



MAKING HEALTH CARE AFFORDABLE FOR ALL AMERICANS

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EXECUTIVE SUMMARY

National health expenditures rose 9.3 percent in 2002, the fastest increase in a decade. Even more troubling was the 9.5 percent jump in the numbers of uninsured between 2000 and 2002, from 39.8 million to 43.6 million. Rising health care costs are a problem for all Americans, but they weigh especially heavily on uninsured and “underinsured” individuals, who pay much of the cost of their health care directly out-of-pocket. Higher costs to patients lead to underuse of appropriate care and greater financial burdens on the sickest.

We can no longer afford or tolerate wasteful spending on care that does not benefit patients, the duplication of expensive procedures, medical errors, or the high administrative costs incurred by the nation’s insurers and providers. Real solutions should directly target these sources of unacceptably high costs, not simply shift costs from employers to workers or from government to the beneficiaries of public programs. Promising long-run solutions include: rewarding health care providers that achieve demonstrably better quality and efficiency, improving high-cost patient care management, reducing medical errors, improving care coordination, and simplifying unnecessarily complex or duplicative insurance practices. Most fundamentally, we must act to achieve automatic and affordable health insurance for all, to ensure that the benefits of modern medicine are widely accessible, and to ensure that investment in health care contributes to economic growth and a healthier, more productive society.

- Health insurance premiums increased 13.9 percent in 2003, faster than the 8.5 percent growth in health care costs. Market forces are likely to bring premiums more in line with costs in future years, but the issue warrants watching.
- Health care expenditures in 2002 were \$1.6 trillion, or 14.9 percent of the gross domestic product. The United States has the highest health care spending of any country, yet we are the only major industrialized nation not to provide health insurance coverage for all.
- Medicare outlays per enrollee continue to grow more slowly than private insurance, averaging 6.2 percent over the 1999–2002 period, compared with 8.7 percent in private health insurance.
- Hospital spending is now the leading source of health care services expenditure growth. While some of the increase is undoubtedly attributable to technological advances that improve health, some is a catch-up from the unsustainably low rates of increase in the mid-1990s.

- Administrative expenses are now the fastest-rising component of national health expenditures. In 2002, the nation spent \$105 billion on private insurance and public administrative expenses, up 16.2 percent from 2001. Private insurance administrative costs are particularly high—12.8 percent of total private insurance outlays, compared with 3.0 percent for Medicare.

Consumer-driven health care, the major private-sector strategy for addressing rising costs, is unlikely to address the fundamental causes of rising health care costs. In fact, it is likely to have adverse consequences for patients.

- Consumer-driven health care contributes to excessive financial burdens on patients, particularly lower-income and sicker patients. If all Americans had a \$1,000 deductible plan, one-third would spend more than 10 percent of their income on health care if they were hospitalized, with even higher rates at the lowest end of the income scale. High deductibles would lead to a major increase in the number of underinsured individuals.
- Patient costs are already unacceptably high. Indeed, they are a major reason why public opinion polls show that the affordability of health care is Americans' second-leading concern.
- Patient cost-sharing is a blunt instrument for reducing utilization of services. It reduces use of effective services that are already underutilized. Studies have documented that drug-tiering and higher copayments are leading patients to skip filling essential prescriptions, increasing adverse medical events, and raising emergency room use.

There are better alternatives for achieving economies in health care than shifting costs to patients. Costs are higher in the United States than in other countries because we pay higher prices for the same services; our administrative costs are higher; and physicians prescribe specialized services that are not clinically justified. If we as a nation were to adopt fundamental reforms—such as an integrated public–private strategy to purchase health services efficiently, demand quality performance, and streamline administrative costs—substantial savings could be achieved.

Short of fundamental reforms, practical steps that could be taken in the near term include:

- **Reducing medical errors and improving care coordination.** A major investment in health information technology, with shared public–private funding, is needed to accelerate the adoption of life-saving and efficiency-enhancing technology.
- **Public reporting of cost and quality data.** Costs incurred over an episode of care and quality vary enormously from hospital to hospital, physician to physician, and area to area. If we are serious about doing better, we need to know where we stand. Much more extensive efforts are required to achieve comprehensive public reporting of cost and quality data on physicians, hospitals, nursing homes, other health care providers, and health plans.
- **Paying for provider performance on quality and efficiency.** Medicare needs to become a leader in “pay for performance” payment methods. While the demonstrations under way are important, Medicare needs to move much more quickly to reward those providers who are both high-quality and low-cost over the course of a patient’s treatment. Doing so would spur the development of information about best practices and provide guidance to private insurers looking for effective ways to promote high-performance care.
- **Development and promulgation of clinical guidelines and quality standards.** Public programs and private insurers would benefit from a federal agency charged with establishing the scientific basis for effectiveness not just of new drugs but of specialty consultations, procedures, and tests. A national institute on clinical excellence and effectiveness has shown results in other countries and is a model we should adopt. We also need a substantial investment in research and demonstrations, far in excess of resources currently devoted to the Agency for Healthcare Research and Quality.
- **Better management of high-cost patients.** Public programs and private insurance need to be willing to pay for services of non-physician personnel that are needed for high-cost care management, such as advanced practice nurses, pharmacist medication monitoring, and home “telemonitoring” of conditions such as asthma and congestive heart failure.
- **Improved administrative efficiency.** The U.S. has an extraordinarily complex and fragmented system of health insurance. Ultimately, solutions that would simplify eligibility for insurance and improve the stability of health insurance coverage are needed to cut the administrative costs in our system. Testing statewide electronic insurance clearinghouses to pool insurance eligibility and, potentially, claims payment in a single place should be a priority.

- **Automatic and affordable health insurance for all.** Employers, federal and state governments, and individuals must all share responsibility for achieving automatic and affordable health insurance for all. The most realistic strategy is a combination of group insurance options including: employer coverage for those who are working; a new Congressional Health Plan, modeled on the Federal Employees Health Benefits Program, for small businesses and individuals; an expansion of the State Children’s Health Insurance Program to low-income families and individuals with incomes below 150 percent of poverty; and an option for uninsured older adults and disabled adults to obtain early coverage under Medicare (e.g., by eliminating the two-year waiting period for the disabled, covering spouses of Medicare beneficiaries, and permitting older adults to “buy in” to Medicare). Premium assistance based on income is required to make premiums affordable for all enrollees.

Together, these steps would take us a long way toward ensuring that this country has a high-performing health system worthy of the 21st century.

MAKING HEALTH CARE AFFORDABLE FOR ALL AMERICANS

Karen Davis

Thank you, Mr. Chairman, for this invitation to testify today on what's driving up health care costs and the rising numbers of uninsured. The recent announcement that national health expenditures jumped 9.3 percent in 2002, the fastest increase in a decade, is indeed troubling.¹ Even more so is the 9.5 percent jump in the number of uninsured Americans between 2000 and 2002, from 39.8 million to 43.6 million.²

Rising health care costs are a problem for all Americans, but they weigh especially heavily on uninsured and "underinsured" individuals, who pay much of the cost of health care directly out-of-pocket. Insured workers also feel the brunt, as employers are increasingly passing costs onto them in the form of higher deductibles, greater cost-sharing, and larger shares of employee premiums. Strife over health insurance is once again provoking employer–employee confrontations and eroding business and worker productivity.

Increased costs to patients also lead to underuse of appropriate care and greater financial burdens on the sickest. The direct financial impact on working Americans is undoubtedly one of the contributors to recent poll results showing that the affordability of health care is second among the public's concerns, after the economy and jobs.³ And, of course, since 46 percent of all health expenditures come from government health programs such as Medicare and Medicaid, as well as those run by the Veterans Administration, the Department of Defense, and others, rising costs also mean increased government budgetary outlays. State fiscal pressures that are leading to cutbacks in Medicaid and the State Children's Health Insurance Program (SCHIP) are particularly troubling.

What we all want from our health care system is not necessarily cheaper care, but the efficient use of resources to provide high-quality care to all Americans. We can no longer afford or tolerate wasteful spending on care that does not benefit patients, the duplication of expensive procedures, medical errors, or the high administrative costs incurred by the nation's insurers and providers. Real solutions should directly target these sources of unacceptably high costs, not simply shift costs from employers to workers or

¹ Katherine Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs*, 23(1):147-159, January/February 2004.

² U.S. Census Bureau, *Health Insurance Coverage in the United States: 2002*, September 2003.

³ Washington HealthBeat, *Affordable Care Second Behind Economy as Voter Concern*, January 14, 2004.

from government to beneficiaries of public programs. Promising long-run solutions include: rewarding health care providers that achieve demonstrably better quality and efficiency, improving high-cost patient care management, reducing medical errors, improving care coordination, and simplifying unnecessarily complex or duplicative insurance practices.

Most fundamentally, we must act as a nation to achieve automatic and affordable health insurance for all, to ensure that the benefits of modern medicine are accessible, and to ensure that investment in health care contributes to economic growth and a healthier, more productive society.

Rising Health Insurance Premiums: Out of Reach for Many Americans

After three years of double-digit increases, health insurance premiums for employer-sponsored coverage have reached truly staggering levels. In 2003, the average premium was \$9,068 for a family policy and \$3,383 for an individual worker.⁴ Employees paid \$2,412 directly for family coverage annually—more than \$200 per month—and \$508 annually for single coverage. Some economists argue, furthermore, that the employer share is shifted backward onto workers in the form of lower wages; even if this is only partially the case, the cost to workers is considerably greater. When employers do not sponsor coverage, insurance premiums in the individual market for comparable coverage is even more expensive—when it is available at all. Half of American families make less than \$50,000 per year;⁵ few of them could afford more than \$10,000 a year in health insurance premiums on their own.

The 13.9 percent increase in health insurance premiums in 2003 attracted particular attention.⁶ Premiums would have been even higher if employee deductibles and other forms of cost-sharing had not increased, effectively reducing the comprehensiveness of coverage for the insured. At the same time, insurance spending for medical services—benefits—per enrollee are not increasing at double-digit rates. In fact, health spending per enrollee in the first half of 2003 increased 8.5 percent.⁷

⁴ The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2003*, 2003.

⁵ U.S. Census Bureau, *Income in the United States: 2002*, September 2003.

⁶ Jon Gabel et al., “Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing,” *Health Affairs*, 22(5):117-126, September/October 2003.

⁷ Bradley C. Strunk and Paul B. Ginsburg, *Tracking Health Care Costs: Trends Slow in First Half of 2003*, Data Bulletin No. 26, Center on Health System Change, December 2003.

