

The Path to a High Performance U.S. Health System

A 2020 Vision and the Policies to Pave the Way

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

FEBRUARY 2009



THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable,

including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.



THE PATH TO A HIGH PERFORMANCE U.S. HEALTH SYSTEM: A 2020 VISION AND THE POLICIES TO PAVE THE WAY

The Commonwealth Fund
Commission on a High Performance Health System

February 2009

ABSTRACT: This report from the Commonwealth Fund Commission on a High Performance Health System offers recommendations for a comprehensive set of insurance, payment, and system reforms that could guarantee affordable coverage for all by 2012, improve health outcomes, and slow health spending growth by \$3 trillion by 2020—if enacted now to start in 2010. Central to the Commission’s strategy is establishing a national insurance exchange that offers a choice of private plans and a new public plan, with reforms to make coverage affordable, ensure access, and lower administrative costs. Building on this foundation, the report recommends policies to change the way the nation pays for care, invest in information systems to improve quality and safety, and promote health. By stimulating competition and delivery system changes aimed at providing more effective and efficient care, the policies could yield higher value and substantial savings for families, businesses, and the public sector.

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PREFACE

With the economy in crisis and health costs increasing faster than incomes, a growing number of adults and children are losing access to care and coverage, placing them at health and financial risk if they become sick. Despite high levels of spending, the U.S. health system falls short of producing the quality and outcomes that should be possible, considering the available resources, medical science, and centers of excellence. To move quickly in a more positive direction, the Commonwealth Fund Commission on a High Performance Health System presents *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*. This report provides Commission recommendations for an integrated set of policy actions to expand health insurance to all; change the way we pay, invest in, and organize care to achieve better outcomes; and substantially slow the growth in projected national health spending.

It is urgent to start now. It will take leadership and bold steps to move over the next decade toward a health system that achieves better access, quality, and value in return for our investment. As discussed in the Commission's 2007 report, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, providing universal coverage is essential, but equally critical are policies that change the way we pay for and deliver care with a focus on health, disease prevention, prudent use of resources, and innovation to aim higher. The strategic policies offered in this report present a framework for comprehensive policies in which insurance, payment, and system reforms interact to provide a catalyst for dynamic change.

To illustrate the potential of positive action, we provide estimates of the impact of policies that follow this strategic approach. The analysis indicates it would be possible to reduce projected spending by a cumulative \$3 trillion by 2020, achieve universal coverage, and improve outcomes—if we start now.

The Commission offers these recommendations knowing that the path ahead is clearly visible, but daunting. However, the human and economic costs if we fail to act are worse. Thus, the Commission urges that leadership, political will, and resolve be summoned now to overcome resistance to change and proceed forward.

James J. Mongan, M.D.

Chairman

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Executive Director

The Commonwealth Fund Commission on a High Performance Health System

ACKNOWLEDGMENTS

The Commonwealth Fund Commission on a High Performance Health System guided the strategic vision and recommendations that it believes will be necessary to put the nation on the path to high performance. All members support and endorse the recommendations presented in this report.

The Commission thanks Commonwealth Fund senior staff for developing the analysis and preparing the report. Cathy Schoen, Fund senior vice president and Commission director of research, led the analysis team and preparation of the report with Stuart Guterman, Fund assistant vice president; Karen Davis, president; and Stephen Schoenbaum, executive vice president. We also thank the Fund's Sabrina How and Kristof Stremikis for research assistance. Finally, we thank Deborah Lorber and Suzanne Barker Augustyn of the Fund for editorial, design, and production assistance.

A NOTE TO READERS

On behalf of the Commission on a High Performance Health System, The Commonwealth Fund contracted with The Lewin Group to model policy specifications that illustrate the potential gain of a comprehensive approach to health reform. The Lewin Group's John Sheils and Randall Haught prepared the estimates in this report using the authors' specifications, which were developed to reflect each component of the Commission's recommendations. The results based on those specifications drew from available evidence as to their potential impact on those who would be affected and their behavioral responses.

The Lewin Group is one of the leading health care and human services consulting firms in the United States, with more than 35 years of experience serving organizations in the public, nonprofit, and private sectors. The Lewin Group is a wholly owned subsidiary of Ingenix, which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and is responsible for the integrity of any data that it produces for The Commonwealth Fund.

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EXECUTIVE SUMMARY

The time has come for comprehensive health reform that will put the nation on a path to a high performance health system. This report by the Commonwealth Fund Commission on a High Performance Health System presents an integrated “system” approach to change. It proposes a set of policies that would provide affordable health insurance for all, designed to support a set of payment and system reforms. In combination, the policies would provide a catalyst for an innovative delivery system capable of providing better access and improved population health while significantly slowing the growth of health spending.

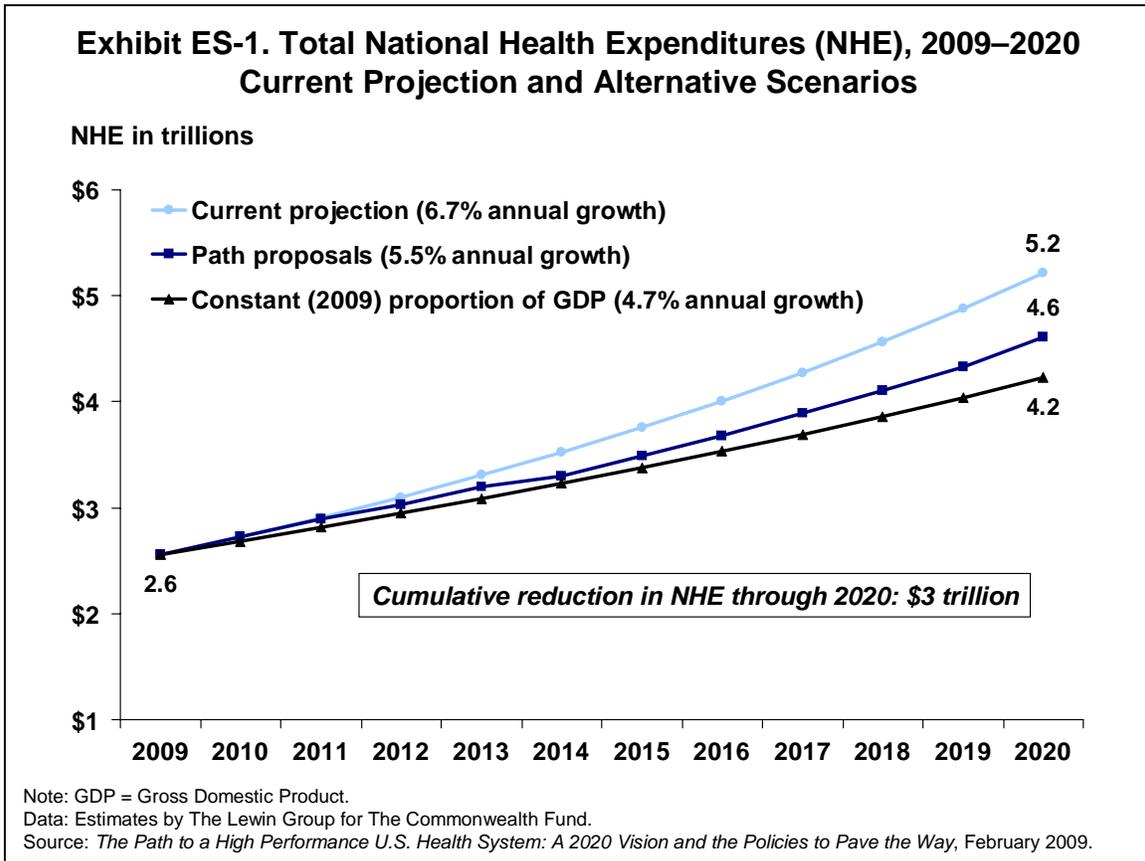
The nation’s health and economic security are at risk: rising costs are putting pressure on families, businesses, and governments, and sharp increases in the number of uninsured and underinsured are leaving millions without access to care or essential financial protection when sick. The U.S. health care system is already the most expensive in the world, by far, and total health spending is projected to double by 2020—rising from a projected \$2.6 trillion in 2009 to \$5.2 trillion by 2020 to consume 21 percent of the nation’s economic resources (gross domestic product). To achieve more affordable coverage and ensure access for everyone in the country, we must change the way health care is delivered and the way we pay for care. We must focus on value. Despite having centers of excellence, our health care system falls short. It fails to produce the outcomes and care it could, wastes resources, often fails to provide the right care at the right time, and delivers unacceptably wide variations in quality and safety. Unless we move to a high performance delivery system and improve the value of care that is delivered, efforts to expand coverage will be difficult, if not impossible, to sustain over time.

The United States needs to be on a different path, one guided by a positive vision of what should be possible and by policies leading to outcomes we should expect. This is a historic political opportunity—with a majority of the public seeking profound change and a new administration and Congress taking office—for taking bold steps to ensure the health security of all.

In this report, the Commission recommends an integrated set of policies to extend coverage to all by: establishing a national insurance exchange that offers a choice of private plans and a new public plan; requiring everyone to have coverage, with income-related premiums to make coverage affordable; and instituting insurance market reforms that focus competition on outcomes and value. On this foundation, payment policies would change the way we pay for care to enhance the value of primary care and move

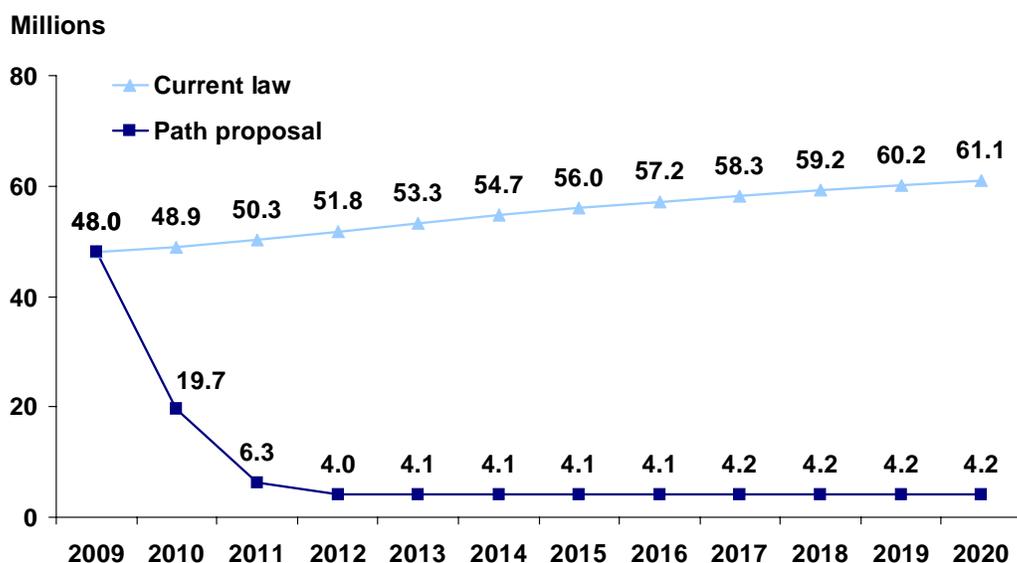
from fee-for-service to more “bundled” methods of paying that encourage coordinated care and hold providers accountable for improving health outcomes and prudent use of resources. Investment policies would accelerate the spread and use of health information technology and establish a center for comparative effectiveness to enhance knowledge and appropriate use of evidence-based care. Population health policies would promote health and disease prevention, with benchmarks and goals to spur a culture of innovation and continuous improvement.

This integrated approach could achieve access for all, improve population health, and provide more positive patient experiences. Moreover, an analysis of specific policies consistent with this approach indicates that they could slow the growth in national health spending by a cumulative \$3 trillion through 2020, compared with current projections (Exhibit ES-1)—if we start now.



Designed to extend affordable insurance to everyone and create a foundation for essential payment and system reforms, the insurance framework would achieve near-universal coverage, ensure access and continuity, and lower premiums (Exhibit ES-2).

**Exhibit ES-2. Trend in the Number of Uninsured, 2009–2020
Under Current Law and Path Proposal**



Note: Assumes insurance exchange opens in 2010 and take up by uninsured occurs over two years. Remaining uninsured are mainly non-tax-filers.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

THE COMMISSION’S STRATEGIC VISION

The Commission has identified five essential strategies for comprehensive reform:

- **Affordable coverage for all.**
- **Align incentives with value and effective cost control.**
- **Accountable, accessible, patient-centered, and coordinated care.**
- **Aim high to improve quality, health outcomes, and efficiency.**
- **Accountable leadership and collaboration to set and achieve national goals.**

Together, these strategies comprise the framework for this report with recommendations for policies that would move from concept to action.

TAKING THE PATH: COMMISSION RECOMMENDATIONS

The Commission offers the following set of recommendations to move onto a path to a high performance health system. The Commission believes all the recommendations are desirable, many necessary, but none on its own sufficient to achieve high performance. Designed to move forward quickly with a sense of urgency, the comprehensive reforms

include significant changes that would introduce a new dynamic and more positive path over the next decade. With cost pressures mounting and coverage eroding, the stakes are high. Starting now is crucial.

1. Affordable Coverage for All: Ensure Access and Provide a Foundation for System Reform

To build on the current mixed private and public coverage system to extend affordable health insurance to all with a strategy designed to ensure access and continuity *and* provide a foundation for payment and system reforms, the Commission recommends policies that:

- Establish a health insurance exchange that offers an enhanced choice of private plans and a new public plan. This new public plan would offer comprehensive benefits with incentives for disease prevention and payment methods that reward results. It would build on Medicare's claims administrative structure and national provider networks. The exchange and new public plan would be open to all, including large employers.
- Require individuals to have coverage and employers to offer coverage or contribute to a trust fund for insurance, sharing responsibility to pay for insurance for all.
- Provide income-related premium assistance to make coverage affordable.
- Expand eligibility for and improve payment under Medicaid and the Children's Health Insurance Program to improve affordability and access. Eliminate Medicare's two-year waiting period for the disabled.
- Set a minimum benefit standard to ensure access and adequate protection from the financial burden of obtaining needed health care.
- Reform health insurance markets to improve insurance efficiency, access, and affordability by prohibiting premium variation based on health and guaranteeing offer and renewal of coverage to all regardless of health status.

By moving from fractured to continuous insurance coverage, these reforms would lower insurance administrative costs and provide a foundation for more coherent and effective payment and system reforms. All payment reforms would apply to current public programs (i.e., Medicare and Medicaid) and to the new public plan offered through the exchange to the under-65 population. Market reforms would focus competition among insurers on improving health outcomes and adding value. Businesses, patients, and families could choose among an array of national and regional private plans and the nationwide publicly sponsored option.

2. Aligned Incentives and Effective Cost Control: Payment Reform to Enhance Value

Change the way we pay for care to reward high quality and prudent stewardship of health care resources and to encourage reorganization of care so that it is well-coordinated and responsive to patients' needs. To move away from the current fee-for-service payment system toward one that emphasizes value rather than volume, the Commission recommends policies to:

- Strengthen and reinforce patient-centered primary care through enhanced payment of primary care services and changing the way we pay for primary care to encourage the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention.
- Promote more effective, efficient, and integrated health care delivery through adoption of more bundled payment approaches to paying for care over a period of time, with rewards for quality, outcomes, and patient-centered care, as well as rewards for efficiency tied to high performance.
- Correct price signals in health care markets to better align payments with value.

3. Accountable, Accessible, Patient-Centered, and Coordinated Care:

Organize and Redesign the Delivery System to Improve Patient Experiences

Move from the current fragmented health care delivery system to one that is patient-centered, accessible, and organized so that patients and families can navigate care easily *and* one that holds providers accountable for high-quality, effective care across the continuum of care and over time. To move toward a delivery system in which everyone has a personal source of care that is accessible, coordinates care, and is accountable for obtaining the best health results, the Commission recommends policies that:

- Have patients designate a personal source of care that meets standards of accessibility, quality, and coordination and can serve as a medical home.
- Facilitate appropriate care and manage chronic conditions through integrated delivery systems that provide a continuum of care or provide funding and technical assistance for statewide and community efforts to support and connect primary care and more specialized resources in informal or virtual networks.
- Develop provisions in which providers participating in a hospital–physician organization receiving bundled payments would be eligible for medical liability coverage on favorable terms.

4. Improved Quality and Health Outcomes: Invest in Infrastructure and Public Health Policies

Invest in infrastructure to improve the availability, quality, and usefulness of information for health care decision-making by patients, providers, and payers and encourage a culture of continuous learning. To achieve these goals the Commission recommends actions that would:

- Accelerate adoption and use of health information technology (HIT) by establishing system standards, requiring electronic reporting of clinical information, and providing start-up funding for a national health information network so information follows the patient and is available to providers and patients.
- Support and inform better health care decision-making by establishing a Center for Comparative Effectiveness and Health Care Decision-Making, encouraging shared decision-making based on evidence, and using recommendations to develop value-based benefit designs that preserve choice but encourage appropriate care.
- Provide more transparent information to guide and drive innovation by requiring all-population, all-payer quality, patient experiences, and cost data with benchmarks of top performance.

Invest in improving population health with the goal of lowering the rates of preventable illness and improving health outcomes for chronic conditions with efforts to:

- Target public health initiatives on prevention of illness, including expansion of immunizations that are demonstrated as effective and public health actions and tax incentives and other initiatives to reduce obesity and decrease tobacco use and promote healthy lifestyles.
- Design health insurance benefits to encourage and support preventive care and essential care for chronic conditions, with positive incentives for patients to engage in health promotion and keep existing chronic conditions under control.
- Intensify the focus on preventing and managing chronic conditions, including incentives for more coordinated care and setting goals to improve outcomes for chronic conditions that account for the bulk of health care needs and spending.

5. Accountable Leadership and Collaboration: Coordinated Efforts to Improve the Health System

Leadership, new national policies, and collaboration among the public and private sectors will be necessary to set and achieve national goals for high performance. To provide accountable leadership and foster collaboration, the nation will need to establish mechanisms to set and achieve national goals, enable public programs to serve as prudent purchasers of

care, and ensure coordination of practices and policies that cut across public programs and private sector activities. In addition to insurance reforms, we need national leadership to:

- Set performance targets and provide incentives and technical assistance to meet them.
- Authorize public programs, including Medicare, to be more active purchasers of high-value health care for their beneficiaries, rather than passive payers. This would include implementing and facilitating the adoption and rapid spread of innovative payment policies to elicit a more effective, efficient, and responsive delivery system.
- Establish a national insurance exchange that would operate at national, state, and regional levels to allow participation of regional private health plans and integrated delivery systems.
- Establish a Center for Comparative Effectiveness and Health Care Decision-Making.
- Set national standards to accelerate adoption and use of health information technology and a national health information network.

ESTIMATED IMPACTS

Using a set of policies to illustrate concepts proposed by the Commission, this report analyzed the potential impact of those policies. The findings indicate that if all were implemented in 2010, it would be possible to extend affordable coverage to all and improve population health, while simultaneously reducing the growth in national health spending by a cumulative \$3 trillion by 2020 compared with current projections.* This substantial sum is the accumulation of incremental savings each year, with a reduction in the projected annual rate of growth in national health expenditures from 6.7 percent to 5.5 percent. Notably, even after this substantial reduction, national health spending still would exceed the projected annual growth in gross domestic product (GDP). Although the percent of GDP spent on health care would be lower in 2020 than what is currently projected—18.4 percent of GDP compared with the projected 20.8 percent—it would account for a higher share of the U.S. economy than in 2009 (16.9 percent).

* These estimates are based on an extensive modeling effort by The Lewin Group. Lewin used specifications developed to reflect each component of the Commission's recommendations. The results based on those specifications drew from available evidence as to their potential impact on those who would be affected and their behavioral responses. The Lewin Group is one of the leading health care and human services consulting firms in the United States, with more than 35 years of experience serving organizations in the public, nonprofit, and private sectors. The Lewin Group is a wholly owned subsidiary of Ingenix, which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and is responsible for the integrity of any data that it produces for the Fund.

The policies included in the analysis interact and are mutually supporting. All contribute to the net cumulative effect on potential savings and improvement in value (Exhibit ES-3). Each slows the rate of growth in national health spending compared with current projections. ([See summary on page xxvii](#) for policies used for purposes of modeling coverage and cost estimates.)

Exhibit ES-3. Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020

Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform

- Net costs of insurance expansion –\$94 billion
- Reduced administrative costs –\$337 billion

Payment Reform: Aligning Incentives to Enhance Value

- Enhancing payment for primary care –\$71 billion
- Encouraging adoption of the medical home model –\$175 billion
- Bundled payment for acute care episodes –\$301 billion
- Correcting price signals –\$464 billion

Improving Quality and Health Outcomes: Investing in Infrastructure and Public Health Policies to Aim Higher

- Accelerating the spread and use of HIT –\$261 billion
- Center for Comparative Effectiveness –\$634 billion
- Reducing tobacco use –\$255 billion
- Reducing obesity –\$406 billion

Total Net Impact on National Health Expenditures, 2010–2020 –\$2,998 billion

Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

These estimated impacts are contingent on their effectiveness in stimulating change in the way providers, patients, and insurers (both public and private) behave, and how they react to the new opportunities the proposed policies would create. The Commission developed the set of policies with a vision of potential dynamic change—a chain of events that interact over time. A central feature is the insurance exchange structured to expand choice of plans in the context of market rules that prohibit competition on the basis of risk selection. This design could promote competition based on value to drive innovation among insurers and better organization of care. The public plan plays a central role in harnessing markets for positive change.

The effectiveness of these reforms depends on payers becoming more prudent purchasers. Transforming Medicare into a more active purchaser of care—with innovative payment

methods that move away from fee-for-service to more bundled payments and mechanisms to hold providers accountable—could stimulate and support changes in behavior that improve performance. Comprehensive insurance with premium differences reflecting value and cost-sharing, aligned with effective care and better outcomes, would provide patients with incentives to seek high-value care and promote appropriate use of resources.

Success will require that key stakeholders join together to make difficult decisions and undertake the steps necessary to transform the health care delivery system and move along the path to high performance.

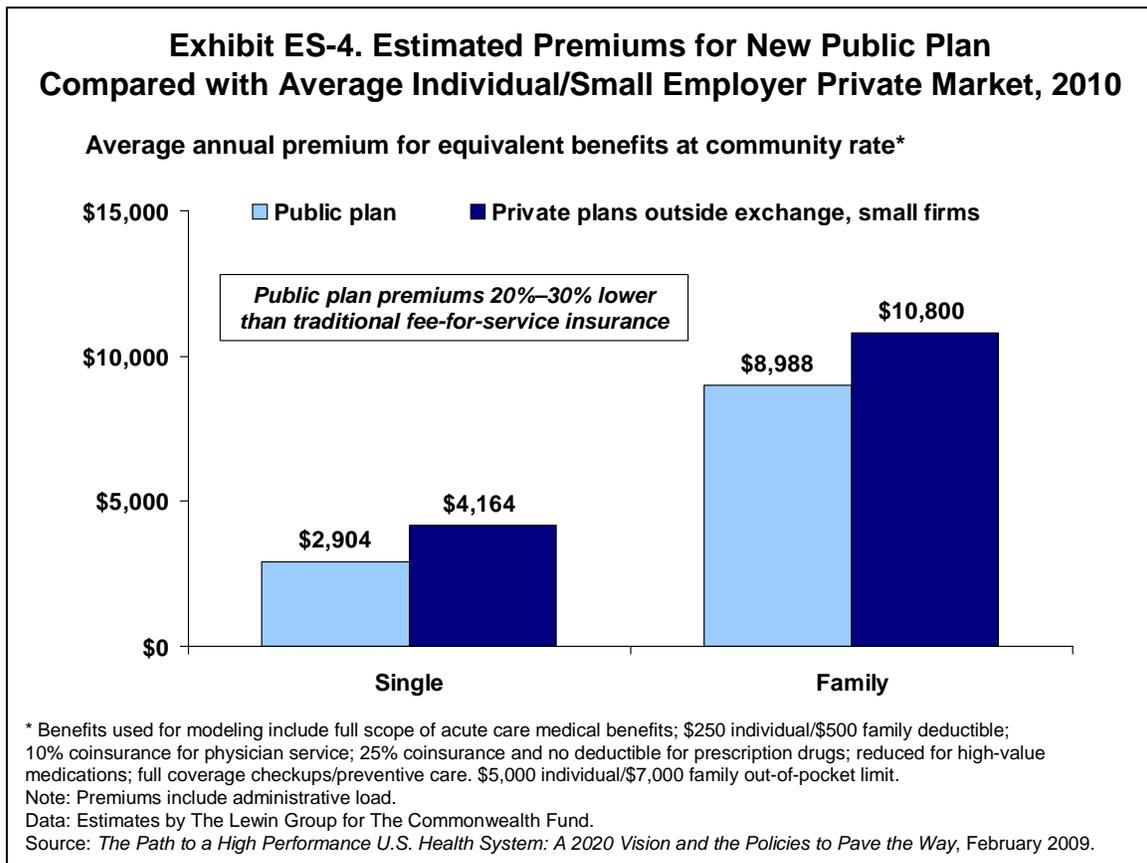
Impact on Health Insurance Coverage

The insurance framework proposed by the Commission includes the creation of a new national insurance exchange that would offer private insurance plans and a new public plan option, expansion of existing public programs, market reforms, provisions for affordability, and requirements that all have coverage to reach universal participation. By establishing a new public plan available nationwide, the framework would also provide the basis for a new competitive dynamic in insurance markets and provide a strong foundation for payment and system reforms.

The insurance expansion would achieve near-universal coverage. The number of uninsured would drop from an estimated 48 million in 2009 (16 percent of the U.S. population) to 4 million by 2012 (1 percent of the population), with nearly everyone insured over the next decade (Exhibit ES-2). Absent new directions, the number of uninsured is projected to rise to 61 million or more by 2020.

By building on existing insurance coverage, this framework would permit individuals to keep their current coverage if it works for them while providing new choices through the insurance exchange, including a range of private plans and the new public plan. Small employers in particular would be able to offer their employees a choice of multiple plans. Large employers would gain a nationwide plan plus employee choice of regional plans. All those enrolled through the exchange would be able to keep their coverage as jobs or circumstances changed. The exchange could be open in stages to allow reasonable time to set up. In the modeling, the exchange starts out by opening to small firms and individuals, opens to midsized companies in two years, and opens to all employers by 2014. With the advantages of continuity and choice, including a public plan option, the modeling estimates that over time most of the privately insured market (about two-thirds) would elect to receive coverage through the exchange.

