



**PUTTING THE U.S. HEALTH SYSTEM
ON THE PATH TO HIGH PERFORMANCE**

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Invited Testimony

U.S. House of Representatives, Committee on Ways and Means

**Hearing on “Health Reform in the 21st Century:
Expanding Coverage, Improving Quality, and Controlling Costs”**

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Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on Health Reform in the 21st Century: Expanding Coverage, Improving Quality, and Controlling Costs. With the economy in crisis and health costs increasing faster than incomes, families, employers, and federal, state, and local government budgets are feeling the pressure. Yet, despite the high level of spending, the U.S. health system falls short of producing the quality and outcomes that should be possible. We can do much better. But to do so will require extending insurance coverage to everyone; changing the way insurance markets work; moving away from fee-for-service payment to encourage value rather than volume; rewarding more patient-centered, effective, and efficient care; and the leadership and commitment needed. It is urgent to start now—the longer we wait, the worse these problems get and the more difficult they are to confront.

A recent report of The Commonwealth Fund Commission on a High Performance Health System, [*The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*](#), offers an integrated system framework that moves the U.S. health system on a path to high performance—slowing the growth in health care costs, ensuring access to quality care, and protecting families. The Path framework encompasses five key strategies:

- **Affordable coverage for all: access and foundation for payment and system reforms**
 - Insurance exchange: choice of private plans and new public health insurance plan
 - Market reforms, affordability, and shared responsibility
- **Align incentives: payment reform to enhance value**
 - Accessible, patient-centered primary care
 - Move from fee-for-service to more “bundled” payment, with accountability
 - Align price signals with efficient care and value

- **Accountable, patient-centered, coordinated care**
- **Aim high to improve quality and health outcomes**
 - Invest in infrastructure and information
 - Promote health and disease prevention
- **Leadership and collaboration among private and public stakeholders**

Analysis of specific policies consistent with this approach indicates that an integrated set of policies could slow the growth in national health spending from a 6.7 percent annual rate of growth over the 2010–2020 period to 5.5 percent. Doing so would yield total system savings of a cumulative \$3 trillion through 2020, compared with current projections. Employers would save \$231 billion over this period—providing much needed relief to struggling businesses. State and local governments, hard hit by the economic crisis, would save \$1 trillion. Households would save \$2.3 trillion over the period, averaging \$2,300 per family per year in 2020 alone. As the central source of financing for coverage expansions, the federal government’s costs would increase during early years. The federal government’s cumulative net costs—with all of the components of the Path framework in place—would be \$593 billion over 2010–2020. Most of the federal expenses would occur in early years as a result of initial investments. These upfront investments would yield a substantial return for the nation and the federal government: by 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections.

The Path framework would achieve near-universal coverage, ensure access, enable continuity of care and coverage, and lower premiums. The numbers of uninsured would drop quickly, falling to less than 1 percent of the population without health insurance coverage by 2012. In addition, coverage would be improved for millions of the underinsured, those with inadequate coverage that put them at high financial risk if sick or injured.

The central feature of the Path framework is an insurance foundation that would enable rapid progress toward slowing the growth in national health spending—with gains in efficiency and value nationwide. Based on the belief that the U.S. needs to find its own unique path forward, the insurance framework builds on the strengths of private and public insurance while offering new choices for families and businesses. The creation of a national health insurance exchange with a choice of private plans and a new public health insurance plan would provide a mechanism for employers and individuals to obtain coverage with multiple advantages. The approach would:

- Build on and harness the strengths of both private insurance and publicly sponsored insurance;
- Improve choice and continuity, and provide a secure option nationwide that will always be there;
- Broaden the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve;
- Ensure that markets work in the public interest and serve as a counterbalance to undue market power by insurers or providers;
- Reduce administrative cost and complexity—making it easy to enroll, select a plan, and change or keep coverage; and
- Provide a less-expensive foundation for expanding health insurance coverage to everyone and thus lower the federal cost of covering the uninsured and improving coverage for the underinsured.

By focusing competitive market forces in the public interest, this framework offers a path to rapid gains in slowing the growth in national health spending, and it does so in a way that also improves access and financial protection for families.

One major advantage of the public health insurance plan is that it broadens the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve. The Commission recommended payment policies that would reward value—better outcomes and more-efficient care. The payment reforms would apply to Medicare, Medicaid, and the public health insurance plan and could be adopted and adapted by private insurance. The reforms would:

- Enhance payment for primary care by revising the Medicare fee schedule and updates;
- Encourage adoption of the medical home model to promote coordinated care with new payment methods for primary 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 posed by the current fee-for-service system that pay for volume with reforms to spur the reorganization and reorientation of

the health care delivery system to improve quality and promote more prudent use of resources.

The President has called for bold change to address the crushing financing burdens of rising health care costs for both businesses and families. His proposed health reform reserve fund, included in budget reconciliation, would provide the essential start for reform. The American Recovery and Reinvestment Act of 2009 made key investments in health information technology and generation of evidence-based information about medical care to support patients and clinicians.

Building on this start and moving forward will require deciding how to secure insurance coverage and change payment incentives to emphasize value, not volume. Medicare can innovate but it cannot go alone. Reforms that seek to bend the cost curve and improve coverage for those under age 65 will need to incorporate these payment and system reforms to have coherent policies and a significant impact. In short, we need a “system” approach to take a new path for the nation’s health system.

Although politically difficult, there is an urgent need to move in a new direction. The comprehensive reforms proposed here will help spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure all families are able to get the care they need with financial security. The cost of inaction is high. With both a historic political opportunity and a clear path toward a high performance health system, the time has come to take bold steps to ensure the health and economic security of this and future generations.

PUTTING THE U.S. HEALTH SYSTEM ON THE PATH TO HIGH PERFORMANCE

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The Commonwealth Fund**

Thank you, Mr. Chairman, for this invitation to testify on Health Reform in the 21st Century: Expanding Coverage, Improving Quality, and Controlling Costs. Even before our severe economic crisis, it was clear that we cannot afford to continue on our current course—with ever-rising numbers of uninsured and the health sector consuming an ever-greater share of our national economy. 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. Even millions of insured families today are confronting access barriers and facing financial hardship as a result of inadequate coverage and uncovered medical bills. Employers also are feeling the pressure as health care becomes a larger and larger part of their operating costs, making it more difficult for them to compete in an increasingly difficult market. Moreover, federal, state, and local budgets are being increasingly consumed by health care spending. Yet, despite the high level 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.

We can do much better. But to do so will require extending insurance coverage to everyone; changing the way insurance markets work; moving away from fee-for-service payment to encourage value rather than volume; rewarding more patient-centered, effective, and efficient care; providing information to support better health care decision-making; and setting ambitious goals for improvement in population health with the leadership and commitment required to meet those goals. All of these changes are necessary to alter the unsustainable path we are now on. It is urgent to start now—the longer we wait, the worse these problems get and the more difficult they are to confront. 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. It requires health reform that focuses on access, quality, and cost—not just one component of the problem, but rather an integrated, systems approach.

An integrated set of policies building on our current mixed private and public insurance system would establish a new insurance foundation that could harness market forces to work in the public interest. This framework, coverage for all, combined with

payment and system reforms, has the potential to slow the growth of health costs that confront families and businesses across the U.S. substantially *and* improve access, quality, and health outcomes. These comprehensive reforms emphasize choice, build on the best in our current system and help it work better, and enhance the value the nation receives in return for our substantial investment in health care.

Path to a High Performance Health System

The Commonwealth Fund Board of Directors established a Commission on a High Performance Health System in 2005 with the charge to develop such a framework for policy action. Its recent report, [*The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*](#), is an integrated system approach that moves the U.S. health system on a path to high performance—slowing the growth in health care costs, ensuring access to quality care, and protecting families.¹ In offering this framework (referred to as the Path framework), the Commission recognizes that while the path ahead is clearly visible, it is 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 to put the U.S. health system on the path to high performance.

The Path framework encompasses five key strategies:

- **Affordable coverage for all: access and foundation for payment and system reforms**
 - Insurance exchange: choice of private plans and new public health insurance plan
 - Market reforms, affordability, and shared responsibility
- **Align incentives: payment reform to enhance value**
 - Accessible, patient-centered primary care
 - Move from fee-for-service to more “bundled” payment, with accountability
 - Align price signals with efficient care and value
- **Accountable, patient-centered, coordinated care**
- **Aim high to improve quality and health outcomes**

¹ The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

- Invest in infrastructure and information (information technology; research on evidence-based care; transparency and public reporting; training, technical assistance, and support to improve care)
- Promote health and disease prevention
- **Leadership and collaboration among private and public stakeholders**

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 health insurance 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 (and provide rewards as well) 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.

A central feature of the design is an insurance exchange, offering expanded choices of private plans and a new public health insurance plan. Offered through the exchange, the new public health insurance plan 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 the standard option offered to federal employees and members of Congress with value-based benefits that encourage prevention and essential care (Exhibit 1). 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 Public Health Insurance Plan Offered in Insurance Exchange		
	Current Medicare benefits*	New Public Health Insurance 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 Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, February 2009).



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

This framework provides a foundation for more affordable and continuous insurance coverage, offers more choice, and lays the groundwork for payment and system reforms. All payment reforms recommended for Medicare would also apply to the new public health insurance plan, considerably increasing leverage to achieve transformation of the delivery system. To streamline public purchasing and improve access for Medicaid beneficiaries, the reforms peg Medicaid payment to Medicare levels and methods, with an increase in federal matching rates to offset costs to states.

A summary of policy modeling specifications prepared by Commission staff used in generating coverage and cost estimates is contained in the [Appendix](#). Estimates were prepared by The Lewin Group. 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.