Although many insurance companies are reporting record profits,⁸ the divergence between premiums and underlying cost trends is probably a temporary phenomenon. In the underwriting cycle, premiums typically rise more slowly than costs when costs are accelerating and faster than costs when costs start decelerating. Market forces are likely to bring premiums more in line with costs in future years, but the issue warrants watching, especially given the consolidation within the insurance industry in recent years and the accompanying increase in insurers' market power.

Certainly, expenditures under the Medicare program, while also accelerating, are not matching the rise in private insurance premiums. Medicare outlays per enrollee for comparable benefits increased 6.2 percent over the 1999–2002 period, compared with 8.7 percent in private health insurance and 10.7 percent in the Federal Employees Health Benefits Program (excluding benefits not covered by Medicare or private insurance, such as prescription drugs, home health, and skilled nursing facility services).⁹ It will be important, however, to monitor the effect of additional funds provided to Medicare managed care plans in recent legislation on future insurance company profits and total Medicare outlays.

The most serious consequences of rising health care premiums, particularly the rise in premiums paid directly by employees, is that some low-wage workers decline health insurance coverage even when it is offered by employers, while those with insurance are forced to forgo needed care because of high deductibles. Over one-fifth of uninsured workers—3.5 million people—are eligible for employer health insurance coverage but fail to take it up, largely because of the high cost of their share of the premium.¹⁰ Low-wage workers are particularly apt to decline coverage when eligible. Seventeen percent of workers making less than \$10 an hour declined coverage, compared with 8 percent of those making \$15 an hour or more.¹¹

⁸ Dinah Wisenberg Brin, "U.S. Health Insurers Seen Posting Solid Earnings as Costs Moderate," *Wall Street Journal Online*, January 15, 2004 6:59 pm EST; Paula L. Stepankowsky, "Aetna Pres Reiterates At Least 15% '04 Profit Growth View," *Wall Street Journal Online*, January 14, 2004, 7:57 am. EST; Business Wire, Inc., "HMO Profits Jump 60% in First Quarter 2003, According to Weiss; More than 80% of Companies Profitable," January 20, 2004; Associated Press State and Local Wire, "Blue Cross Profits among Country's Fastest Rising in Early 2003," January 22, 2004; Glenn Singer, "HMO Profits Get Healthy Bounce in '03; Medical Costs Didn't Rise as High as Projected, Which Has Helped Boost Bottom Lines," *South Florida Sun-Sentinel*, December 30, 2003.

⁹ Katherine Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs*, 23(1):147-159, January/February 2004.

¹⁰ The Commonwealth Fund 2001 Health Insurance Survey.

¹¹ Analysis of 2000 Medical Expenditure Panel Survey by Sherry Glied and Douglas Gould of Columbia University for The Commonwealth Fund.

Higher deductibles also contribute to underinsurance. They cause the low-income insured to forgo needed medical care or create crippling medical bill problems. Over half of the uninsured and nearly one-third of low-income insured individuals reported problems paying medical bills in 2001.¹² In addition, more than half of the uninsured and over one-fourth of low-income insured individuals reported problems obtaining needed care.¹³ With the marked rise in patient cost-sharing in the last 3 years, these problems are undoubtedly more severe today.

Trends in Health Care Costs

The important question is why health care expenditures are rising at such a rapid rate. In 2002, the nation spent \$1.6 trillion for health care, or 14.9 percent of gross domestic product (GDP). This is a major jump from 13.3 percent of GDP in 2000, due to accelerating health care costs as well as relatively weak nominal GDP growth. By 2012, health spending is projected to more than double.¹⁴

Health spending is a combination of increases in prices of individual services, increased numbers of services, or a shift in the composition of services toward more specialized, higher-cost services. In the mid-1990s, prices went up at a slower rate, reflecting to some extent moderation in economy-wide inflation but also reflecting discounted prices under managed care and budget cuts in Medicare and Medicaid. But since 1998, prices of services have been accelerating somewhat as providers decline to take sharply discounted managed care provider payment fees.

But most importantly, since the mid-1990s the quantity of services consumed has been increasing. This may reflect new technology and, to some degree, an aging population. However, it could also reflect some “provider-induced” demand—for example, as physicians attempt to generate additional income by providing more services, working longer hours, or ordering more tests. Some recent data for the Medicare program point to sharp increases in the provision of specialized services, such as pacemaker insertion.¹⁵ This may be an attempt by physicians to gain back some of the reduction in physicians’ real income that occurred in the late 1990s.¹⁶

¹² The Commonwealth Fund 2001 Health Insurance Survey.

¹³ The Commonwealth Fund 2001 Health Insurance Survey.

¹⁴ Stephen Heffler et al., “Health Spending Projections for 2002-2012,” *Health Affairs* web exclusive, February 7, 2003.

¹⁵ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2003.

¹⁶ Marie C. Reed and Paul B. Ginsburg, *Behind the Times: Physician Income, 1995-1998*, Center for Studying Health System Change, Data Bulletin No. 24, March 2003.

Hospital spending is now the leading source of overall health services expenditure growth. In 2002, hospital costs accounted for more than one-third of overall spending growth, physician expenditures for one-fifth, and prescription drugs for one-sixth. As a result of rapid increases, the hospital share of total national expenditures has grown. Again, this may be an attempt by hospitals to recover from sharply discounted managed care fees and Medicare hospital savings in the mid- to late 1990s. For example, hospital costs grew annually at 8.8 percent in the late 1980s and early 1990s, and slowed to 3.5 to 4 percent from 1993 to 2000. But during 2000 to 2002, hospital costs again grew 8 to 10 percent annually, suggesting that the slowdown in the mid-1990s was not sustainable given the rising wages of hospital employees and the costs of supplies, including prescription drugs, purchased by hospitals. Some of the increase is clearly attributable to technological advances that improve health or maintain functioning and are highly valued by society.

Prescription drug spending has “moderated” somewhat, climbing at a 15.3 percent rate in 2002, down from 17.1 percent between 1997 and 2000. Drug prices are increasing at about 5 percent a year, with the remainder of the spending growth reflecting either a rise in the number of prescriptions or a shift toward more costly medications. While forecasts by the Centers for Medicare and Medicaid Services (CMS) suggest that prescription drug spending will slow to 10 percent between 2003 and 2011, much will depend on industry’s response to the new prescription drug legislation. This is an area that merits close monitoring.

Finally, it is shocking that administrative expenses are now the fastest-growing component of national health expenditures. In 2002, the nation spent \$105 billion on private insurance and public administrative expenses, up 16.2 percent from 2001.¹⁷ Over the last five years, increases in administrative costs have consistently outpaced increases in total health expenditures. Private insurance administrative costs are particularly high—12.8 percent of total private insurance outlays, compared with 4.9 percent for public programs and only 3.0 percent for Medicare. This does not include administrative costs within physician offices, clinics, or hospitals, where administrative costs have been rising due to ever more complex and fragmented insurance arrangements.

Is Consumer-Driven Health Care the Answer?

Given the public backlash against managed care, it has become fashionable to suggest that increasing patient cost-sharing is the best, or even the “only,” private sector strategy

¹⁷ Katherine Levit et al., “Health Spending Rebound Continues in 2002,” *Health Affairs*, 23(1):147-159, January/February 2004.

remaining to slow health care costs.¹⁸ But Americans spend far more out-of-pocket for health care than the citizens of any other industrialized nation, and all of these nations have lower health care spending per capita. In 2002, Americans spent \$213 billion out-of-pocket, up from \$147 billion in 1993 and \$25 billion in 1970.¹⁹ Despite improvements in benefits covered over time, rising health care costs and growing numbers of uninsured have kept patient out-of-pocket costs relatively constant as a percent of GDP, from 2.4 percent in 1970, to 2.2 percent in 1993, to 2.0 percent in 2002.

Increasing patient cost-sharing has well-known adverse consequences. First of all, it contributes to excessive financial burdens, particularly on lower-income and sicker patients. A recent study found that a \$1,000 deductible, for example, would cause one-third of all Americans to spend more than 10 percent of their income on health care if they were hospitalized.²⁰ A \$2,500 deductible would cause two-thirds of all Americans to spend more than 10 percent of their income if hospitalized. Rates are far higher, of course, for those at the lowest end of the income scale. People with the potential for such high out-of-pocket costs in the event of serious illness are considered to be underinsured. No one could seriously advocate making one-third or two-thirds of Americans underinsured in the name of creating “cost-conscious consumers.”

Even Medicare leaves many beneficiaries facing high out-of-pocket costs. The elderly as a whole spent 22 percent of their income on health care in 2000 from a combination of Part B premiums, Medigap premiums, cost-sharing for covered services, and uncovered services (including prescription drugs).²¹ That proportion is projected to rise to 30 percent by 2025. While the new Medicare prescription drug legislation will assist many Medicare beneficiaries, there are gaps in benefits and beneficiary premiums that rise markedly over time.²² For low-income Medicare beneficiaries or for those with serious health problems, the risk of severe financial hardship remains considerable.

An extensive literature documents that cost-sharing is a blunt instrument for reducing utilization of services. It reduces both those effective services that are already

¹⁸ “David E. Rosenbaum, “The Nation: Do Some Pay Too Little for Health Care?” *The New York Times*, October 26, 2003. “As we’ve moved away from managed care as a cost-control device, we have no choice but to move to higher deductibles and co-pays,” [quoting John F. Holahan, Urban Institute]; “Jonathan Gruber [MIT]... argues that to limit overuse of health care, people should have to pay enough of the cost out-of-pocket that it pinches.”

¹⁹ Katherine Levit et al., “Health Spending Rebound Continues in 2002,” *Health Affairs*, 23(1):147-159, January/February 2004.

²⁰ Sally Trude, *Patient Cost Sharing: How Much is Too Much?* Center for Studying Health System Change, December 2003.

²¹ S. Maxwell et al., *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, December 2000.

²² New York Times, “Patches for the Drug Program,” p. 14, January 25, 2004.

underutilized as well as services that are “supply-sensitive.” The RAND Health Insurance Experiment, for example, found that low-income children facing cost-sharing had half the probability of receiving highly effective care for acute conditions that are appropriate and necessary compared with low-income children not facing cost-sharing. For low-income adults, these rates were similar. But even higher-income children and adults with cost-sharing had a lower probability of receiving effective medical care than comparable children and adults not faced with no cost-sharing.²³

While the RAND study took place in the late 1970s, more recent studies confirm the effect of cost-sharing on receipt of essential care. A Canadian study found that cost-sharing for prescription drugs reduced use of both essential and less essential drugs, increased the risk of adverse events, and increased visits to the emergency department.²⁴ A recent U.S. study found much the same effect in an employer plan switching from a one-tier formulary to a three-tier formulary with increased enrollee copayments for medications.²⁵ Those facing increased copayments under all three tiers had a 16 percent decline in filling prescriptions for ACE inhibitors and a 21 percent decline in filling prescriptions for statins, compared with 6 percent and 11 percent for those experiencing no change in copayments.