The new public plan option would provide a less expensive alternative for the uninsured and underinsured than what is currently available in the individual and small business insurance markets. Savings would derive from significantly lower administrative costs and use of Medicare’s reformed provider payment rates. Estimates indicate premiums for the public plan would be at least 20 percent below those currently available for a comparable benefit package in the private market (Exhibit ES-4). The availability of the public plan option would thus provide a catalyst for private plans to innovate and reexamine the way they operate and pay for care.



With the flexibility to establish more integrated care networks and a variety of payment policies, private plans—by focusing on quality and value—could compete with each other and outperform the public plan, if they innovate. Provisions could encourage multipayer synchronization to ensure coherent policies and reduce administrative complexity. The goal is more vigorous, innovative, and value-driven competition focused on outcomes and a more streamlined, efficient health insurance financing system.

Impact on Care, Quality, and Outcomes

Changing the way we pay for care to align incentives with value is critical. The payment reforms proposed by the Commission would enhance the value of primary care and change the way we pay to stimulate care delivery through patient-centered medical homes with the capacity to provide access, coordinate care, and use information systems and teams to manage chronic conditions. Moving to more bundled payments, with provisions for accountability for outcomes, would align incentives with the value rather than volume of care delivered and would support hospitals, physicians, and other clinicians working together to care for patients. Building a solid infrastructure of information systems and programs to enhance prevention of disease and promote population health would emphasize innovation to meet current and future community health needs.

The Commission envisions a health system that provides patients with personal sources of care who know their medical history, ensures timely access, helps coordinate care, and uses essential clinical information to provide the right care with an emphasis on health and disease prevention. Payment and information systems would stimulate and support a patient-centered care system that is coordinated, accessible, and safe.

With a focus on prevention and improving outcomes for chronic disease, the nation could achieve substantial improvements in population health with policies that align incentives with the provision of right care and prudent use of resources, provide clinicians with information system tools and decision support, and build and expand public health programs. We should aim for healthier, more productive lives through prevention of disease, earlier intervention, and effective management of chronic conditions, including people with multiple comorbidities. In addition, more effective and humane care for people with late-stage diseases could address the huge variations in care.

By setting targets and implementing policies that meet and raise benchmarks of top performance, we have the opportunity to save lives, improve the quality of life and care experience, lower safety risks to patients, and prevent the onset of disease and complications. As illustrated by key indicators from the Commission's National Scorecard on U.S. Health System Performance, improving average performance to targets or benchmarks set by current top performers by 2020 would achieve substantial gains in population health and patient experiences (Exhibit ES-5).

**Exhibit ES-5. Achieving Benchmarks:
Potential People Impact if the United States Improved
National Performance to the Level of the Benchmark**

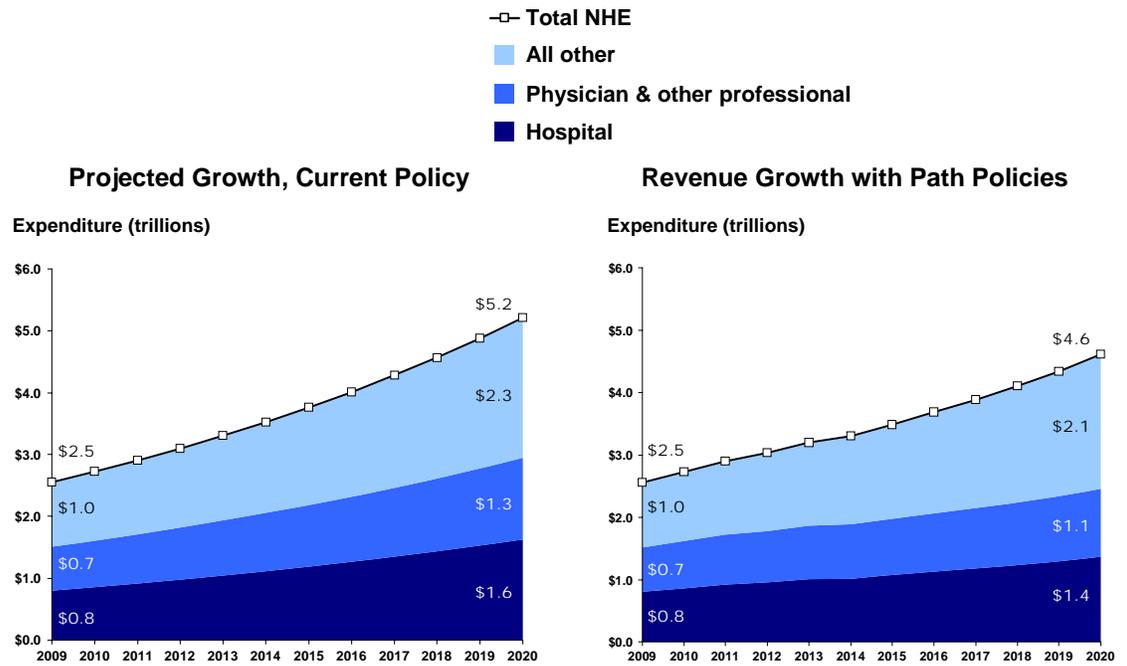
	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	58%	99%	73 million increase
Percent of adults (age 18 and older) receiving all recommended preventive care	50%	80%	68 million increase
Percent of adults (ages 19–64) with an accessible primary care provider	65%	85%	37 million increase
Percent of children (ages 0–17) with a medical home	46%	60%	10 million increase
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	58%	70%	5 million increase
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	18%	14%	180,000 decrease
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	240	126	250,000 decrease
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	156	49	70,000 decrease
Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)	700	465	640,000 decrease
Deaths before age 75 from conditions amenable to health care, per 100,000 population	110	69	100,000 decrease
Percent of primary care doctors with electronic medical records	28%	98%	180,000 increase

* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target.
Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008), with benchmarks from top performance.

Impact on Providers

While slowing expenditure growth to 5.5 percent per year is a significant change from recent years, hospitals, physicians, and other providers’ revenues would continue to experience growth each year. This growth would be only marginally slower than what is currently projected, as revenues continue to increase due to medical advances and an aging population (Exhibit ES-6). Payment reforms would support and provide incentives for practice innovations and more productive resource use.

Exhibit ES-6. Total National Health Expenditure (NHE) Growth by Provider Sector, Current Projections and with Policy Changes, 2009–2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Distribution of Impact Across Major Payer Groups

All major sectors would benefit from improved health and from slower growth in spending, compared with projected trends. By 2020, the cumulative reduction in the growth of national health spending compared with trends of \$3 trillion would be distributed across the major groups that pay for health care: the federal, state, and local governments; private employers; and households (Exhibit ES-7).

Exhibit ES-7. Path Net Cumulative Impact on National Health Expenditures (NHE) 2010–2020 Compared with Baseline, by Major Payer Groups

Dollars in billions

	Total NHE	Net federal government	Net state/local government	Private employers	Households
2010–2015	–\$677	\$448	–\$344	\$111	–\$891
2010–2020	–\$2,998	\$593	–\$1,034	–\$231	–\$2,325

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.

Data: Estimates by The Lewin Group for The Commonwealth Fund.

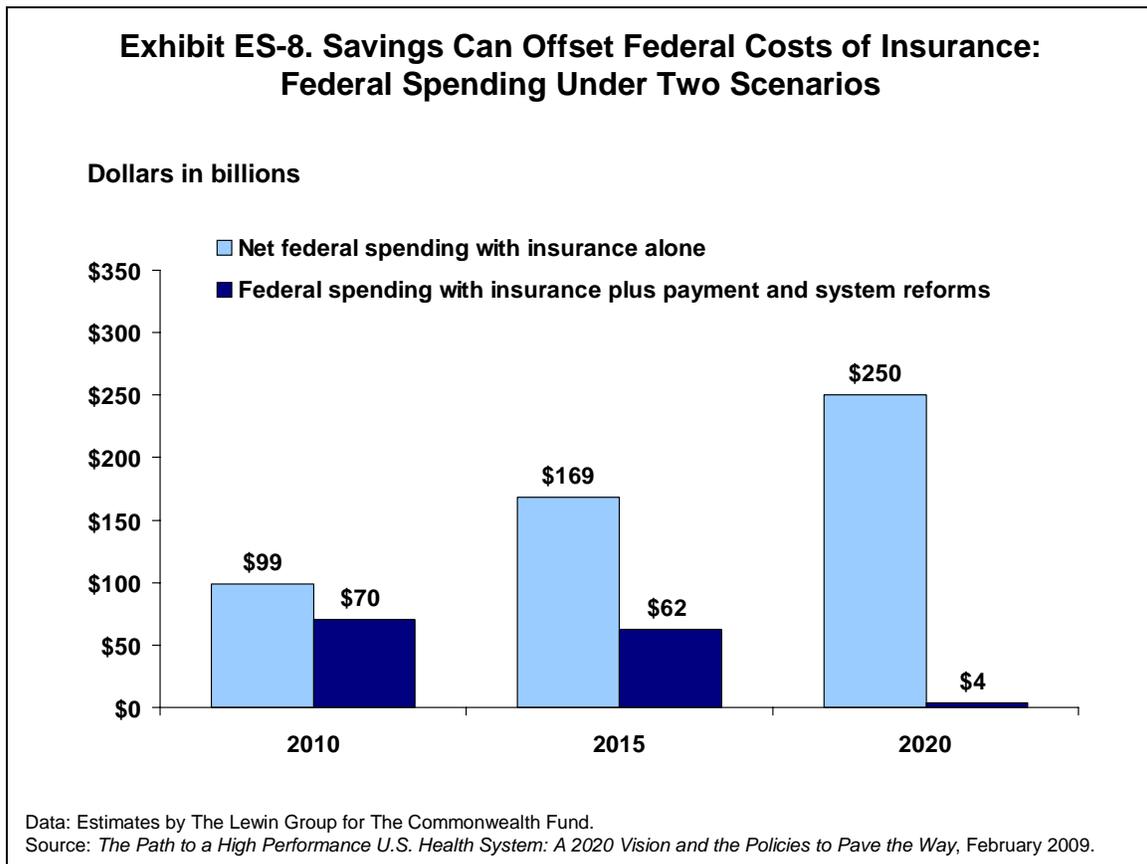
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Most of the savings would accrue to individuals and families as a result of slower growth in premiums and out-of-pocket spending, federal premium assistance, and expansion of public programs to make insurance affordable. The savings would accrue across all income groups, including higher-income households. State and local governments would also realize substantial savings relative to current projections.

Employers who currently provide insurance and their employees would also realize significant savings as a result of lower premiums and more equitable sharing of the costs of family coverage across all employers. Over time, new system savings would offset costs for employers and workers as premium growth slows, with net cumulative employer savings of \$231 billion by 2020.

As the central source of financing for coverage expansions, the federal government’s costs would increase during early years to make coverage affordable. The insurance design specified for modeling also provides federal funding to offset state and local costs of expanding Medicaid and raising Medicaid payment rates to Medicare levels. As a result, there would be an increase in net federal government spending during the decade. With system reform policies in place, however, the net federal cost of insurance

expansion and investing in the care system declines rapidly. By 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections (Exhibit ES-8). Over the 2010 to 2020 period, the net federal budget outlays are estimated to be \$593 billion—with most incurred in the first five years.



The Commission did not specify a plan to finance the federal expansion. As the report discusses, there are a number of ways to pay for such costs, with net gains to all as the nation invests in a healthier and more secure future. As state governments, households, and employers all save significantly, policies could recapture some of the savings or modify design features to finance federal support of insurance for all.

CONCLUSIONS

Moving forward on a comprehensive reform agenda and making significant progress quickly require major changes. In a care system that touches so many lives and generates over \$2 trillion in revenue per year, such changes will be very difficult to make. Yet, if we fail to act now with bold reforms, the situation we face in the future will be much worse.

The insurance design, including the exchange and new public plan, seeks a dynamic, competitive strategy that retains a mixed private and public insurance system, with the best of what each sector has to offer. The challenge will be achieving a balance in which the public and private plans compete within market rules or regulations that stimulate innovation and outcomes in the public interest. It will be important to develop a mechanism to set the price point and payment policies in a nonarbitrary fashion. The goal should be to provide incentives and support for high-quality and efficient care systems, with rational public and private insurance payment policies. The Commission will continue to explore and address this issue in upcoming reports.

It will take time and flexibility to develop innovative payment reforms to stimulate the kinds of delivery system changes needed. Currently, public programs like Medicare, the Civilian Health and Medical Program of the Uniformed Services, and the Federal Employee Health Benefit Program set payment policies in multiple ways. If the new public plan and Medicare are to support improved performance, they will need the authority and flexibility to act on behalf of beneficiaries, with targets set by Congress and the President. This will also require accountability for preserving and enhancing access and health outcomes. A new national health council, Medicare board, or other mechanism will be necessary to enable Medicare and the new public plan to serve as prudent purchasers, to facilitate and spread innovative payment policies, and to collaborate with private and other public payers within a multipayer system.

Significant reform will also be needed to change the way we pay for care to focus on value and to set up a national exchange in which all insurers agree to accept everyone and charge the same premium, regardless of health. Providing positive incentives for patients to seek high-quality, effective care and assess alternatives will require investment in information systems, public reporting, and support for evidence-based medicine and mechanisms for applying that evidence.

Overall, moving on a path to high performance will require that we, as a nation, reach consensus that the status quo is not acceptable. It will require bold action on behalf of the greater good of the population, health outcomes, and economic security. Successful implementation of effective policies will require leadership with authority to act and collaboration across sectors to achieve targets and goals.

The results presented in this report underscore several key themes and build on the Commission's earlier analysis of strategies to achieve a high performance system:

- **We should aim high. Better access and health outcomes, along with slower cost growth, are possible. It is urgent to start now.** The consequences of maintaining the status quo—in terms of both human and economic costs—put the nation at risk. Early action has the potential for substantial cumulative benefits. Delay increases the magnitude of the problems. We cannot afford to continue on our current path.
- **A comprehensive system approach is essential. We need to simultaneously expand coverage and take bold action to improve quality and efficiency.** There is no “magic bullet” that can alone address rising costs, access, and quality. A coherent set of policies aimed at misaligned incentives, an information deficit, and structural flaws that drive costs up and drag outcomes down is necessary to improve.
- **Better information is a key to improved performance. We need to invest for the future.** Improving the health system requires a clinical information system to support patients and clinicians; better evidence on the effectiveness of treatments, drugs, and devices; and information to compare performance at the national, community, and provider levels.
- **Insurance provides an essential foundation for payment and system reforms.** If designed to ensure access and improve insurance efficiency, coverage expansion provides a base for payment and system changes that create more consistent signals and drive delivery systems to higher performance. Benefit design can provide incentives for preventive care and essential care for chronic disease. Less fragmented coverage enables purchasing leverage for change. Universal coverage, coupled with payment and system reforms, would provide a catalyst for significant gains in value.
- **Value means more than savings.** Higher value includes improvements in quality, equity, access, and healthy lives, in addition to savings. The potential to improve health outcomes, not just savings, should drive decisions for the future.
- **Achieving high performance will require all stakeholders to take part in solutions and come together to focus on the gains for patients and the nation.** Expanding coverage to everyone, improving performance, and achieving national health system savings will not be easy. It will require a shift in the way we pay for and deliver care, as well as major insurance reforms. Payers and providers must address current payment inequities and reach consensus on reforms to support efficient, high-value care.

- **Leadership is critical.** Building consensus requires leadership and public–private collaboration. Successful implementation of effective policies requires leadership with authority to act and collaboration across sectors to achieve targets and goals.

As a nation, we all gain by moving in new directions to expand coverage and implement payment and system reforms, with a focus on improving health, patient experiences, and value. The stakes are high if we fail to act.

Windows of opportunity for real health reform do not stay open for long. While the challenge is daunting, it is imperative that our new federal leadership move swiftly to change direction and put the U.S. health system on the path to high performance.

Summary of Policy Modeling Specifications for Coverage and Cost Estimates

Coverage

- **National Health Insurance Exchange.** Offers businesses and individuals a choice of private plans and a new public plan, phased in by size of firm with all eligible by 2014. Premium of the public plan would be community rated within broad age bands. Benefits are similar to the standard option in the Federal Employees Health Benefits Program. The plan would use Medicare's claims administrative structure and reformed payment methods and rates.
- **Individual Mandate.** All individuals are required to obtain coverage.
- **Affordability.** Premiums are capped at 5 percent of income for low-income individuals and 10 percent of income for those in higher-income tax brackets.
- **Shared Financial Responsibility.** Employers are required to provide coverage or contribute to a trust fund. The example used in the model included 7 percent of payroll, up to \$1.25 an hour.
- **Medicaid/SCHIP Expansion.** All individuals with incomes up to 150 percent of the federal poverty income level are eligible for Medicaid acute care benefits. Medicaid provider payment rates are raised to Medicare levels. The federal matching rate is increased to offset state costs.
- **Medicare.** The two-year waiting period for coverage of the disabled is eliminated. Medicare beneficiaries are offered a supplement with the same acute care benefits as in new public plan and premium affordability provisions.
- **Insurance Market Reforms.** Require community-rate premiums (age bands permitted) and guaranteed issue and renewal of policies. Premium and insurance information would be publicly available on the Web.

Payment Reform: Aligning Incentives to Enhance Value

- **Enhance Payment for Primary Care.** Increase Medicare payments for primary care by 5 percent and apply differential updates for primary care and other care.
- **Encourage Development and Spread of Patient-Centered Medical Homes.** Provide payment per patient in addition to fee-for-service to practices qualified to provide patient-centered care. Reduced premiums and cost-sharing available to patients who designate a primary care practice as their medical home. Shared savings would be distributed on the basis of performance.
- **Bundled Payments for Acute Care Episodes.** Expand acute care payment to include services during the hospital stay and 30 days post-discharge in a global fee. The policy would be phased in, starting with inpatient services in 2010, then post-acute care in 2013, and hospital inpatient and outpatient physician care in 2016.

- **Correcting Price Signals.** Modify payments by: 1) slowing the rate of Medicare payment updates in geographic areas with high costs; 2) reducing prescription drug costs by having Medicare pay Medicaid prices for drugs used by dually eligible beneficiaries and determining Medicare payments for unique drugs with effective monopolies based on prices paid in other countries; and 3) resetting benchmarks for Medicare Advantage plans in each county to projected per-capita spending under traditional Medicare.

Investing in Information Infrastructure

- **Accelerate the Adoption and Use of Health Information Technology.** Require all providers to report key health outcomes electronically by 2015 to qualify for payment updates. Provide funding to support health information networks and assistance for safety-net providers and small practices through a 1 percent assessment on insurance premiums and Medicare outlays.
- **Center for Medical Effectiveness and Health Care Decision-Making.** Create a mechanism to develop information on the clinical and cost-effectiveness of alternative treatment options. Fund the Center with a .05 percent assessment on insurance premiums and Medicare and Medicaid spending. Use the information in benefit designs with higher out-of-pocket costs or differential pricing depending on comparative effectiveness and include physician–patient shared decision-making.

Promoting Health and Disease Prevention

- **Reduce Tobacco Use.** Increase federal taxes on tobacco products by \$2 per pack of cigarettes. Use revenues to fund public health programs and insurance expansion.
- **Reduce Obesity and Alcohol Use.** Establish a new tax on sugar-sweetened soft drinks of 1 cent per 12-ounces to finance state obesity prevention programs, and increase the federal excise tax on alcohol by 5 cents per 12-ounce can of beer, with proportionate increases on other alcohol products. Use funds for prevention and insurance expansion.

Methodology Note: Modeling the Commission recommendations required detailed specifications for each of the policy approaches. The following specifications were used for illustrative purposes. Recognizing that multiple policy variations are feasible for key policy reforms, the Commission endorses the strategic approaches rather than the specific policy parameters used to model potential effects. The main report provides further detail. The Lewin Group technical report, *The Path to a High Performance U.S. Health System: Technical Documentation*, is available online at www.Lewin.com for data and parameters used to estimate 2010–2020 impacts.

THE PATH TO A HIGH PERFORMANCE U.S. HEALTH SYSTEM: A 2020 VISION AND THE POLICIES TO PAVE THE WAY

I. INTRODUCTION

The U.S. health care system falls far short of the kind of performance the nation should expect given current medical knowledge and the vast resources devoted to health care. Despite centers of excellence and advances in medical science, the health system often fails to deliver care and outcomes people need and wastes resources. While the objective is providing the right care at the right time to all patients, the reality is that there is disturbingly wide variation in quality and safety, which puts patients at risk. Instead of focusing on patients' overall health needs, care is all too often organized around individual services provided by individual providers. This results in poorly coordinated care, with information only available regarding specific components of care, not about the sum of the patients' needs. Duplication, unnecessary complexity, errors, and disappointing results are pervasive.

Comprehensive health reform and bold actions to change direction are necessary to put the nation's health system on a path to high performance. The U.S. health care system is already the most expensive in the world by far, with projections pointing to costs rising much faster than incomes. Rising health care costs, deteriorating coverage, and poor performance threaten the nation's health and place financial pressure on families, businesses, and the public sector. There is urgent need for a clear vision and coherent action to change the trajectory and move in a new direction. We cannot afford to continue on the current path.

A high performance health system would provide everyone with timely access to safe, high-quality, and effective care. It would emphasize prevention and health and do so within a delivery system that organizes care around the patient, coordinated across providers and settings. Such a system would operate in a continuous learning environment, in which successes in providing better care and value spread through the health system.^{1,2}

In November 2007, The Commonwealth Fund Commission on a High Performance Health System outlined a strategic approach for change for the nation with its report, *A High Performance Health System for the United States: An Ambitious Agenda for the*

*Next President.*³ In December of that year, the Commission identified a set of policy options aimed at “bending the curve”; that is, reducing the current trajectory of health care costs while improving value.⁴ With the onset of the most severe economic crisis the nation has faced in decades, it is ever more urgent to move the health system to a path to high performance.⁵

To move from concept to action, this report by the Commission offers a set of policies that represents a comprehensive approach to transformative change by 2020. The policies are informed by a view of a health system that is achievable and by the actions necessary to provide a catalyst for systemic change. Developed as an integrated set, these policies could pave the way toward a “2020 vision” of a high performance health system.

Designed to move forward quickly and with a sense of urgency, the comprehensive reform seeks to disrupt the status quo and introduce a new dynamic—a chain of events that could realize the triple goals of achieving universal coverage with access for all, improving health outcomes, and significantly slowing cost growth over the next decade. The aim is to provide an integrated system approach to change, with strategic actions interacting and reinforcing each other to drive the health system in a new direction.

The Commission has identified five key elements of a high performance health system:⁶

- affordable coverage for all;
- aligned incentives to enhance value and effective cost control;
- accountable, accessible, patient-centered, coordinated care delivery systems;
- aiming high to improve health outcomes, quality, and efficiency; and
- accountable leadership and collaboration to set and achieve national goals.

The set of policies and recommendations offered in this report are designed to achieve these objectives. Specifically, the policies would simultaneously:

- expand coverage to ensure access and provide a solid foundation for system reforms to improve quality and efficiency;
- change the way we pay for care to support and stimulate patient-centered, coordinated, effective and efficient care;
- change the way we deliver care to ensure care is patient-centered, accessible, and coordinated;

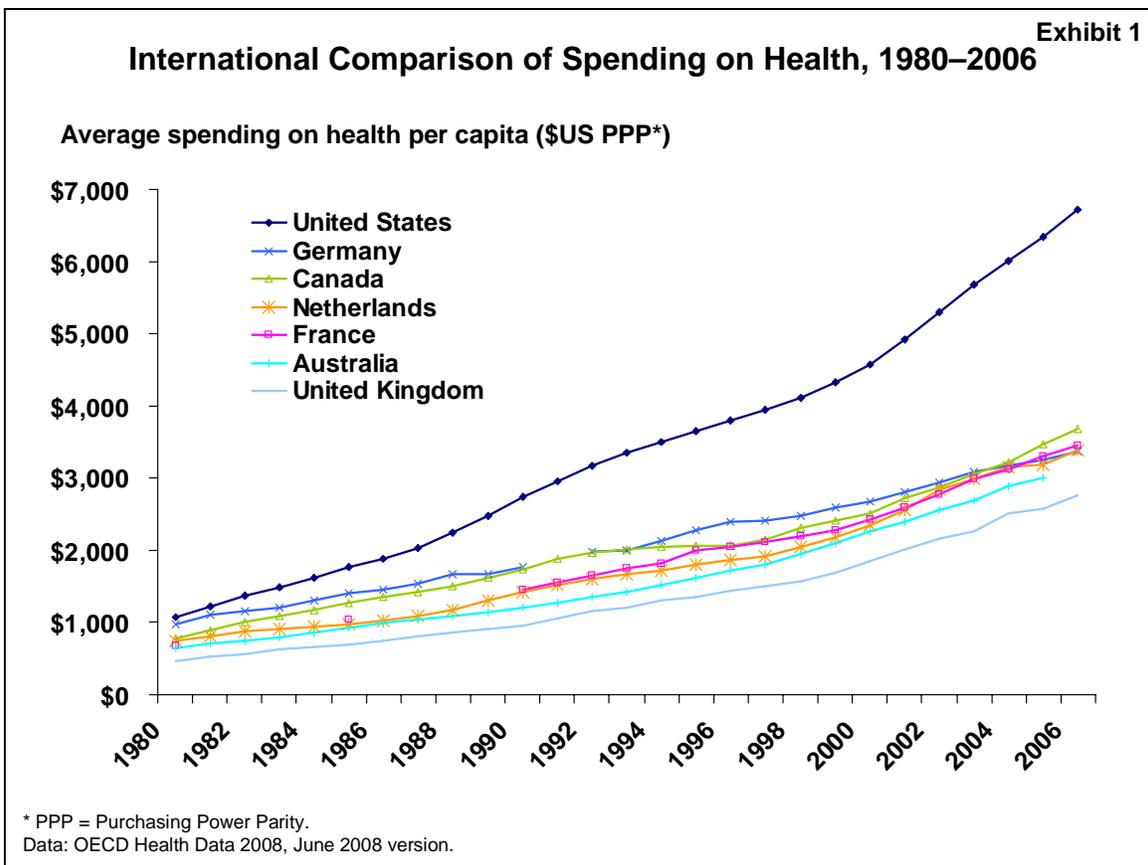
- invest in the infrastructure and population health policies necessary to improve care and health; establish benchmarks and assess performance; and drive and monitor improvement in disease prevention and population health outcomes; and
- provide a framework for leadership, with coherent national goals and policies.