Estimated Impacts and Outcomes

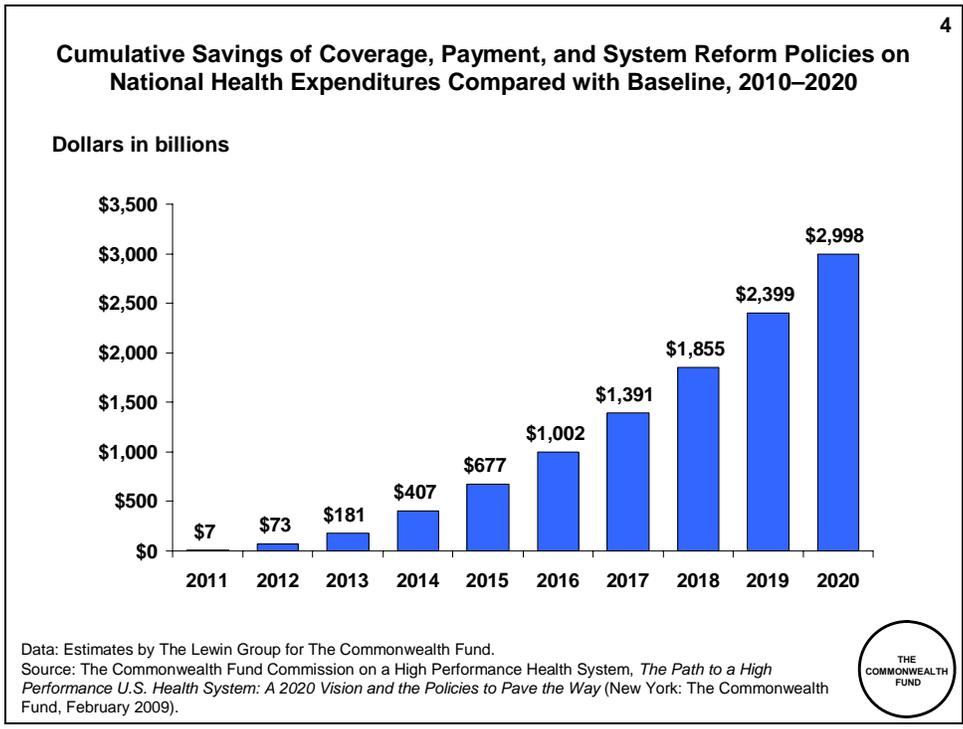
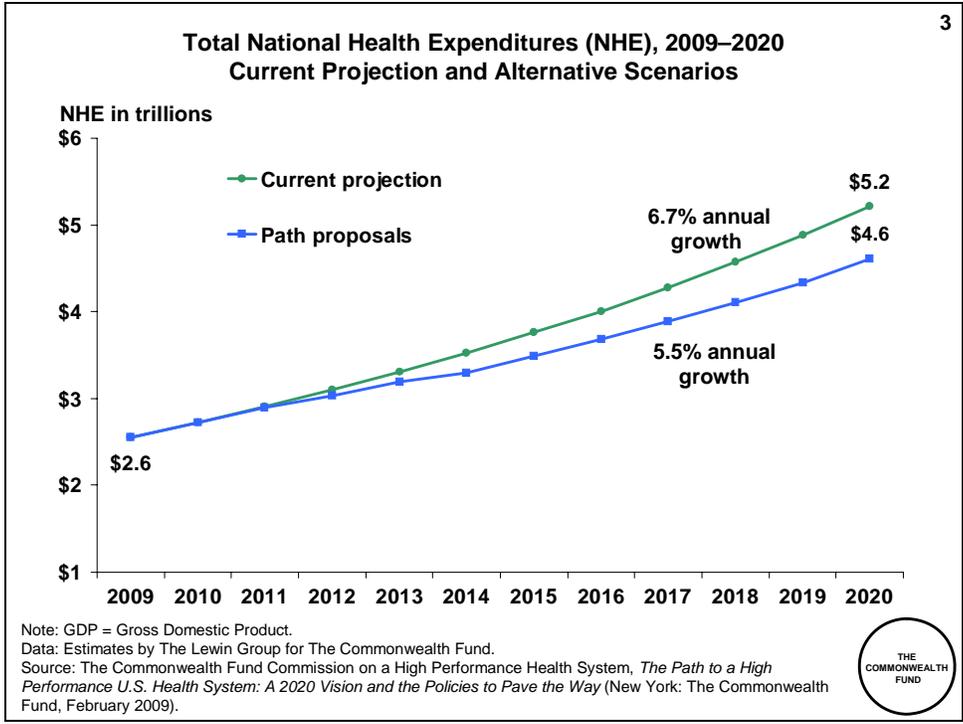
The Path framework could achieve access for all while providing more affordable choices for those who currently are insured, substantially slow the growth in health costs, and improve population health, with more positive patient experiences. Analysis of specific policies consistent with this approach indicates that an integrated set of policies could slow the growth in national health spending from a 6.7 percent annual rate of growth over the 2010–2020 period to 5.5 percent. Doing so would yield total system savings of a cumulative \$3 trillion through 2020, compared with current projections (Exhibits 2, 3, and 4).

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Overall Findings

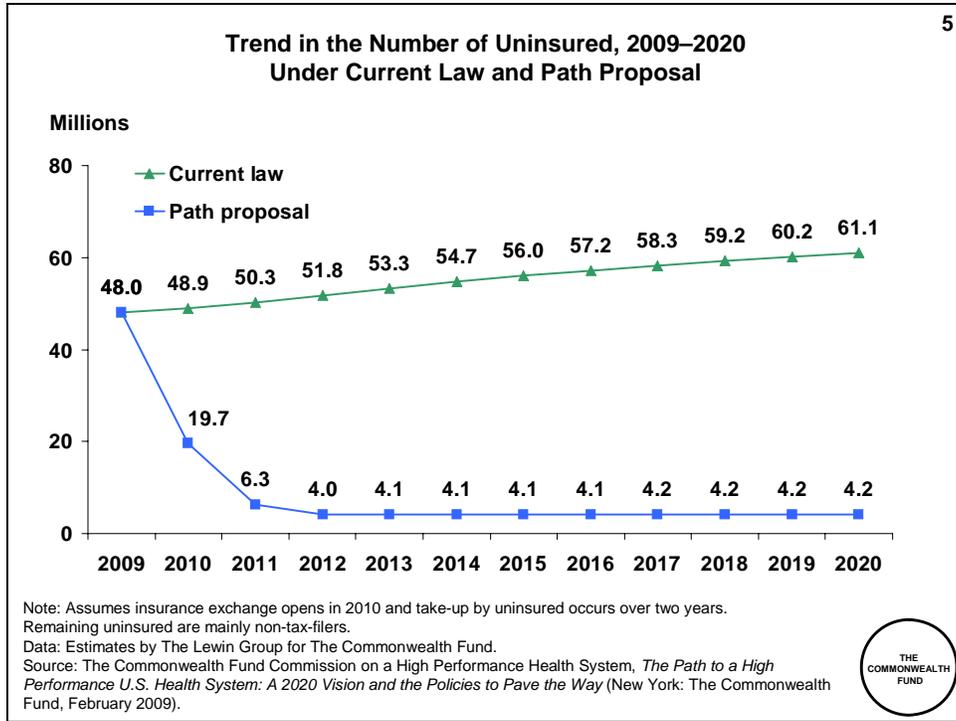
- **Possible to extend affordable insurance to all and improve health outcomes and cost performance**
 - Nearly all, 99 percent, insured within 2 years
 - Insurance reforms would enhance access, choice, continuity and lower premiums
- **Insurance, payment, and system reforms could slow spending growth by cumulative \$3 trillion through 2020**
 - Decreases annual growth from 6.7 to 5.5 percent
- **Families, businesses, and the public sector all would spend less compared to current projections**
 - Savings accrue across all income groups
 - Savings could partially offset federal costs of investing in insurance and system reforms
- **Critical to start now: policies interact over time**
- **A comprehensive approach is essential**





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. If we continue on our current path, the numbers of uninsured will increase from 48 million to 61 million in

2020—even assuming our economy quickly recovers. Under the Path framework, the numbers of uninsured would drop quickly to about 4 million people or 1 percent of the population without health insurance coverage (Exhibit 5).



The most important aspiration we all share for the health system is that it will ensure that our families and we are able to attain and maintain the best possible health. Studies by the Institute of Medicine as well as The Commonwealth Fund Commission’s national and state scorecards have documented that we currently fall far short of attainable benchmarks for quality, safety, and health outcomes.² If we were to embrace the policies set forth in the Path report, we should be able to achieve benchmarks of high performance. By 2020 there could be 100,000 fewer deaths a year, 80 percent of adults receiving all recommended preventive care (instead of 50 percent currently), better control of chronic conditions, and major reductions in hospitalizations for preventable conditions (Exhibit 6). The value we obtain for our investment in the health care sector would be improved markedly, and put the United States in its rightful place as a leader in the health and health care it provides to its people.

² The 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); and J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, June 2007).

**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.



The savings from this transformation of the health system would be shared by businesses, households, and state and local governments. Employers that 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, 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 (Exhibit 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 Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, February 2009).