What Alternatives Exist for Achieving Economies in Health Care?

Looking at the experience of other countries suggests that it is certainly possible to spend less on health care while achieving comparable or better health outcomes. The major reason U.S. health care costs are higher is not that other countries ration care; in fact, the United States has fewer hospital days per capita than other countries and about the same number of physician visits.²⁶ Rather, the reason is that costs are higher in this country because we pay higher prices for the same services, our administrative costs are higher, and Americans receive far more specialized services, such as MRIs and invasive heart procedures.²⁷

While the U.S. health system is the most costly, it is striking how similar the rate of increase in real health spending has been across countries in the last decade. Real

²³ K. N. Lohr et al., “Use of Medical Care in the RAND HIE,” *Medical Care* 24, supplement 9 (1986):81-87.

²⁴ R. Tamblyn et al., “Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons,” *Journal of the American Medical Association* 285:421-429, 2001.

²⁵ Haiden A. Huskamp et al., “The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending,” *The New England Journal of Medicine* 349(23):2224-2232, December 4, 2003.

²⁶ Karen Davis and Barbara Cooper, *American Health Care: Why So Costly?* The Commonwealth Fund, June 2003.

²⁷ Gerard Anderson et al., “It’s the Prices, Stupid: Why the United States is So Different from Other Countries,” *Health Affairs*, 89-105, May/June 2003.

spending per capita in the United States rose by 3.2 percent per year in the 1990s, compared with 3.1 percent for all OECD industrialized countries.²⁸ This finding suggests that trends may be more a reflection of technological change, or rising labor and other supply costs, than specific government policies.

Despite the U.S. reliance on managed care—which most view as successful in achieving at least “one-time” savings—other countries using alternative strategies had much the same experience. Spending growth per capita in New Zealand, for example, was 2.9 percent, perhaps owing to such policies as aggressive negotiation for lower drug prices and a long-standing system of no-fault medical malpractice. In response to general economic difficulties, Canada curbed federal health spending markedly in the mid-1990s and experienced 1.8 percent annual increases in real health spending per capita. However, public backlash at the closure of hospital beds and reduced accessibility of services led to investment of new resources in Canadian health care in recent years. The United Kingdom had higher spending growth (3.7 percent annually in the 1990s), as a result of policy commitments to increasing the resources devoted to health care.

One of the lessons from the international experience is that health care is highly valued by the public, and government efforts to restrain spending often meet with opposition from the public as well as providers. In each country, public dissatisfaction with the health system seems to be particularly sensitive to policies that increase patient out-of-pocket costs or visibly reduce accessibility to health care services.²⁹ This suggests that greater success may be achieved over the long run by designing targeted policies that focus on administrative costs, duplication and waste, medical errors, or care that is both better for patients and lowers cost.

If the United States were more willing to use the power of government to negotiate prices for medical services and prescription drugs, it could probably achieve considerably lower prices. However, we seem committed to a pluralistic system of many different private insurers and public programs, each attempting to get the best deal it can on its own, rather than a concerted effort to purchase services collectively or all-payer rate-setting. Other countries also are more willing to use supply constraints—for example, limiting the number of physicians of different types who are permitted to practice—and to use salaried payment systems for specialists, which eliminate incentives to provide unnecessary services to generate income.

²⁸ Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October 2002.

²⁹ Cathy Schoen et al., “Health Insurance Markets and Income Inequality: Findings from an International Health Policy Survey,” *Health Policy* 52(2):67-85, March 2000.

An alternative that may be feasible for the United States is to be more proactive about assessing when individual services are necessary and rewarding health care providers that provide the “right care” efficiently. For example, clinical criteria for the use of imaging tests such as MRIs and specialized procedures or specialist referrals could be developed and payment restricted to those instances in which the best available scientific evidence suggests the care will be effective.

Modern information technology also shows promise, in cutting administrative expenses, reducing medical errors, prompting physicians to order tests or services only when clinically warranted, and making it easier to retrieve clinical information so that tests do not have to be repeated. Better information systems would also make it possible to assess provider performance in order to identify physicians, hospitals, and other providers that provide either superior quality care or greater efficiency, or preferably both. Best practices could then be disseminated widely, encouraging others to achieve the same levels of performance or tailoring financing incentives to reward best practices.

Reducing Medical Errors and Improving Care Coordination

It has been almost five years since the Institute of Medicine released its study *To Err Is Human* and sounded the alarm about the seriousness of medical errors.³⁰ Yet, our nation is far from broadly instituting procedures that are known to protect patients, reduce deaths, eliminate complications and costly hospital stays, and, in so doing, reduce health care costs.

A recent study of 18 patient safety indicators identified by the Agency for Healthcare Research and Quality (AHRQ) found that these medical errors account for 2.4 million extra hospital days, \$9.3 billion of excess charges, and nearly 33,000 deaths.³¹ When foreign objects are left in the patient after surgery, patients need repeat surgery, recover less quickly, and spend more time in the hospital.³²

Information technology (IT) shows particular promise for reducing medical errors. One study found that the rate of nonintercepted, serious medication errors at one

³⁰ L. T. Kohn, J. M. Corrigan, and M.S. Donaldson, eds., *To Err is Human: Building a Safer Health System*, Washington, DC: National Academies Press, 1999.

³¹ C. Zhan and M. R. Miller, “Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization,” *Journal of the American Medical Association*, October 8, 2003:1868-1874.

³² A. A. Gwande et al., “Risk Factors in Retained Instruments and Sponges After Surgery,” *New England Journal of Medicine* 348: 229-235, 2003

hospital fell by 55 percent with a physician computer order entry system.³³ The net savings for the hospital were estimated at between \$5 to \$10 million a year. And, of course, this does not measure the “savings” for the patients, which are not only desired but also yield economic benefits through increased productivity (e.g., fewer missed work days). Computer-based surveillance of adverse medical device events also shows promise.³⁴

All providers should be encouraged to establish systems that reduce errors, whether they are computer-based or techniques such as bar coding. Government can facilitate these efforts through sharing in the costs of IT systems, promulgating IT standards, and requiring error reporting.

Private-sector efforts can also assist. For example, The Commonwealth Fund has provided support for the development, dissemination, and use of tools to help hospitals self-assess whether safe medication practices are in place. The Institute for Healthcare Improvement runs a Breakthrough Series that has demonstrated success, through a technique known as medication reconciliation, in reducing adverse drug events occurring when patients are discharged from the hospital and resume taking prior medications along with those given to them at the hospital. Yet, only a limited number of U.S. institutions have been trained in these techniques.

The U.S. is particularly at risk because of our more complex health system. U.S. patients take more medications and see more physicians, thus creating more opportunities for mistakes to occur. The 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults found that 18 percent of U.S. adults with health problems reported experiencing a medical error that caused serious problems in the past two years, compared with 9 percent of U.K. patients and 15 percent of Canadians.³⁵

The complexity of our health system not only leads to medical errors but leads to problems with coordinating care across health care providers. According to the survey, one-fifth of sick adults in the U.S. had a time in the past two years when they were sent

³³ David W. Bates et al., “Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medication Errors,” *Journal of the American Medical Association* 280 (15):1311-1316, October 21, 1998.

³⁴ Matthew H. Samore, “Surveillance of Medical Device-related Hazards and Adverse Events in Hospitalized Patients,” *Journal of the American Medical Association*, 292(3):325-334, January 21, 2004

³⁵ Robert Blendon et al., “Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries,” *Health Affairs* (May/June 2003):106-121.

for duplicate tests by different health professionals.³⁶ One of four sicker adults reported that medical records or test results did not reach their doctor's office in time for appointments. When records are not available, patients may need to come back another time, wasting both patient and physician time. Information technology could improve efficiency by making records easily accessible when they are needed, reducing the need to repeat tests, and making sure that information is in the hands of providers at the time it is needed.

Paying for Performance: Quality and Efficiency

Poor quality extends beyond medical errors to include failing to provide patients with care that could benefit them or overuse of services without therapeutic benefit. A study by the RAND Corporation this year underscored concerns that clinicians are failing to provide many patients with the most clinically appropriate care.³⁷ Only 55 percent of Americans received recommended care. The results held for preventive care, care for acute conditions, and care for chronic conditions. For example, pneumonia patients received recommended care only 39 percent of the time, and hip fracture patients only 23 percent of the time.

Overuse of services is clearly an area where quality could be improved and costs reduced. But rarely is a specific procedure never appropriate; rather, procedures are appropriate under some circumstances and not others. Unlike several other countries, the United States does not have a federal agency charged with developing and approving clinical guidelines based on the latest scientific evidence that govern when a particular procedure should be used. AHRQ has a National Guidelines Clearinghouse with professionally developed guidelines, but the agency no longer develops or recommends guidelines. Without such an effort, progress in reducing overuse is likely to be slow.

Just how variable current practice is has been underscored by several recent studies. An analysis of Medicare quality-of-care indicators by state shows widespread differences.³⁸ A team of investigators at Dartmouth College has found wide variations in Medicare costs per beneficiary and in the use of "supply-sensitive" services across

³⁶ Robert Blendon et al., "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs* (May/June 2003):106-121.

³⁷ Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003):2635-2645.

³⁸ Stephen F. Jencks, Edwin D. Huff, and Timothy Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association* (January 2003) 289: 305-312.

hospital service areas.³⁹ But particularly interesting are new analyses that show wide variation in both quality and efficiency. For example, within the Premier network of hospitals, outcomes for coronary artery bypass graft vary five-fold and costs vary by three-fold. There is no systematic relationship between cost and quality.⁴⁰ Rewarding those hospitals that achieve high quality and low cost would be a spur to others to emulate best practices and would lead to improved care for all.

Better Management of High-Cost Patients

Health care costs are heavily concentrated in the sickest patients. Ten percent of people account for 69 percent of health care outlays.⁴¹ In recognition of this fact, private managed care plans are beginning to concentrate their care management efforts on either those patients who are most costly or those who are predicted to be most costly in the future. Through predictive modeling techniques, plans can identify which patients are most likely to be on a trajectory toward high costs. For example, Partners HealthCare System in Boston identifies patients who make increasing use of emergency rooms and uses call banks of nurses to find out if patients are adhering to their medications and to screen for such problems as depression. Kaiser-Permanente health system goes beyond simple disease management; it tailors its monitoring practices differently for those patients who are at a stage where they can manage their condition on their own than for those requiring substantial assistance.