To examine the potential for change, Commission staff developed specifications to illustrate each set of recommended policies. On behalf of the Commission, The Commonwealth Fund contracted with the health care policy firm The Lewin Group to estimate their impact on the trajectory of costs and coverage compared with projections under the current system.⁷ All the estimates assume these policies would be enacted as a group in 2010, with effects unfolding through 2020.

After describing the need for urgent action to enact change, the report provides an overview of the Commission's vision for a high performing health system and its recommendations. The report then provides a more detailed discussion of the policies in each strategy area, including specifications used for modeling. The final sections present estimates of the effects of slower spending growth by payers and providers and conclude with cross-cutting themes and policy implications.

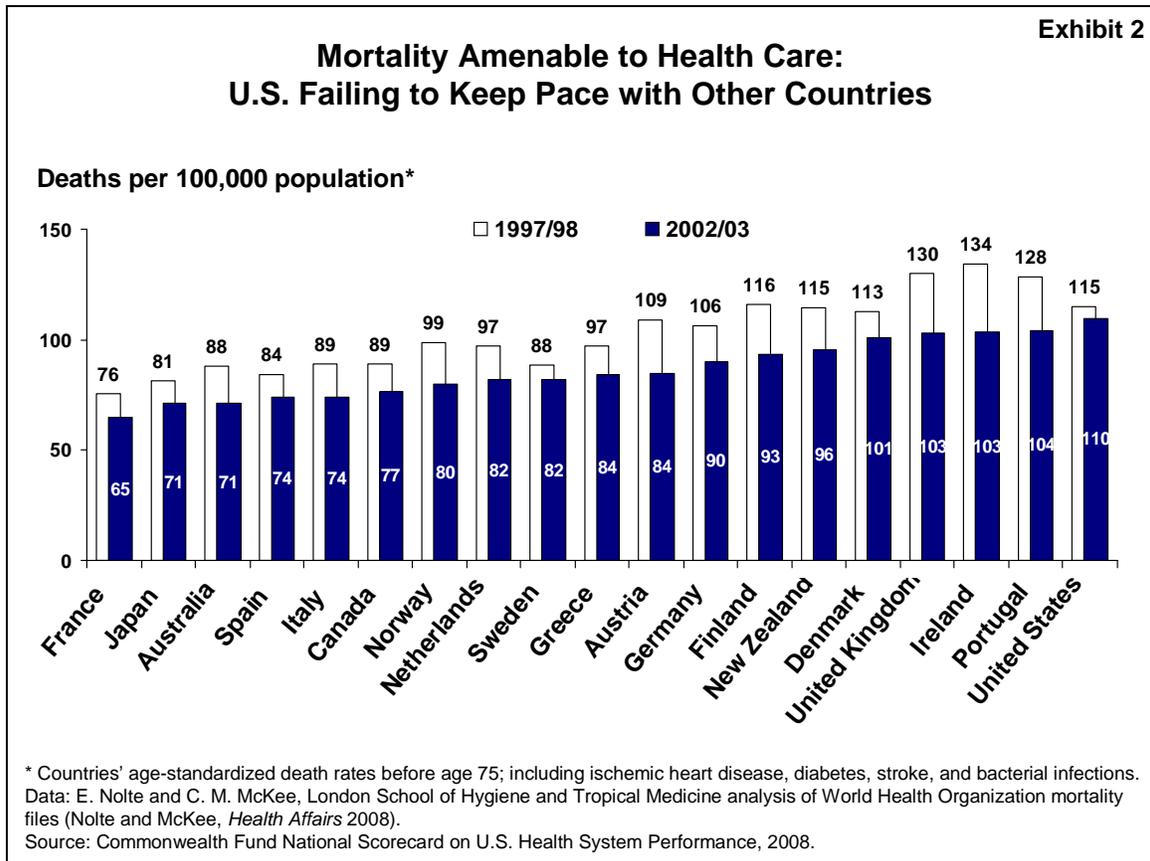
II. THE NEED FOR NEW DIRECTION

Expensive Care: High Spending, Low Returns. The United States leads the world in health care spending—at more than twice the per-person spending of other major industrialized countries—with costs projected to continue to rise rapidly over the next decade (Exhibit 1). Health care already consumes 17 percent of the nation’s economy (or gross domestic product) and will reach 21 percent by 2020 if trends continue.⁸ In making this extraordinary investment, we should expect the best care. Yet there is clear evidence that the U.S. is not reaping high value commensurate with its investment.



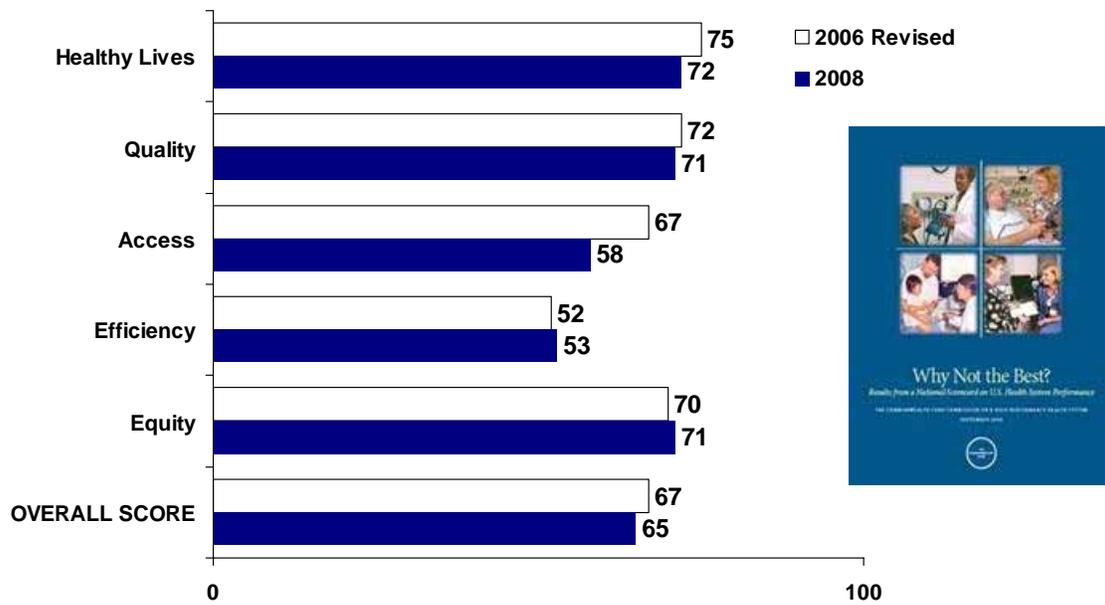
Despite devoting the most resources to its health system, the U.S. is failing to keep pace with gains made by other countries. The nation is now in last place behind 18 other high-income countries on mortality amenable to health care before age 75—deaths potentially preventable with timely, effective health care or early efforts to screen and prevent onset of disease (Exhibit 2).⁹ Although the U.S. improved on this measure by 4 percent between 1997 and 1998 and 2002 and 2003, other countries achieved an average improvement of 16 percent over the same period. The difference between the U.S. and

the countries with the lowest mortality rates amounts to 100,000 premature, potentially preventable deaths each year.



We are moving in the wrong direction on many other indicators. The Commission's 2008 National Scorecard on U.S. Health System Performance finds disturbing evidence of widespread variations in quality and outcomes, poor coordination, and complications of chronic disease that could have been prevented with timely access to effective care.¹⁰ Relative to what should be achievable—and to what is achieved in other countries and the best-performing areas of this country—the U.S. falls short across an array of dimensions, including access, quality, equity, and efficiency (Exhibit 3).

Failure to Improve: National Scorecard on U.S. Health System Performance

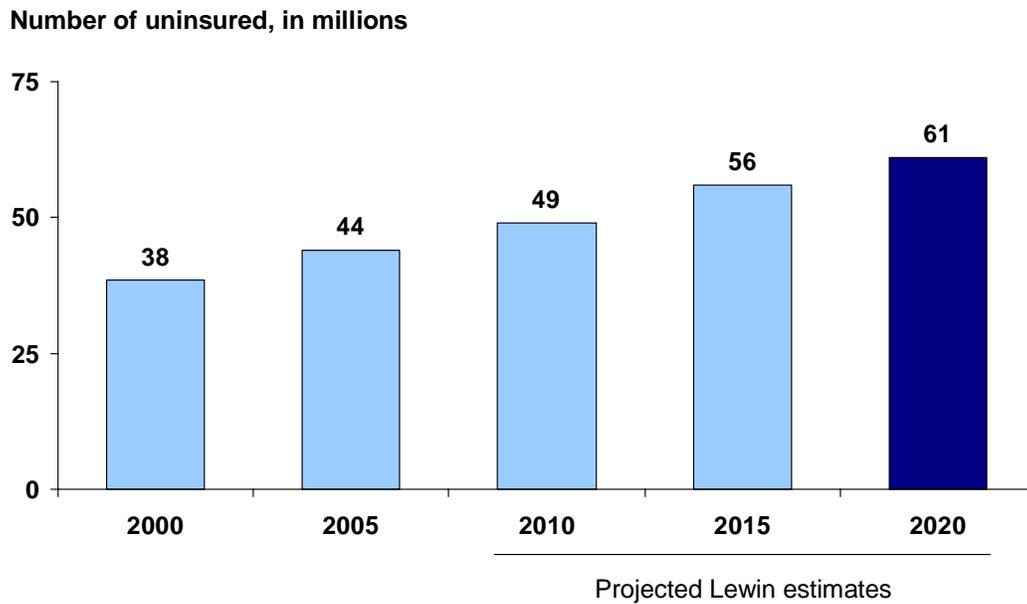


Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

These deficiencies only stand to worsen in the current economic crisis. The soaring costs of health care have already put intense economic pressures on businesses, as well as on patients and their families. The nation’s health and economic security are at risk unless we change direction.

Losing Ground on Insurance. Without action to stem the tide, the number of people who are uninsured at any moment in time is expected to increase from 46 million in 2006 to 61 million by 2020, assuming recovery from the current severe recession (Exhibit 4).¹¹ Moreover, these estimates do not reflect the number of people who lose coverage for periods during the year: almost 30 percent of adults under age 65 are uninsured for some time during the year.¹²

Uninsured Projected to Rise to 61 Million by 2020 Not Counting Underinsured or Part-Year Uninsured

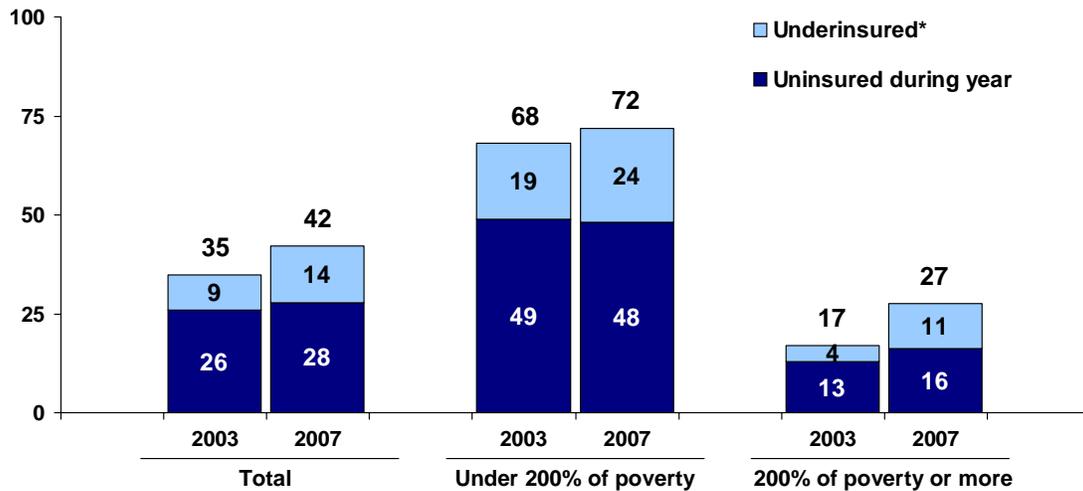


Data: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2001 and 2006; Projections to 2020 based on estimates by The Lewin Group.

The trend toward ever higher cost-sharing and thinner insurance benefits has led to a sharp increase in the number of people who are underinsured—that is, those who face high out-of-pocket medical costs relative to income, despite being insured all year. More than two of five adults ages 19 to 64, were either uninsured during the year or underinsured as of 2007, a sharp increase since 2003 (Exhibit 5).¹³

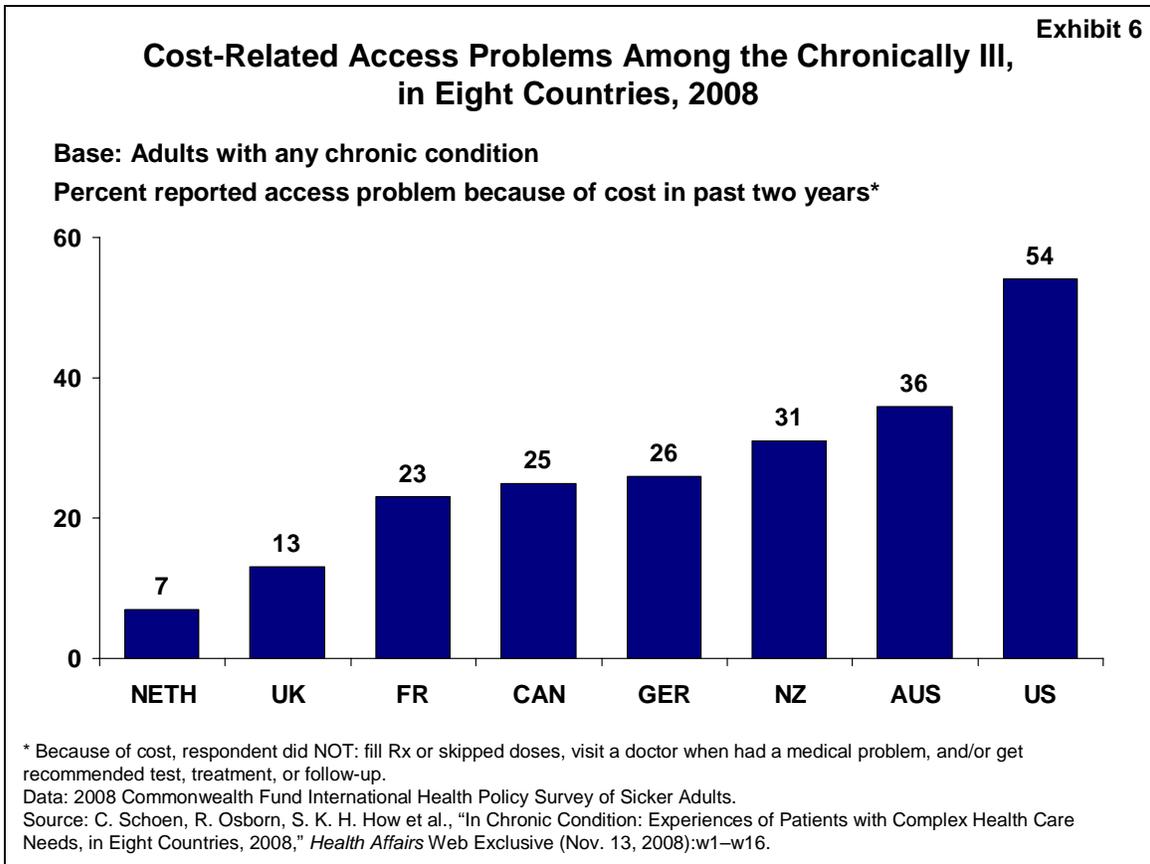
**Two of Five Adults Uninsured or Underinsured
25 Million Underinsured
60 Percent Increase in Underinsured from 2003 to 2007**

Percent of adults (ages 19–64) who are uninsured or underinsured



* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income, or 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
 Data: 2003 and 2007 Commonwealth Fund Biennial Health Insurance Survey.
 Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

The failure to provide continuous, affordable coverage that ensures access and financial protection to everyone in the U.S. contributes to the poor performance of the health system. Poor access is both a quality and a safety concern, and it drives up health care costs. The U.S. has higher rates than other countries for sick or chronically ill adults forgoing needed care because of costs, including going without needed medications.¹⁴ As of 2008, more than half of chronically ill adults did not see a doctor when they were sick or did not adhere to and follow up on recommended care (Exhibit 6).



Poorly coordinated care and inadequate information systems further put the uninsured and underinsured at risk, especially those with multiple conditions who are typically cared for by various clinicians, in different sites of care. Among eight countries surveyed, the U.S. stands out: one-third of chronically ill patients reported prescription, diagnostic test, or medical errors.¹⁵

Inadequate insurance and gaps in coverage undermine the financial security of middle- and lower-income families and contribute to the nation's financial crisis. Including those struggling to pay bills, facing collection agencies, or paying off medical debt, 72 million adults are under financial stress due to medical care (Exhibit 7). Families are accumulating credit card debt, exhausting savings, and taking out second mortgages on homes to cope.¹⁶

Medical Bill Problems and Accrued Medical Debt, 2005–2007

Percent of adults ages 19–64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
Any of the above bill problems	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
Any bill problems or medical debt	34% 58 million	41% 72 million

Data: 2005 and 2007 Commonwealth Fund Biennial Health Insurance Surveys

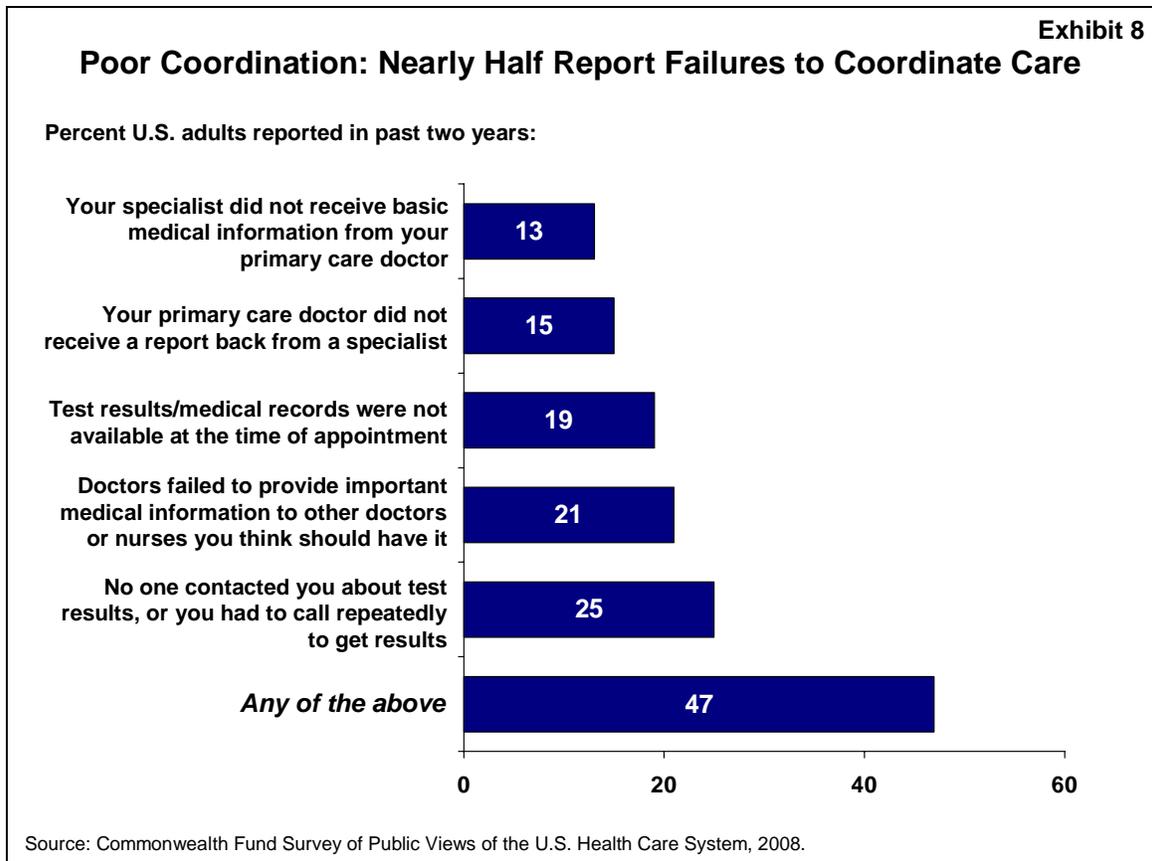
Source: S. R. Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Surveys, 2001–2007*, The Commonwealth Fund, August 2008.

Patients at Risk: Weak Primary Care Access and Prevention. In addition to gaps in health insurance coverage, lack of timely access—including access to appropriate care after hours—is widespread. In a recent survey, nearly three-quarters of all adults were not able to see their doctor quickly (the same or next day) when sick, found it difficult to get through to their doctors by phone, or said it was difficult to get care after regular work hours without going to the emergency room.¹⁷ A primary care shortage has exacerbated emergency room (ER) crowding for conditions more appropriately treated by community physicians who know their patients' medical histories. ER waits and crowding are reaching crisis proportions as both insured and uninsured patients turn to the ER for basic care.¹⁸

Preventive measures can avoid or delay the onset of many conditions. Yet, adults in the U.S. receive the recommended screenings and preventive care for their age groups only half the time.¹⁹ In addition, appropriate interventions and collaborations among providers and patients can improve outcomes for chronically ill patients. Yet often we fail to provide the right care in the right setting at the right time or coordinate care. This includes providing poorly integrated emergency care rather than coordinated primary and specialty care.

Weak primary care access and prevention lead to poor outcomes and high costs. Patients end up admitted or readmitted to hospitals, undergoing surgery or expensive procedures for complications that could have been prevented, such as amputations or kidney dialysis for diabetics. Indeed, instead of acting early to stop the onset of diabetes or complications associated with diabetes, we build dialysis centers and, for Medicare patients, cover the costs of treating end-stage renal disease.²⁰

Fragmented, Poorly Coordinated Care and Unacceptably Wide Variations in Quality. Even patients with insurance coverage are at risk, due to a fragmented, poorly coordinated care system that relies on paper medical records. Basic information about allergies, medications, medical history, or recent diagnostic or lab test results does not follow patients through the health care system. As a consequence, patients confront duplication and delays when records are not available as needed, wasting time and resources and putting patients at risk for medical errors. Nearly half of all adults encounter breakdowns in care coordination or instances of flawed information exchange (Exhibit 8).²¹ An estimated 75 percent of hospital readmissions for Medicare beneficiaries are potentially preventable with well-managed care during transitions and effective hand-offs as vulnerable patients leave the hospitals.²²



Across the U.S., where you live, where you receive care, and insurance status matter significantly in terms of care experiences, health outcomes, and costs.²³ There are, indeed, centers of excellence and benchmarks of high performance within the U.S., but average performance is well below benchmark level, and the bottom tier of performance is often far below average. This unacceptably wide variation in quality indicates opportunities to improve.

Physicians and patients often lack comparative information about the relative clinical effectiveness or costs of alternative treatment choices, including medications and technologies. Despite a proliferation of expensive procedures, devices, and prescription medicines, there is no systematic way of comparing or assessing current practices or new technologies. A recent study noted the U.S. health system operates with a pervasive “information deficit”²⁴ without the information infrastructure necessary to measure, compare, and improve the way care is organized and delivered.

Misaligned Incentives. Delivery of ineffective, duplicative, and often unsafe and wasteful care is fueled by the current fee-for-service payment system, which rewards volume rather than value. Physicians and hospitals face strong incentives to fragment rather than integrate and coordinate the care necessary for promoting health and achieving better patient outcomes.

Current payment systems do not reward or support the spread of delivery systems that provide a continuum of preventive, acute, and chronic care and deliver better results more efficiently. As a result, patients and families are often on their own to find the best specialists and hospitals for their conditions and to patch together medical information and advice from multiple providers. Simply put, no one is accountable for the total care of the patient. Moreover, medical record systems that contain all of a patient’s relevant medical history, test results, and treatment information from multiple providers are rare. These exist only in a few integrated delivery systems that care for fewer than one of 10 Americans. Even in such systems, current payment incentives can be misaligned and fail to support better quality and health outcomes. Care systems can actually lose money by providing higher quality, better outcomes, and lower costs.²⁵

Payment systems undervalue primary care and fail to pay in a way that would encourage the development of high-quality, patient-centered medical homes with the capacity to provide timely access and coordinated care to patients.^{26,27} This would include expanded primary care capacity to work as teams, 24-hour access, support of clinical information systems, and management of chronic conditions. As a consequence, opportunities to

intervene early to prevent the onset of the disease are largely overlooked in lieu of high-cost, intensive medical care once illness has become acute or severe.

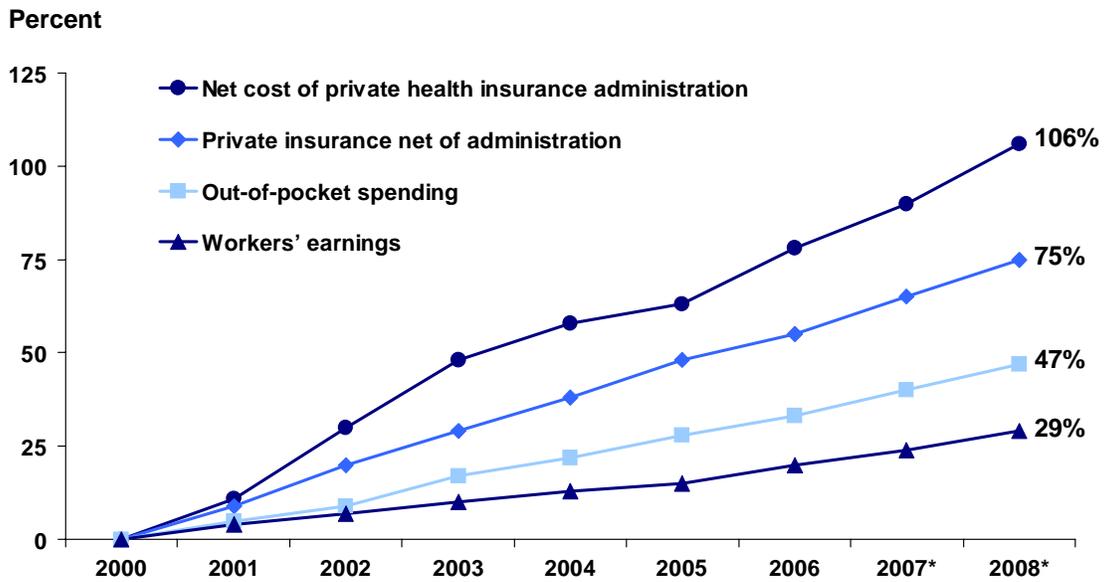
Insurance benefit designs that impose high cost-sharing for essential preventive care and effective medications put patients at risk and are misaligned with efforts to hold physicians accountable for providing recommended care. Failure to design benefits with a focus on value undermines effective care and can result in increased costs.²⁸

Churning in and out of coverage poses further health risks to patients. Gaps for low-income patients with chronic disease result in increases in admissions to the hospital for complications that could have been avoided with continuous access.²⁹

In addition to fragmenting care, discontinuity of insurance coverage increases administrative costs and erodes incentives to invest in population health and disease prevention for the long term.³⁰ Further, competing private insurance plans can often gain at the margin by using benefit designs that segment patients by health risk or deny coverage and care to the sickest. For instance, by limiting benefits for chemotherapy without regard to effective care or cost-sharing, insurance companies can lower premiums. However, this strategy makes little sense in terms of meaningful access, financial protection, or paying for delivery of the right care to very sick patients.