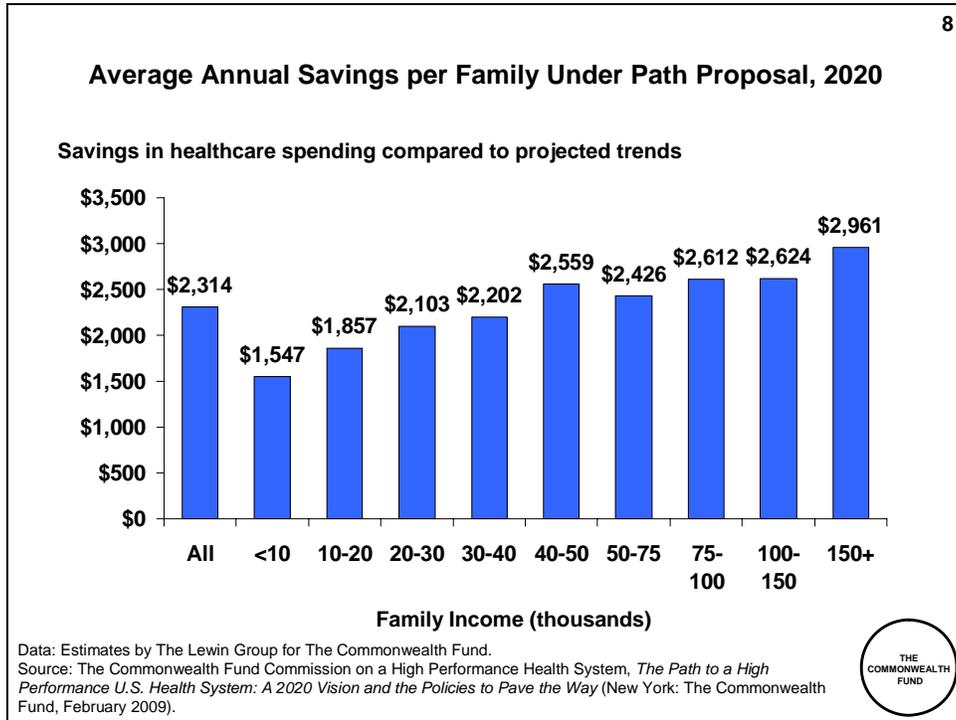


The combination of slower cost growth and policies specified in the analysis result in an estimated \$1 trillion in state and local government cumulative savings by 2020, compared with projected levels. Savings would come from four sources: 1) federal support for dually eligible Medicaid and Medicare 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 4) state and local government savings due to lower and slower-growing public employee health benefit costs.

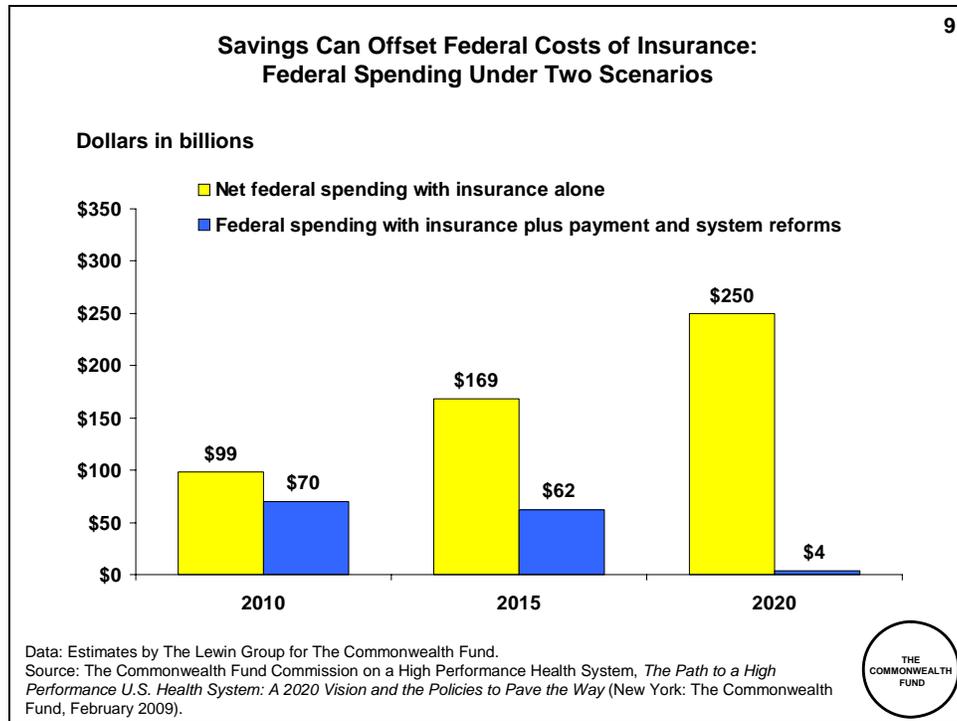
Most of the savings, however, would accrue to individuals and families as a result of federal support of premium assistance, expansion of public programs to make insurance affordable, and the reduction in the growth in premium and health care costs over time. Household cumulative savings would exceed \$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. By 2020, savings per family would result from less rapid cost growth in premiums due to delivery system

changes in response to reforms. Estimated savings would average \$2,300 per family per year in 2020 (Exhibit 8).



As the central source of financing for coverage expansions, the federal government’s costs would increase during early years. The Path framework provides federal funding to offset the state and local costs of expanding Medicaid and raising Medicaid payment rates to Medicare levels; the estimates of its impact did not involve reallocating state/local government savings from other reforms. Similarly, no new sources of federal revenue were specified to offset the cost of providing income-related premium protection for the entire population, including current Medicare beneficiaries. As a result, the federal government’s cumulative net costs—with all of the components of the Path framework in place—would increase by \$593 billion through 2020. Federal savings from the payment and system reforms provide increasing offsets to the additional federal costs of insurance expansion and system investments, so that the estimated additional cost to the federal government falls sharply from 2015 to 2020. By 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections (Exhibit 9).



Transforming the Market for Insurance

Employment-sponsored health insurance would continue to be the mainstay of health insurance coverage for those under age 65. However, the Path framework addresses many of the flaws in the current system. It gives employers the option of either purchasing coverage directly from private insurers or bringing their employees as a group into the national health insurance exchange. Creating a national health insurance exchange with choice of private plans and a public health insurance plan as a mechanism for employers to obtain coverage for their employees as well as for individuals outside the employment-based system has many advantages. The approach would:

- Build on and harness strengths of both private insurance and publicly sponsored insurance;
- Improve choice and continuity, and provide a secure option nationwide that will always be there;
- Broaden the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve;
- Ensure that markets work in the public interest and serve as a counterbalance to undue market power by insurers or providers;
- Reduce administrative cost and complexity—making it easy to enroll, select a plan, and change or keep coverage; and

- Provide a less-expensive foundation for expanding health insurance coverage to everyone and thus lower the federal cost of covering the uninsured and improving coverage for the underinsured.

By focusing competitive market forces in the public interest, this framework offers a path to rapid gains in slowing the growth in national health spending, and it does so in a way that also improves access and financial protection for families. To focus insurance competition on improving outcomes, market reforms would require that all insurers offer coverage to everyone wishing to enroll and charge the same premium for the same benefits, irrespective of health status.

Private insurers would be able to add value and compete with a focus on improving health outcomes and prudent use of resources. Private insurers would have the flexibility to select provider networks of high-performing physicians and hospitals, to innovate with new payment incentives, to improve care management tools, and value-benefit designs. Such flexibility would help foster partnerships with health care systems to improve value.

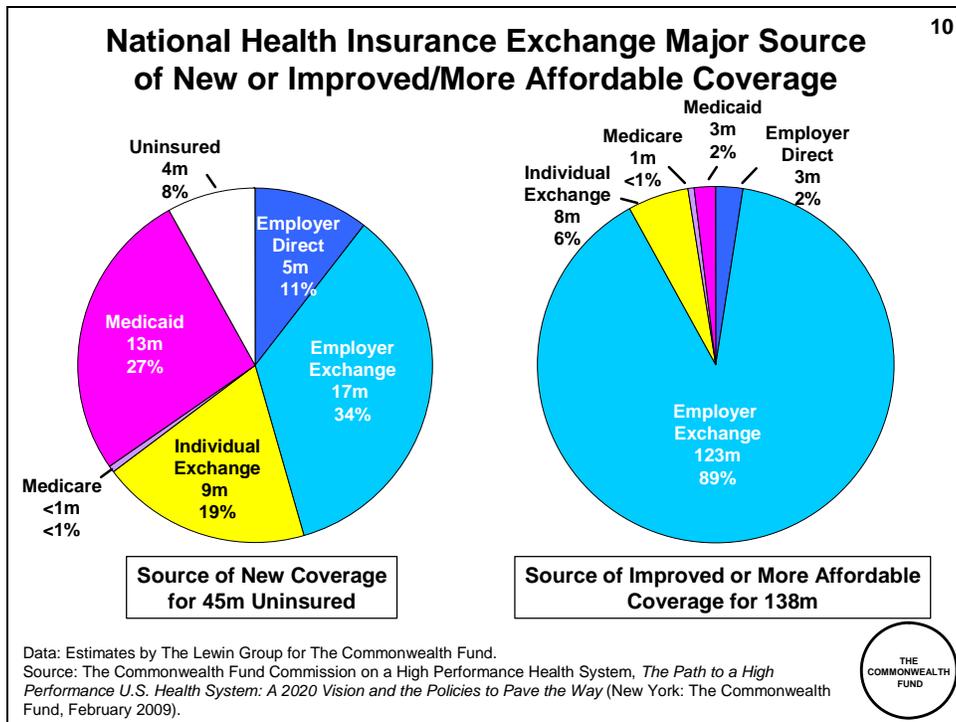
The exchange would open up markets to regional health plans. Currently, employers often restrict choices to a few plans and most small firms are unable to offer choices. It is thus difficult for regional health plans and care systems to market to these employers. The insurance exchange, operating at the state as well as the national level, would open up markets and enable such local and regional private health systems to offer coverage to residents in their geographic area participating in the exchange.