Many of these techniques require services and personnel not typically reimbursed by public programs such as Medicare or private insurers. Researchers at the University of Pennsylvania, for example, have documented that using advanced practice nurses to follow patients with congestive heart failure home from the hospital can be effective in reducing re-hospitalization and in lowering annual per capita expenditures—in this case, from \$9,600 to \$6,200 per patient.⁴² The Commonwealth Fund is supporting an evaluation of an Aetna demonstration in the Philadelphia area to test this concept more broadly.

Another approach is “telemonitoring” patients who make intensive use of emergency rooms or hospital care. A pilot test of a handheld computer called the Asthma

³⁹ Elliott S. Fisher et al., “The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care,” *Annals of Internal Medicine* (February 2003) 138: 273–287.

⁴⁰ Stephen Grossbart, Ph.D., Director, Healthcare Informatics, Premier, Inc., “The Business Case for Safety and Quality: What Can Our Databases Tell Us,” 5th Annual NPSF Patient Safety Congress, March 15, 2003

⁴¹ A. C. Monheit, “Persistence in Health Expenditures in the Short Run: Prevalence and Consequences,” *Medical Care* 41, supplement 7:1153-1164, 2003.

⁴² M. D. Naylor, “Making the Business Case for the APN Care Model,” report to The Commonwealth Fund, October 2003; estimated charges by Mark Pauly.

Buddy at New York City's Coney Island Hospital found that having children who are heavy users of emergency room services key their peak flow rate into the device and answer questions about their condition daily is successful in markedly reducing ER use and inpatient hospitalization. Again, The Commonwealth Fund is supporting an evaluation of a randomized controlled trial of this approach in five New York City public hospitals.

These strategies show great promise in markedly reducing costs for the most costly patients. However, to become widespread, public programs such as Medicare and Medicaid, as well as private insurers, will need to be more willing to cover the costs of non-physician personnel and supplies required for these high-cost care management programs.

Improving Administrative Efficiency

In addition to improving care management, using modern information technology to reduce the cost of administrative expenses should be a high priority for the future. When medical records are available electronically, fewer clerks are needed to file and retrieve medical records. Pharmacists need to make fewer calls to physicians to clarify prescriptions.

The Institute of Medicine committee on which I served recommended an electronic insurance clearinghouse be established at the state level.⁴³ If all insurance companies and public programs such as Medicare and Medicaid were to pool enrollee information in a single database, providers could easily verify insurance coverage through one system. Doing so could eliminate much of the cost incurred when people change insurance coverage.⁴⁴ It could eliminate much of the difficulty of conducting outreach to enroll eligible people in public programs by making it possible, for example, to cross-check lists from tax records against insurance coverage. It would also be an effective mechanism for electronic claims submission. Other ideas that would eliminate wasteful duplication of effort include a single database for provider certification and verification of physician licenses.

We have a very fragmented health insurance system that produces enormous churning in health insurance coverage. Over a four-year period, 85 million people are

⁴³ Institute of Medicine, *Fostering Rapid Advances in Health Care*. The National Academies Press, November 2002.

⁴⁴ Pamela Farley Short et al., *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured*, The Commonwealth Fund, November 2003.

uninsured. Two million people lose or change coverage every month.⁴⁵ The cost of enrolling and disenrolling and re-enrolling people contributes to the high administrative cost of the U.S. health system. Each insurer has its own approach to handling enrollment and claims payment. It also has its own rules for payment of providers, adding to the administrative costs of physician practices and hospitals. Reducing wasted resources on these administrative costs could be accomplished through statewide efforts to coordinate and pool administrative information.

Conclusion

If we have the world's costliest health system yet still fail to provide everyone with access to care—and fall far short of providing the safe, high-quality care that it is possible to provide—the conclusion that there is room for improvement is inescapable.⁴⁶ Only by facing this fact squarely and putting into action the best ideas and experiences across the United States and around world can we achieve a vision of American health care that includes: automatic and affordable health insurance for all, accessible health care, patient-responsive care, information- and science-based care, and commitment to quality improvement.⁴⁷

If we are to achieve a truly high-performance health system, bold action is required. The following steps would start us on this course:

- **Public reporting of cost and quality data on physicians, hospitals, nursing homes, other health care providers, and health plans.** The CMS has been a leader in posting nursing home quality data on its website, but this is just a modest beginning. The new Medicare prescription drug legislation also spurs reporting by hospitals of a limited set of quality-of-care indicators. If we are serious about doing better, we need to know where we stand, routinely collecting comprehensive quality measures across a broad range of providers.
- **Investment in health information technology.** Other countries are quickly surpassing the U.S. in the adoption of electronic medical records and electronic prescribing.⁴⁸ They are doing so because the government has been willing to

⁴⁵ Pamela Farley Short et al., *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured*, The Commonwealth Fund, November 2003.

⁴⁶ Karen Davis et al., *Room for Improvement: Patients Report on the Quality of Their Health Care*. The Commonwealth Fund, April 2002, and Karen Davis, et al. *Mirror, Mirror on the Wall: Looking at the Quality of American Health Care Through the Patient's Lens*. The Commonwealth Fund, January 2004.

⁴⁷ K. Davis, C. Schoen, and S. Schoenbaum, "A 2020 Vision for American Health Care." *Archives of Internal Medicine*, Vol. 160, No. 22: 3357–62.

⁴⁸ Gautam Naik, "England Plans Major Revamp of Health Care," *The Wall Street Journal*, December 3, 2003.

invest in the infrastructure and establish the standards required to make this potential a reality.

- **Development and promulgation of clinical guidelines and quality standards.** It is long past time to simply pay for services rendered without establishing a scientific basis for effectiveness, not just for new drugs but for consultations, procedures, and tests. This could be accomplished through establishment of a new National Institute on Clinical Excellence and Effectiveness.⁴⁹
- **Paying for performance.** Medicare and private insurers tend not to vary payment rates with quality. They pay for defects, whether those defects are surgeries that need to be repeated; infections that arise from failing to use state-of-the-art technology, such as catheters impregnated with antibiotics for heart valve patients; or medication errors. CMS has embarked on some modest initiatives to begin testing pay-for-performance rewards. Medicare can and should be a leader in promoting quality. These efforts need to be substantially expanded and best practices documented and disseminated. Medicare's leadership can be instrumental in moving private payers as well; to date, very few private insurers have instituted "value-based purchasing" strategies.⁵⁰
- **Investment in research.** We urgently need to gather evidence on what works to improve care, eliminate waste and ineffective care, and promote greater efficiency, including use of modern information technology, team work, and improved care processes. Any industry that fails to invest in research to improve quality and efficiency is going to be a backward industry. The federal government pays \$505 billion for health care but devotes only \$300 million to the AHRQ budget to learning effective ways to improve performance of the U.S. health system. The report on U.S. health care quality recently issued by AHRQ is an important starting point. But it needs to be followed with an investment in research up to the task of ensuring that this nation has a high-performing health system worthy of the 21st century.
- **Statewide electronic insurance clearinghouses.** It is important to move toward greater efficiency in the administration of our fragmented, complex system of health insurance coverage. Ultimately, solutions that would simplify eligibility for public programs and improve the stability of health insurance coverage are

⁴⁹ Stephen C. Schoenbaum, Anne-Marie Audet, and Karen Davis, "Obtaining Greater Value from Health Care: The Roles of the U.S. Government," *Health Affairs*, November/December 2003.

⁵⁰ Vittorio Maio, Neil Goldfarb, Chureen Carter, and David Nash, *Value-Based Purchasing: A Review of the Literature*. The Commonwealth Fund, May 2003 and Neil Goldfarb, Vittorio Mario, Chureen Carter, Laura Pizzi and David Nash, *How Does Quality Enter Into Health Care Purchasing Decisions?* The Commonwealth Fund, May 2003.

needed to cut the administrative cost in our system. Movement toward electronic administration of insurance can also achieve important savings. One particularly promising initiative would be testing statewide electronic insurance clearinghouses to pool together information on insurance eligibility.

- **Automatic and affordable health insurance for all.** Employers, federal and state governments, and individuals must all share responsibility for achieving automatic and affordable health insurance for all. The most realistic strategy is a combination of group insurance options including: employer coverage for those who are working; a Congressional Health Plan, modeled on the Federal Employees Health Benefits Program, for small businesses and individuals; an expansion of SCHIP to low-income families and individuals with incomes below 150 percent of poverty; and an option for uninsured, older adults and disabled adults to obtain early Medicare coverage (e.g., by eliminating the two-year waiting period for the disabled, covering spouses of Medicare beneficiaries, and permitting uninsured older adults to “buy in” to the program).⁵¹ Premium assistance based on income is required to make premiums affordable for all enrollees. Mechanisms to ensure that everyone is automatically enrolled in one of these four group options would help millions of Americans who currently fall through the cracks of coverage. Action is imperative; continued paralysis is exacting an unacceptable toll. The Institute of Medicine has estimated that 18,000 deaths of adults ages 25 to 64 occur each year as a direct result of being uninsured. Moreover, the Institute of Medicine estimates the lost economic benefit at \$65 billion to \$130 billion a year.⁵²

Thank you very much for the opportunity to join this panel. I look forward to learning from my fellow panelists and answering any questions.

⁵¹ Karen Davis and Cathy Schoen, “Creating Consensus on Coverage Choices,” *Health Affairs* (April 23, 2003); Sara Collins, Karen Davis, and Jeanne Lambrew, *Health Care Reform Returns to the National Agenda*, The Commonwealth Fund, January 2004.

⁵² Institute of Medicine, *Insuring America’s Health: Principles and Recommendations*, The National Academies Press, January 2004.