The complexity and fragmentation of the current insurance system add cost without value. Net costs of private insurance administration, including underwriting, marketing, claims payment, and profit margins have grown faster than total health spending for the past decade—more than doubling from 2000 to 2008 (Exhibit 9).³¹ These costs do not include the internal costs to providers of multiple reporting forms, formularies, and prices for the same care, and proliferation of marginally different benefit designs. Insurance complexity results in additional staff and consumes physician time that could otherwise be devoted to patient care.

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2008



* 2007 and 2008 NHE projections.
 Data: Authors' calculations based on A. Catlin et al., "National Health Spending in 2006," *Health Affairs*, Jan./Feb. 2008; and S. Keehan et al., "Health Spending Projections Through 2017," *Health Affairs* Web Exclusive (Feb. 26, 2008). Workers' earnings from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2008*.

The combination of fractured insurance and a lack of comparative information on cost or clinical effectiveness undermine the ability of markets to work or reflect value (i.e., outcomes and total costs). This is especially true in more monopolized seller markets. The U.S. pays far more for specialized care or products than other nations.³² A recent study found the U.S. pays 50 percent more for comparable drugs and pays for a more expensive mix of drugs than do other developed countries.³³ The U.S. also pays more for surgical devices such as hip and knee prostheses.³⁴

Rising costs are putting families, businesses, and federal, state, and local budgets under severe stress. With deteriorating coverage and broad evidence of poor quality and wasteful care, our health care system is in a state of emergency. There is urgent need to act and change direction. We cannot afford to continue on our current path.

III. TAKING THE PATH TO HIGH PERFORMANCE: AN INTEGRATED SYSTEM APPROACH

A. What Type of Health System Do We Want? What Is Possible?

Moving in a new direction requires a vision of the care system we would like to have and a comprehensive set of policies to pave the way. With the overarching goals of improving health and providing more patient-centered and high-value care, the Commission envisions a high performance health care delivery system with the following key attributes:³⁵

- All patients have access to appropriate care, including after-hours care with multiple points of entry; care is patient-centered and responsive to patient needs.
- All clinically relevant patient information is available to all providers at the point of care; electronic information systems enable information to flow with patients.
- Care is well-coordinated among multiple providers, and transitions across care settings are well-managed.
- All providers—including nurses and all members of health care teams—are accountable to their patients and each other and collaborate to deliver safe, effective, efficient care with excellent outcomes.
- There is clear accountability for the total care of patients.
- The health system is continually innovating and learning to improve outcomes, patient experiences, and the value of care.

The delivery system would be supported by an insurance system that provides universal, affordable coverage; ensures access with financial protection; and allows individuals and families to select and stay with doctors and care systems. Payment systems would support and reward value. Information systems and efforts to promote population health would drive strategies to improve. Primary care physicians and nurses providing care in small practice settings would receive assistance to ensure the best care for patients, including access to information and specialized services for patients with complex conditions.

To move quickly in a more positive direction for families, businesses, federal, state and local governments, and the nation will require an integrated system approach. We need national leadership and a comprehensive and coherent set of mutually supporting insurance, payment, and system reforms that will improve health, enhance the patient experience, and increase value while significantly slowing cost growth.

B. An Integrated System Approach: Commission Recommendations

The Commission envisions a set of mutually supporting policies, in which reforms to extend affordable health insurance for all are designed to provide a foundation for payment and system reforms. The goal of this integrated approach is systemic change in which insurance, payment, and system reforms interact to yield a more patient-centered delivery system that achieves high-value outcomes (i.e., quality and costs) within a culture of continuous learning.

The Commission developed the set of policies based on a diagnosis of factors contributing to poor performance and opportunities to improve. Given the multiple sources of poor access, quality, and inefficient care, multiple policies designed to work together are necessary. No single policy is sufficient to achieve high performance.

In this context, the Commission offers the following set of recommendations for a framework for comprehensive policy reforms, organized into five strategic areas.

1. Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform

The Commission sought an insurance expansion design that would provide affordable insurance for everyone, with continuity, ensured access, and financial protection, and at the same time provide a foundation for payment and other system reforms. With the goal of rapid progress, the Commission also sought a design that could foster a new competitive dynamic in insurance markets, focused on better outcomes and lower costs with lower insurance-related administrative costs.³⁶

The insurance framework proposed here draws on concepts included in President Obama's proposal for insurance expansion and earlier work sponsored by the Commission.³⁷ It would build on current public and private insurance coverage while offering new choices. The central feature of the reform is a new health insurance exchange that would operate nationwide, and also at state or regional levels. The exchange would offer a choice of private plans and a new public plan to the under-65 population. The public plan would include benefits and payment policies designed to enhance the efficiency and effectiveness of care. There would be positive incentives for providing evidence-based preventive care, acute and chronic care, and behavioral health services. This new public plan would build on Medicare's provider networks and claims administration. Insurance market reforms would require community rating and guaranteed issue and renewal inside and outside the exchange and would prohibit underwriting based on health risks.

To ensure affordability and reach near-universal coverage, everyone would be required to have insurance with income-related premiums available to make coverage affordable. Acute care coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) would be expanded to all low-income households, including childless adults, and Medicare's two-year waiting period for the disabled would be eliminated. To share responsibility for financing, all employers would be required to share in the costs of coverage, either by providing coverage directly or contributing to a national insurance trust fund to finance coverage. In effect, the framework would provide new health insurance choices while allowing continuation of current coverage for those for whom it is working well.

This coverage framework provides a new foundation for payment and other system reforms. All payment reforms described below would apply to the new public plan, Medicare, and Medicaid. To promote equity for Medicaid beneficiaries and simplify and integrate public program payment policies, Medicaid rates would be raised to Medicare levels, with the federal government providing enhanced matching funds to offset added state costs.

Building on the current mixed private and public coverage system to make affordable health insurance and access universally available, ensure continuity, *and* provide a foundation for payment and system reforms, the Commission recommends policies to:

- Establish a health insurance exchange that offers an enhanced choice of private plans and a new public plan.
 - i. The new public plan would offer comprehensive benefits with incentives for disease prevention and payment methods that reward results. It would build on Medicare's claims administrative structure and national provider networks.
 - ii. The national exchange would operate at state and regional levels to enable participation of regional private health plans and integrated delivery systems.
- Require individuals to have coverage and employers to offer coverage or contribute to a trust fund, with shared a responsibility to pay.
- Provide income-related premiums to make coverage affordable.
- Expand eligibility for and improve payment under Medicaid/SCHIP to enhance affordability and access and eliminate the two-year waiting period for the disabled.
- Set a minimum benefit standard to ensure access and adequate protection from the financial burden of obtaining needed health care.

- Reform health insurance markets to improve insurance efficiency, access, and affordability by prohibiting premium variation based on health and guaranteeing offer and renewal of coverage regardless of health status.

Section IV of this report describes policy specifications used for purposes of modeling and presents results of the analysis.

2. Aligned Incentives and Effective Cost Control: Payment Reform to Enhance Value

The Commission recommends changing the way we pay for care to reward value and to encourage reorganization of care so that it is accessible, coordinated, and responsive to patient needs. The recommended payment reforms would strengthen primary care, accelerate the development of patient-centered medical homes, and move away from the current fee-for-service system to more “bundled” payments for care. The reforms would provide a graduated set of incentives to move from the current fragmented delivery system to more coordinated, integrated care. Pricing signals would encourage the most efficient, effective care. New payment methods would include accountability for outcomes, patient experiences, and prudent use of resources—all largely absent at this time—ensured by reporting requirements and incentives.

There are a range of payment reforms that would achieve these objectives, including global fees, shared savings, and variations on mixed capitation/fee arrangements, including full capitation for integrated systems. Ideally, payment reform would proceed with a series of incremental changes and pilots or test cases that could spread to a wider range of organizations, depending on their ability to manage and accept responsibility for a progressively larger bundle of services.³⁸ New payment methods could stimulate as well as support delivery system innovation to move toward more effective, efficient care arrangements. Innovations in care arrangements could then facilitate further changes in payment methods over time.

To move away from the current fee-for-service system toward a payment system that emphasizes value, rather than volume, the Commission recommends changing the way Medicare and public programs pay for care with policies that:

- Strengthen and reinforce patient-centered primary care through enhanced payment for primary care services, including changing the relative value of primary care over time through differential payment updates.

- Encourage the adoption of the medical home approach by offering new per-patient payments for patient-centered primary care practices that ensure access and coordination, with positive incentives for patients to participate.
- Promote more effective, efficient, and integrated care by moving to more bundled payments for care needs over a period of time with shared savings and incentives tied to high performance.
- Correct pricing signals to better align payments with value and stimulate spread of more efficient, effective care systems.

In the analysis, all these changes would apply to the public plan offered through a national insurance exchange, Medicaid, and Medicare. Private payers are assumed to incorporate these changes to the extent they are attractive and feasible.

3. Accountable, Accessible, and Coordinated Care: Organize and Redesign the Delivery System to Improve Patient Experiences

The Commission envisions a care system in which patients have personal sources of care who know them, serve as advocates to help get the care needed, help coordinate care, and are accountable for the best possible health outcome results. Toward this end, the Commission recommends policies that:

- Have patients designate a source of care that meets standards of accessibility, communication, and care coordination and can serve as a medical home.
- Facilitate appropriate care and managing chronic conditions through integrated delivery systems that provide a continuum of care or funding and technical assistance for statewide and community efforts to support and connect primary care and more specialized resources in informal and virtual networks.
- Develop provisions in which providers participating in a hospital–physician organization receiving bundled payments would be eligible for medical liability coverage on favorable terms.

4. Improving Quality and Health Outcomes: Investing in Infrastructure and Public Health Policies

Information systems as well as payment reforms will be essential to support more integrated, patient-centered care and to encourage a culture of continuous learning.

Health information technology (HIT), including clinical decision-making, is a prerequisite for supporting systemic efforts to improve and coordinate care. In addition,

patients and physicians need better information to guide clinical decisions and compare alternatives. Information to assess the comparative effectiveness of different ways of managing conditions can support better pricing and value-based benefit designs.

To promote patient-centered care and innovation, the Commission recommends improving the availability and usefulness of information and encouraging continuous learning, using actions to:

- Accelerate adoption and effective use of HIT, by establishing standards for systems, requiring electronic reporting of clinical information, and providing start-up funding for a national health information network to allow information to follow the patient and be available to providers and patients.
- Support and inform better health care decision-making by establishing a Center for Comparative Effectiveness and Health Care Decision-Making, encouraging shared decision-making based on evidence and using recommendations to develop value-based benefit designs that preserve choice but encourage appropriate care.
- Provide more transparent information to guide and drive innovation by requiring all-population, all-payer quality, patient experience, and cost data, with benchmarks for top performance.

The information produced by these policies must be transparent. That is, it must be available, consistently defined, understandable, and relevant, as well as formatted for effective use in decision-making.

Improving health requires a comprehensive approach to preventing disease, managing chronic conditions, and implementing public health initiatives. The leading chronic diseases—diabetes, asthma, congestive heart failure, coronary artery disease, and depression—account for a disproportionate share of national health expenditures each year, including early onset of acute conditions and complications. The nation could lower health risks and help people lead healthy and productive lives by focusing on early prevention and managing conditions to slow or prevent the progression of disease.

To improve population health, lower the rates of preventable illness, and improve health outcomes for chronic conditions, the Commission recommends a comprehensive approach to:

- Target public health initiatives on prevention of illness, including expansion of effective immunizations and programs and incentives to reduce obesity, decrease tobacco use, and promote healthy lifestyles.
- Design value-based health insurance benefits to encourage and support preventive and essential care for chronic conditions, with incentives to participate.
- Intensify the focus on preventing and managing chronic conditions with incentives for coordinated care and goals to improve outcomes for chronic conditions.

5. Accountable Leadership: Coordinated Efforts to Improve the Health System

All of the above reforms require setting goals, leadership with authority to implement policies, and collaboration across the health care system. To implement policies and foster collaboration, the nation needs to establish mechanisms for setting and achieving national goals and ensuring coordination of practices and policies that cut across public programs and private sector activities. In addition to insurance reforms, these leadership efforts would include national efforts that:

- Set performance targets and provide incentives and assistance to meet them.
- Authorize public programs, including Medicare, to be active purchasers of high-value health care, rather than passive payers. This would include implementing and facilitating the adoption and rapid spread of innovative payment policies to elicit a more effective, efficient, and responsive delivery system.
- Create a national insurance exchange, operating at national and state/regional levels to enable participation of regional private plans and integrated systems.
- Establish a center for comparative effectiveness and health care decision-making.
- Set national standards to accelerate adoption and use of HIT and enable a national health information network.

IV. POLICY SPECIFICATIONS USED FOR MODELING AND ESTIMATED IMPACTS

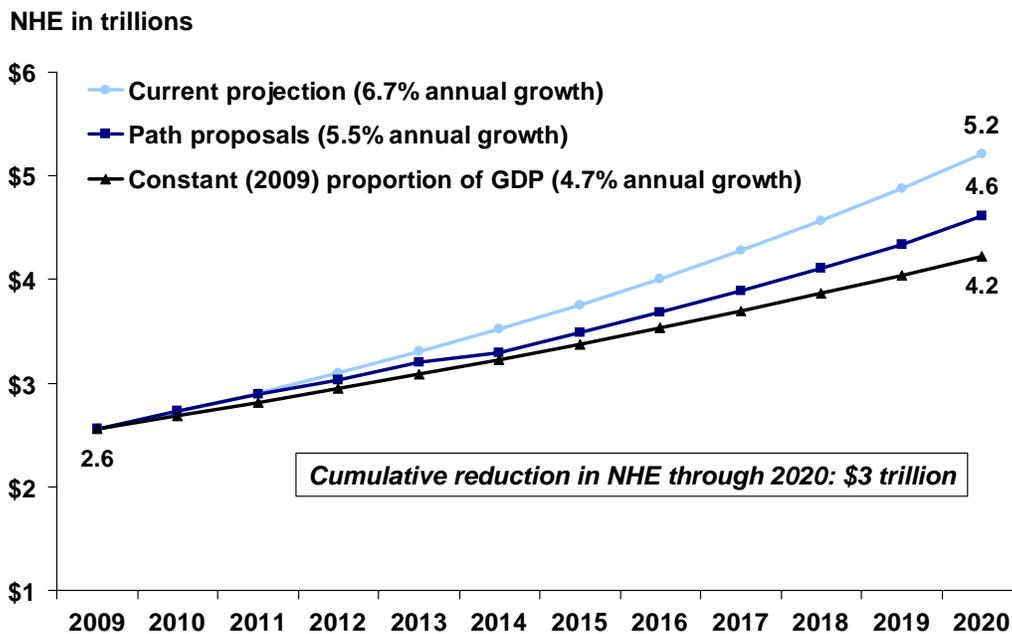
The Commission recommendations encompass a broad range of policy variations. To examine the potential for change by 2020, Commission staff developed specifications to illustrate each set of policies. Using these specifications, The Lewin Group estimated the impact of the policies on the trajectory of costs and coverage compared with projections under the current system.³⁹ All estimates assume the policies are enacted as a group in 2010 and assess the effects through 2020.

This section presents the specifications and overall results of the policies used in the analysis.

A. Overview: Impact on Cost and Coverage Compared with Projected Trends

The modeling analysis indicates that if the policies were implemented in 2010, it would be possible by 2020 to achieve a high performance health system with access for all, better health outcomes, and patient experiences—and, in the process, reduce the growth in national health spending by a cumulative \$3 trillion compared with current projections (Exhibit 10). This substantial sum is the accumulation of incremental savings each year, with a reduction in the projected annual rate of growth in national health expenditures from 6.7 percent to 5.5 percent. Notably, even after this substantial reduction, national health spending still would exceed the projected annual growth in gross domestic product (GDP). Although the percent of GDP spent on health care would be lower in 2020 than what is currently projected—18.4 percent of GDP compared with the projected 20.8 percent—it would account for a higher share of the U.S. economy than in 2009 (16.9 percent).

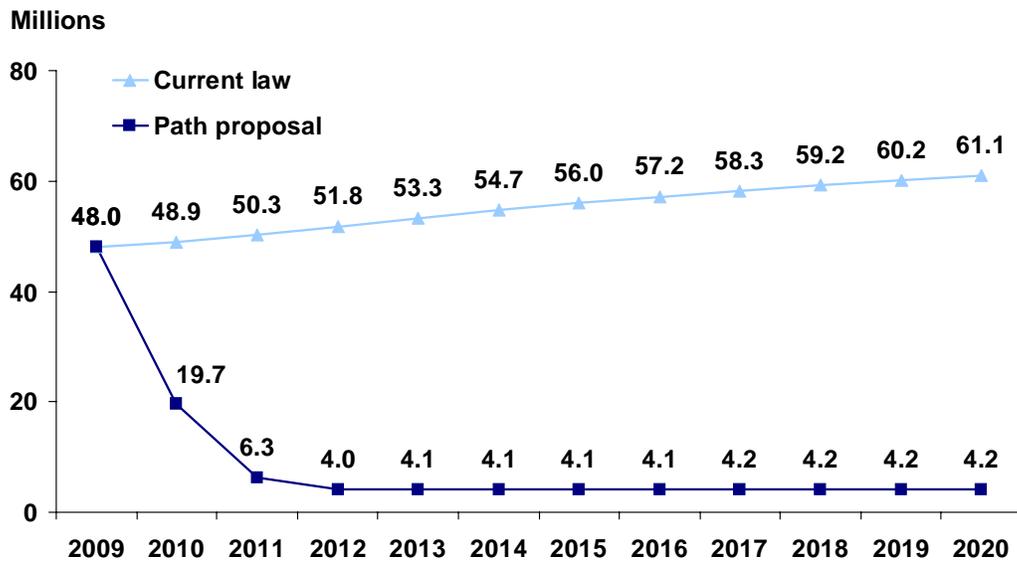
Total National Health Expenditures (NHE), 2009–2020 Current Projection and Alternative Scenarios



Note: GDP = Gross Domestic Product.
 Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Designed to extend affordable insurance to everyone and provide a foundation for essential health system reforms, the insurance framework would achieve near-universal coverage, insuring all but 1 percent of the population. The number of uninsured would drop to 4 million, compared with a projected increase to 61 million (Exhibit 11). As discussed below, the insurance reforms would also lower premiums and ensure access and continuity.

Trend in the Number of Uninsured, 2009–2020 Under Current Law and Path Proposal



Note: Assumes insurance exchange opens in 2010 and take-up by uninsured occurs over two years. Remaining uninsured are mainly non-tax-filers.
 Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Changing the payment system to emphasize value; organizing the health care delivery system to ensure care is easily accessible and well coordinated; investing in information to guide and drive better care, outcomes, and innovation; and promoting population health and disease prevention could catalyze patient-centered care and create a culture of health improvement, continuous learning, and high performance. All major stakeholders—families, businesses, and public sectors—would gain from improved health and slowed growth in health spending.

The policies are mutually supporting. Insurance design, payment reform, and information systems would interact to achieve dynamic change. At the same time, each reform contributes to enhancing value by achieving savings and improving the quality and outcomes of health care (Exhibit 12). The estimated net cumulative savings by 2020 indicate that all the major policy components included in the analysis have the potential to slow the growth of spending significantly.

Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020

Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform

- Net costs of insurance expansion –\$94 billion
- Reduced administrative costs –\$337 billion

Payment Reform: Aligning Incentives to Enhance Value

- Enhancing payment for primary care –\$71 billion
- Encouraging adoption of the medical home model –\$175 billion
- Bundled payment for acute care episodes –\$301 billion
- Correcting price signals –\$464 billion

Improving Quality and Health Outcomes: Investing in Infrastructure and Public Health Policies to Aim Higher

- Accelerating the spread and use of HIT –\$261 billion
- Center for Comparative Effectiveness –\$634 billion
- Reducing tobacco use –\$255 billion
- Reducing obesity –\$406 billion

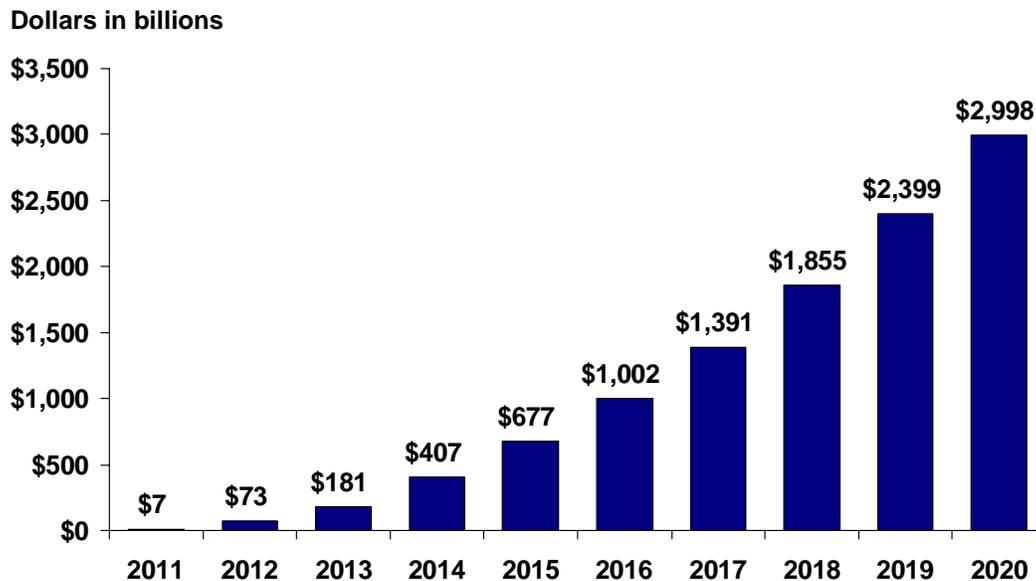
Total Net Impact on National Health Expenditures, 2010–2020 **–\$2,998 billion**

Data: Estimates by The Lewin Group for The Commonwealth Fund.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

The potential savings build and accumulate over time. National expenditures are expected to continue to grow by nearly 7 percent per year, starting on a base of \$2.6 trillion. Thus, slowing the pace of growth adds up quickly to substantial savings (Exhibit 13).

Cumulative Savings of Coverage, Payment, and System Reform Policies on National Health Expenditures Compared with Baseline, 2010–2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

The following sections discuss the goals and principles that guided development of policies in each of the five strategic areas. Each section provides details of policies used in modeling and results of the analysis.

B. Affordable Coverage for All: Essential Foundation for System Reforms

1. Insurance Framework and Principles

The insurance reforms specified for analysis build on concepts included in President Obama’s proposal for insurance expansion and on earlier work sponsored by the Commission.^{40,41} As a framework for coverage expansion, the Commission sought a design that would: 1) expand affordable coverage to all and ensure access with continuity; 2) stimulate a new competitive dynamic among insurers and providers, focused on better outcomes and cost performance; 3) build on current public and private insurance; 4) ensure coverage regardless of health status; and 5) provide for equitable financing with shared responsibility.

The Path analysis includes a national insurance exchange that offers a choice of private plans and a new public plan. Modeled on the Massachusetts “connector” concept, as well as approaches used by the Netherlands and Switzerland, the insurance exchange would

establish basic standards, include insurance market reforms, and provide publicly transparent, Web-based comparisons of choices to facilitate enrollment. The exchange would operate at both the national and state or multistate regional level to allow local or regional health plans to participate.

To minimize disruption in current insurance arrangements, the expansion builds on and expands public and private group insurance options. To reach near-universal coverage and ensure affordability, the design includes a requirement that everyone have insurance and provides for income-related premiums to make coverage affordable.⁴² The requirement to have coverage would be enforced through the tax system, with tax credits and automatic enrollment facilitating participation.⁴³

The design also expands Medicaid/SCHIP acute care benefits to low-income families, including childless adults, with full premium assistance and low cost-sharing. Medicaid rates are equalized with Medicare to ensure access and coordinate public program payment policies. To achieve equitable financing across employers, all employers would either offer and provide coverage or contribute to a national trust fund for coverage.

To ensure access regardless of health risks and pool risk broadly, national market reforms would require community rating and guaranteed issue and renewal and would prohibit underwriting based on health status or underlying conditions. Nationwide insurance rules would apply inside and outside the insurance exchange.

2. Coverage Specifications Used for Modeling

Estimating the potential impact on coverage and costs required specifying each of the above elements. The summary box below lists specifications used in modeling.

A central feature of the design is an insurance exchange, offering expanded choices of private plans and a new public plan option. Offered through the exchange, the new public plan option would use Medicare's provider networks and claims administration while modernizing payments and benefits. To avoid the need for supplemental coverage, benefits would include a comprehensive package similar to large private employer group coverage or the standard option offered to federal employees and members of Congress with value-based benefits that encourage prevention and essential care (Exhibit 14). As discussed in the sections on payment, cost-sharing and deductibles would be lowered to provide positive incentives to designate a primary care practice as a medical home or to encourage care essential to managing chronic conditions.

**Benefit Design for Medicare-Sponsored Public Plan
Offered in Insurance Exchange**

	Current Medicare benefits*	New Public Plan in Exchange
Deductible	Hospital: \$1,024/benefit period Physician: \$135/year Rx: \$275/year**	Hospital/Physician: \$250/year for individuals; \$500 for families Rx: \$0
Coinsurance	Physician: 20% Rx: Depends on Part D plan	Physician: 10% Rx: 25% Reduce for high-value & chronic disease care/medical home Preventive services: 0%
Ceiling on out-of-pocket	No ceiling	\$5,000 for individuals \$7,000 for families
Insurance-related premium subsidies	Medicare Savings Programs Low-Income Subsidy	Premium cap ceiling of 5% of income for low-income beneficiary premiums or 10% if higher income

* Basic benefits before Medigap.