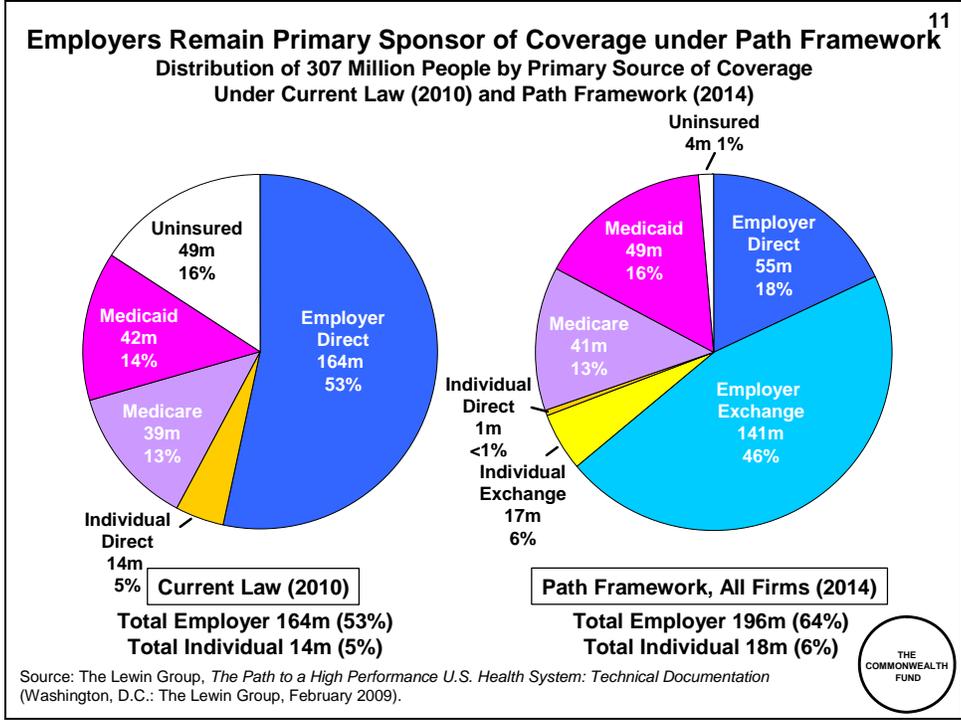
A public health insurance plan has the advantages of simplicity with one fixed benefit design, nationwide availability, broad provider networks with nearly all hospitals and physicians participating as they do in Medicare, and leverage to align provider incentives to foster transformation of health care delivery to achieve better quality and greater efficiency. Private insurers would be free to adopt innovations in payment reform in the public health insurance plan, as they have in the past in the case of Medicare's physician resource-based fee schedule. The public health insurance plan might also over time adopt private sector innovations, as they are moving to do with "pay for results" bonuses for higher quality. The competition of private and public insurers would spur each to improve and also offer opportunities to learn and collaborate.

Notably, the public insurance plan would pay claims using contracts with private insurers, as Medicare does today. This would assure economies of scale. For the first

time, there would also be the opportunity for pooled all-payer data systems for the under-65 population.

By 2014 when all employers are eligible to purchase coverage through the national health insurance exchange, an estimated 64 percent of the U.S. population (196 million people) would have coverage under employer-sponsored insurance, rather than 53 percent currently. This would include those employer groups who opt to join the insurance exchange. When coverage is obtained through the exchange—and it is estimated that by 2014 more than 70 percent of the workforce would do so, attracted by lower premiums, better benefits, and greater choice—employees could select from among a number of private health plans as well as the new public health insurance plan. An estimated 26 million uninsured would be covered through the exchange, and over 130 million of the currently insured would also participate to obtain improved or more affordable coverage (Exhibits 10 and 11).

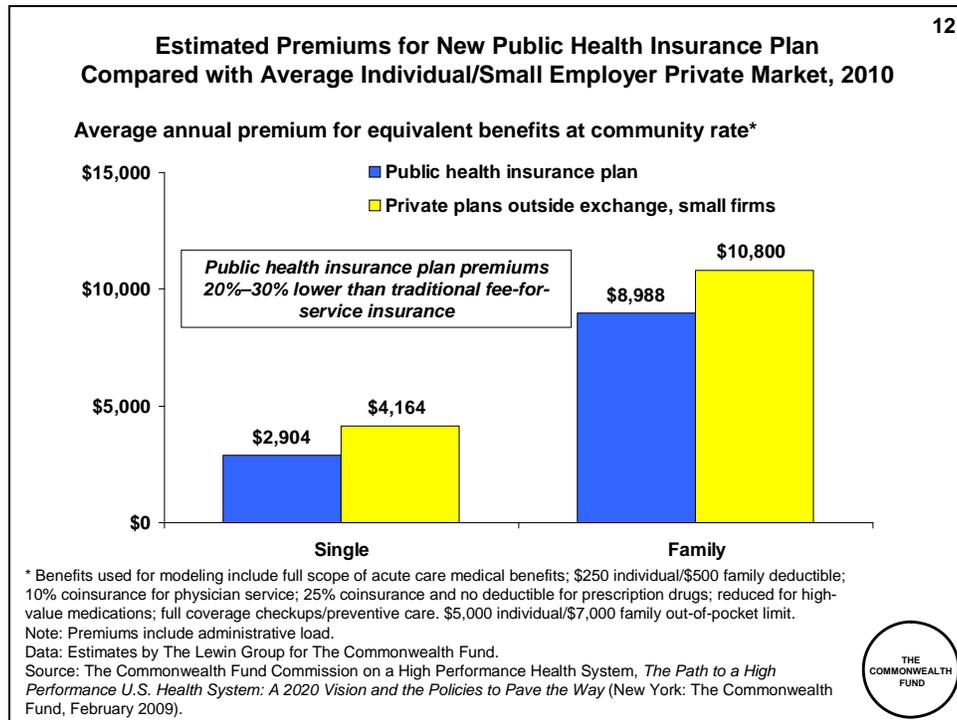




For most employees, this would provide considerably greater choice of plans than is now offered by their employers. It would reduce turnover in coverage. As more employers join the exchange, people could keep coverage as they change jobs or lose jobs during a period of unemployment. And, unlike the experience in the late 1990s and early 2000s in the Medicare managed care market, enrollees in the nationwide public health insurance plan could be assured that their plan would not be dropped from their geographic area. Notably, the decision to join the exchange or select private or public health insurance plans would be voluntary—decisions to switch would indicate a move to more-affordable or higher-quality options.

Initially, premiums available under the public health insurance plan would be an estimated 20 percent or more lower than private insurance now available to small firms (Exhibit 12). The reduced cost stems from lower administrative costs as well as payment rates. Within the exchange and the public health insurance plan, small firms would for the first time have the economies of large-group coverage. This would be a major source of relief to businesses that provide health insurance to their employees in these tough economic times. Small businesses face higher premiums for the same benefits than do large businesses—or the same premium buys far less. As a result, employees working for small businesses that sponsor coverage typically face much higher deductibles, limits or caps on benefits, and gaps in benefits—putting them at high risk when sick or injured.

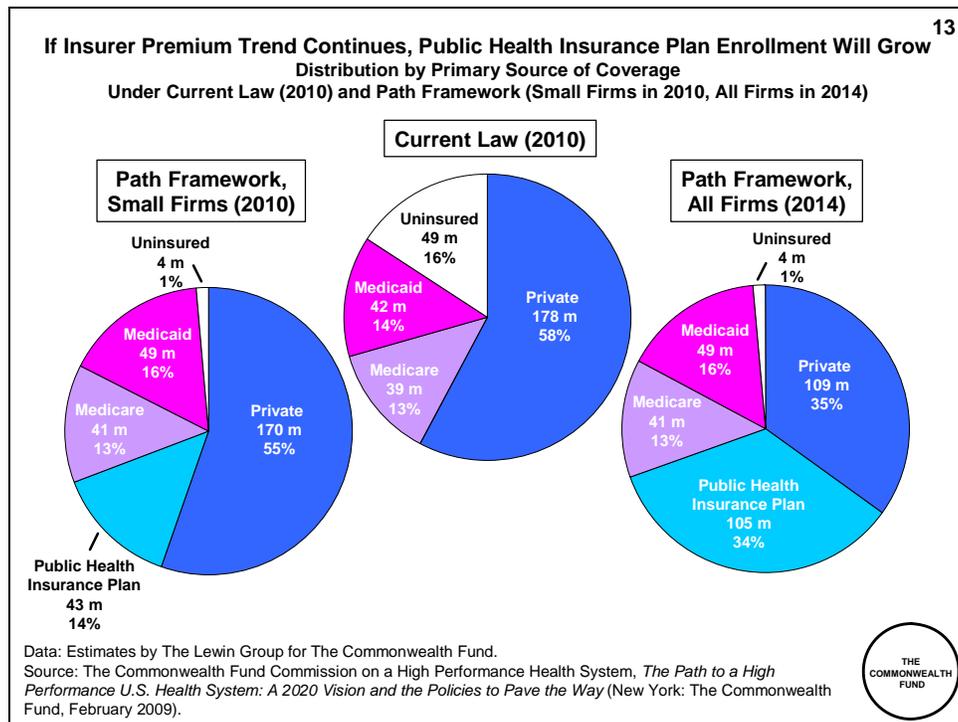
The exchange would provide small firms with many of the advantages of scale and broad risk pools.



Phasing of enrollment in the exchange would first open coverage to employees of firms with fewer than 100 employees and individuals under age 65 not covered under employer plans, followed by employees of firms with fewer than 500 employees in 2012, and firms of all sizes by 2014. This gradual opening of exchange enrollment gives private insurers who cover larger firms time to adjust their business plans to take advantage of their inherent strengths and develop strategies for meeting the premium competition posed by a public health insurance plan. The staged expansion also provides time for private insurance payment rates to realign to markets where there are no longer large numbers of uninsured and Medicaid pays at Medicare levels.