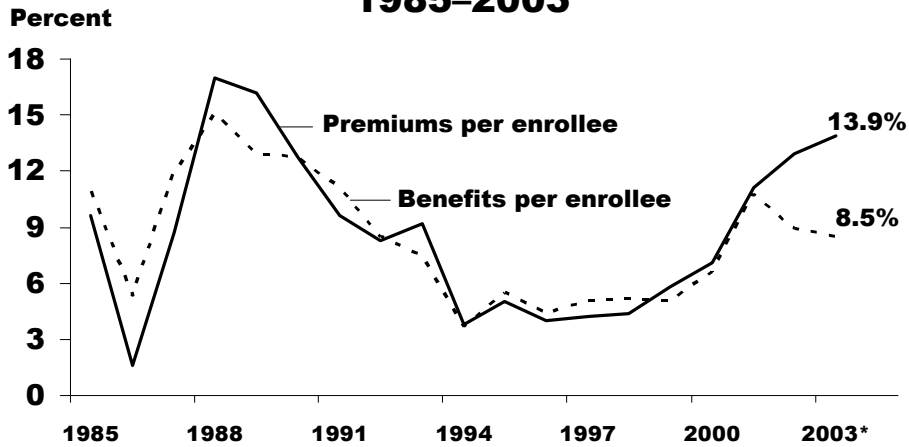


Making Health Care Affordable for All Americans

Karen Davis
President, The Commonwealth Fund
January 28, 2004

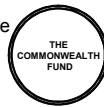
Hearing on
“What’s Driving Health Care Costs and the Uninsured?”
Senate Committee on Health, Education, Labor, and Pensions

Growth in Per Enrollee Private Health Insurance Premiums and Benefits, 1985–2003

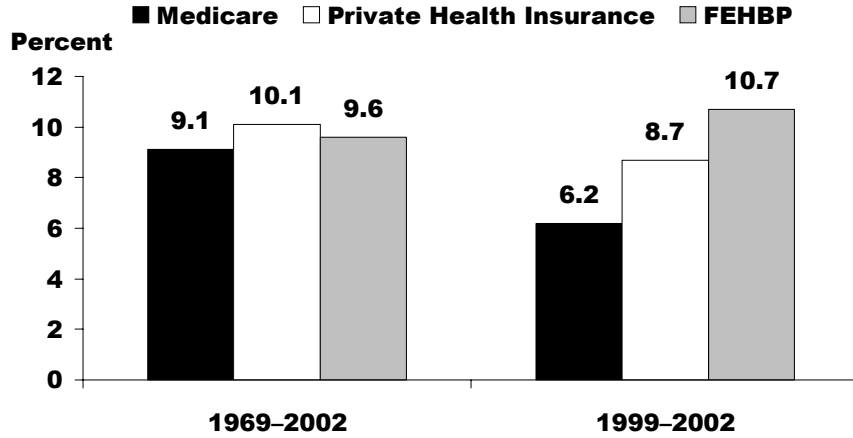


* Data for growth between Spring 2002 and Spring 2003

Source: S. Heffler et al., “Health Spending Projections for 2002–2012,” *Health Affairs* (Web Exclusive February 7, 2003) for 1985–2001 premiums and benefits (historical data) and 2002–2003 benefits (projected data); *Employer Health Benefits 2003 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, September 2003 for 2002–2003 premiums (historical data).



Percent Annual Per Enrollee Growth in Medicare Spending and Private Health Insurance and FEHBP Premiums for Common Benefits ²

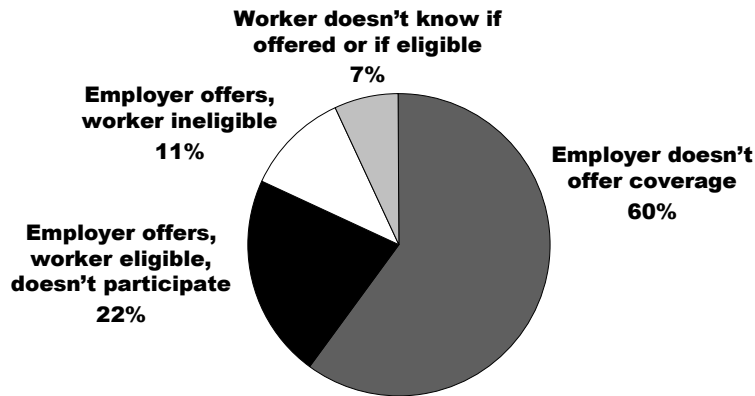


Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147-159.



Uninsured Workers Lack Insurance Coverage for Multiple Reasons, Including Not Accepting Offered Coverage ³

Total 15.4 Million Uninsured Workers Ages 19-64

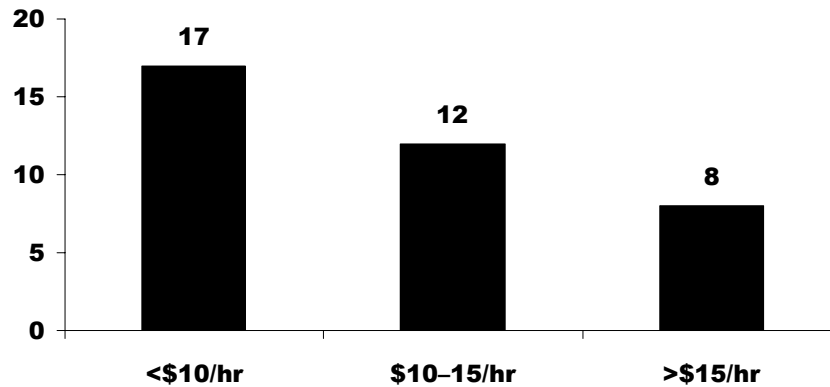


Source: S.R. Collins et al., *On the Edge: Low-Wage Workers and Their Health Insurance Coverage*, Commonwealth Fund, April 2003.



Low-Wage Workers at Risk for Not Accepting Employer Coverage When Offered

Rate workers DO NOT take-up offered coverage



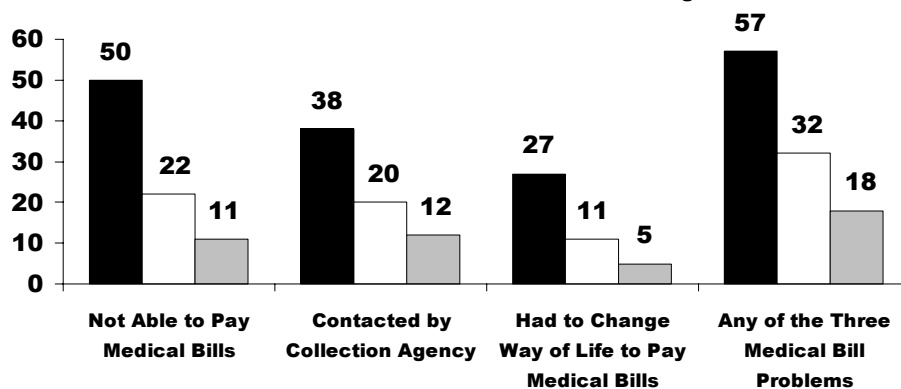
Source: Analysis of 2000 Medical Expenditure Panel Survey by Sherry Glied and Douglas Gould of Columbia University.



High Premiums and Out-of-Pocket Costs Create Financial Burdens on Patients

Percent of workers who had the following problems in the past year due to cost

■ Lower-income* uninsured □ Lower-income insured** ▒ Higher-income insured



* "Lower-income" is defined as having annual family income of less than \$35,000.

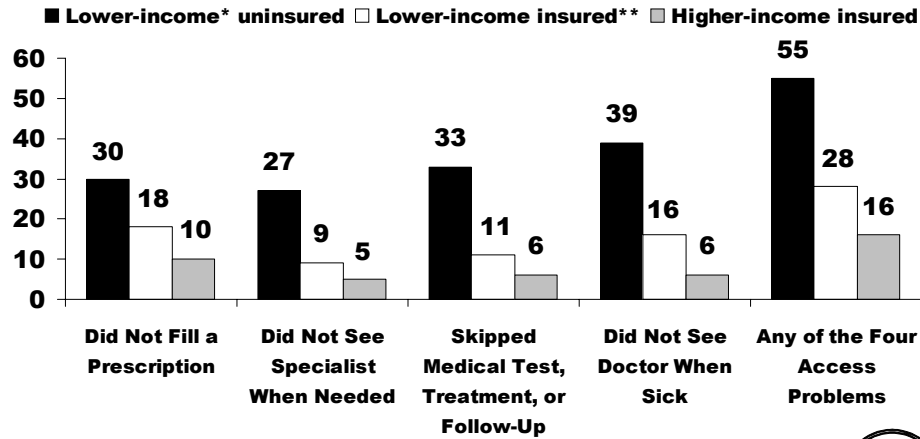
** "Insured" is insured all year.

Source: The Commonwealth Fund 2001 Health Insurance Survey.



High Premiums and Out-of-Pocket Costs Lead to Patients Not Getting Needed Care

Percent of workers who had the following problems in the past year due to cost



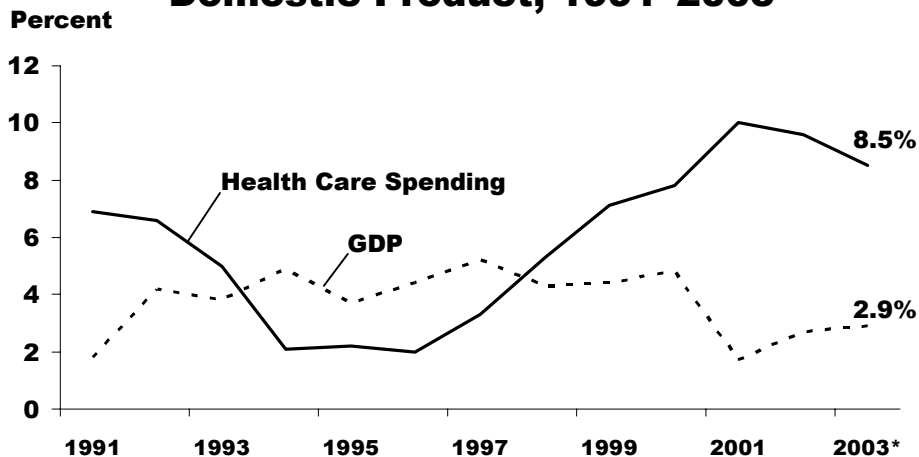
* "Lower-income" is defined as having annual family income of less than \$35,000.

** "Insured" is insured all year.

Source: The Commonwealth Fund 2001 Health Insurance Survey.



Annual Change Per Capita in Health Care Spending and Per Capita Gross Domestic Product, 1991–2003



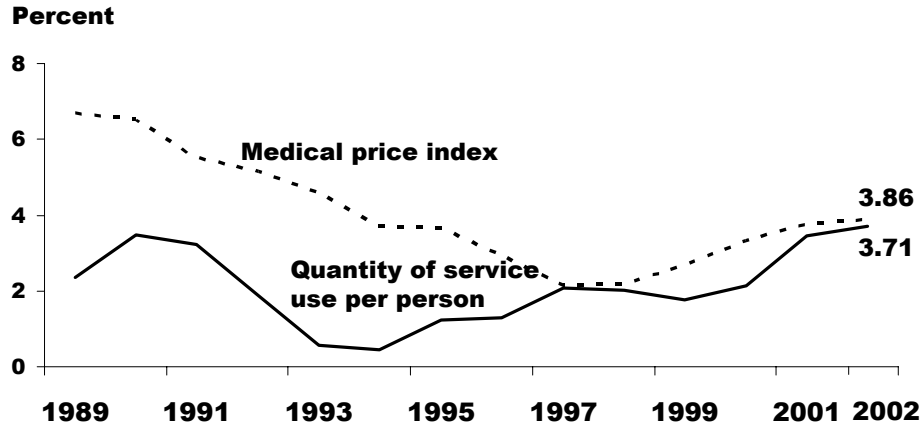
* Data for January through June 2003, compared with corresponding months in 2002.