** Part D coverage varies, often deductible. Most have "doughnut" hole and use tiered, flat-dollar copayments.

Note: Benefit design also would apply to Medicare Extra supplement option available to Medicare beneficiaries.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

The exchange would be initially open to individuals and small employers (i.e., those with fewer than 100 employees). In three years (2012) it would open to employers with fewer than 500 employees. In five years (2014) it would open to all employer groups. To avoid fragmentation of employer groups, in firms that offer group coverage, employees would only be eligible to buy through the exchange if the employer elected this arrangement for all employees.

This framework provides a foundation for more affordable coverage and choices and for payment and system reforms. All payment reforms described below that apply to Medicare would also apply to the new public plan. To streamline public purchasing and improve access for Medicaid beneficiaries, the reforms increase Medicaid payment rates to Medicare levels, with an increase in federal matching rates to offset costs to states.

Affordable Coverage for All: Elements of Insurance Expansion Used in Modeling

- National insurance exchange to enable coverage continuity and affordable choices
 - Connector offers a choice of private plans or a new Medicare-sponsored public plan to the under-65 population
 - The public plan would use Medicare provider networks and claims administration; it would have modernized benefit design and payment reforms
 - National exchange would also operate at the state or multistate regional level to enable local health plans to participate
 - Starting 2010: open to individuals and small employers (fewer than 100 employees)
 - Would open to larger employers (fewer than 500 employees) in three years (2012) and all employers in five years (2014)
- Insurance market reforms to focus competition on outcomes and value
 - National minimum standard of benefits: emphasis on value-based design elements, prevention
 - Community rating, with guaranteed issue and renewal; prohibit premiums based on health risk (i.e., no underwriting)
 - Insurance rules operate inside and outside the exchange
 - Transparent posting and comparison of insurance choices
 - Provisions for electronic enrollment and administrative simplification
- All individuals required to participate; income-related premiums for affordability
 - Income-related premium: cap at 5 percent of income for low income; 10% higher income
 - The premium rate used to calculate assistance would be benchmarked to the lowest cost plan (identified as the public plan in this analysis).
- All employers required to offer coverage or contribute to a trust fund to share financing (7 percent of payroll expenses, up to \$1.25 hour)
- Medicaid/SCHIP expansion to low-income persons
 - Expand to 150 percent of poverty for acute care, including childless adults
 - Provide full premium and low cost-sharing; option to choose exchange plans
 - Medicaid payment rates would be raised to Medicare level
 - Federal match enhanced to finance the expansion and offset state costs
- Medicare reform for current beneficiaries (aged and disabled)
 - Eliminate the two-year waiting period for disabled
 - Offer new Medicare Extra benefit supplement to avoid the need for Medigap/Part D (same benefit design as offered in new public plan)

3. Impact of Path Insurance Expansion on Coverage and Affordability

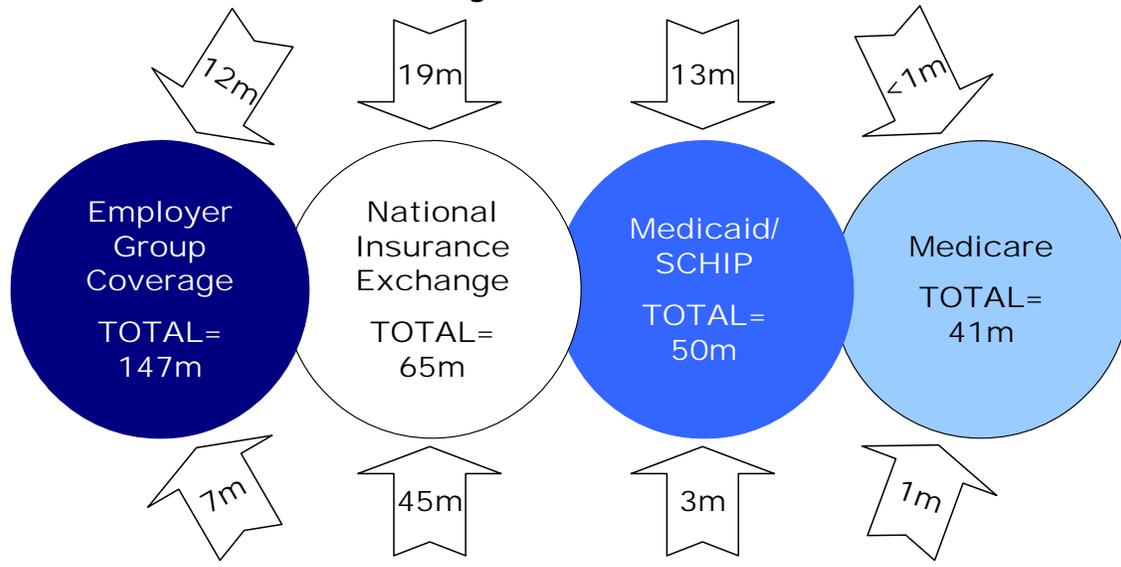
The shared responsibility insurance expansion approach described above would achieve near-universal coverage. The number of uninsured would drop from an estimated 48 million in 2009 to 4 million (with 1 percent remaining uninsured) by 2012 when fully implemented. Without such action, the numbers of uninsured are projected to rise to 61 million by 2020.

By building on existing insurance coverage, this insurance framework would permit individuals to keep their current coverage if it works for them, while providing new choices through the insurance exchange. When open to individuals and small firms, the approach would initially retain roughly the current balance between private and public insurance coverage.

Employer groups and individuals buying coverage through the insurance exchange would have choices and be able to keep coverage over time, promoting continuity of care and coverage. Medicare's nationwide network of providers and claims administration would be available to all, as would national and regional private plan choices. The modeling estimated the exchange would cover about 65 million people initially—approximately two-thirds enrolled in the public plan and one-third in private plans. Three-fourths of the uninsured would obtain coverage under Medicaid, SCHIP, or through the insurance exchange. The expansion would improve coverage for an estimated 57 million currently insured individuals who switch to new sources, as less expensive or better choices become available (Exhibit 15).

**Path to High Performance Foundation:
Automatic and Affordable Health Insurance for All in 2010**

New Coverage for 45 Million Uninsured



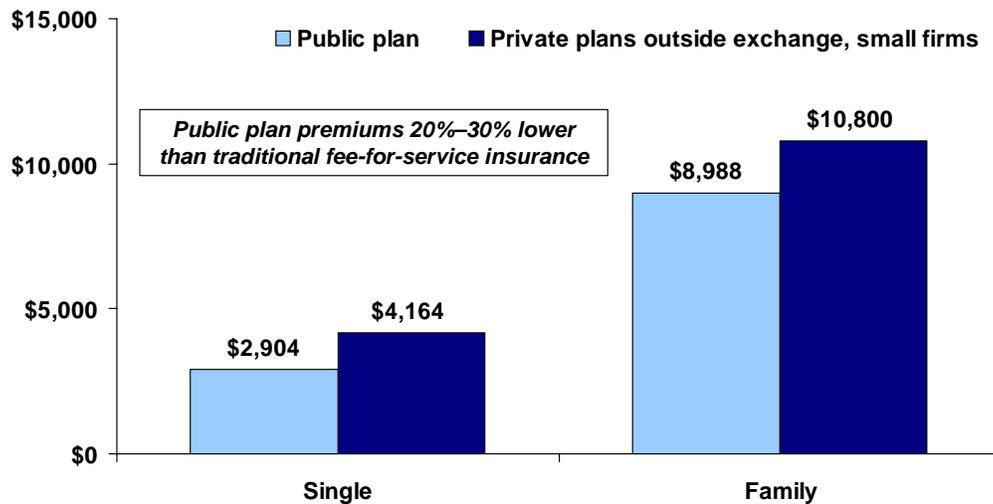
Improved or More Affordable Coverage for 57 Million Insured

Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

The new public plan would provide a less expensive option for covering the uninsured, due to savings in administrative costs and use of Medicare provider payment rates. The modeling estimates that premiums for the public plan would be at least 20 percent below a comparable benefit package for those insured through fee-for-service insurance plans in private individual and group markets (Exhibit 16). This advantage comes from a lower share of the premium for administrative overhead (public plan administrative costs would be an estimated 30 percent to 65 percent lower depending on group size) and the effect of lower provider payments (see [Appendix Exhibit A-1](#)). The modeling assumes rates paid by fee-for-service private insurance plans do not decline substantially once the country reaches near-universal coverage and Medicaid rates rise to Medicare levels.

Estimated Premiums for New Public Plan Compared with Average Individual/Small Employer Private Market, 2010

Average annual premium for equivalent benefits at community rate*



* Benefits used for modeling include full scope of acute care medical benefits; \$250 individual/\$500 family deductible; 10% coinsurance for physician service; 25% coinsurance and no deductible for prescription drugs; reduced for high-value medications; full coverage checkups/preventive care. \$5,000 individual/\$7,000 family out-of-pocket limit.
 Note: Premiums include administrative load.
 Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

With the advantages the exchange would offer in terms of premiums and choices, the modeling estimates that most of the market would move into the exchange over time. Because it does not offer provisions for risk equalization across the insurance market, it is possible that self-insured larger employers with lower risks might stay out of the exchange. This could apply upward pressure on premiums in the exchange due to risk selection. However, the relatively healthy mix of newly eligible uninsured and the requirement that all employees of a given employer participate as a group would help mitigate such a possibility.

Once the exchange opens to all employers, the modeling estimates that this premium advantage plus the nationwide network and range of choices would result in most of the employer and individual market moving into the exchange over time. When open to all employers, about half of the population would buy coverage through the exchange (Exhibit 17).

Exhibit 17. Current Coverage and Estimated Distribution with Insurance Exchange, New Public Plan, Market Reforms, and Individual Mandate, 2010

Source of Coverage	Population Distribution in 2010			
	Under Current Law	Under Reforms and Insurance Exchange, if Exchange Open to		
		Individuals and firms with less than 100 employees	Individuals and firms with less than 500 employees	All individuals and employers
Total (millions)	307.1	307.1	307.1	307.1
Insurance Exchange*	0.0	64.6	81.2	157.5
Employer	0.0	45.9	62.8	140.5
Individual	0.0	18.7	18.4	17.0
Private Direct Purchase				
Employer**	163.5	147.2	130.9	55.1
Individual	14.3	1.1	1.1	1.1
Medicare***	38.9	40.5	40.5	40.5
Medicaid/SCHIP	41.5	49.5	49.4	48.8
Uninsured	48.9	4.0	4.0	3.9

* Modeling estimates about one-third would enroll in private plans and two-thirds in the public plan, if private plans are unable to reduce the premium differential.

** Employer includes active employees, retirees, and TRICARE.

*** Medicare includes those dually eligible for Medicaid and Medicare.

Note: The exchange would initially be open to small firms in 2010, to firms with less than 500 employees in 2012, and to all employers in 2014. For purposes of comparison, above estimates are based on population distribution in 2010.

Data: Estimates by The Lewin Group for The Commonwealth Fund.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

By using Medicare payment rates for the public plan option, the currently insured who opt for this choice would most likely obtain coverage at lower costs than what they currently pay. Raising Medicaid payment rates to Medicare rates would help equalize access for Medicaid beneficiaries and streamline public payer policies. Covering the uninsured would free up federal funds now used for “disproportionate share hospitals.” Once everyone has insurance, these funds could be reallocated to finance Medicaid reforms. As in other countries, to the extent that some people remain uninsured—including undocumented workers—there would be a continued need for some direct funding for the uninsured.

Operating the exchange would involve administrative expenses. However, the public plan’s use of Medicare’s claims administration and a single benefit design would significantly reduce administrative costs over time. Compared with baseline projections, insurance administrative costs would decrease by an estimated cumulative \$337 billion

by 2020 (Exhibit 12). Notably, these estimates do not include the potential savings to provider administrative costs if payer processes and payment policies were simplified, streamlined, and coordinated.

C. Payment Reform: Aligning Incentives to Enhance Value

Our health care delivery system is fragmented. There is poor coordination of care across providers, services, and settings; poor communication among providers, patients, and families; a focus on high-cost, intensive medical interventions rather than high-value primary care; and a lack of accountability for patients' treatments, outcomes, and efficiency of resources used.

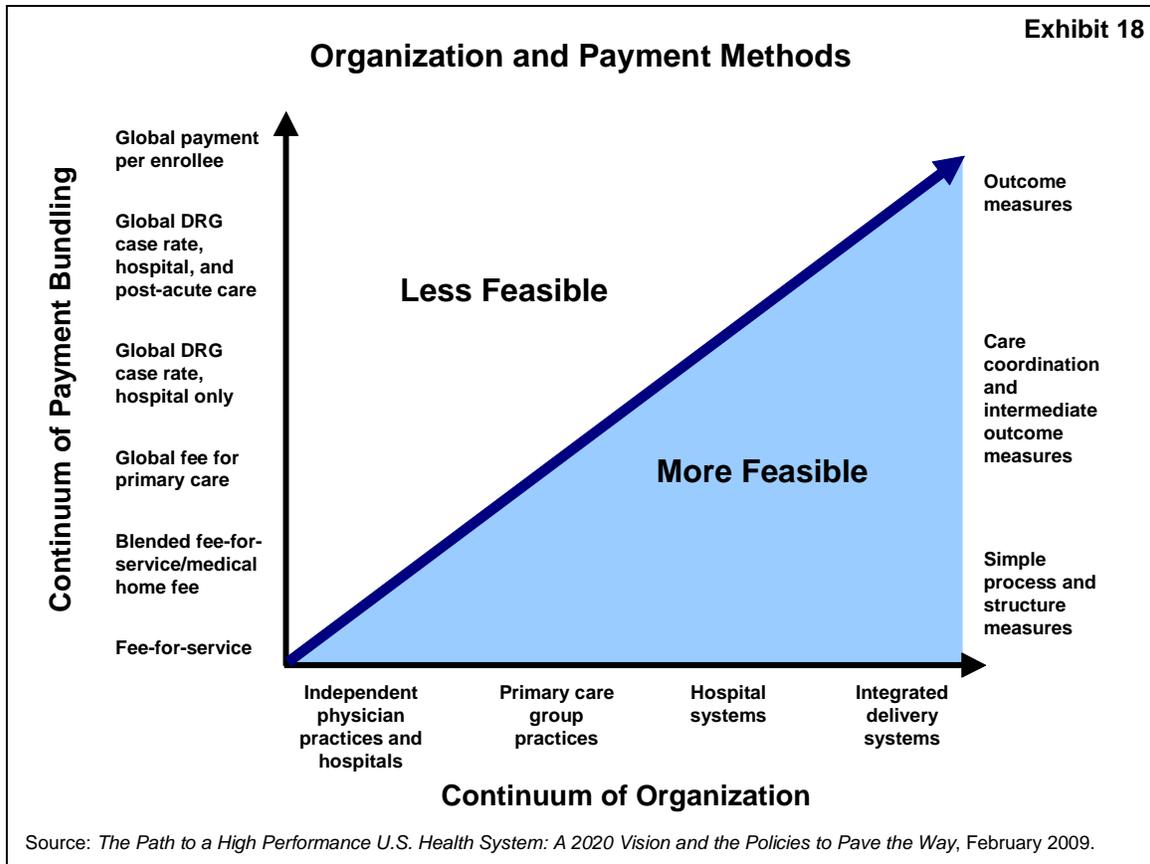
This fragmentation is fueled by the way we pay for health services. Fee-for-service payment emphasizes the provision of health services by individual providers, rather than health care coordinated across providers to address patients' needs. It undervalues primary care and preventive care and provides incentives to use more complex services, even when better, simpler, and lower-cost treatments are available. Care coordination is often not rewarded or even compensated.

The payment reforms recommended by the Commission seek to address this shortcoming by enhancing the value of patient-centered primary care and paying for more cohesive bundles of services that encourage and enable providers to consider their patients' needs and provide more appropriate, integrated, and efficient care.

1. A Framework for Payment Reform

Payment and health care delivery are closely linked. As payment changes, those who deliver care will innovate in response to new incentives. The right incentives can encourage providers to work together—either in formal relationships or less formal arrangements—in ways that allow them to take broader responsibility for the patients they treat and the resources they use and benefit from doing so. As organizational arrangements evolve, payment methods can be adjusted to encourage and reward increasing levels of accountability, with continuous development and improvement over time.

The concept of using payment to stimulate more organized care with greater accountability for outcomes and cost is illustrated below (Exhibit 18). The goal is to move up the gradient to more integrated arrangements that provide patient-centered, high-value, coordinated care.⁴⁴



Specific payment policy changes included in the analysis described below would:

- enhance payment for primary care by revising the Medicare fee schedule;
- encourage adoption of the medical home model to promote coordinated care;
- implement bundled payment for acute care episodes to encourage integrated care; and
- correct price signals in health care markets to align payments with value.

These policies replace the adverse incentives provided by the current fee-for-service system with reforms to spur the reorganization and reorientation of the health care delivery system.

2. Payment Reform Specifications Used for Modeling

To illustrate the potential impact of payment reform, the Commission has identified an array of payment policies that could be applied to providers of primary care and acute and post-acute care services. Together, these policies would emphasize accessible, high-quality primary care and encourage and enable providers to assume increasing accountability for coordinating care and managing resources during acute care episodes.

The goal of these reforms is to create incentives for health care providers to be accountable for the total care of patients, including health outcomes and prudent use of resources in the provision of care, to improve care coordination and reduce fragmentation of the delivery system and slow the growth of national health spending.⁴⁵ They build on the Commission's previous work on the ways in which payment reform and appropriate incentives could be used to move from the current fragmented system to organized, patient-centered, accountable health care delivery.⁴⁶

The analysis assumes that these changes would be applied to Medicare, Medicaid, and the public plan option offered through the national insurance exchange. The estimates assume the reforms would spread to commercial insurance over time, to the extent that they are attractive and feasible to implement.⁴⁷ The modeling highlights the potential for reduced cost growth as payment incentives encourage and support more integrated care.

3. Strengthening and Investing in Innovative Primary Care

A high performance health system would provide everyone with timely access, emphasize prevention and chronic care management, organize care around the patient, and coordinate care across settings. Every person needs a regular provider who is accessible, knows the patient's medical history and maintains a complete medical record that is accessible both to other providers and to the patient, and works with the patient to ensure care is appropriate, timely, coordinated, and focused on his or her needs. Such care requires the availability and use of robust clinical information systems, including medical records and additional functionality such as registries and decision support. This approach to high-quality, patient-centered primary care has been termed a "patient-centered medical home."

The Commission's vision includes changing the way we pay, to place a higher value on primary care services.⁴⁸ These policies could encourage medical professionals to choose careers in primary care to ensure an adequate and available workforce. The first set of policy changes would enhance the value of primary care. The second would encourage and support the adoption of patient-centered medical homes.

a) Enhancing Payment for Primary Care: Revising the Medicare Fee Schedule

The policy includes two features:

- **Adjusting the Relative Value Weights to Emphasize Primary Care Services**

The Medicare Payment Advisory Commission (MedPAC) recommended in its June 2008 *Report to Congress* that a payment adjustment be made for primary

care services billed under the Medicare physician fee schedule and furnished by primary care–focused practitioners.⁴⁹ The policy option modeled in this report provides a 5 percent increase in 2010 payment levels for evaluation and management services (other than those provided in hospital inpatient settings) provided by geriatricians, family practitioners, internists, and pediatricians, as well as nurse practitioners and physician assistants. Payment levels for other services are decreased so that the total amount of Medicare physician payments in 2010 would be unchanged.

- **Applying Differential Updates for Primary Care Services**

The modeling applied differential updates for primary care versus other services to enhance the value of primary care over time and slow the growth of payments for specialized care and procedures.

In addition, the modeling included a requirement that overvalued services (defined as the 100 fastest-growing procedures) be subject to prior authorization to be eligible for Medicare payment. This follows MedPAC’s recommendations in its March 2006 *Report to Congress* to identify overvalued services and revise payment for those services.⁵⁰

These policies would reduce the differentials between payments for primary care and other specialties. They would also slow the growth of spending for technical procedures, expensive diagnostic tests, and specialized care in cases where increasing volume has driven up total spending. These policies would reduce national health spending, relative to currently projected levels, by an estimated \$71 billion through 2020.

b) Encouraging Development and Spread of Patient-Centered Medical Homes

This payment policy would include a new per-patient payment in addition to traditional fee-for-service payments to support increased access to primary care services, more time spent with patients, and a team approach to care. Participating practices would be required to provide evidence of capacity to provide enhanced patient-centered care, with particular emphasis on ability to provide appropriate and coordinated care for persons with chronic conditions and multiple comorbidities. Positive incentives—reduced premiums or cost-sharing—would encourage patients to designate a primary care practice that meets the qualifications to serve as their medical home. The policy has three elements:

- **New Per-Patient Medical Home Payment**

Qualified providers who elect to participate in the program would receive a per-member, per-month medical home fee, in addition to all currently covered fee-for-service payments. The amount of the per-member, per-month payment would vary depending on the severity of illness of the enrolled patient.

- **Qualifications for Medical Home Status**

To qualify for participation in the program and for the medical home payment, primary care providers would need sufficient capacity. Qualifying factors would include:

- providing enhanced access (e.g., 24-hour coverage, timely appointments);
- using information technology to improve patient care (e.g., electronic health records with registries, reminders, e-prescribing, and clinical decision support);
- offering care management and care coordination services; and
- reporting quality and patient experience measures.

- **Incentives for Patients**

Positive incentives would be provided to encourage patients to enroll and designate a primary care practice. Medicare beneficiaries would receive a discount on their Medicare Part B premiums, funded by the savings achieved under the program. Those insured under the Medicare-sponsored public plan in the insurance exchange would have their deductibles waived and lower cost-sharing for primary care as incentives to designate a primary care home.

Savings in total health spending for enrolled groups would be shared by patients, providers, and payers. Participating providers could receive their share of savings as year-end bonuses based on performance on clinical quality and patient experience measures.

The medical home approach would be required for Medicaid beneficiaries. The Medicaid provision would build on similar efforts used in North Carolina and other states seeking to enhance chronic care management and provide for a team-based approach to enhance primary care.⁵¹

These policies would reduce national health spending, relative to currently projected levels, by an estimated \$175 billion through 2020.

4. Implementing Bundled Payment for Acute Care Episodes

New payment methods would apply to acute care episodes (including the hospital stay and 30 days post-discharge) to encourage hospitals and other providers to develop the capacity to provide high-quality and efficient care for their patients. By offering a bundled payment (i.e., a global fee covering a specified set of services), these reforms would provide an opportunity for hospitals and other providers to share savings from

reducing complications and readmissions and allow more flexibility in allocating resources. The size and scope of the bundle would be increased over time to allow providers time to respond to the increasing incentive to work together. The policy specified for purposes of modeling would evolve in stages:

a) Acute Care Global Case Rate

This policy would provide a single payment for a bundle of care that includes inpatient hospital services and extends for a period of 30 days after admission. The payment rate received by the admitting hospital would cover the initial stay and any additional hospital admissions that occur within the time period. Under this approach, hospitals would have an incentive to perform or arrange for follow-up care for patients they discharge to avoid the cost of readmissions. MedPAC estimates that 18 percent of Medicare patients are readmitted within 30 days of a hospital discharge and that 75 percent of these readmissions are potentially preventable, costing \$12 billion in 2005.⁵²

b) Including Post-Acute Care

This policy would include post-acute care (e.g., skilled nursing, home health) in the bundled payment. In doing so, providers in various settings will be encouraged to collaborate to ensure that patients receive post-discharge care in a coordinated, effective, and efficient manner. MedPAC's analysis indicates that 40 percent of Medicare hospital patients use some type of post-acute care after discharge and that 20 percent of those patients use multiple post-acute care services.⁵³ Variations in subacute care and hospital readmissions both account for significant variation in total costs per hospital episode.⁵⁴

c) Including Physician Inpatient and Emergency Room Care

By expanding the bundle of services to include physician care in inpatient settings and emergency rooms, physicians would become jointly responsible with the hospital for the coordination, effectiveness, and efficiency of care provided. Physicians have primary responsibility not only for the services provided during the hospital stay, but also for the choice of the hospital to which the patient is admitted. In addition, the physician plays a role in determining the setting to which the patient is discharged and providing follow-up care after discharge, either in a post-acute care setting or at home. Bringing all the providers under the same payment umbrella should encourage better communication and collaboration between physicians and hospitals.

Payment based on these successively more inclusive bundles would be phased in. The model starts in 2010, with the acute care global case rate applied to all hospitals currently under Medicare prospective payment (i.e., short-stay hospitals, excluding critical access

hospitals). The model expands the bundle to include post-acute care in 2013 and to include inpatient physician care in 2016. This phased approach would give providers time to prepare for the new system and give Medicare time to develop appropriate rates for the various bundles of care.

We anticipate that the incentives provided by progressively more bundled payments would lead to increasingly efficient resource use, with bonuses available for high performance on measures of clinical quality and patient experience. These policies would reduce national health spending, relative to currently projected levels, by an estimated \$301 billion through 2020.