To compete, private insurers will need to add value and lower overhead. If private insurers continue on their current premium trend course, the market would shift markedly toward enrollment in the public health insurance plan. If they fail to respond, they would lose market share. In 2010 when only small firms are in the exchange, an estimated 14 percent would be enrolled in the public health insurance plan and 55 percent would be in private insurance plans—either through the exchange or purchased directly by employers (Exhibit 13). By 2014, if private insurance premium trends continue—and private insurers fail to respond to new opportunities, the market would be split evenly between

private plans and the public health insurance plan, with 35 percent in private plans and 34 percent in the public health insurance plan. Many, if not most, of private insurance enrollees would be enrolled through community health plans associated with integrated delivery systems that can achieve economies by redesigning the delivery of services. Private plans could use their greater flexibility—as well as the fact that, with everyone covered and Medicaid rates improved, they would no longer need to pay higher rates to subsidize care for the uninsured or make up Medicaid shortfalls—to compete for enrollees in the new market mechanism.



Key Role of an Insurance Exchange and Public Health Insurance Plan

One major advantage of the public health insurance plan is that it broadens the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve. The Commission recommended that payment policy provisions in Medicare, Medicaid, and the public health insurance plan would:

- Enhance payment for primary care by revising the Medicare fee schedule and updates;
- Encourage adoption of the medical home model to promote coordinated care with new payment methods for primary 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.

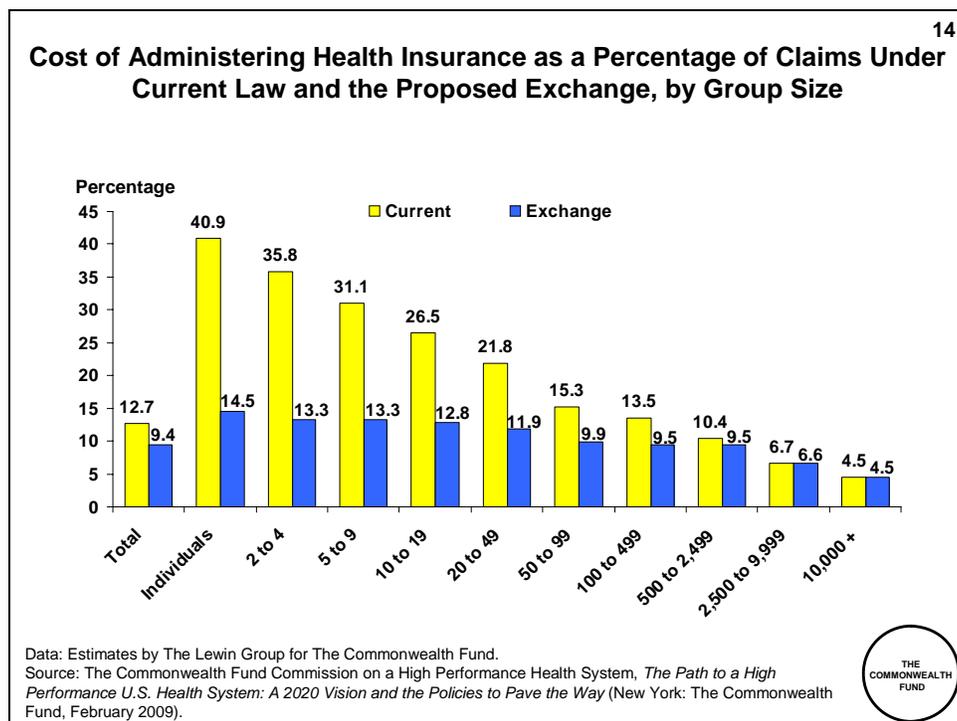
These policies replace the adverse incentives posed by the current fee-for-service system that emphasize volume with reforms to spur the reorganization and reorientation of the health care delivery system to improve quality and make more prudent use of resources. Medicare is the single most important source of payment for providers, representing 28 percent of hospital revenues and 20 percent of physician revenues. But this is still a minority of revenues. Extending provider payment reform to Medicaid and the public health insurance plan would apply this leverage to well over half of provider revenues. The primary care payment reforms would thus give primary care physicians and nurse practitioners the wherewithal to transform their practices into medical homes. Similarly, changed incentives for hospital and care systems would provide significant rewards to hospitals accountable for care not just during an initial hospitalization but over the course of patient recovery. Hospitals could gain rather than lose money by preventing complications that put patients at risk and lead to readmissions or churning in and out of post-acute care facilities. Shared savings from these changes in practice would ensure that efficient, accountable providers thrive, while substantially easing the financial burdens on businesses and families. Without a public health insurance plan, the rewards may not be sufficiently strong to effect major changes in provider behavior, and in any event any savings would only accrue to Medicare, not to employers and other payers of health care.

In recent years, the market for health insurance has become increasingly concentrated.³ In most states, three or fewer insurers account for over half of all enrollment. Indeed, in many states one carrier dominates, accounting for half or more of enrollment in the under-65 market. Insurance company margins increased rapidly in the early 2000s as market consolidation occurred and premiums outstripped increases in medical care outlays. Health care providers have also consolidated into larger systems of care, or into larger units bargaining with large insurers. One advantage of a public health insurance plan is that it ensures markets work in the public interest and serves as a counterbalance to undue market power by insurers or providers. By offering a public health insurance plan that does not aim to make a profit and employing provider payment methods and rates that reward efficient providers, it protects the public interest against concentrated market power.

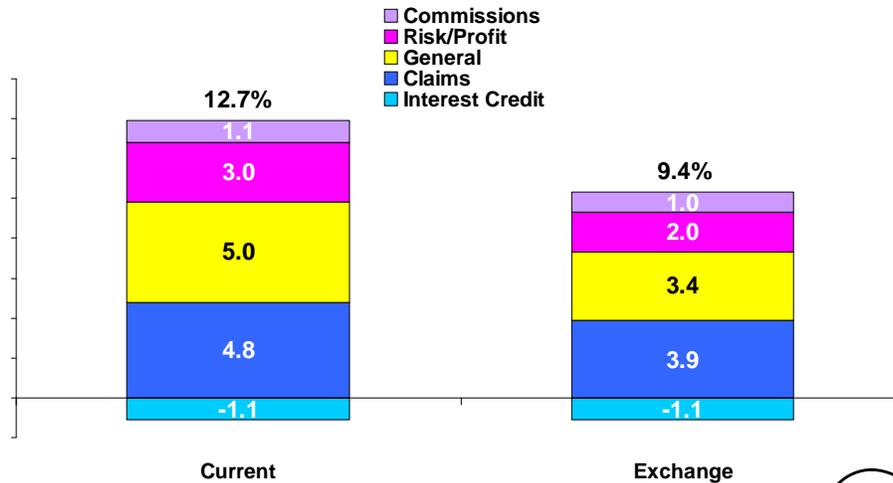
The exchange reduces administrative cost and complexity, making it easy for individuals to compare plans and premiums, select and enroll in a plan, and keep or change coverage. An estimated \$337 billion in administrative costs would be saved over

³ J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov./Dec. 2004 23(5):11-24.

the period 2010–2020. Small businesses and individuals gain the most—as administrative costs now represent on average 40 percent of premiums in the individual market and 15 percent to 35 percent of premiums in small businesses with fewer than 100 employees (Exhibit 14). Private plans offered through the exchange would have much lower administrative costs than currently as a result of reduced churning, lower marketing costs, and eliminating costs for underwriting for health risks (Exhibits 14 and 15). Overall, the exchange is expected to have administrative expenses of 4.5 percent of average premiums—in addition to administrative costs within health plans. The public health insurance plan is estimated to have administrative expenses of 3.5 percent, similar to large-group risk pools. Including the costs of operating the exchange, the premium for the public health insurance plan would include administrative costs of 8 percent. These costs would likely be lower than the average for private plans. Some of the advantages of the public health insurance plan include the absence of expenses for commissions, advertising, lower administrative salaries, and no markups for returns to investors. With a large risk pool, the public health insurance plan would hold its own reserves and earn the return on reserves similar to arrangements for federal employees and large firms. The public health insurance plan would contract with private companies to administer claims.



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

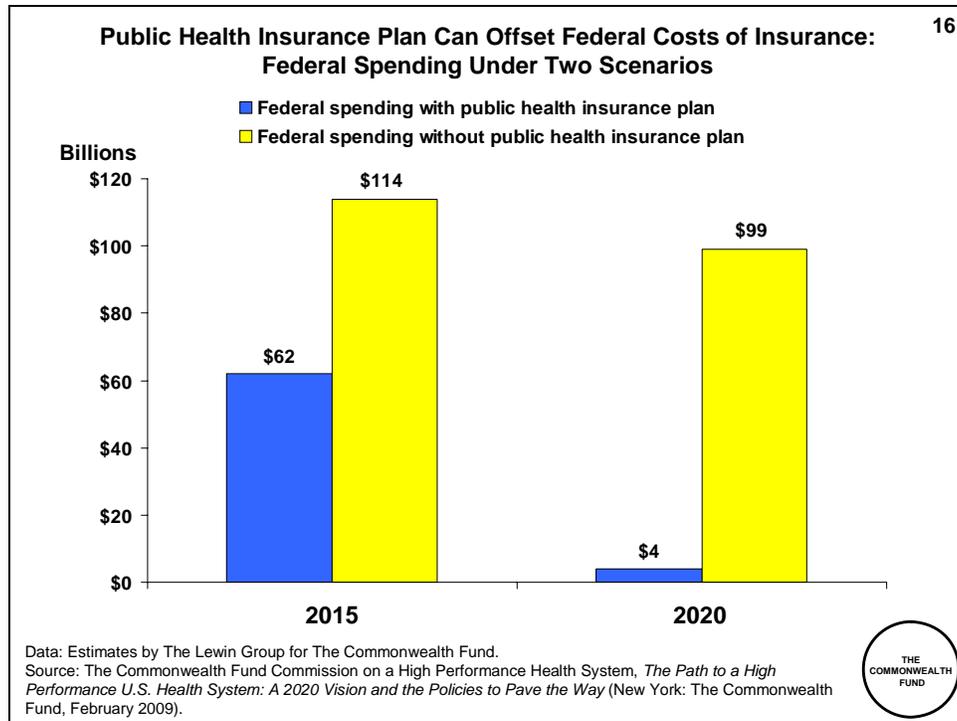


Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, February 2009).