Source: B. Strunk and P. Ginsburg, "Tracking Health Care Costs: Trends Stabilize But Remain High in 2002," *Health Affairs* (Web Exclusive June 11, 2003); B. Strunk and P. Ginsburg, *Tracking Health Care Costs: Trends Slow in First Half of 2003*, Center for Studying Health System Change, December 2003.



Annual Percentage Change in Medical Price Index and Quantity of Service Use Per Capita, 1989–2002

8

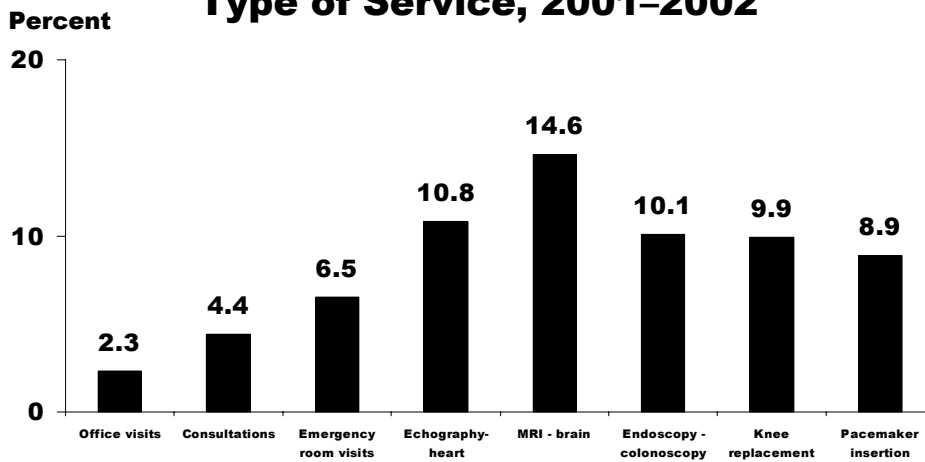


Source: K. Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154–164 for 1989–2001; Center for Medicare and Medicaid Services, Office of the Actuary for 2002.



Percentage Growth in Medicare Per Capita Use of Physician Services, by Selected Type of Service, 2001–2002

9



Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2003.



Physicians' Net Income from Practice of Medicine, 1999, and Percent Change, 1995–1999

	Average reported net income	Percent change in income, adjusted for inflation		
	1999	1995-97	1997-99	1995-99
All patient care physicians	\$187,000	-3.8%*	-1.2%*	-5.0%*
Primary care physicians	\$138,000	-5.4*	-1.1	-6.4
Specialists	\$219,000	-3.5*#	-0.6	-4.0*#

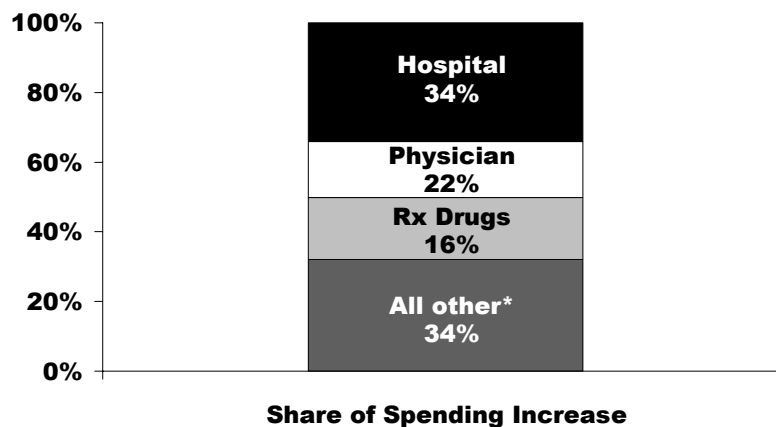
*Rate of change is statistically significant at $p < .05$.

#Rate of change for specialists is significantly different from change for primary care physicians at $p < .05$.

Source: M.C. Reed and P.B. Ginsburg, *Behind the Times: Physician Income, 1995–99*. Center for Studying Health System Change, Data Bulletin No. 24, March 2003.



Hospital Costs Are a Major New Source of Increased Outlays, 2002

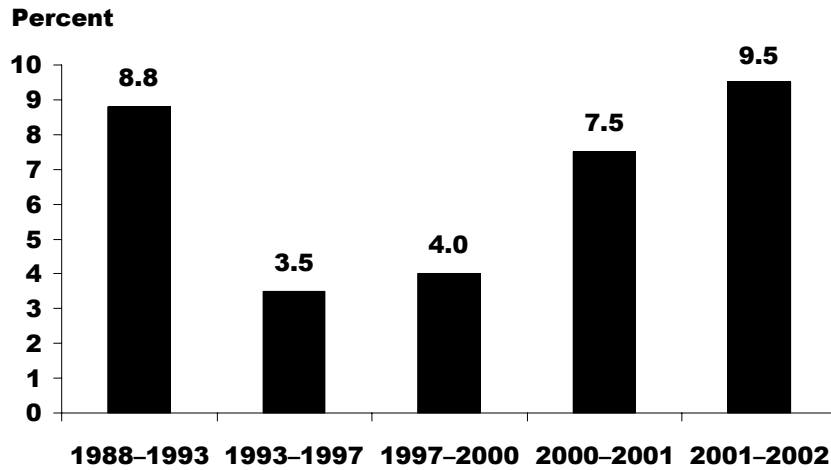


* Includes spending for dental, other professional, and other personal health care services; home health and nursing home care; durable and other nondurable medical products; administration and insurance net cost; government public health; medical research; and medical construction.

Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.



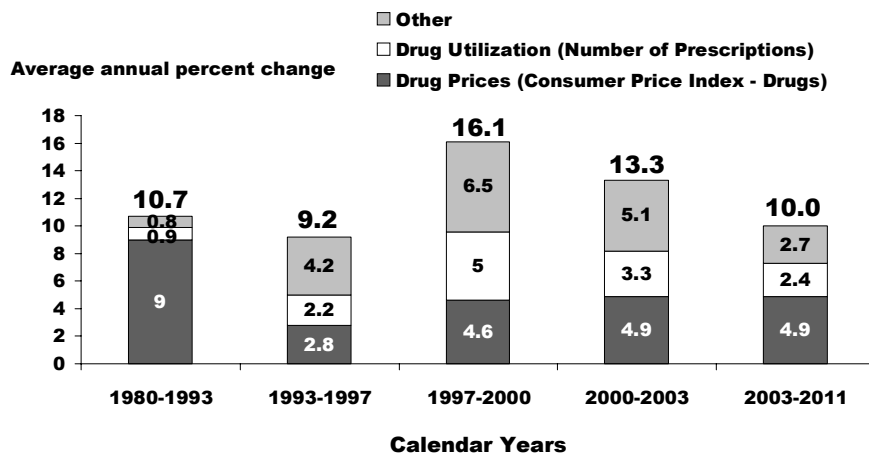
Average Annual Growth in Hospital Costs, 1988–2002



Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.



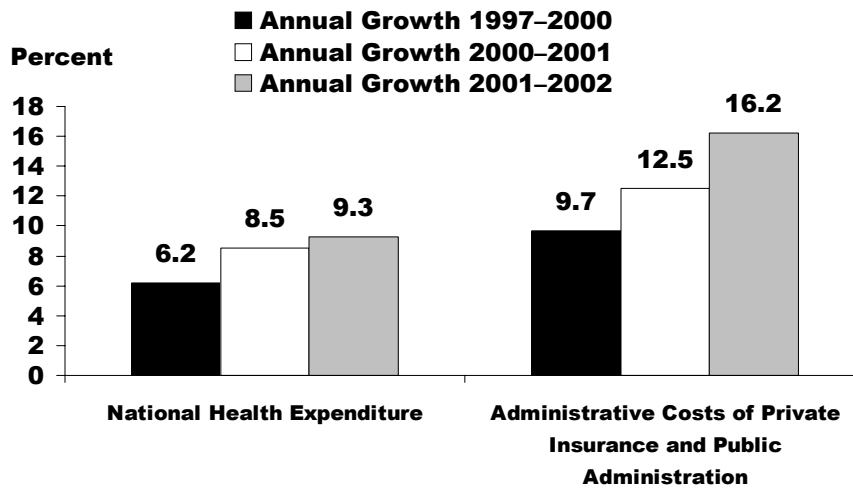
Factors Accounting for Growth in Prescription Drug Spending per Capita, 1980–2011



Note: Data for 2000–2011 are projections.
 "Other" includes quality and intensity of services, and age-gender effects.
 Source: Centers for Medicare and Medicaid Services, The CMS Chart Series, 2003.



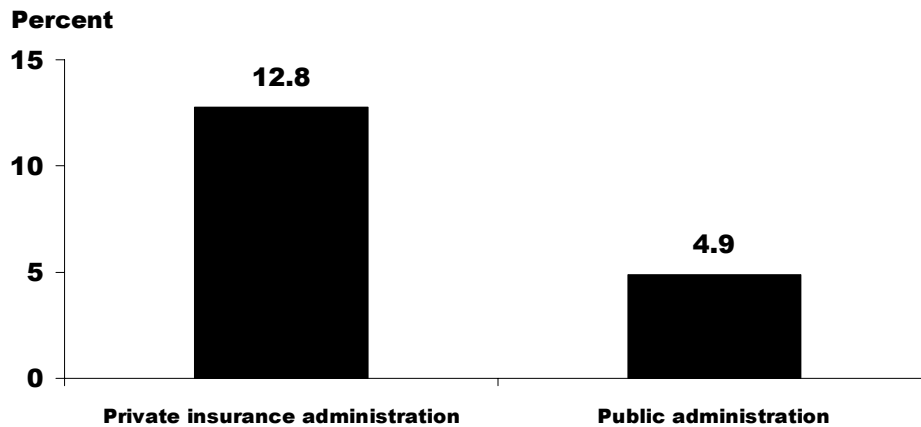
Administrative Costs Are Surging



Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.



