Streamlined Billing	350
Health IT	180
Insurer Efficiency	100
Comparative Effectiveness Research	480
Prescription Drug Advertising	210
Payment Reform and Prevention	1100
Public Health Insurance Option	230
Ending Government Overpayments	93