Most importantly from a federal budget perspective, the public health insurance plan provides a less-expensive foundation for expanding health insurance coverage to everyone and thus lowers the federal cost of covering the uninsured and improving coverage for the underinsured. Twenty-six million of the uninsured would obtain coverage through the national health insurance exchange, while 13 million would be added to Medicaid or the Children’s Health Insurance Program (CHIP) (Exhibit 10). Many—an estimated 9 million—would buy directly through the exchange as individuals. Most of the remainder would be insured through their employers, including those participating in the exchange and thus offering the new public insurance option. To share responsibility for financing, the reforms include a requirement that employers cover their employees or contribute to a national coverage trust fund.

Without a public health insurance plan, the uninsured covered through the exchange would be covered at commercial insurer premiums with providers paid at commercial insurer rates. This would substantially increase the costs of covering the uninsured. It would increase federal budget outlays by an additional \$500 billion over the 2010–2020 period relative to what it would cost under an exchange with a public health insurance plan—even assuming that all of the Path recommended payment, system, and public health reforms are adopted (Exhibit 16).



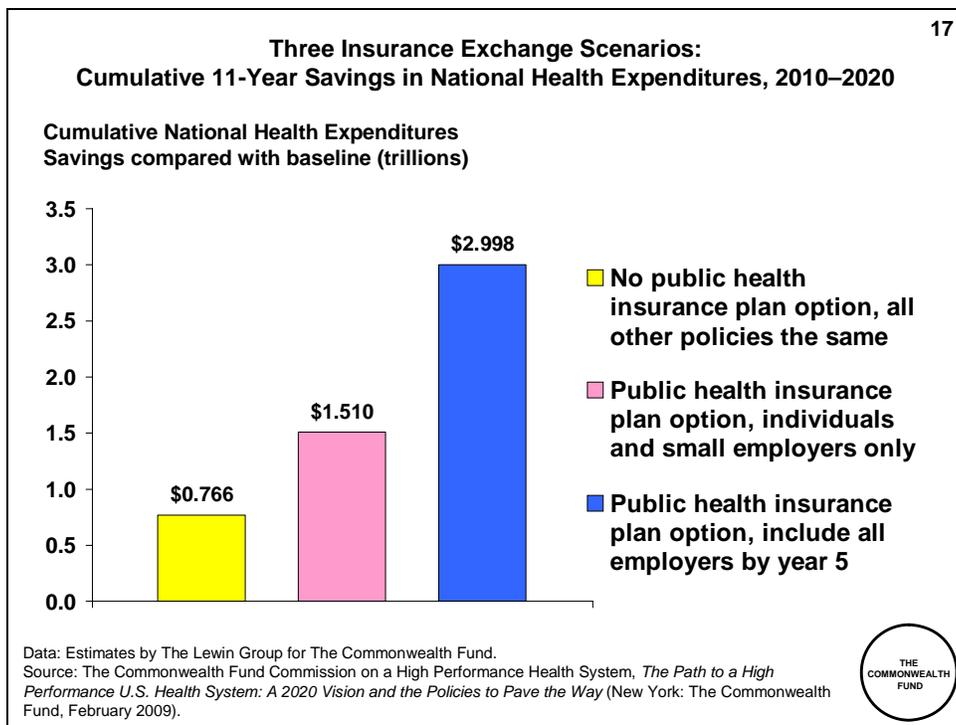
Accelerating Gains in Efficiency and Value: Bending the Cost Curve

The Commonwealth Fund Commission came to the inescapable conclusion that bending the curve of health spending requires a marked departure from the current health care financing and delivery system. By creating a uniquely American system in building on the best that both the private sector has to offer as well as tapping the leverage that a public health insurance plan can provide, significant health system savings can be realized.

The insurance exchange and opportunity to enroll in a public health insurance plan play a central role in stimulating the competitive markets and gaining leverage. In coming to this conclusion, the Commission 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, with no public health insurance plan. 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 health insurance plan competitor to set a price mark.

The modeling indicates that all three scenarios have the potential for significant savings by 2020. But the original scenario—an exchange that sponsors a public health

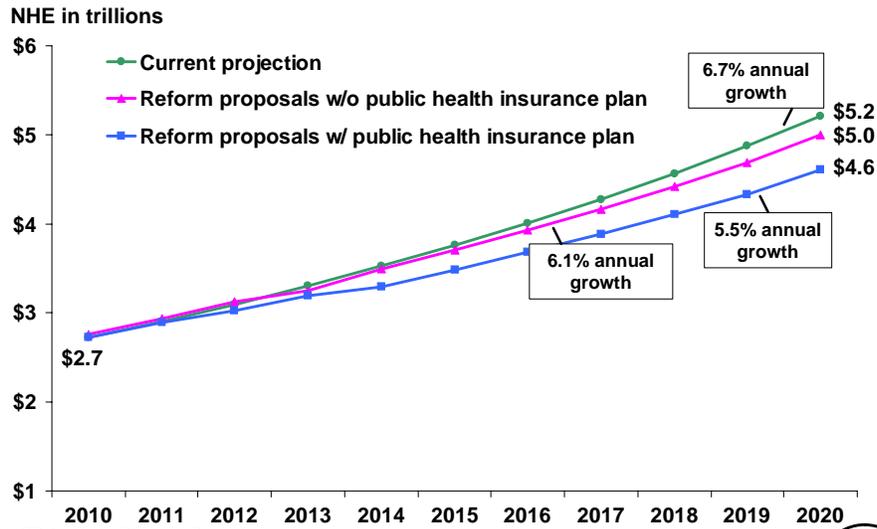
insurance plan, in addition to private plans, and is open to all employers—would achieve the greatest reduction in spending growth. This scenario could save nearly \$3 trillion by 2020 if opened to all employers in 2014, compared with \$1.5 trillion if the exchange and public plan were only open to individuals and small employers with fewer than 100 employees. An exchange offering only private plans would save about \$800 billion 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, because no mechanism exists to realign private insurance payment levels with resource costs (Exhibit 17).



Without a public health insurance plan alternative, spending on health care still slows from 6.7 percent annual increases to 6.1 percent. However, employers would see their costs increase by \$905 billion over 2010–2020, rather than the net savings of \$231 billion with a public health insurance plan available in the exchange. Administrative savings would be \$70 billion over the 2010–2020 period rather than \$337 billion, and savings from various payment reforms would be similarly reduced (Exhibits 18, 19, and 20).

Total National Health Expenditures (NHE), 2010–2020 Current Projection and Alternative Scenarios

18



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



Path Net Cumulative Impact on National Health Expenditures (NHE) 2010–2020 Compared with Baseline, With and Without Public Health Insurance Plan, by Major Payer Groups

19

Dollars in billions

	Total NHE	Net federal government	Net state/local government	Private employers	Households
With Public Health Insurance Plan	-\$2,998	\$593	-\$1,034	-\$231	-\$2,325
Without Public Health Insurance Plan	-\$766	\$1,112	-\$655	\$905	-\$2,128

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 Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, February 2009).



**Major Sources of Savings Compared with Projected Spending,
Net Cumulative Reduction of National Health Expenditures, 2010–2020
Exchange With and Without Public Health Insurance Plan as in Path Report**

	With Public Health Insurance Plan	Without Public Health Insurance Plan
<i>Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform</i>		
•Net costs of insurance expansion	–\$94 billion	\$1,385 billion
•Reduced administrative costs	–\$337 billion	–\$70 billion
<i>Payment Reform: Aligning Incentives to Enhance Value</i>		
•Enhancing payment for primary care	–\$71 billion	–\$63 billion
•Encouraging adoption of the medical home model	–\$175 billion	–\$155 billion
•Bundled payment for acute care episodes	–\$301 billion	–\$266 billion
•Correcting price signals	–\$464 billion	–\$407 billion

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



The insurance framework and new public health insurance 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 health insurance plan and private plans compete with each other with market rules that stimulate innovation and outcomes in the public interest. Developing a mechanism to set the price point and payment policies in a non-arbitrary 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.

Slowing Cost Growth with Payment Reform that Emphasizes Value

With increased emphasis on primary care, improved coordination, and the elimination of unnecessary and duplicative services, spending growth would slow relative to current projections. The payment reforms each yield substantial savings compared with projected trends (Exhibit 21). As a set, the reforms would realign incentives with a focus on better health outcomes and more efficient use of resources, including eliminating duplication of tests and preventing complications that lead to admission to the hospital or use of emergency rooms for chronic disease or complications that result in readmission to the hospital after discharge.