Private Insurance Administrative Costs as a Percent of Private Insurance Outlays and Public Program Administration as a Percent of Public Outlays, 2002

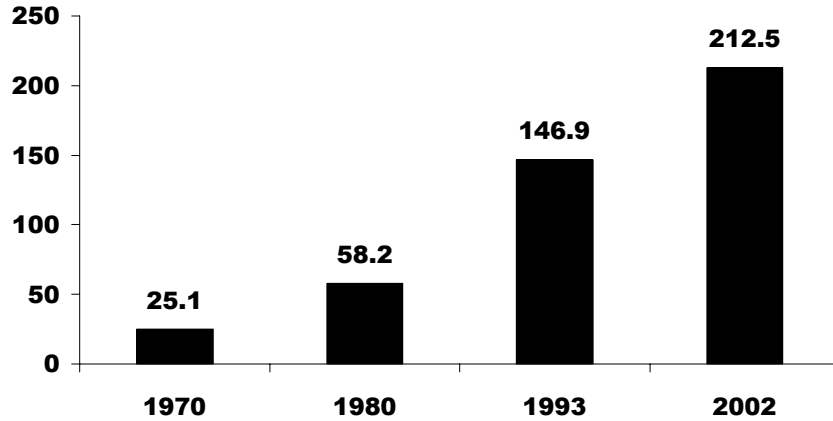


Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.



Out-of-Pocket Costs to Patients Are a Major Expense, 1970–2002

Dollars, billions

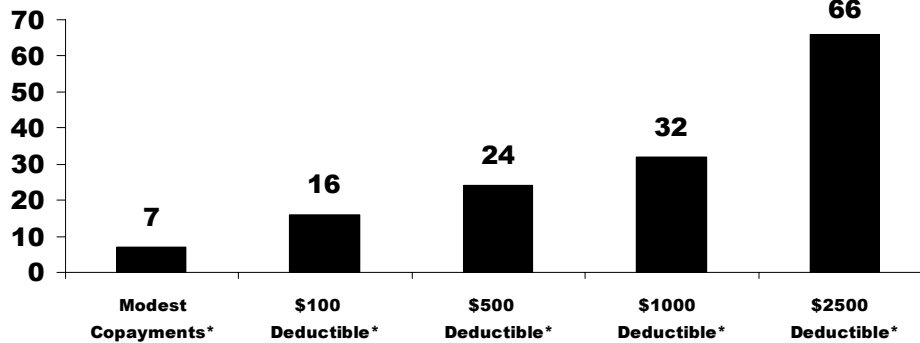


Source: K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* (January/February 2004): 147–159.



Percent of Hospitalized Patients with Out-of-Pocket Costs Exceeding 10 Percent of Income by Cost-Sharing Amount

Percent



* Notes:

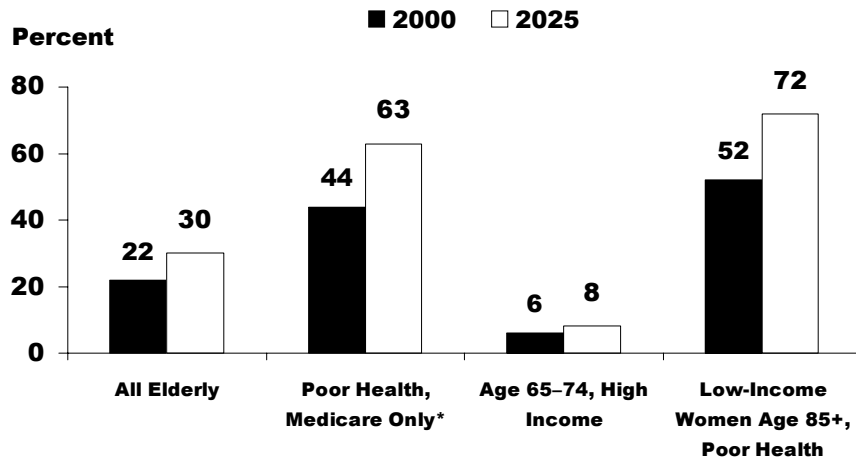
Modest Co-payments Option has \$20 co-pay for physician visits, \$150 co-pay for ED visits, and \$250 co-pay per day inpatient hospitalization; \$100 Deductible Option has 10% in-network coinsurance and 20% out-of-network coinsurance; \$500 Deductible Option has 20% in-network coinsurance and 30% out-of-network coinsurance; \$1000 Deductible Option has 20% in-network coinsurance and 30% out-of-network coinsurance; \$2500 Deductible Option also 30% in-network coinsurance, 50% out-of-network coinsurance; Maximum out-of-pocket limits are set at \$1,500 more than deductible for all options.

Source: S. Trude, *Patient Cost Sharing: How Much is Too Much?* Center for Studying Health System Change, December 2003.



Elderly Cost-Sharing Is High

Projected Out-of-Pocket Health Care Spending as a Share of Income, 2000 and 2025



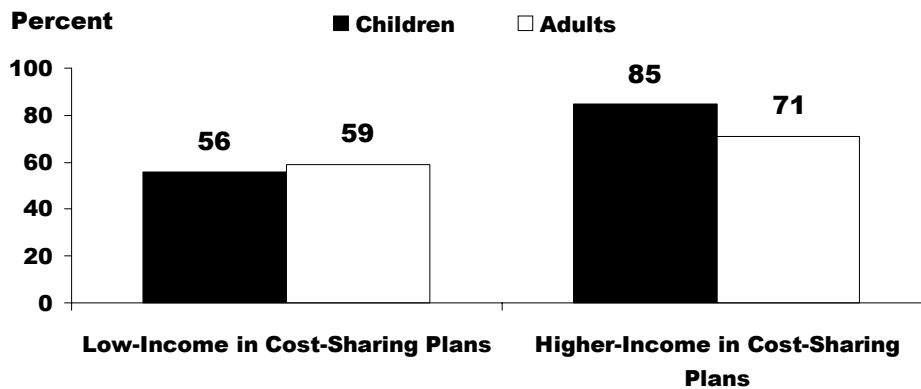
* No insurance beyond U.S. Medicare basic benefits.

Source: S. Maxwell et al., *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, December 2000.



Cost-Sharing Reduces Likelihood of Receiving Effective Medical Care

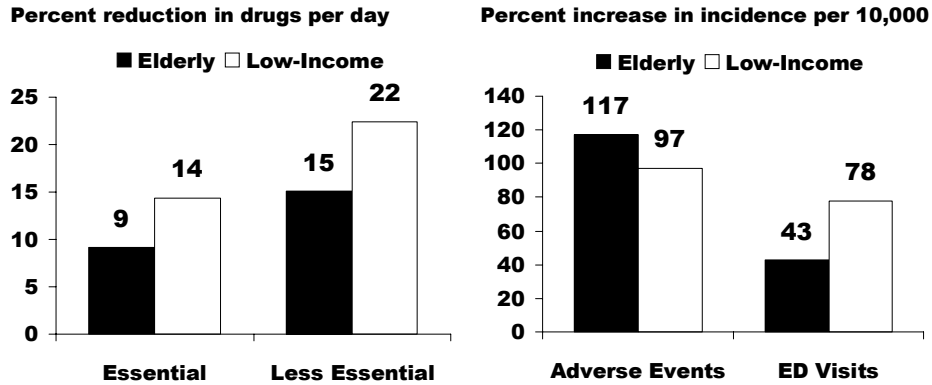
Probability of receiving highly effective care for acute conditions that is appropriate and necessary compared to those with no cost-sharing



Source: K.N. Lohr et al., "Use of Medical Care in the RAND HIE," *Medical Care* 24, supplement 9 (1986): S1-S87.



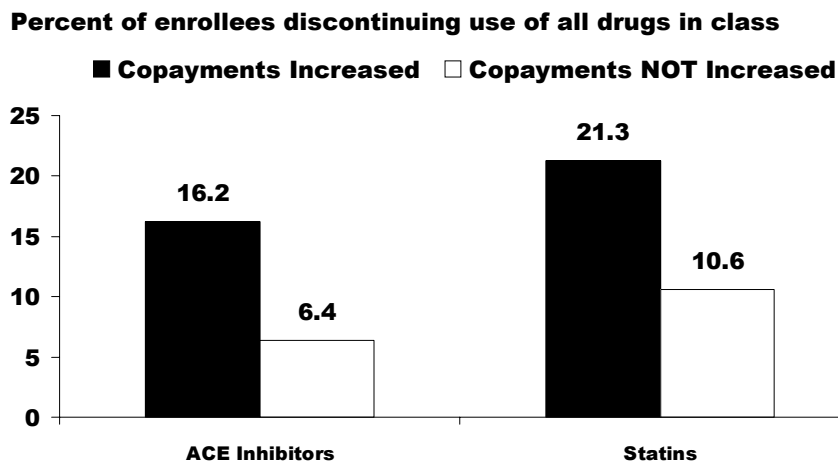
Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events



Source: R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *Journal of the American Medical Association* (January 24, 2001): 421-429.



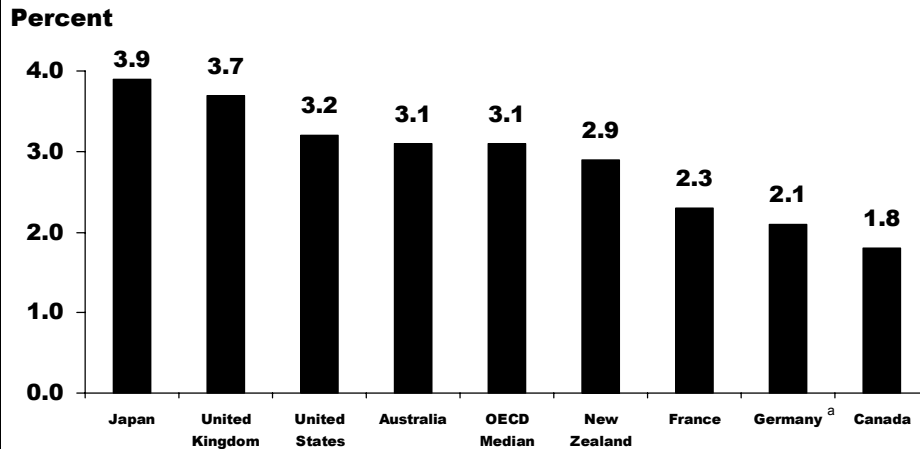
Tiered Prescription Drug Cost-Sharing Leads to People Not Filling Prescriptions



Source: H.A. Huskamp et al., "The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending," *New England Journal of Medicine* (December 4, 2003): 2224-32.



Average Annual Growth Rate of Real Health Care Spending per Capita Between 1990 and 2000 in Selected Countries



^a 1992–2000

Source: G. Anderson, et al., *Multinational Comparisons of Health Systems Data*, 2002. The Commonwealth Fund, October 2002.