5. Correcting Price Signals

Providing appropriate incentives that lead to more efficient and effective care also involves bringing health care prices in line with value. This report examines three such policies: slowing Medicare payment growth in high-cost areas; revising the way Medicare pays for certain drugs used by beneficiaries; and resetting benchmark rates used to determine payments to Medicare Advantage (MA) plans.

a) Slowing Medicare Payment Growth in High-Cost Areas

Moving from fee-for-service to bundled payments would make providers more accountable for outcomes and the allocation of health care resources. But the way those resources are used varies considerably across geographic areas—in Miami, Florida, Medicare spending per enrollee was \$14,359 in 2005, while in Rapid City, South Dakota, it was \$5,281.⁵⁵ To encourage more prudent use of resources particularly in high-cost areas, payment updates for all providers in each year could be based on total Medicare spending per beneficiary in each area relative to the national median. The update in each area would be adjusted to reflect the percentage difference between Medicare spending per beneficiary in the region and the national median, with the full update being applied for providers in low-cost areas (those with costs below the median), no update for providers in areas with very high costs (those with costs at least 20 percent above the median), and reduced updates (according to a sliding scale) for other areas with high costs (less than 20 percent above the median). The update adjustments would be recalculated each year, based on the most recent data on Medicare spending per beneficiary, so that areas that improve their costs relative to the national median can improve their payment updates over time. This policy would reduce national health spending, relative to currently projected levels, by an estimated \$223 billion through 2020.

b) Revising Medicare Payment for Certain Drugs

Policies to reduce prices paid for prescription drugs under Medicare involve three specific mechanisms proposed by Frank and Newhouse.⁵⁶ The first, drawing on the fact that Medicare plans currently pay higher rates for drugs used by dual-eligible beneficiaries than Medicaid pays for the same drugs, is a mandate that Medicare drug plans not pay more than the Medicaid rate for dual eligibles. The second, drawing on the fact that manufacturers of therapeutically unique drugs effectively have a monopoly, is that the Secretary of Health and Human Services be authorized to set the price for therapeutically unique drugs, using prices paid by other countries to identify a target range. The third calls for the Secretary to establish a purchasing collaborative of all public payers and allows large employers and multi-employer purchasing groups to participate voluntarily. These policies would reduce national health spending, relative to currently projected levels, by an estimated \$76 billion through 2020.

c) Resetting Medicare Advantage Benchmark Rates

Finally, the current mechanism for setting payment rates for private plans under MA overpays plans and fails to establish benchmarks for efficient care. In 2008, Medicare paid these plans an estimated \$8.5 billion more than their enrollees would have been expected to cost under traditional Medicare.⁵⁷ In addition to inflating Medicare spending at a time when the program's continued solvency is uncertain, these extra payments diminish the incentive for MA plans to operate efficiently.⁵⁸ To correct price signals and encourage more efficient care, the policy would set benchmark rates for each county, which are used in determining payments to MA plans, equal to the county's projected per-capita spending under traditional Medicare.⁵⁹ This policy would reduce national health spending, relative to currently projected levels, by an estimated \$165 billion through 2020.

6. Payment Reform: Implications for National Health Expenditures

Based on the modeling estimates, the payment reform policies described here have the potential to slow the growth of health care spending by an estimated \$1.0 trillion by 2020, compared with baseline projections (Exhibit 12). Moreover, the potential impact of these policies could accelerate over time due to their increased emphasis on services that provide value and the reorganization of the health care delivery system.

The policies recommended by the Commission are synergistic—one policy enhances another's effectiveness. For example, the health insurance coverage expansion enlarges the population for whom payment reforms are applicable, largely eliminating the need for cross-subsidies from private insurers currently used to cover the care of the uninsured.

Those cross-subsidies are inefficient—they mask the relationships between payments and resources used to provide care, making it more difficult to control costs.

Investing in better information and information systems would make payment reform more effective. Paying for value requires knowledge about outcomes—health, patient experiences, and costs of care. Investments in an HIT infrastructure and in developing and deploying policies to use it will make it easier to obtain that required knowledge. Use of advanced information systems offers the potential to increase the effectiveness of payment policies aimed at higher value.

Perhaps the most important impact of the payment reforms, however, is the incentives they provide for a more responsive, effective, and efficient health care delivery system. Spending on health care will be met with increased value, better care, more positive experiences, and improved health outcomes.

D. Accessible and Coordinated Care: Organizing and Redesigning the Delivery System to Improve Patient Care Experiences

The Commission report, *Organizing the U.S. Health Care Delivery System*, discussed the need for reorganizing care and provided examples of different approaches, including fully integrated systems. This section considers policies and mechanisms that could support organizing and redesigning the delivery system with a focus on clinicians and practices that are not part of formal, fully integrated systems.

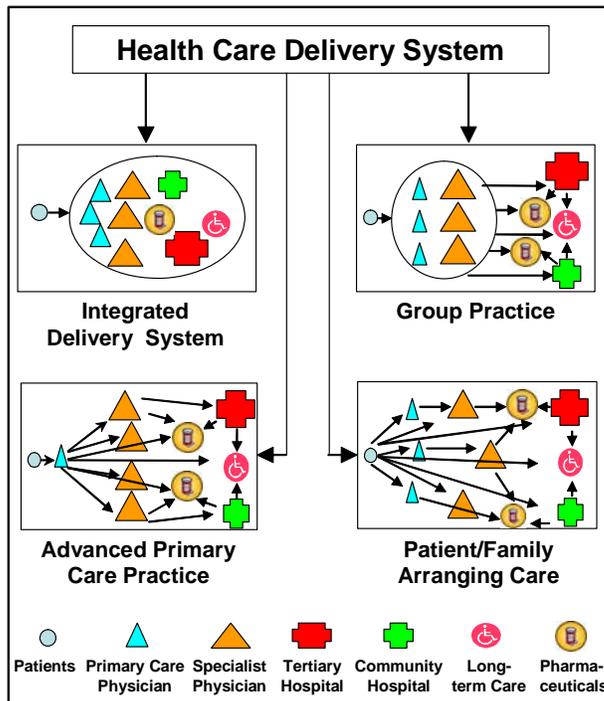
1. Background

Patients with chronic or complex health problems typically receive health care from multiple physicians in multiple settings, making imperative the need for accurate collection, aggregation, and transfer of information among providers and teamwork. These processes are impeded by a fragmented health care delivery system in which the patient or a family member often assumes responsibility for integrating care across the array of doctors, hospitals, and vendors. Organizing health care delivery can lead to better patient experiences, fewer errors, less waste and duplication, and better accountability for the quality and efficiency of care delivered. As observed by Shortell and Schmittiel, “The American health care system is the poster child for underachievement. The largest limiting factor is not lack of money, technology, information, or even people but rather a lack of an organizing principle that can link money, people, technology, and ideas into a system that delivers more cost-effective care (in other words, more value) than current arrangements.”⁶⁰

Although there are significant variations in performance, a growing body of evidence shows that, overall, organizations do matter. Health care delivery organizations that deliver the continuum of preventive, acute, and chronic care have the capacity to deliver better care.⁶¹ Larger group practices perform better than solo or small practices. They are twice as likely to engage in quality improvement and utilize electronic medical records; patients in large practices have lower mortality from heart attacks than patients in solo practices.⁶² Similarly, independent practice association (IPAs)—networks of physicians in solo or small practices—may perform better than unorganized solo or small practices. Integrated medical groups perform better than looser networks without shared information or teamwork. Integrated medical groups have greater use of HIT, greater engagement in quality improvement programs, and better clinical performance than poorly integrated independent practice associations (IPAs). Health maintenance organizations that include more group or staff-model physician networks have higher performance than less integrated networks on composite clinical measures.

There are multiple ways to organize care systems to improve performance, including less formal networks that are supported by shared resources or linked through teams, information systems, and referral relationships. Depending on geographic location, existing resources, and population density, some approaches are more appropriate and feasible than others. Exhibit 19 illustrates possible approaches. These efforts require innovations in public policy to facilitate and provide the funding necessary to accelerate spread.

Delivery System Models for Care Coordination



- Incentives for public and private insurance enrollees to designate medical home with:
 - an advanced primary care practice;
 - a group practice; or
 - an integrated delivery system
- New payment methods for delivery systems assuming accountability for total patient care, patient outcomes, and resource use
- Performance standards for each of these delivery systems
- Funding for regional or state efforts to provide primary care practices with:
 - IT network portal and IT support;
 - case management support;
 - after-hours access;
 - QI and care redesign; and
 - data reporting and profiling feedback

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

2. Policies to Develop and Support Informal Networks and Shared Resources

In addition to facilitating the growth of fully integrated care systems where feasible, the Commission recommends fostering and accelerating the spread of communitywide networks to enable better access, coordination, and outcomes. These efforts include policies that:

- Have patients designate a personal source of care that meets standards of accessibility, communication, and care coordination and serves as a medical home.
- Facilitate appropriate care and management of chronic conditions through integrated delivery systems that provide a continuum of care or provide funding and technical assistance to facilitate statewide and community efforts to support and connect primary care and more specialized resources in informal or virtual networks.
- Develop provisions in which providers participating in a hospital–physician organization that receives bundled payments would be eligible for medical liability coverage on favorable terms.

These recommendations seek collaboration among states, private sector, and regional leaders to innovate and develop informal or virtual networks and system capacity that support physician practices to improve access, teamwork, and coordination. These recommendations envision a creative process in which the federal government facilitates and supports state and regional efforts to improve. Thus, with the exception of support for health information networks and payment reforms to spread patient-centered medical homes, we did not include specific policies in modeling.

a) Informal Networks and System Innovation

Policies to stimulate better primary care and establish medical homes are key to providing access, accountability, and better coordination. But moving forward also requires connections, with systems for facilitating rapid, accurate transfer of information to and from medical homes and consulting specialists, pharmacies, laboratories, after-hours services, emergency rooms, and hospitals, all with appropriate protection of the patient's privacy. For smaller practices that are not part of fully integrated systems, this requires constructing a "medical neighborhood."⁶³

Such efforts include developing and supporting a set of "utilities" or shared services available to patients and provider practices. These include: organized after-hour care services that provide advice and patient consultations (and preclude the need for an ER visit); health information networks; care teams for patients with chronic conditions, including nurses who work with multiple practices; transition care nurses who follow up with patients after hospital discharge and connect with primary care physicians; and telemedicine. Support systems can also provide technical assistance to redesign office practices or improve quality in focused areas, including coordinating or working with emerging retail clinics, sometimes known as "minute" clinics.

Examples exist within the United States, including large integrated delivery systems like the Veterans Health Administration, Kaiser Permanente, and Geisinger. In addition, North Carolina has organized and funded networks, called Community Care of North Carolina, to provide these services to physicians in solo or small group practices.⁶⁴ Vermont is currently developing communitywide capacity to focus on chronic disease.⁶⁵

Such services are prevalent in other countries, too, such as New Zealand, Denmark, and the Netherlands. In these countries, patients receive primary care services mainly through small practices of general practitioners. In Denmark and the Netherlands, there are organized off-hours services staffed with capable professionals, including general practitioners. In New Zealand, primary care physicians can choose from several primary

health organizations operating in their region and funded by the government. The organizations provide most of the above-mentioned functions, as well as public health promotion activities.

All three countries have widespread implementation of electronic medical records. In New Zealand, the primary health organizations assist practices in implementing information technology. In Denmark, information about patient encounters after-hours is uniformly transmitted to the primary care physician through a nationally organized and funded health information exchange. This same information exchange is used by patients to schedule appointments with specialists and obtain laboratory test information. (Denmark has 5.4 million people, comparable to a statewide or regional exchange in the United States.) Denmark also has a national electronic prescribing system that supports better and safer service to patients and is designed to maximize the use of the least expensive drugs available for any specific clinical indication.

There are several reasons to integrate across care settings or within complex care settings, such as hospitals. These include reducing preventable rehospitalizations, decreasing duplication and waste, and achieving better patient experiences. There are many different policies and practices to facilitate a reduction in preventable rehospitalizations. Bundling payments, as discussed earlier, is one. Another is to provide services such as advanced practice care coordination nurses who follow patients from inpatient to outpatient settings. Initially developed and evaluated by Naylor et al, this method could be adapted and offered by insurers or incorporated within organized health care delivery systems.⁶⁶

A range of policies and actions—inspired by innovative practices within the United States and abroad—could provide new shared resources or a set of utilities and services for patients and the primary care practices.⁶⁷ These include:

- A health information technology infrastructure that includes mechanisms for exchange of information between the primary care practice and other sites of care and technical support to ensure the technology is used, maintained, updated, and enhanced, appropriately and efficiently.
- Development of organized after-hours services so primary care practices can ensure patients will receive competent care 24 hours a day, 7 days a week. Patients can be comfortable knowing that information from after-hours encounters will be coordinated with other care they receive.

- Information and assistance with referral of patients to specialized services, including information on quality and cost of specialist physicians, laboratories, and imaging services.
- Organized support available to practices as part of a team, including nurse-clinicians who help manage chronic conditions, concurrent mental and physical health problems, and multiple comorbidities, particularly important for preventing hospitalizations and rehospitalizations.⁶⁸
- Telemedicine and other innovations that link remote practices to each other and more specialized resources.
- Quality improvement and care redesign technical assistance, including assistance incorporating systems to help practitioners follow evidence-based guidelines for diagnosis and treatment of patients.
- Public reporting and peer feedback on quality of care and resource use, including generating information required by payers for performance bonuses and providing feedback to providers on quality of care compared with peers.

The Commission recommendations seek to accelerate and support the spread of such innovative efforts, including more flexible Medicare and Medicaid policies to enable communitywide all-payer initiatives.

b) Accountability: Positive Incentives to Address Liability Concerns

The Commission encourages greater shared accountability for a continuum of health care services. Bundling payments for care needs over a period of time—including physician, hospital, and other clinical care—provides a financial incentive for hospitals and physicians to join forces to improve quality of care and reduce avoidable complications, hospital readmissions, or episodes of care. A key issue is how to stimulate the development of more and better organizations that achieve synergy between the interests of physicians and hospitals. For example, bundled payment arrangements have the potential of stimulating greater collaboration and organization of physicians and hospitals.

Another way to stimulate collaboration is adoption of “enterprise liability” as an approach to malpractice liability reform.⁶⁹ For several years, physicians have been extremely concerned about the “malpractice crisis” and the high costs of traditional malpractice insurance. Most discussion has centered on capping payments for non-economic damages. Most malpractice suits that result in awards, however, reflect harm to patients. One reason to encourage better organization of health care is to reduce harm to patients. There are many ways to reduce harm, and malpractice reform policies should

encourage reduction of adverse events.⁷⁰ Under enterprise liability, physicians, in addition to being credentialed through hospitals or large organized groups, are licensed in association with a hospital or large organization affiliation. Liability, thus, is the responsibility of the “enterprise,” not the individual physician. The organization has an incentive to ensure that its affiliated physicians are competent and that the entire organization works collaboratively to reduce harm to patients and the possibility of malpractice suits.

As an incentive to participate and to form hospital–physician organizations, the Commission recommends developing provisions in which providers participating in hospital–physician organizations that receive bundled acute episode case rate payments would be eligible for medical liability coverage on favorable terms.

E. Investing in Infrastructure and Public Health Policies

1. Investing in Information Infrastructure

a) Background and Framework

Information is the backbone of effective and efficient health care delivery. Currently, an information deficit contributes substantially to the inefficiency of our health care system.⁷¹ Investing in information systems and the infrastructure to support the delivery system is essential to inform, drive, and monitor effective and efficient care, as well as efforts to improve care. Providers need up-to-date clinical decision support and information from not only their own encounters with their patients, but also from visits with other providers. Clinical information should follow patients and be readily available to all providers at the point of care. Information should also be available for aggregation and analysis to assess care against current standards and to develop new knowledge about the effects of specific care practices on groups of patients and populations.

If used appropriately, HIT can be a valuable tool to support systemic efforts to improve and coordinate care and reduce overall costs.⁷² Electronic medical records, when implemented with process redesign efforts, can help physicians improve quality and reduce medical errors. Health information exchanges, in which providers share information, can improve care coordination, reduce risks to patients, and avoid duplication. However, widespread adoption of HIT has not occurred in the United States.⁷³ One barrier to adoption is that, while providers purchase HIT, the primary economic benefits accrue across the care system to patients and payers.⁷⁴ Providing financial incentives to adopt and use HIT, plus an investment in health information network capacity with standards for interoperability, would accelerate the spread and use of HIT.

In addition, better information on the comparative effectiveness of available treatments, drugs, and devices is needed to support decision-making by providers, payers, and patients. The rapid growth of spending in the United States, combined with relatively poor performance, has led to calls for better decision-making and better evidence with which to make treatment decisions.⁷⁵ The wide variation in practice patterns across the country, with no apparent relationship between greater utilization and spending and better health outcomes, indicates that better decision-making could reduce health spending substantially without sacrificing quality.⁷⁶ Comparative effectiveness information could help providers make better clinical decisions regarding the best treatments for their patients, help payers make better coverage and payment decisions based on effectiveness and value, and help patients understand alternatives and participate in decisions about their own care.⁷⁷

Merely making information available, however, is unlikely to produce the improvements needed. For instance, chronically ill patients receive only half of the currently known recommended care for their conditions, and practice patterns vary widely.⁷⁸ Approaches that help synthesize information about treatments and outcomes—as in patient-shared decision-making, where patients receive information about treatment options—may reduce unwarranted variations in the use of invasive procedures and improve patient satisfaction.⁷⁹ Information systems that provide better information for medical decisions, as well as incentives to encourage more effective use of currently available information, would reduce unnecessary care, increase effective care, and improve the management of chronic conditions. This could lead to lower health care costs in the long run while maintaining or improving health care quality and outcomes.

There is also a lack of data on all-population and all-payer outcomes. For example, across any geographic area, we do not know how many people have diabetes, if they are receiving all recommended care, or if their disease is under control. Even cancer registries are spotty. It is thus difficult to identify or learn from benchmarks of high performance, much less provide information to patients to make timely, informed choices about care. Similarly, there is a lack of good information for clinicians to learn about the effects of specific care practices on various types of patients.

b) Information Policy Specifications Used in Modeling

Investing in better information, alongside policies to better use the information, would support continuous learning to improve health outcomes and productive use of resources. The Commission's vision of comprehensive reform focuses on three key areas:

- accelerate the adoption and use of HIT;
- establish a center for medical effectiveness and health care decision-making; and
- require transparent all-population, all-payer data on quality, outcomes, and costs.

The analysis of the potential yield from such investment assumes the information is used by patients, providers, and payers, with appropriate protection of patient privacy.

Comparative data would be clearly and consistently defined, relevant, and provided in a format useful for decision-making.

- **Accelerating the Adoption and Use of HIT**

Recent experience indicates that efforts to invest in information technology may be wasted if not coupled with strong incentives to use new systems and the capacity for independent clinical practices to exchange information across sites of care. The Path policy thus ties financial incentives to reporting information electronically, supports public investment in the capacity for health information exchange, and assists safety-net providers and small practices.

Under this policy, the federal government, through Medicare, would require reporting of key health outcome information electronically to qualify for payment updates. Starting in 2015, providers would be required to report specified clinical information electronically to a central database. Minimum standards would enhance the capacity for exchange and protect privacy (Exhibit 20).

Health Information Technology

- **Goal: Accelerate the adoption and use of effective health information technology with capacity for decision support and information exchange across care sites.**
- **Why? To improve care outcomes, safety, and value**
 - Information flow with patients—patient-centered care
 - Connect care: reduce duplication and enhance coordination
 - Decision support
 - Facilitate standards, recommended care, reporting and transparency
- **Accelerate Adoption and Use**
 - Require electronic reporting of clinical information—use payment incentives
 - Initial funding to support spread to safety net and set up exchange
 - Establish national entity for standards and electronic exchange
 - Standards of information—type of information; minimum elements
 - Standards of privacy
 - Technical standards for transferable, interoperable information

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

To provide funding to establish health information network capacity at the state and national levels, plus assistance for safety-net providers and small practices, the federal government would levy a 1 percent assessment on private insurance premiums and allocate 1 percent of Medicare expenditures to promote the adoption and use of HIT. These revenues would be divided between a central data network and state-level networks. The central coordinator would use the funds to develop network capacity, secure data, and support regional efforts to implement secure exchanges with patient electronic medical records (EMRs), decision support systems, and computerized physician order entry (CPOE) for medications and other medical services. Funds would also be available to assist small practices and safety-net and rural providers in acquiring necessary HIT.

A key focus of this policy is to enhance the exchange of information across systems maintained by individual providers. This technology, called health information networks, permits exchange of EMR and CPOE data across practices, resulting in less duplication of tests for patients treated by multiple specialists and reduced medical errors from contraindicated medication and incomplete patient data. As the benefits of such exchange are a public good—one that is shared by all—free-market mechanisms are unlikely to

promote widespread adoption of information networks. Thus, public support or incentives to use HIT and information networks are essential to accelerate adoption and effective use.

By 2015 (i.e., five years after the program begins), all hospitals and physician practices would be required to have health information systems in place and report on key data elements electronically to receive full payment updates from Medicare, Medicaid, and the public plan offered through the national insurance exchange.

- **Establishing a Center for Medical Effectiveness and Health Care Decision-Making**

Under this policy, a Center for Medical Effectiveness and Health Care Decision-Making would be established as a public-private partnership to improve decision-making by health care providers, payers, and consumers. The Center would identify the information required to make better medical decisions; collect information, if it exists; and generate information in cases where it does not. It would make the information available to providers and patients for clinical care decisions and encourage payers to use that information for coverage, payment, and health care determinations.

The Center would operate as a quasi-governmental entity possessing legal characteristics of both the public and the private sector so that it could receive funding from both sectors. To provide resources, operating funds would come from contributions equal to 0.05 percent of projected Medicare spending from the Medicare Hospital Insurance Trust Fund, 0.05 percent of projected federal Medicaid spending from general revenues, and an assessment of 0.05 percent of private insurance premiums.

The Center would have a mandate to produce and publicize information that identifies and encourages the adoption of best practices and the authority to recommend certain incentives consistent with that objective. It would assess available evidence, including treatment and care outcomes within major health systems in the U.S. or internationally. National policy would guide priorities for new research to build the evidence base (Exhibit 21).

Center for Comparative Effectiveness

- **Goal: Establish a Center for Comparative Effectiveness to provide better information about what works well for which patients**
 - Would operate with national priorities for evidence
 - Priorities set national policy

- **Responsibility**
 - Review/synthesize existing evidence plus contract for scientific research (outcomes and costs)
 - Analysis of existing clinical processes of care as well as new technology
 - Makes recommendations to insurers (public and private) regarding benefit design and pricing/payment policy

- **Independent and trusted source**
 - First-rate science, technical expertise
 - Efficient process to diffuse to clinicians and publish
 - Independent: operates in public interest
 - Budget for staff and research

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Specifically, under this option the Center would:

- Provide targeted funding for research intended to evaluate existing and new devices, drugs, procedures, and other treatment regimens it identified as most important for improving the overall appropriateness of health care and health care spending.
- Require the use of patient decision aids in the evaluation of treatment options for selected procedures, consistent with the findings produced by research and other available information.
- Recommend increased copayments for treatment options or differential pricing that discourage inappropriate and encourage appropriate management of chronic illness or in instances where evidence indicates less expensive yet equally effective alternatives are available. This effort would inform “value-based” benefit designs.

The policy assumes that public and private payers incorporate these recommendations from the Center into benefit design and payment or pricing policies. The payment and coinsurance provisions are designed to create financial incentives for patients and physicians to avoid high-cost treatments that are no more effective than other, lower-cost

alternatives. Benefit designs could also use prior authorization systems for clear cases in which a treatment's effectiveness depends on the patient's health condition.

The analysis assumes that Medicare and the Medicare-sponsored public plans would adopt a value-based benefit with incentives to provide and use care consistent with evidence and that Medicaid and private health plans would adopt similar policies.

- **Requiring All-Population, All-Payer Reporting on Quality and Costs**

Working with states, the federal government would develop public reporting on all-population and all-payer data systems. This effort would build on current Medicare Hospital, Nursing Home, and Home Health Compare databases and would be expanded to include health outcomes and cost comparisons. National, regional, and state databases would also include standardized reporting of insurance revenues and claims to allow comparisons of administrative, marketing, and other overhead costs, as well as medical loss ratios and margins. National guidelines for public reporting would draw from innovative state systems and innovative efforts in other countries. Publicly reported data would help inform improvement efforts by providing benchmarks or targets based on top performance. Spread of HIT would enable an ever-richer information resource that could be used to identify and learn from efforts to reach and raise benchmarks of top performance in health outcomes and patient care experiences.

Exhibit 22 outlines core concepts for such an all-population information resource.

All-Population Data with Benchmarks

- **All-population, all-patient, all-payer data**
 - Ideally would include care process, clinical outcomes, patient experiences, and costs and enable benchmarking and monitoring changes
 - Minimum uniform set, including all-payers
 - Health outcomes (e.g., percent diabetes under control; cancer survival rates)
 - Data flow from HIT capacity to report outcomes
 - Web comparison of insurance choices, costs and benefits, experiences; include share of premium for administrative/overhead/profit
- **National with capacity for state or geographic analysis and benchmarks**
 - Designed so states could add, build with more detailed data where available
 - Could build up or incorporate from existing state database efforts
 - Build on existing national and state efforts
- **Transparent with capacity to benchmark and compare, monitoring changes over time**

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

c) Potential Impact on National Health Expenditures and Value

The policies described here are intended to increase the capacity of the health system to collect, process, produce, and analyze information, with improved capacity to measure, learn, and improve. The information would also inform payment policies. The goal is a health system and health markets rich in information to inform care decisions and to support a culture of continuous learning.

The modeling indicates these information policies, if implemented in 2010, have the potential to slow the growth of health care spending by an estimated cumulative \$895 billion by 2020 (Exhibit 12). As with other policies described in this report, the impact of an improved health care information infrastructure should accelerate over time, yielding better health outcomes as well as high-value care.

Insurance expansion design and payment reforms will enable and require more effective use of information. Better information enhances the ability of delivery systems to provide more patient-centered care, with a focus on disease prevention and outcomes, and allows payment and pricing policies to focus on outcomes and value. The synergy likely to result from such interdependent and mutually supporting reforms offers the potential for rapid gain and transformative change.

Modeling such dynamic change and behavioral change is thus likely to be conservative and underestimate potential gains in health and system performance.

2. Promoting Population Health and Disease Prevention

a) Chronic Disease and Population Health: Opportunities to Improve

The treatment of chronic illnesses such as diabetes and heart disease, and their corresponding complications, places a large burden on our health system. The Centers for Disease Control and Prevention estimates that the medical costs for people with chronic disease account for more than 75 percent of total health care expenditures.⁸⁰ Among the chronically ill, a disproportionate amount of cost is incurred by sicker patients with multiple chronic diseases. In the Medicare fee-for-service population, the costliest 15 percent of beneficiaries account for 75 percent of total spending.⁸¹

Leading chronic diseases—diabetes, asthma, congestive heart failure, coronary artery disease, and depression—account for a disproportionate share of potentially preventable complications, severe acute conditions, and related comorbidities. With early interventions to prevent the onset of disease or deterioration in health, the nation could substantially lower health risks and help people lead healthier, longer, and more productive lives.