Net Impact of Path Payment Reform Recommendations on National Health Expenditures Compared to Current Projection, 2010–2020 (in billions)

21

	Total NHE	Private Employers	State & Local Governments	Households	Federal Budget
Total Payment Reforms	-\$1,010	-\$170	-\$10	-\$82	-\$749
Enhanced payment for primary care	-\$71	-\$28	-\$2	-\$11	-\$30
Encouraged adoption of Medical Home model	-\$175	-\$25	-\$13	-\$36	-\$101
Bundled payment for acute care episodes	-\$301	-\$75	-\$4	-\$11	-\$211
Correcting price signals					
• High cost area updates	-\$223	-\$64	-\$3	-\$29	-\$127
• Prescription drugs	-\$76	+\$22	+\$12	+\$5	-\$115
• Medicare Advantage	-\$165	\$0	\$0	\$0	-\$165

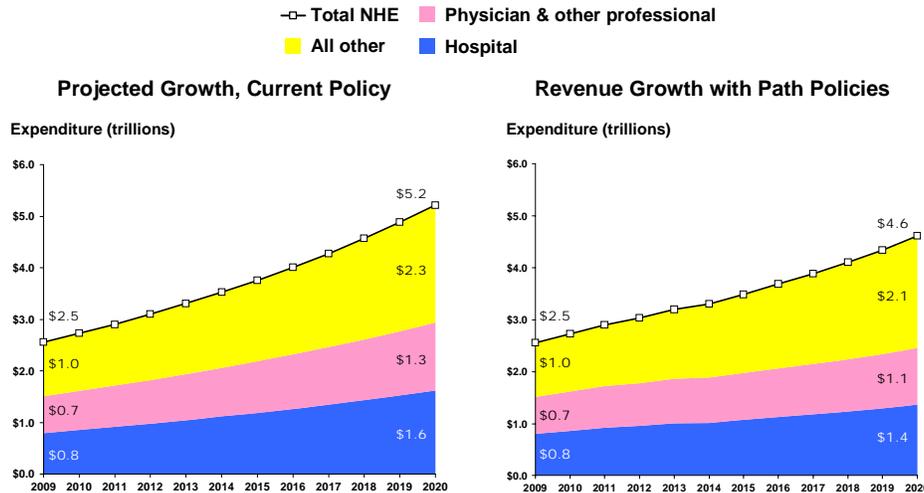
Data: Estimates by The Lewin Group for The Commonwealth Fund.
 Source: S. Guterman et al., *Reforming Provider Payment: Essential Building Block for Health Reform* (New York: The Commonwealth Fund, forthcoming).



Yet, national health expenditures would continue to grow over the decade, albeit at a slower pace. With payment and system reforms, and the leverage afforded by the public health insurance plan available to all employers, health spending by 2020 would still be 73 percent higher than current spending.

While slowing annual expenditure growth from 6.7 percent to 5.5 percent amounts to a significant change, hospital, physician, and other provider revenues would continue to experience growth each year. Growth would only be marginally slower than current projections, as demand for care continues to increase due to medical advances and an aging population (Exhibits 22 and 23). Medicaid would help offset the effect of the public health insurance plan paying at Medicare rates. These provisions will be particularly beneficial to safety net providers that now carry a disproportionate share of care to the uninsured and Medicaid beneficiaries.

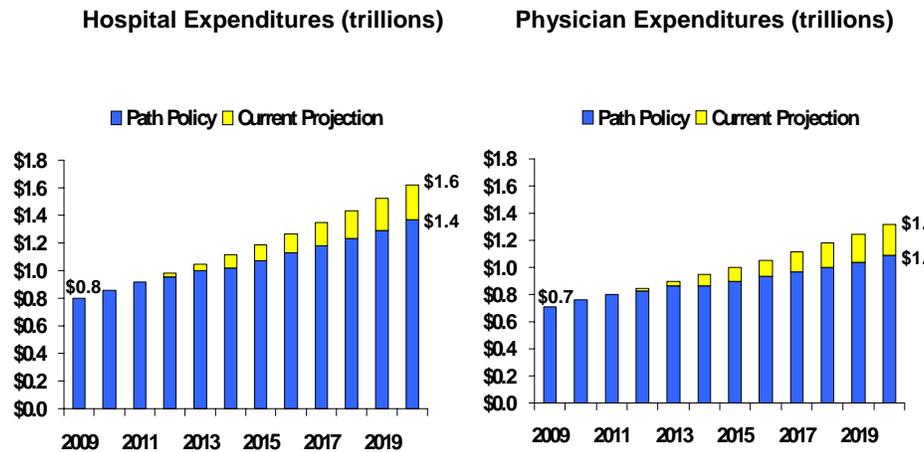
Total National Health Expenditure (NHE) Growth by Provider Sector, Current Projections and with Policy Changes, 2009–2020



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



Total National Health Expenditure Growth for Hospitals and Physicians, Current Projections and with Policy Changes 2009–2020



Data: Estimates by the Lewin Group for The Commonwealth Fund.
 Source: S. Guterman et al., *Reforming Provider Payment: Essential Building Block for Health Reform* (New York: The Commonwealth Fund, forthcoming).



In the initial years (2010–2013), these increased revenues offset any shift from small business and individual coverage into the public health insurance plan. By 2014, as large businesses have access to the exchange, if insurers do not adopt the public health insurance payment rates or use other private insurer strategies to compete

effectively and slow the growth of premiums, more workers would enroll in the public health insurance plan.

Nonetheless, it should be stressed that providers as a whole will continue to experience revenue gains steadily throughout the period. The phasing also gives them an opportunity to redesign care in a way that lowers avoidable hospital readmissions and hospitalizations for chronic conditions that are not adequately controlled—thus becoming eligible for shared savings. 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.

Benefits for Patients

The Commission’s report makes a compelling case for systemic change in our health system (Exhibit 24). Most importantly, these reforms would make the health care system work better for patients and families.

24

Implications for Stakeholders of Path

- **System Savings**
 - \$3.0 trillion system savings 2010-2020 with a public health insurance plan option; \$0.8 trillion system savings 2010-2020 without public health insurance plan option
- **Employers**
 - Public health insurance plan option more affordable than premiums in small business market: 20-30% lower premiums
 - Savings to employers including payment and system reforms of \$231 billion over 2010-2020
- **Families**
 - Secure and affordable coverage for all
 - Households save \$2.3 trillion over 2010-2020, average savings of \$2314 per family in 2020
- **Providers**
 - Provider revenues enhanced by increasing Medicaid payment to Medicare levels and buying in uninsured at Medicare rates
 - Payment reforms reward primary care and high performers
 - But slower revenue growth over time than current law
- **Insurers**
 - Rewards integrated delivery system and private insurers that enhance value
 - Administrative savings of \$337 billion over 2010-2020



Affordable Premiums

The Path proposal’s approach to coverage builds on what works best in our private–public insurance system. A national health insurance exchange offering a public health

insurance plan and a variety of private plans would ensure that everyone has access to affordable coverage. Income-related premium help would be available to make sure that individuals and families in the lowest tax brackets spend no more than 5 percent of income on premiums, and that people in middle-income tax brackets pay no more than 10 percent of income on premiums. For the many working families facing a steep decline in job security, the insurance exchange would provide a stable and portable source of affordable coverage. The plan also calls for opening up Medicaid and CHIP to people with incomes below 150 percent of the federal poverty level (less than \$33,000 for a family of four).

No Discrimination Against the Sick

Under the Path proposal, insurance plans could no longer turn people away because they have an existing medical condition or are considered to be at high risk for one. Nor would individuals with health conditions be charged higher premiums than healthy people because of their health status. As a result, people in poor health who lose their jobs and insurance coverage—who today have few prospects of retaining or affording coverage—would be much less likely to suffer from a lack of care, delayed care, or low-quality care.

Protection from Ruinous Medical Expenses

The public plan offered through the national health insurance exchange would establish a minimum standard benefit package based on the standard option available to members of Congress and federal employees. Employer plans and plans offered through the exchange would be required to meet this standard of coverage—they could also offer more. Deductibles would be \$250 per person or \$500 per family rather than the \$2,000 to \$10,000 deductibles found in some health insurance policies today. Preventive services and services required for treatment of chronic conditions would be covered in full.

Family Savings

The average family would save \$1,140 in 2010 under the plan, thanks to reforms that reduce administrative costs and promote efficiency in the health care system, as well as those that guarantee financial protection from health care bills. By 2020, the average family would save \$2,314 annually, with families of all income levels spending less because of slower cost growth. These dollars would provide substantial relief to families that are now financially strapped because of medical bills and often have to choose between medical care and other basic necessities.

Coverage and Care and Security for All

The Path proposal would extend affordable health insurance to everyone. The number of uninsured—now at 46 million and projected to rise to 61 million in 2020—would instead

fall to an estimated 4 million, or about 1 percent of the U.S. population. Even hard-to-reach individuals would likely qualify for free or low-cost coverage if they became ill and sought health care. The proposal would improve coverage or affordability for over 130 million more—with enhanced choice and continuity. Through the exchange, families could stay with their physicians and health plans where arrangements are working well—a change of job or circumstances would no longer trigger involuntary disruptions or churning. An estimated 100,000 lives could be saved through the coverage and system reforms included in the Path framework.

Challenging Change

While health care providers, employers, insurers, the health industry, and taxpayers would benefit in significant ways, the Path framework includes several significant challenges and important decisions for the country to make as it moves down the path to high performance.

Health Care Providers

The most important benefit for physicians is that health insurance for all, with a minimum standard to ensure access and financial protection, would help them deliver the care their patients need. No longer would nearly 40 percent of adults under age 65 say they do not obtain needed care because of cost.⁴ No longer would patients fail to fill a prescription or take it as indicated, fail to receive a mammogram or colonoscopy or see a specialist, or fail to come back for follow-up care because of trouble paying medical bills.