Medical Errors Pose Significant Threat to Patients and Costs to Society

Total 18 types of medical injuries account for 2.4 million extra hospital days, \$9.3 billion excess charges, and 32,591 attributable deaths in the U.S. annually

Medical Error (examples)	Excess Length of Stay, Days per case	Excess Charge, \$	Excess Mortality, %
Complications of anesthesia	0.17 days	\$1,598	0.24%
Foreign body left during procedure	2.08	13,315	2.14
Obstetric trauma, vaginal birth with instrumentation	.07	220	0
Postoperative respiratory failure	9.08	53,502	21.84

Source: C. Zhan and M.R. Miller, "Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization," *Journal of the American Medical Association* (October 8, 2003): 1868–1874.



Care Coordination in Five Nations

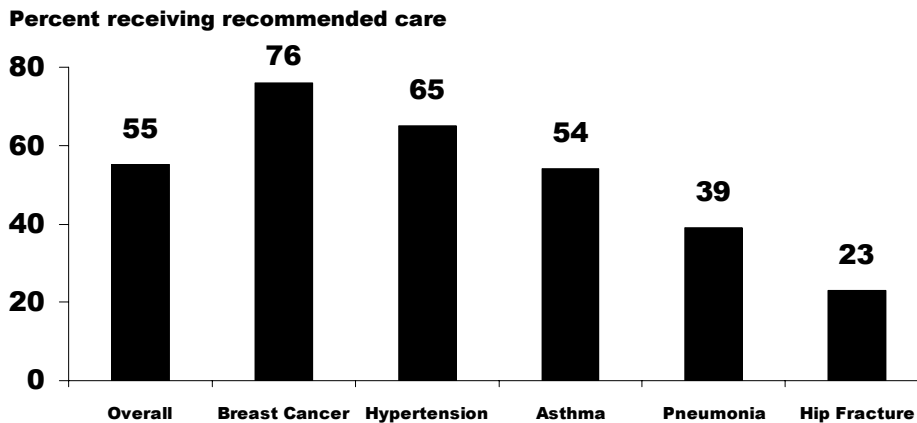
In past two years, Percent of sicker adults:	AUS	CAN	NZ	UK	US
Sent for duplicate tests by different health professionals	13%	20%	17%	13%	22%
Medical records/test results did not reach doctor's office in time for appointment	14	19	16	23	25
Medical errors caused serious problems	13	15	14	9	18

Source: 2002 Commonwealth Fund International Health Policy Survey of Sicker Adults.



About Half of U.S. Adults Receive Recommended Care

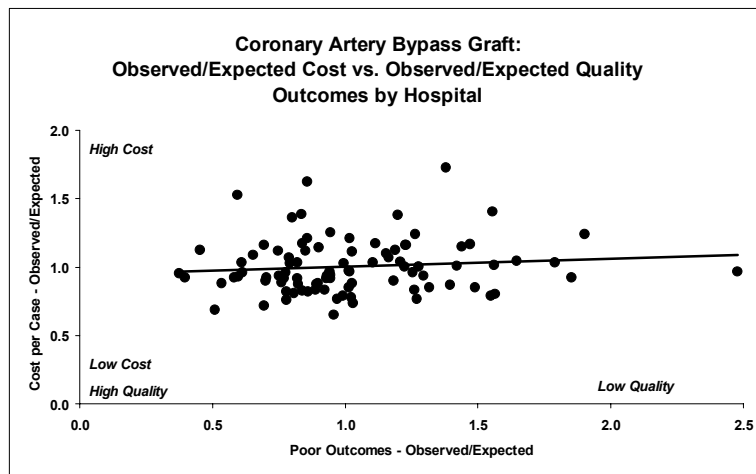
Adherence to Quality Indicators Varies Significantly by Medical Condition



Source: E.A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (June 26, 2003): 2635-45.



Cost and Quality Vary Widely Across Hospitals

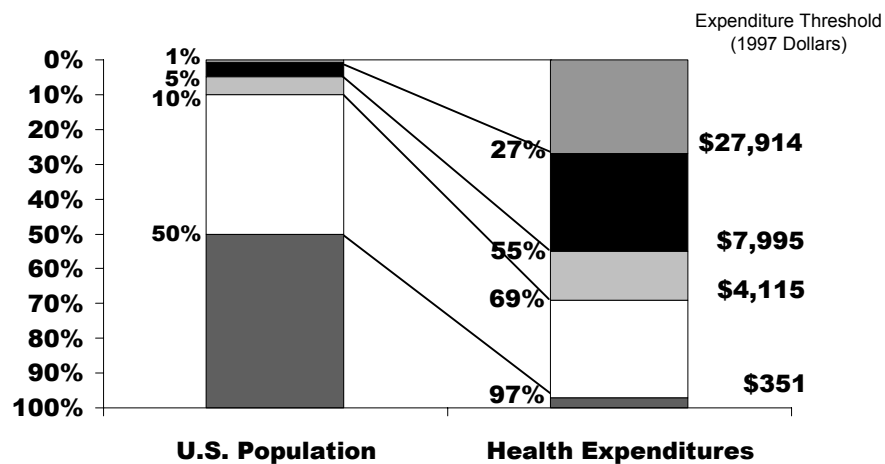


Source: S. Grossbart, Ph.D., Director, Healthcare Informatics, Premier, Inc., "The Business Case for Safety and Quality: What Can Our Databases Tell Us," 5th Annual NPSF Patient Safety Congress, March 15, 2003.



Health Care Costs Concentrated in Sick Few²⁷

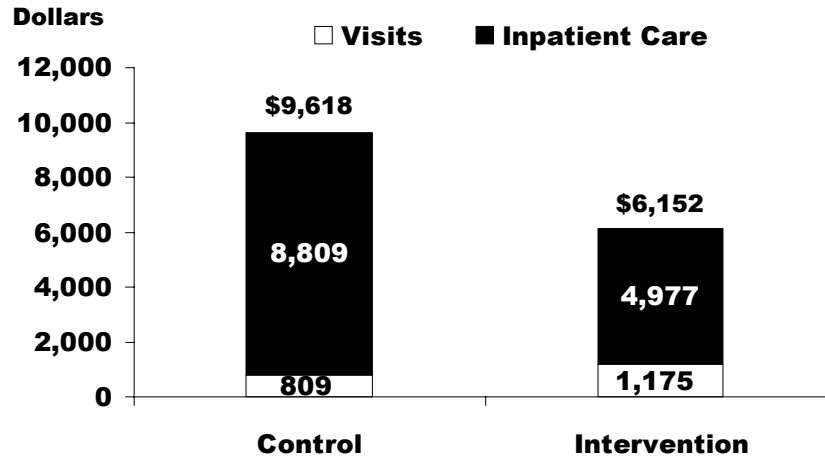
Distribution of Health Expenditures for the U.S. Population, by Magnitude of Expenditure, 1997



Source: A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53-III64.



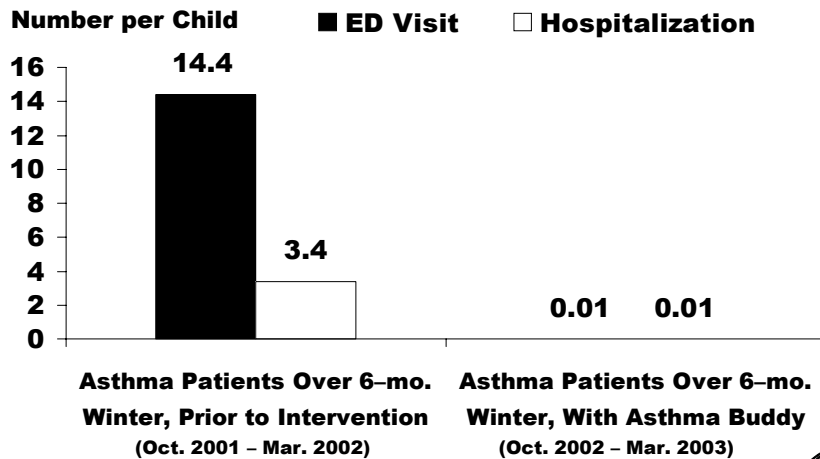
Effect of Advanced Practice Nurse Care on Congestive Heart Failure Patients' Average Per Capita Expenditures



Source: M.D. Naylor, "Making the Business Case for the APN Care Model," report to The Commonwealth Fund, October 2003; estimated charges by Mark Pauly.



Coney Island Hospital's Asthma Buddy Pilot: Effect on Asthma Hospitalization (69 Children Ages 8-16 years, 2001-2003)



Source: Coney Island Hospital, Asthma Buddy Pilot data, 2003.



Achieving a High Performance Health System: What It Requires

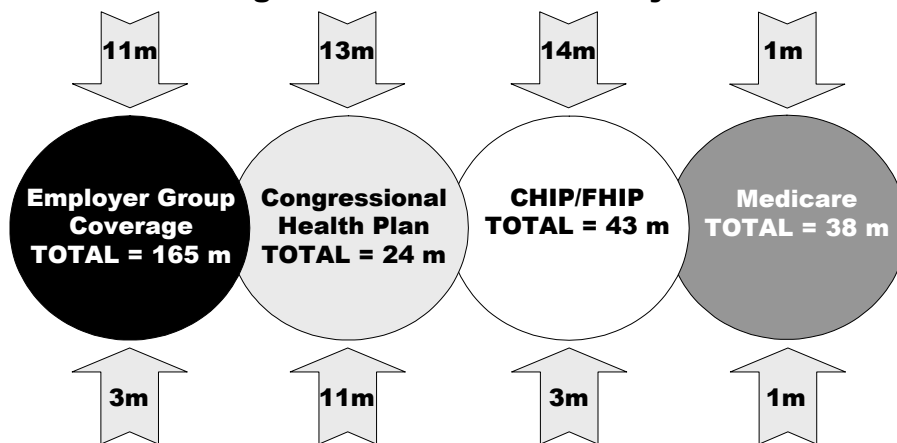
- **Enhanced federal role to promote quality and efficiency:**
 - **Public data on provider quality and efficiency**
 - **Federal agency to establish clinical guidelines, quality standards (e.g. NICE, NICS)**
 - **Financial rewards to providers for high quality, efficient care**
 - **Standards and incentives to adopt IT**
 - **Research and demonstrations on cost-effective care, new incentive payment methods**

- **Public-private partnership:**
 - **Engage entire health care system in continuous quality improvement**
 - **Develop and disseminate quality improvement tools**
 - **Identify and spread best practices**
 - **Encourage learning collaboratives to improve care**
 - **Promote modern information technology**
 - **Reward quality and efficiency**



Creating Consensus on Automatic and Affordable Health Insurance for All

New Coverage for 42 Million Currently Uninsured*



Improved Coverage for 20 Million Currently Insured

Source: K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* (Web Exclusive April 23, 2003).