Universal coverage, if designed to include benefits that ensure essential care and positive incentives for those with chronic disease, could play a key role in promoting health and enhancing disease prevention.⁸² When it includes continuity and cost-sharing that values effective, essential care, insurance can ensure affordable access and promote adherence to recommended care. France, for example, lowers or eliminates patient-cost sharing for essential medications for chronic conditions and waives other cost barriers for those with serious chronic disease. Germany uses positive incentives, like reduced copayments, to encourage participation in disease management programs.⁸³ Alternatively, in the U.S., Kaiser Permanente found that placing a limit on pharmacy benefits led to patients skipping their blood pressure and other essential medications, an increase in costs for hospital and emergency room care, and a spike in mortality.⁸⁴

Payment reforms that support a strong primary care foundation and patient-centered medical homes can be instrumental in engaging patients to manage their conditions. Paying for the care of a patient over time rather than on a fee-for-service basis allows for telephone and e-mail access and time with nurses and other team members. Coupling financial support with health information systems—including registries for decision support, guidelines, and identifying higher-risk patients for outreach and ongoing care—enables more effective and efficient care.

Insurance, payment, and investment in information infrastructure could help pave the way to more effective care for chronic conditions. An all-population database with disease registries that compares outcomes across geographic areas would provide benchmarks of top performance and identify areas for focused communitywide action. Making substantial progress will require setting concrete goals, raising standards to deliver the right care and follow-up care, and spreading best practices from within the U.S. and abroad.⁸⁵

Estimates for potential savings that accrue from better management of chronic conditions and preventive care are included in the net impacts of insurance, payment, and information systems reforms presented above.

Population health measures would help focus delivery system and public health efforts on subgroups or communities with significant burden of disease. The prevention and management of these conditions depends not only on what occurs within the delivery system, but on behaviors and environmental factors, including those in workplaces and schools. In addition to delivery system reforms, public health initiatives are essential for comprehensive reforms that seek to improve population health.

b) Public Health Initiatives: Policies Used in Modeling

Investing in public health initiatives has the potential to improve population health, lower rates of disability, and enhance school and workforce productivity. Smoking and obesity both contribute to high rates of chronic and acute disease with risk of early death, as well as long-term disability. Cigarette smoking and tobacco use is the largest avoidable cause of disease and death in the United States. Tobacco use is associated with lung cancer and other respiratory illnesses, but it also increases the risk of other cancers (e.g., oral cancer, pancreatic cancer), as well as heart disease and stroke. The Centers for Disease Control and Prevention has estimated that between 1997 and 2001, cigarette smoking was responsible for \$167 billion in annual health-related economic losses in the United States (i.e., \$75 billion in direct medical costs and \$92 billion in lost productivity).⁸⁶

The rapid increase in obesity across the country puts the nation's health at high risk. Obesity is a significant risk factor for chronic conditions such as high blood pressure, diabetes, and heart disease. As the prevalence of obesity among adults more than doubled from the 1970s to the 2000s,⁸⁷ the share of national health expenditures attributed to obesity has been estimated at 5.5 percent to over 9 percent, with increases projected into the future.⁸⁸

Public health initiatives aimed at reducing tobacco use and obesity could lessen the burden of such diseases, improve health, and result in substantial health system savings. As part of the overall prevention initiatives, this report includes policies to reduce obesity, tobacco use, and substance abuse; as well as those to improve children's immunization and adult vaccinations for influenza and pneumococcal disease. The four policies illustrate possible public health action approaches.

- **Reduce Tobacco Use and Reduce the Prevalence of Obesity**

- Tobacco: Under this policy, the federal government would increase the federal excise tax on cigarettes by \$2 per pack, with a proportional increase in the taxes on other tobacco products. Revenues from this increase would be used to strengthen the Centers for Disease Control and Prevention's national tobacco control programs, fund block grants to states to support state and local control programs, and fund insurance expansion. States would be eligible for such grants only if they meet minimum tobacco control requirements, such as enacting legislation that bans smoking in enclosed workplaces and public spaces.
- Obesity: This policy would provide funding to support nationwide efforts to address rising rates of obesity by establishing a new federal tax on sugar-sweetened soft drinks at the retail level in the amount of \$0.01 per 12 ounces. Revenues would fund grants to states for obesity prevention programs. States would be eligible for such grants only if they met minimum obesity control requirements such as enacting legislation banning the use of trans fats in the preparation of food in restaurants; requiring restaurants that serve standardized food (e.g., chain restaurants) to prominently display nutritional information; and requiring schools to ban the sale of sugar-sweetened soft drinks, enforce existing U.S. Department of Agriculture (USDA) regulations that prohibit serving school meals of minimal nutritional value, serve meals consistent with USDA guidelines, and provide for regular exercise.

- **Reduce Alcohol Consumption and Increase Funding for Immunizations**

- Under this policy, the federal government would increase the federal excise tax on alcohol by \$0.05 per 12-ounce can of beer, with a similar proportional increase in the taxes on other alcohol products. Revenues from this increase would be used to strengthen national alcohol and illicit substance abuse prevention programs and provide grants to states. These funds could also support mental health and treatment programs in Medicaid.

- Funds would also support a 50 percent increase in funding for the federal section 317 Immunization Grants Program to support and promote childhood immunizations as well as adult vaccination for influenza and pneumococcal disease.⁸⁹

The modeling of potential spending impacts of public health initiatives focused on obesity and tobacco. Estimates of federal costs of all reforms (discussed below) assumed tax revenue for tobacco, sugar, and alcohol would also be used to fund insurance expansion.

c) Potential Impact National Expenditures of Successful Obesity and Tobacco Initiatives

The estimates indicate reduced tobacco use could result in a net cumulative reduction in national health expenditures of \$255 billion over 11 years (Exhibit 12). This results from a reduction in illnesses due to tobacco use. These savings decrease over time because costs of age-related illnesses will increase due to longer lives.

A decline in the rate of obesity could reduce national health spending costs attributed to higher rates of diabetes and cardiovascular disease. If the rate of increase in obesity is cut in half, it is estimated that cumulative 11-year savings would be \$406 billion.⁹⁰

Both policy initiatives would contribute to healthier, longer, and more productive lives in addition to slowing the growth of health spending. The possible tax on sugar-sweetened soft drinks is just one example of a source of tax revenue for funding efforts to reduce rates of obesity. Other sources include taxes on selected fast foods, candy, snacks, or other foods with minimal nutritional value. It is important to note, however, that the proposed taxes are regressive and disproportionately affect low-income consumers.

V. IMPACTS: PAYERS, PROVIDERS, AND THE PUBLIC PLAN OPTION

A. Distributional Impact by Payer and Financing Reforms

All major sectors would gain from improved health and from slowing the growth in health spending compared with projected trends. The impact of the policies is distributed across the groups that ultimately pay for health care: federal government, state and local governments, private employers, and households. By 2020, the aggregate cumulative reduction in national health spending is estimated at \$3 trillion, with the bulk of savings from slower growth in spending accruing to households and state and local governments (Exhibit 23).

Exhibit 23

**Path Net Cumulative Impact on National Health Expenditures
(NHE) 2010–2020 Compared with Baseline, by Major Payer Groups**

Dollars in billions

	Total NHE	Net federal government	Net state/local government	Private employers	Households
2010–2015	–\$677	\$448	–\$344	\$111	–\$891
2010–2020	–\$2,998	\$593	–\$1,034	–\$231	–\$2,325

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Household and Families: Most of the savings would accrue to individuals and families as a result of federal support of premium assistance, expansion of public programs to make insurance affordable, and the reduction in premium and health care costs over time. Household cumulative savings would exceed \$2 trillion by 2020, not including potential increases in wages if employers convert premium savings to higher pay or other employee compensation.

Savings would extend across the income spectrum. Income-related premiums and low-income program expansion would be of particular benefit to modest- and lower-income families. But with lower premiums available through the exchange, high-income families, as well as middle- and low-income families, would save. If fully implemented in 2010, the modeling estimates that savings would average over \$800 per family, if the exchange were open only to individuals and small firms. If open to all, savings would exceed \$1,000 per family (Exhibit 24). By 2020, savings per family would increase due to delivery system changes in response to reforms. Estimated savings would then increase to an average \$2,300 per family per year. Notably, families with incomes of \$75,000 or more—most of whom are already well insured—stand to gain the most from slowing the growth of health care and insurance costs. High-income families would save a projected \$2,600 or more per family per year.

Exhibit 24

Change in Average Annual Family Health Spending Under Path Proposal Compared with Projected Without Reforms: Average Savings per Family

	Average Savings per Family 2010, if Fully Phased		Average Savings per Family 2020*
	Individuals and Small Firms Eligible for Exchange	All Firms Eligible for Exchange	All Firms Eligible for Exchange
All Families	-\$855	-\$1,140	-\$2,314
Under \$10,000	-\$751	-\$762	-\$1,547
\$10,000–\$19,999	-\$860	-\$915	-\$1,857
\$20,000–\$29,999	-\$926	-\$1,036	-\$2,103
\$30,000–\$39,999	-\$904	-\$1,085	-\$2,202
\$40,000–\$49,999	-\$1,014	-\$1,261	-\$2,559
\$50,000–\$74,999	-\$858	-\$1,195	-\$2,426
\$75,000–\$99,999	-\$802	-\$1,287	-\$2,612
\$100,000–\$149,999	-\$739	-\$1,293	-\$2,624
\$150,000 and higher	-\$869	-\$1,459	-\$2,961

Note: Family income in 2010 dollars. By 2020, total household savings would reach an estimated \$342 billion. The estimated savings per family in 2020 use the same family distribution as in 2010 and adjust for population growth.
 Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Employers: Employers who currently provide insurance would realize savings as a result of lower premiums and sharing the costs of coverage more equitably across all employers. Initially employers that do not currently contribute to employee coverage would pay more, but these costs would be built into the wage structure of the nation, similar to Social Security, creating an equal playing field in the labor markets. This shared

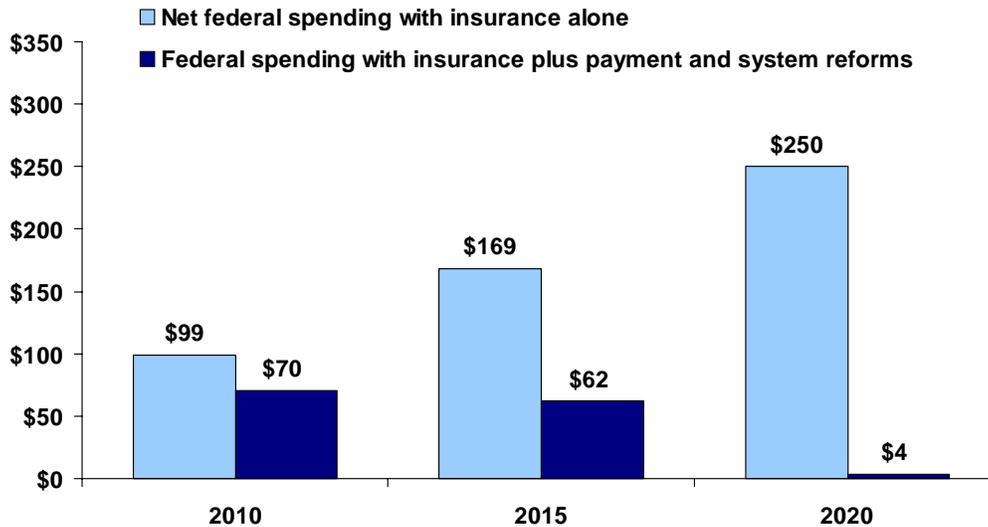
responsibility approach involves all businesses contributing to support the nation's health insurance system. Over time, as premium growth slows, new system savings would offset costs for employers with net cumulative savings of \$231 billion by 2020.

State and Local Governments: The combination of slower cost growth and policies specified in the analysis result in an estimated \$1 trillion in state and local government cumulative savings by 2020, compared with projected levels. Savings would come from four sources: 1) federal support for dually eligible Medicaid and Medicare beneficiaries with a new Medicare Extra supplemental option; 2) eliminating the two-year waiting period for the disabled, many of whom are on Medicaid; 3) reduced state and local support for the uninsured in public clinics and hospitals; and 3) state and local government savings due to lower and slower growth in public employee health benefit costs.

Federal Net Costs and Financing: As the central source of financing for coverage expansions, federal costs would increase during early years. The insurance design provided federal funding to offset the state and local costs of expanding Medicaid and raising Medicaid payment rates to Medicare levels. As a result, net federal government cumulative costs would increase by \$593 billion by 2020. When system reform policies are in place, the estimated net annual cost to the federal government falls sharply from 2015 to 2020 as savings offset the cost of insurance expansion and investing in the care system. By 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections (Exhibit 25).

Savings Can Offset Federal Costs of Insurance: Federal Spending Under Two Scenarios

Dollars in billions



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Deficit financing in the early years could be justified as part of an economic recovery program. Expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. But financing sources will be needed to ensure long-term fiscal soundness. Since state governments, households, and employers all save significantly over the decade, some of the savings could be recaptured to finance federal support of the coverage expansions.

Allowing tax breaks for higher-income households to expire will fund a portion of these ambitious reform initiatives, but these funds will not be sufficient to cover the entire federal cost of the plan. Other sources of long-term financing would need to be identified and assessed, ranging from higher taxes on high-income households to taxes on harmful health products, including sugared soft drinks and tobacco products.

In addition to premiums paid directly by individuals, families, and employers, costs could be financed in numerous ways. Exhibit 26 illustrates possible financing sources and the estimated revenues each would yield over a 11-year period.

**Potential Federal Revenues Options to Fund Insurance Expansion:
2010–2020, Cumulative Revenue in \$ Billions**

	2010 to 2014	2010 to 2020
Institute a 1 percent national sales tax that exempts necessities	\$139.5	\$349.2
Cap employer tax exclusions for premiums at public plan premium level	\$225.8	\$372.5
Early expiration of the top marginal tax bracket*	\$38.0	\$38.0
Increase top two marginal tax brackets by 1 percent	\$155.2	\$176.1
Raise tobacco tax by \$2 per pack	\$150.5	\$322.5
New sugar tax on soft drinks of \$0.01 per 12 ounces**	\$5.5	\$12.1
Increase federal excise tax on alcohol by \$0.05 on 12-ounce beer with proportionate increase on other alcoholic drinks**	\$27.0	\$62.2

* The top bracket reduced rate is due to expire at the end of 2010. This would let it expire one year early.

** These financing sources were already included in the modeling estimates.

Data: Estimates by The Lewin Group for The Commonwealth Fund.

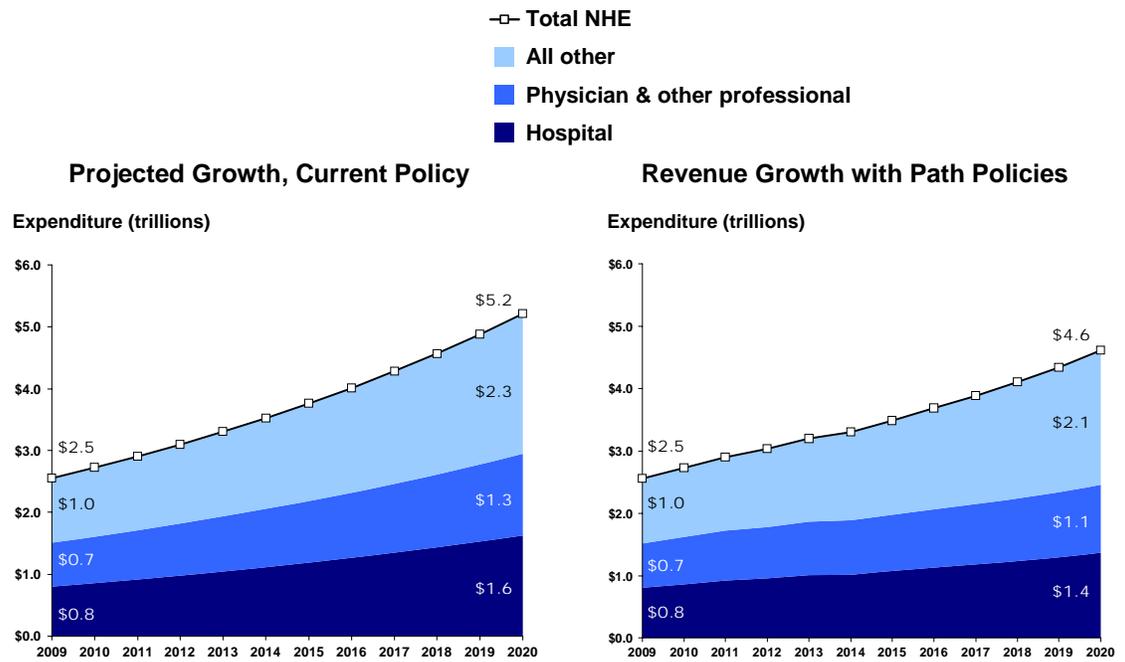
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

B. Impact on Provider Groups

With increased emphasis on primary care, improved coordination, and the elimination of unnecessary and duplicative services, spending growth would slow relative to current projections. Yet, national health expenditures would continue to grow over the decade, albeit at a slower pace. The total increase by 2020 would be 73 percent higher than current spending.

While slowing expenditure growth from 6.7 percent to 5.5 percent amounts to a significant change, hospitals', physicians', and other providers' revenues would continue to experience growth each year. Growth would only be marginally slower than current projections as revenues continue to increase due to medical advances and an aging population (Exhibit 27).

Total National Health Expenditure (NHE) Growth by Provider Sector, Current Projections and with Policy Changes, 2009–2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

The payment changes also increase Medicaid payments to providers and provide revenues from formerly uninsured patients. Increased revenues for those newly insured plus enhanced payments for Medicaid would nearly offset the effect of the public plan at Medicare rates. The modeling estimates the net cumulative reductions in provider payments by 2020 (i.e., new revenues less the adjustment for Medicare rates for those covered by the new public plan) would amount to a \$97 billion cumulative reduction over 11 years.

Payment incentives that emphasize value would support practice innovations. Efficient practices and care systems could gain from bundled payment methods and more productive resource use. Hospitals, physicians, and other health care practitioners—especially those who redesign their systems to deliver care more efficiently—should see increases in net revenue.

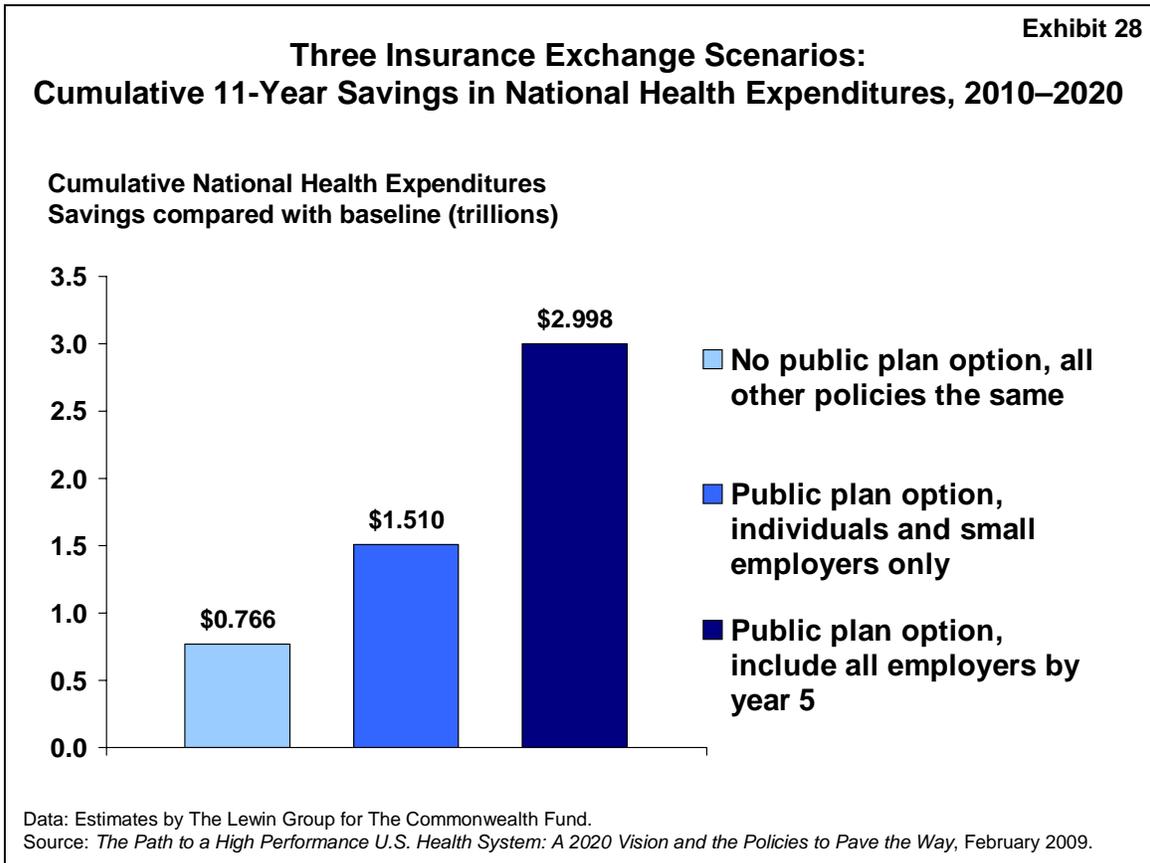
C. The Central Role of the Public Plan: Impact on Longer-Term Cost Growth

The insurance connector and opportunity to enroll in a public plan play a central role in stimulating the competitive markets and gaining leverage. To illustrate the importance of the public-sponsored plan, we examined two other insurance scenarios. One would limit

enrollment through the insurance exchange and access to the public plan to individuals and small employers. The other would limit choices in the insurance exchange to private plans, eliminating the public plan option.

In all three scenarios, the payment reforms would continue to apply to Medicare and Medicaid, as would all other system reforms, including investment in information systems. Private plans could follow Medicare’s lead, but in one scenario there would be no public plan competitor to set a price mark.

As illustrated in Exhibit 28, the modeling indicates all three scenarios have the potential for significant savings by 2020. But the original scenario—an exchange that sponsors a public plan option, in addition to private plans, and is open to all employers—would achieve the greatest reduction in spending growth.



The modeling estimates that this scenario could save nearly \$3 trillion by 2020 if opened to all employers in 2014, compared with \$1.5 trillion if the exchange and public plan were only open to individuals and small employers. A connector offering only private plans would save \$800 million by 2020. This scenario assumes that private insurers

continue to pay well above Medicare rates, without downward adjustment in private payments once higher payments are no longer necessary to cover costs of uncompensated care or Medicaid shortfalls. In other words, the modeling assumes no mechanism exists to realign private insurance payment levels.

The insurance market reforms, exchange, and public plan in combination seek to change the nature of competition in insurance markets. The goal is a new business model for insurance plans in which insurance companies would need to improve the health of the population they serve in order to make money.

The insurance framework and new public plan seek a dynamic, competitive solution that retains a mixed private and public insurance system with the best of what each sector has to offer. The challenge will be achieving a balance where the public plan and private plans compete with each other with market rules or regulations that stimulate innovation and outcomes in the public interest. Developing a mechanism to set the price point and payment policies in a nonarbitrary fashion will be important to value-added constructive competition. The goal should be to provide incentives and support for high-quality and efficient care systems, with rational public and private insurance payment policies. The Commission will continue to explore and address this issue in upcoming reports.

D. Comprehensive Reform: Payment and System Reforms Plus Coverage

The analysis also illustrates the importance of pursuing payment and system reforms, in addition to coverage reforms. The reforms support and sustain each other. With coverage expansions alone, even with a public plan available to all, the potential net cumulative national savings by 2020 would be \$432 billion, compared with nearly \$3 trillion under comprehensive reform (Exhibit 12).

Similarly, without payment and system reforms, federal net costs of expanding coverage would grow with rising health costs. The cumulative increase in federal costs would amount to an estimated \$1.9 trillion over 11 years compared with \$593 billion. ([See Appendix exhibits](#) for cumulative changes by sector with insurance alone, compared with comprehensive reform.)

To achieve more affordable coverage and ensure access for all, we must change the way health care is delivered and the way we pay for care. Unless we move to a high performance delivery system, efforts to expand coverage will be difficult—if not impossible—to sustain over time.

The reforms seek to stimulate change in the way providers, patients, and public and private insurers behave as they react to the new opportunities the proposed policies would create. An insurance exchange structured to expand individual and group choice of plans would promote competition to drive innovation and better organization of care. The public plan plays a central role in this vision of potential change.

The reforms depend on payers becoming more prudent purchasers. Transforming Medicare into a more active purchaser of care is crucial. Strategies include enhanced primary care, innovative payment methods with more bundled payments, mechanisms to hold providers accountable, and supporting changes in behavior to improve performance. Patients would also be motivated to seek value and use resources appropriately due to comprehensive insurance with premium differences and cost-sharing aligned with effective care.

Together, the comprehensive reforms offer the potential to achieve significant gains in population health and care outcomes.

VI. POTENTIAL GAINS FOR THE POPULATION

The nation has the opportunity to make substantial progress toward improving the health of the population and slowing the growth of national expenditures. An integrated set of policies should meet and exceed benchmarks or targets currently set by top performers within the United States or abroad. By reaching targets and providing a coherent set of insurance, payment, and system reforms, we could help everyone lead healthier lives, avoid preventable admissions and readmissions to hospitals, and improve safety and timely, patient-centered access.

Using core indicators from the Commission's 2008 National Scorecard on U.S. Health System Performance as a guide, we should expect near-universal coverage; primary sources of care that serve as accessible, patient-centered medical homes; routine preventive care; and a substantial reduction in complications from chronic disease that lead to hospital visits. By moving toward a health system that provides timely access to effective care, along with public health initiatives to prevent disease, we should expect a reduction in premature deaths from conditions amenable to health care. Reaching benchmarks or targets by 2020 would improve care for millions, reduce complications from chronic disease, and potentially prevent 100,000 premature deaths per year from diseases such as diabetes (before age 50), infections, and screenable cancers (Exhibit 29).⁹¹

We have much to gain by moving in new directions. A system approach to policy changes should result in better access, better outcomes, and slower growth of national expenditures.

**Achieving Benchmarks:
Potential People Impact if the United States Improved
National Performance to the Level of the Benchmark**

	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	58%	99%	73 million increase
Percent of adults (age 18 and older) receiving all recommended preventive care	50%	80%	68 million increase
Percent of adults (ages 19–64) with an accessible primary care provider	65%	85%	37 million increase
Percent of children (ages 0–17) with a medical home	46%	60%	10 million increase
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	58%	70%	5 million increase
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	18%	14%	180,000 decrease
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	240	126	250,000 decrease
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	156	49	70,000 decrease
Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)	700	465	640,000 decrease
Deaths before age 75 from conditions amenable to health care, per 100,000 population	110	69	100,000 decrease
Percent of primary care doctors with electronic medical records	28%	98%	180,000 increase

* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target.

Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008), with benchmarks from top performance.

VII. NATIONAL LEADERSHIP AND COLLABORATION

To achieve significant progress toward the goals of improving the access, quality, and cost performance of the U.S. health care system, strong national leadership and collaboration will be essential. Virtually all developed countries except the United States have taken a strong leadership position to shape their health systems and invest in core systems to improve value. This is true in countries with private, public, multipayer, or mixed private–public insurance systems, as well as those with more unified insurance systems. In those countries with private or mixed insurance systems, government takes a leadership role to establish shared goals, develop policies to support those goals, and encourage shared responsibility and coherent interaction among the public, for whose benefit the health care system exists; providers, who must ensure health care is effective and efficient; and insurers, who pay for the care. This leadership role includes ensuring that insurance markets work to the public benefit.

Given its history, cultural attitudes, and institutions, the United States is unlikely to move to centralized health financing or delivery systems used in other countries. Looking across Europe, each country has developed its own approach, with mechanisms to fit their specific circumstances and the evolution of their health systems. Many have used independent authorities to carry out specific tasks or functions related to health insurance coverage, payment policies, or efforts to develop information systems, including evidence-based information on comparative effectiveness.

Similarly, we need to craft policies and establish collaborative relationships that reflect our circumstances and develop an effective approach that will serve the public interest. The integrated set of policies recommended in this report would require new national health policy or functional roles in five areas:

- **Insurance Exchange:** An insurance exchange that would operate at state, multistate regional, and national levels. This entity would facilitate enrollment and enable Web-based insurance choices and information on premiums and benefits. In addition to providing access to health care, universal coverage also makes payment reform more effective, by bringing everyone “under the umbrella.” Under federal legislation or the exchange, market competition standards (guarantee issue, renewal, same premium regardless of health) would be established. States would work with the exchange to enforce these standards to focus insurance competition on outcomes and value.

- **Payment Policies:** Major public programs would become more active purchasers of high-value health care, rather than passive bill-payers. Taking a more active, prudent purchaser role will require providing a Medicare council or board with authority and flexibility to develop and implement payment reforms or collaborate in multipayer initiatives. As discussed below, working within targets and guidelines set by Congress and the President, such new leadership authority must be accountable for access and high-quality care, as well as payment reforms focused on value. Medicare would also need to develop a new public plan option for the under-65 population.
- **Center for Comparative Effectiveness:** Establish a center for comparative effectiveness and health care decision-making, with the independence, expertise, and authority to make benefit and pricing recommendations to public insurance plans, including Medicare. The center would operate with priorities set by national policy.
- **HIT:** Set national standards to accelerate the adoption and use of health information technology and support national or multiple regional health information networks to facilitate data exchange and provide a new national resource with clinical outcome information.
- **Population Data and Goals:** Develop all-population, all-payer data, including clinical quality and patient experiences and outcome data, which is reported electronically, using benchmarks of high performance.

All five activities must coordinate and collaborate, requiring an overarching leadership structure (Exhibit 30). Given the rich geographic diversity across the United States, all-population health data systems should be developed at the regional, state, and local levels, with the capacity to learn from variations in policy and practice.

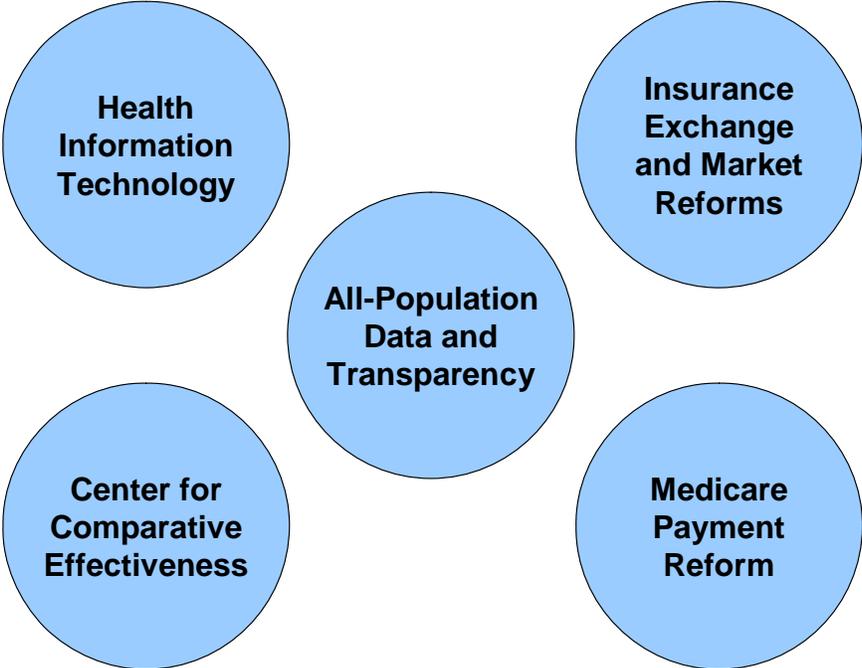
Federal, state, and private payers would also need to collaborate. For example, the insurance exchange could offer plans sponsored by Medicaid or SCHIP to allow low-income families choice and provide a single portal to compare plans. Developing efficient and effective programs for patient care would also likely require coordinating with states to harmonize regulations. Possibilities for organizing the overarching leadership will be discussed in a separate report.

Given the current stress on the Medicare Trust Fund and the potential of Medicare to serve as model or collaborator with other payers, the Commission believes allowing Medicare more flexibility and authority to test and implement payment reforms, with spending targets and guidelines set by Congress, should receive top priority. This would include strong provisions to protect beneficiaries, as well as accountability for achieving goals. Accountability would include ensuring fair treatment of providers, with a focus on provision of effective and efficient care. The executive branch would be accountable for formulating policies and actions to meet spending targets.

Stimulating and supporting delivery system change to provide more effective and high-value care will also take time and flexibility to develop innovative payment reforms. Currently, public programs, including Medicare, the Civilian Health and Medical Program of the Uniformed Services, and the Federal Employee Health Benefit Program, set payment policies in multiple ways. Achieving the goals of coverage for all, improving population health, and slowing the growth of national expenditures to ensure a sustainable, high-quality health system will require changing the way public policy is shaped. More flexibility, with accountability, to enable rapid experimentation and learning will be required. Allowing Medicare to join with other payers for state or area-wide regional testing of payment reforms would permit ongoing learning and allow for policies tailored to local circumstances. A new national health council, Medicare board, or other mechanism will be necessary to enable Medicare and the new public plan to serve as prudent purchasers, to facilitate and spread innovative payment policies, and to collaborate with private and other public payers within a multipayer system. The Secretary of Health and Human Services, operating with a national Medicare board or with advice of a council of experts, would require authority to test and implement new payment and system reforms. Goals would be set by Congress and the President on behalf of the broad public interest.

Setting up an insurance exchange and opening up a new Medicare-sponsored public option would accelerate the pace of change while offering the uninsured, early retirees, and working families an affordable option. Successful implementation of effective policies will require leadership and authority to act and collaborate.

New National Policy Leadership



Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

VIII. CONCLUSIONS

Moving forward on a comprehensive reform agenda and making significant progress quickly requires major changes, which will be difficult to achieve in a care system that touches so many lives and generates over \$2 trillion in revenue per year. Yet, if we fail to boldly act now, the situation we face in the future will be much worse.

Stimulating and supporting delivery system change to create more effective and high-value care, as well as innovative payment reforms, will take time and flexibility to develop. To create changes in Medicare and a new Medicare-sponsored public plan option will require providing Medicare with the authority and flexibility to act on behalf of beneficiaries, with targets set by Congress and the President and accountability for preserving and enhancing access and health outcomes. A new national health council, Medicare board, or other mechanism will be necessary to enable Medicare to serve as a more prudent purchaser, to facilitate and spread innovative payment policies, and to collaborate with private and public payers within a multipayer system. This flexibility requires independent expertise and authority to act with explicit accountability to Congress, the President, and the public.

Significant reform will also be needed to change the way we pay for care to focus on value and to set up a national exchange in which all insurers agree to accept every enrollee and charge the same price, regardless of health. Providing positive economic incentives for patients to seek high-quality, effective care and assess alternatives will require investment in evidence-based medicine and applying that knowledge to public information systems.

Overall, moving on a path to high performance will require everyone to reach consensus that the status quo is unacceptable. It will require bold action on behalf of the greater good of patients, the population's health, and national economic security. Successful implementation of effective policies will require leadership with authority to act and collaboration across sectors to achieve targets and goals.

The results presented in this report underscore several key themes and build on the Commission's earlier analysis of strategies to achieve a high performance system:⁹²

- **We should aim high. Better access, quality, and health outcomes, along with slower cost growth, are possible. It is urgent to start now.** The consequences of

maintaining the status quo—in terms of both human and economic costs—put the nation at risk. Early action has the potential for substantial cumulative benefits over 10 years. Delay increases the magnitude of the problems.

- **A comprehensive system approach is essential. We need to simultaneously expand coverage and take bold action to improve quality and efficiency.** There is no “magic bullet” that can alone address rising costs, access, and quality. A coherent set of policies aimed at misaligned incentives, an information deficit, and structural flaws that drive costs up and drag outcomes down is necessary to improve.
- **Better information is a key to improved performance. We need to invest for the future.** Improving the health system requires a clinical information system to support patients and clinicians; better evidence on the effectiveness of treatments, drugs, and devices; and information to compare performance at the national, community, and provider levels. To improve, information must be used and embedded in policies and practices to enhance effectiveness and efficiency of care.
- **Insurance provides an essential foundation for payment and system reforms.** If designed to ensure access and improve insurance efficiency, coverage expansion provides a base for payment and system changes that create more consistent signals and drive delivery systems to higher performance. Less fragmented coverage would enable leverage as well as more coherent payment policies. Benefit design can provide incentives for prevention and essential care for chronic disease. Universal coverage, coupled with payment and system reforms, would provide a catalyst for significant gains in value.
- **Value means more than savings.** Higher value includes improvements in quality, equity, access, and healthy lives, in addition to savings. The potential to improve health outcomes, not just savings, should drive decisions for the future.
- **Achieving high performance will require all stakeholders to take part in solutions and come together to focus on gains for patients and the nation.** Expanding coverage to everyone, improving performance, and achieving national health system savings will not be easy. It will require a shift in the way we pay for and deliver care, as well as major insurance reforms. Doing so will require that payers and providers address current payment inequities and reach consensus on reforms to support efficient, high-value care.

- **Leadership is critical.** Building consensus requires leadership to put the U.S. health system on the path to achieve targets and goals.

As a nation, we all gain if we move in new directions by expanding coverage and implementing payment and system reforms. We must focus on improving health, patient experiences, and the value we get in return for our high investment in health care. If we fail to act, the stakes are high—our health and economic security are at risk.

Windows of opportunity for real health reform do not stay open for long. While the challenge is daunting, it is imperative that our new federal leadership moves swiftly to change direction and puts the U.S. health system on the path to high performance.

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- ⁹¹ See Commission, *Why Not the Best?* 2008, for a description of benchmarks and analysis of potential effects.
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APPENDIX

A. Exhibits

Exhibit A-1 compares insurance administration costs under the existing system and under the exchange by group size. Exhibits A-2 and A-3 show the estimated net impact by payer from enactment of the insurance reforms alone compared to the combination of insurance expansion with payment and system reforms. Exhibit A-4 provides estimated net impact from each of the major policy reforms. Exhibit A-5 illustrates how federal savings from payment and system reforms would offset the cost of insurance expansion by 2020.

Exhibit A-1. Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size

Size of Group	Claims Administration		General Administration		Interest Credit		Risk / Profit		Commissions		Total Administrative	
	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange	Current	Exchange
Individuals	10.9%	5.4%	19.0%	6.5%	-1.1%	-1.1%	8.7%	2.7%	3.4%	1.0%	40.9%	14.5%
2 to 4	9.5	4.7	14.7	5.7	-1.1	-1.1	6.4	2.3	3.1	1.0	35.8	13.3
5 to 9	8.8	4.7	13.2	5.7	-1.1	-1.1	6.0	2.3	2.2	1.0	31.1	13.3
10 to 19	7.4	4.7	10.8	5.2	-1.1	-1.1	5.6	2.3	1.9	1.0	26.5	12.8
20 to 49	6.5	4.3	8.9	4.7	-1.1	-1.1	5.1	2.3	1.2	1.0	21.8	11.9
50 to 99	4.4	3.8	5.6	3.2	-1.1	-1.1	4.5	2.3	0.7	1.0	15.3	9.9
100 to 499	4.2	3.8	4.7	2.8	-1.1	-1.1	4.1	2.3	0.6	1.0	13.5	9.5
500 to 2,499	4.0	3.6	4.6	3.0	-1.1	-1.1	2.6	2.3	0.3	1.0	10.4	9.5
2,500 to 9,999	3.9	3.5	2.0	1.4	-1.1	-1.1	1.4	1.4	\$6*	1.0	6.7	6.6
10,000+	3.1	2.8	0.9	0.7	-1.1	-1.1	0.8	0.8	\$6*	1.0	4.5	4.5
Total	4.8%	3.9%	5.0%	3.4%	-1.1%	-1.1%	3.0%	2.0%	1.1%	1.0%	12.7%	9.4%

Note: Only small firms are permitted to enter the exchange, which we assume includes firms with fewer than 25 workers.

* Self-funded plans pay a fee of about \$6 per worker per month. Assumes that all firms with 2,500 or more workers are self-funded.

Data: Estimates by The Lewin Group for The Commonwealth Fund. Analysis of the Effect of Creating a Mandatory Insurance Pool developed by the Hay Group, "Cost and Effects of Extending Health Insurance Coverage," Congressional Research Service 1990.

Source: The Lewin Group, *The Path to a High Performance U.S. Health System: Technical Documentation*, February 2009, p. 13-14.

**Exhibit A-2. Net Impact of Insurance Reform Policies Alone,
Including Exchange and Public Plan, By Major Payer Groups**

\$ billions	Annual Net Impact											Cumulative Net Impact
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2010–2020
National Health Expenditure	28	43	21	23	-64	-68	-72	-77	-83	-88	-94	-432
Federal Government	99	121	138	153	156	169	185	203	217	232	250	1,924
State and Local Government	-18	-30	-42	-47	-65	-70	-76	-83	-88	-94	-101	-713
Private Employers	47	71	44	46	14	15	16	17	17	18	19	324
Households	-100	-119	-118	-130	-169	-182	-197	-215	-229	-244	-263	-1,966

Data: Estimates by The Lewin Group for The Commonwealth Fund.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

**Exhibit A-3. Net Impact of Insurance, Payment,
and System Reform Policies, by Major Payer Groups**

\$ billions	Annual Net Impact											Cumulative Net Impact
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2010–2020
National Health Expenditure	1	-8	-66	-108	-226	-270	-325	-389	-464	-544	-599	-2,998
Federal Government	70	83	85	79	68	62	56	47	29	10	4	593
State and Local Government	-18	-35	-52	-62	-84	-94	-107	-123	-139	-155	-166	-1,034
Private Employers	51	70	27	13	-21	-30	-41	-53	-69	-85	-94	-231
Households	-102	-126	-126	-139	-190	-208	-232	-260	-286	-315	-342	-2,325

Data: Estimates by The Lewin Group for The Commonwealth Fund.

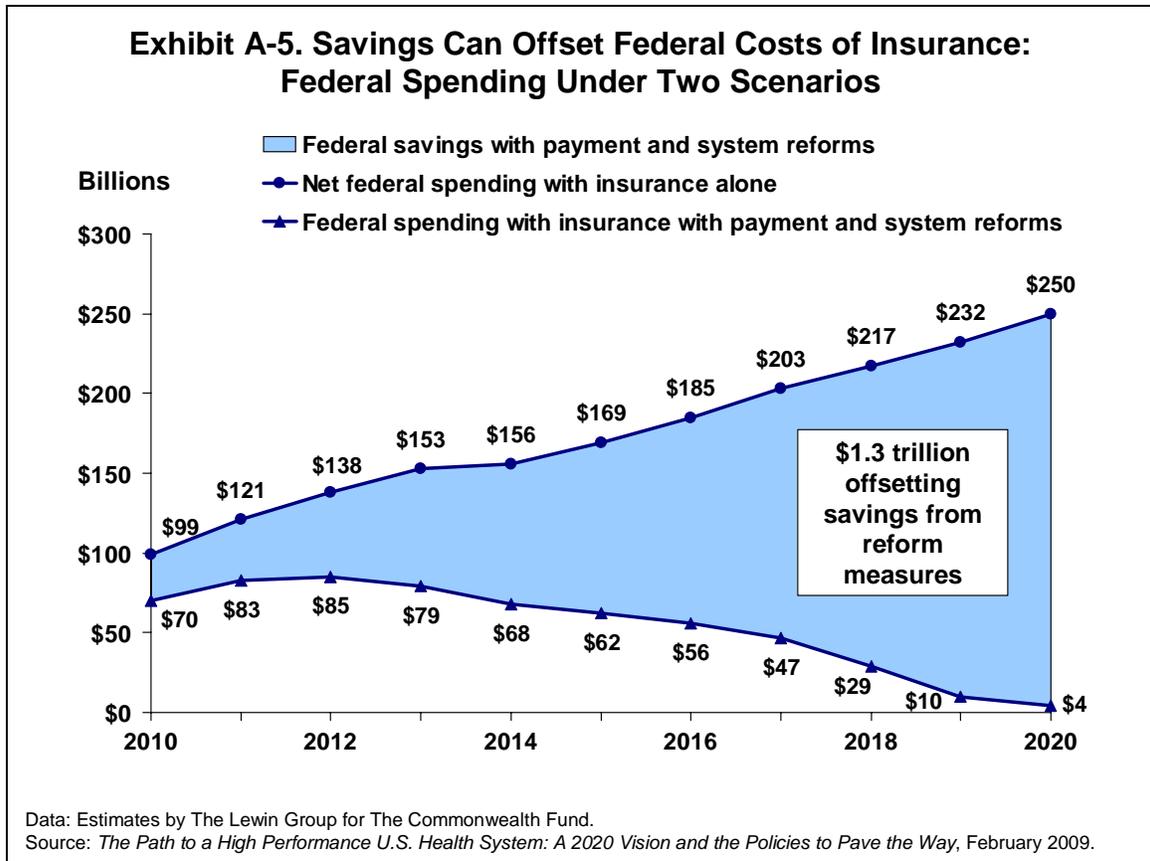
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Exhibit A-4. Sources of Path Savings, Net Impact by Payer and National Health Expenditures: Insurance Alone and All Reforms, 2010–2020

\$ billions	Total NHE	Federal Government	State and Local Government	Private Employers	Households
Net Cost of Insurance Expansion and Reduced Administrative Costs	-\$432	\$1,924	-\$714	\$323	-\$1,964
Payment Reform: Aligning Incentives to Enhance Value					
Enhanced payment for primary care	-\$71	-\$30	-\$2	-\$28	-\$11
Encouraged adoption of the medical home model	-\$175	-\$101	-\$13	-\$25	-\$36
Bundled payment for acute care episodes	-\$301	-\$211	-\$4	-\$75	-\$11
Correcting price signals	-\$464	-\$407	\$9	-\$42	-\$24
Improving Quality and Health Outcomes: Investing in Infrastructure and Public Policies to Aim Higher					
Accelerating the spread and use of HIT	-\$261	-\$101	-\$71	-\$26	-\$63
Center for Comparative Effectiveness	-\$634	-\$232	-\$120	-\$172	-\$110
Reduced tobacco use	-\$255	-\$95	-\$46	-\$75	-\$39
Reduced obesity	-\$406	-\$154	-\$73	-\$112	-\$67
TOTAL NET IMPACT, 2010–2020	-\$2,998	\$593	-\$1,034	-\$232	-\$2,325

Data: Estimates by The Lewin Group for The Commonwealth Fund.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.



B. Methodology Notes

The Commission endorses the strategic approaches rather than the specific policy parameters used to model potential effects—recognizing that there may be alternative ways to specify the key policy reforms it recommends. Modeling the Commission recommendations, however, required detailed specifications for each of the policy approaches. On behalf of the Commission, staff developed specifications for illustrative purposes and The Commonwealth Fund contracted with The Lewin Group to estimate the likely impact of the policies using specifications provided by the Fund.

The Lewin Group provided all estimates for the potential impact of the policies specified to illustrate a comprehensive approach to insurance, payment, and system reforms. The Lewin technical report, *The Path to a High Performance U.S. Health System: Technical Documentation* (available at www.Lewin.com), provides further detail on data used for the estimates and modeling assumptions. In interpreting these estimates, it must be remembered that they depend on the specifics of the proposals as modeled, assumptions about how rapidly and how well they could be implemented, and the behavioral responses of key stakeholders. Given the limitations inherent in modeling possible future interactions, the estimates tend to focus on first-round effects, rather than the potential dynamic gains as a new set of incentives spurs behavioral change and synergies develop as policies interact.

Following the tradition of estimates for federal policies, the analysis presents point estimates rather than a range. For example, the estimate of nearly \$3 trillion in cumulative savings through 2020 could be viewed as an intermediate—but most likely—estimate. A more optimistic estimate, assuming that the payment and system reform policies were 2 percent more effective per year, would result in estimated total cumulative savings compared with baseline national health expenditures of \$3.3 trillion; a more pessimistic estimate, assuming that these policies are 2 percent per year less effective, would produce estimated cumulative savings of \$2.7 trillion.

The estimates draw on existing evidence regarding likely responses to policy changes relative to national projections of spending, absent policy change. Where the effectiveness of a policy is particularly uncertain, the estimates use specific assumptions of the policy's potential effectiveness. In all cases, these assumptions represent reasonable professional judgments—supported to the extent possible by corresponding estimates in the literature—of the likely consequences of pursuing each option.

Modeling the future with complex policy changes is inherently challenging and risky. The technical challenges include the uncertainty of estimating dynamic effects over time. Just as important, the estimates assume effective design and implementation, and therefore do not reflect the difficulty of achieving agreement, designing complex policy changes, or the organizational adjustments required to implement them successfully.

In some policy areas, the Congressional Budget Office (CBO) has recently provided estimates of possible spending impacts. In particular, CBO's December 2008 *Budget Options, Volume 1* examined a policy to establish a Center for Comparative Effectiveness, policies that would encourage provider adoption of health information technology (HIT), and several payment policies. For both the Center and HIT, CBO's estimates are notably different from policies in the Path report. One source of the difference is that CBO's focus is on the impact of policy changes on the federal budget. Another major difference is that although the policies analyzed by CBO are similar in focus to those in this report, the policies specified differ in key respects. We describe some of these differences below:

- **Center for Comparative Effectiveness:** Most of the estimated savings from the Path proposal to establish a Center for Comparative Effectiveness derive from the assumption that insurance policy changes would use the Center's findings to change benefits and pricing policies to influence and change provider and patient behavior. The goal would be to discourage ineffective care and encourage high-quality care and the most cost-effective treatment. This would apply to existing treatment and medications as well as new technologies. Unlike the legislation that generated the CBO estimates, the Path policy includes provisions that require providers to engage in shared decision-making with their patients when there are alternative treatment regimens available for a given condition and increase patient out-of-pocket payments for services the application of which are not supported by the available evidence. Such policies could also include reference pricing for prescription medications. As a result, there are direct incentives to change behavior in response to the available information, which produce large savings.
- **Accelerating HIT:** Unlike the CBO estimates of policies to encourage or require the use of HIT, the Path policy includes a sizeable investment in health information exchange networks (HIENs), in addition to incentives for individual or groups of providers to adopt HIT. In fact, more than two-thirds of the estimated savings from the HIT policies analyzed in the Path report are from investments in HIENs and interoperability. That said, the Path estimates of the impact of policies to encourage HIT adoption are higher than those developed by CBO (primarily due to Lewin's

inclusion of savings from improved quality of care, particularly from management of patients with chronic conditions), but most of the difference results from the effects of investment in HIENs.

Estimates produced by different models may differ. It is important to determine whether those differences relate to the parameters used in the models themselves or in the specifications of the policies. In short, the design of policies matter.

FURTHER READING

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*An Analysis of Leading Congressional Health Care Bills, 2007–2008: Part I, Insurance Coverage*](#) (Jan. 2009). Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi.

[*Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*](#) (Aug. 2008). Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustgi.

[*Organizing the U.S. Health Care Delivery System for High Performance*](#) (Aug. 2008). Anthony Shih, Karen Davis, Stephen Schoenbaum, Anne Gauthier, Rachel Nuzum, and Douglas McCarthy.

[*Public Views on U.S. Health System Organization: A Call for New Directions*](#) (Aug. 2008). Sabrina K. H. How, Anthony Shih, Jennifer Lau, and Cathy Schoen.

[*Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*](#) (July 2008). The Commonwealth Fund Commission on a High Performance Health System.

[*The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation*](#) (May 2008). Douglas McCarthy, Rachel Nuzum, Stephanie Mika, Jennifer Wrenn, and Mary Wakefield.

[*The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings*](#) (May 2008). Karen Davis, Cathy Schoen, and Sara R. Collins.

[*Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*](#) (Dec. 2007). Cathy Schoen, Stuart Guterman, Anthony Shih, Jennifer Lau, Sophie Kasimow, Anne Gauthier, and Karen Davis.

[*A High Performance Health System for the United States: An Ambitious Agenda for the Next President*](#) (Nov. 2007). The Commonwealth Fund Commission on a High Performance Health System.

[*A Roadmap to Health Insurance for All: Principles for Reform*](#) (Oct. 2007). Sara R. Collins, Cathy Schoen, Karen Davis, Anne Gauthier, and Stephen C. Schoenbaum.

[*Denver Health: A High-Performance Public Health Care System*](#) (July 2007). Rachel Nuzum, Douglas McCarthy, Anne Gauthier, and Christina Beck.

[*Aiming Higher: Results from a State Scorecard on Health System Performance*](#) (June 2007). Joel C. Cantor, Cathy Schoen, Dina Belloff, Sabrina K. H. How, and Douglas McCarthy.

[*Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*](#) (Jan. 2007). Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum.

[*Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*](#) (Sept. 2006). The Commonwealth Fund Commission on a High Performance Health System.

[*Framework for a High Performance Health System for the United States*](#) (Aug. 2006). The Commonwealth Fund Commission on a High Performance Health System.



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