To help physicians deliver care in a way that works for patients, the Path framework makes changes that would alter the way hospitals and doctors are paid to provide incentives and support for changing the way health care is organized. The reforms would also provide incentives for patients. All patients would be encouraged to enroll with a physician or nurse practitioner practice that meets the standards of a “patient-centered medical home” that makes care available 24/7—with lower-cost sharing to provide incentives to designate a primary care “home.” Such practices would be paid to provide enhanced access and coordination and would be held accountable for ensuring that their patients get all recommended care by using information technology and office systems to remind patients about preventive care and assisting them with obtaining needed specialty care.

⁴ The 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).

These practices would be supported and rewarded with an extra “medical home” fee per enrolled patient paid by insurers and public programs, as well as extra bonuses for high performance in preventive care and chronic care management. Physicians would be encouraged to practice in more integrated delivery systems or virtual networks, working with other physicians, nurses, pharmacists, and other health professionals in a team approach to ensure coordination of care and shared accountability for health outcomes. This is a major change from our current isolated solo or small physician practice style of care, and will require not just funding but technical assistance and infrastructure support. To support provider groups as they reorganize—a challenging task even for large providers—the government could fund regional or state health information exchange networks, facilities that offer after-hours care to patients from different practices, case management help, and more.

Likewise, hospitals would be accountable not only for care during the hospital stay but follow-up care for 30 days following discharge, with incentives to improve transitions in care, reduce complications that result in readmissions, and coordinate care as patients go back home or to rehabilitation facilities or other post-acute care. Hospitals would be rewarded and share savings for reducing complications and assisting patients with recovery, as well as ensuring that post-acute services are tailored to patients’ needs. To carry out this role, hospitals would need to modernize their information systems and participate in health information exchange networks that ensure prompt information about hospital and emergency room care gets back to patients’ primary care physicians.

Providers who accept accountability for patient health outcomes and prudent use of resources would be rewarded. Those who provide unnecessary, duplicative, or avoidable services would face revenue losses and would need to improve their processes of care and reposition their business operations. Moreover, a phased approach to payment reform will give providers time to prepare for the new payment methods and allow Medicare to develop appropriate rates, methods, and administrative structures that will support greater care coordination.

Employers

Along with households and governments, employers are expected to be part of the solution to gaps in coverage, variable quality, and high costs. In the estimates, all employers would be required to either provide to their employees health insurance that meets minimum standards or required to contribute 7 percent of worker earnings, up to \$1.25 an hour, toward an insurance trust fund to help finance affordable premiums.

While costs will initially increase for employers who do not currently shoulder some of the responsibility for providing coverage, businesses of all sizes stand to gain under the Path framework. Reforms will slow the rise in premiums with net cumulative employer savings of \$231 billion over the period from 2010 to 2020—and both employers and their employees would no longer have to deal with a health insurance system that frequently fails to provide reliable coverage, adequate protection against the financial burden of illness, and reasonable control over cost growth.

Insurers

Perhaps the most challenging change is the proposed shift in the role of private insurers. Insurers would be required to provide coverage to all—healthy and sick alike—on the same terms. In addition, they would need to compete with a public health insurance plan that would be offered to all individuals and employers at a starting premium at least 20 percent lower than current premiums in the individual and small-business market.

To compete against a public health insurance plan with lower administrative costs and greater leverage over provider prices, private plans would need to bring added value, improved quality, and greater efficiency through tools available to them, such as selection of provider networks, utilization management, and benefit design. Competition from a public health insurance plan has the potential to transform—rather than undermine—the private health insurance market. This transformation will require insurers to focus on adding value and lower the current projected trend in premiums.

Offering a public health insurance plan as a choice is key to system savings. The Path report shows that \$0.8 trillion would be saved by the coverage, payment, and system reforms without a public plan option, while \$3 trillion would be saved with a public plan. The public health insurance plan is critical to lower administrative costs and to ensure that savings from payment reform are passed on to employers and workers.

Under the Path framework, if private insurers fail to respond appropriately, an estimated 109 million Americans would retain private coverage, compared with the 178 million they now cover. But it is entirely likely that private insurers will, in fact, alter their business operations to compete effectively with the public health insurance plan. Moreover, like Medicare, the public health insurance plan would contract with private insurers to administer claims for those enrolled through the public plan, which would expand their administered services business. Private insurers would play an important role, but they would have to adjust to new market circumstances and focus on providing more effective and efficient coverage.

An example of a model that would thrive under the new system is integrated delivery systems that are able to provide higher-quality care more efficiently—through their own hospitals and physician group practices. They would experience a major expansion of enrollment, with an estimated 50 million enrolled in such systems of care. Private insurers that are not linked to an integrated delivery system may try to emulate some of the practices that lead organized care systems to achieve substantial savings, such as funding nurses in physician practices to help patients with chronic conditions.

Health Industry

Any reform that estimates \$3 trillion in savings compared with current trends in a sector of the economy that is otherwise expected to spend \$42 trillion represents a major shift to stakeholders. Pharmaceutical companies, for example, could expect to be paid lower prices for some high-priced medications as the government becomes a more active purchaser of prescription drugs. In addition, research on comparative effectiveness and information to enable more evidence-based medicine may find that certain new drugs do not offer added benefits compared with those currently available. Although such medications might be included in formularies, this information would make it unlikely that private or public insurers would pay more for the new drugs. Making information available to physicians would be critical—too often they now rely on manufacturers rather than independent sources of information regarding what works well for which patients, and physicians rarely have comparative prices for similarly effective treatment options.

There are also business opportunities for the health industry. The uninsured will be able to afford needed medications. Currently only 40 percent of adults with hypertension, for example, have that condition controlled.⁵ New information systems and incentives for chronic care management could lead to a major increase in use of effective medications.

The near-universal adoption of information technology and health information exchange networks envisioned by the Path report—and given an important jump-start by the American Recovery and Reinvestment Act of 2009—will also provide business opportunities for the health industry. Accelerating the adoption and use of effective health information technology—with the capacity for decision support and information exchange across care sites—is required to bring about needed change in our care delivery system.

These investments will yield significant returns. Rather than denying patients effective care, utilizing value-based benefit design based on comparative effectiveness

⁵ The 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).

research will facilitate the use of safe, clinically proven care within the system and provide the information needed to improve value.

Taxpayers

The President's budget establishes a health reform reserve fund of \$634 billion to help finance improved coverage. This includes \$318 billion over 10 years (2010–2019) in new tax revenues, and \$316 billion in savings, largely from Medicare and Medicaid. Including these funds in budget reconciliation will be key to fashioning a health reform proposal. The President has indicated that this is a down payment on coverage for all.

The Path framework envisions affordable health insurance for all, and pays for those reforms with significantly more extensive reforms than yet set forth by the President.

As currently configured, the Path set of policies would also result in net federal budget outlays of \$593 billion over the 2010–2020 period. By contrast, state and local government net outlays would decline by \$1.034 trillion. Other design choices—such as increasing premiums paid by states to buy public coverage for the low-income elderly and disabled—could reallocate more of the savings to the federal government.

Deficit financing in the early years can be justified as part of an economic recovery program because expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. Making important investments in coverage, payment, and delivery reform now will reap savings in the long term. These actions, taken together, have the potential to bend the curve of our unsustainable spending on health and generate systemwide savings of \$3 trillion by the end of the next decade, reaping the return in future years for investments made now.

Health Security and Long-Term Fiscal Responsibility: A 2020 Vision

The President has called for bold change to address the crushing financing burdens of rising health care costs for both businesses and families. As he signaled at the Health Summit, the “perfect” should not be the enemy of the “essential.” His budget calls for bending the health care cost curve for the nation, while achieving better outcomes and quality, and more secure insurance for all, including those who now have insurance. His proposed health reform reserve fund is an essential down payment to be included in budget reconciliation. The American Recovery and Reinvestment Act of 2009 made key investments in health information technology and generation of evidence-based information about medical care to support patients and clinicians. Building on this start and moving forward will require deciding how to secure insurance coverage and change

payment incentives to emphasize value, not volume. Medicare can innovate but it cannot go alone. It accounts for 20 percent of all health expenditures—the single largest payer but still only a minority of revenues for most providers. In most markets, private insurers have even less leverage and tend to follow Medicare payment methods, paying more rather than innovating. The currently fractured insurance system has layers of complexity, multiple prices for the same care, and few incentives focused on value. Reforms that seek to bend the cost curve and improve coverage for those under age 65 will need to incorporate these payment and system reforms to have coherent policies and a significant impact. In short, we need a “system” approach to take a new path for the nation’s health system.

Although politically difficult, there is an urgent need to move in a new direction (Exhibit 25). The comprehensive reforms proposed by the Commission will help spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure that all families and individuals are able to get the care they need with financial security. The cost of inaction is high. The nation needs national leadership and public–private sector collaboration to forge consensus to move in a positive direction. With both a historic political opportunity and a clear path toward a high performance health system, the time has come to take bold steps to ensure the health and economic security of this and future generations.

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Agenda for Change

- **The U.S. has a historic opportunity to adopt reforms that will achieve a high performance health system**
- **The key ingredient is instituting a reform proposal that will ensure quality, affordable health insurance for all**
 - The U.S. has a path towards expansion of health insurance to all
- **Coverage for all must be pursued *simultaneously* with comprehensive reforms in cost, quality and access**
 - Payment reform to encourage integrated health care organizations and other providers to be accountable for results and resources
 - Rewarding primary care and patient-centered medical homes
 - Instituting a global fee covering hospital, physician, and other services including 30-day follow-up for acute episodes of care
 - Incentives for adoption of information technology
 - Information on comparative effectiveness and evidence-based medicine



Appendix

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. Premiums 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/CHIP 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-rated 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 specifications above 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.

**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.