

2010 Annual Report President's Message



Realizing the Potential of Health Reform



Karen Davis
President
The Commonwealth Fund

The Commonwealth Fund is a private foundation that promotes a high performance health care system providing better access, improved quality, and greater efficiency. The Fund's work focuses particularly on 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.

Contents

Preface: Realizing the Potential of Health Reform	1
What Is Affordable Health Care?	5
Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums	8
The Costs of Failure: Economic Consequences of Failure to Enact Nixon, Carter, and Clinton Health Reforms	12
Committing to Improvement in All Areas of Health Care	15
Health Reform: Insights from Around the World	16
National Leadership to Achieve a Performance-Driven Health System	19
Forging Health Reform Consensus	23
The Way Forward with Health Reform	27
A New Era in American Health Care	31
Who Is Helped by Health Reform?	33
How Will the Health Care System Change Under Health Reform?	39

Realizing the Potential of Health Reform



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Preface

The landscape of American health care has changed dramatically since the Patient Protection and Affordable Care Act was signed in March 2010. Federal and state agencies, the health insurance industry, and others are taking the first steps toward achieving the three goals President Obama set forth when Congress began crafting reform legislation last year:

- expand access to affordable health insurance for people without coverage;
- make health insurance more affordable for those who already have it; and
- slow the rise in health care costs for individuals, families, and employers while not adding to the federal budget deficit.

Over the course of the heated debate leading to the health reform bill's passage, Congress dealt with many difficult political issues: whether to include a public plan, how to regulate the health insurance industry and make coverage affordable, how to control Medicare costs, and how to finance reform. As these critical decisions were being made, The Commonwealth Fund produced a steady stream of timely, on-point research and analysis, while our staff lent their considerable expertise whenever called upon.

Once the law passed, the Fund quickly marshaled its resources to help realize the potential of the comprehensive health reform by: helping health care leaders and the American people understand the changes and what they mean for them; informing implementation of the reform package and assessing its potential to move the United States on a path to a high performance health system; and laying the groundwork for future health care delivery system reforms and health policy action.

Given the law's scope and complexity, its potential is not yet assured. Success will depend on all parties coming together to put the pieces in place, as well as on careful oversight and tracking of health system performance. It will also be important to swiftly apply new knowledge gained as innovations are tested, so that best practices and models can be spread throughout the health system.

Some of the long-term questions that need to be addressed as experience is gained include:

- Will stronger measures be required to control health care costs?
- Are the provisions designed to ensure affordability for families adequate?
- What is the shared responsibility of employers?

- Will tighter regulation of the insurance industry be required? And will a public insurance plan be needed as a competitive alternative to private plans?
- What financing is needed to ensure long-term sustainability?

The following essays, published on The Commonwealth Fund Blog over a one-year period, take readers on a journey through the busy months leading to the passage of this historic law and the first stages of its implementation.

[What Is Affordable Health Care?](#) reviewed the affordability provisions in the three versions of the bill under consideration at the time: those proposed in the House of Representatives, the Senate Committee on Health, Education, Labor, and Pensions (HELP), and the Senate Finance Committee. Parsing the bills' differences in approaching Medicaid program expansion, essential insurance benefits, and premium subsidies for low- and moderate-income families, this essay stressed the importance of "reaching consensus on what constitutes affordability and committing the necessary funds to achieve it."

[Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums](#) also tackled affordability, looking at how dramatically premium inflation has outpaced wage increases over the last decade. Citing Commonwealth Fund and Congressional Budget Office analyses, I observed that offering a public health insurance plan, alongside private plans, to all individuals and employers is our most effective weapon in combating health care costs. The essay also considered other cost-containment options, such as a mechanism for negotiating provider payments under all plans—public and private.

[The Costs of Failure: Economic Consequences of Failure to Enact Nixon, Carter, and Clinton Health Reforms](#) made a powerful case for reform by examining trends in health spending over the past 50 years. The analysis showed that if health reform measures proposed by previous presidents had been enacted and succeeded in slowing spending growth by as little as 1.0 or 1.5 percentage points annually, spending trends in the U.S. would have been closer to those seen in other major industrialized countries. Moreover, fewer adverse health consequences and economic burdens would have been borne by American families, businesses, and government.

In addressing the stagnation of health plan quality, Commonwealth Fund Senior Research Advisor Douglas McCarthy suggested in [Committing to Improvement in All Areas of Health Care](#) that this plateau might "reflect the limits of what managed care plans can achieve without integration of care delivery and support for physicians and patients in improving quality, as well as the absence of a broader commitment to public reporting and improvement."

In [Health Reform: Insights from Around the World](#), Fund Senior Vice President Cathy Schoen, Vice President Robin Osborn, and I discussed how the health reform debate has been informed by health systems in other countries. With a [Commonwealth Fund survey](#) of primary care physicians in 11 countries finding U.S. shortcomings in access, quality, health outcomes, and value, we called for national leadership to make needed reforms in insurance coverage and health care delivery.

[National Leadership to Achieve a Performance-Driven Health System](#) called for developing a set of national performance goals and improvement targets, along with supporting policies, resources, and

and actions. The essay also recommended that the president issue an annual report to Congress on the state of health system performance.

Published at a time when headlines were focused on discord in Congress, [Forging Health Reform Consensus](#) highlighted the marked similarities to be found across the three House and Senate reform bills—namely, more choices, greater incentives for accountability, increased transparency, shared responsibility, a redirection of resources, and new opportunities for learning and acting as reform is implemented.

[The Way Forward with Health Reform](#) addressed some of the misleading claims concerning the impact of health reform and the lack of understanding of its potential to improve patients' experiences.

In [A New Era in American Health Care](#), Vice President Sara Collins, Ph.D., and I celebrated the passage of comprehensive health reform legislation and outlined the ways it will increase access to needed care, provide new benefits, and slow health care spending growth, as well as test new ways of paying health care providers to improve quality.

[Who Is Helped by Health Reform?](#) reviewed how different groups will benefit from the new coverage options, benefit standards, and insurance market rules. An accompanying essay, [How Will the Health Care System Change Under Health Reform?](#), discussed a host of lesser-known provisions that, together, will place new emphasis on preventive and primary care and reward quality.

As these final essays suggest, The Commonwealth Fund has already embarked on its new goal of helping the country realize the potential of reform. Guided by the foundation's mission to promote a high-performing health system that achieves better access, improved quality, and greater

efficiency, particularly for society's most vulnerable, we have reorganized our research programs to better enable us to address emerging issues in this new era in American health care.

The Fund's programs are now organized into four key areas: Delivery System Improvement and Innovation; Health Reform Policy; Health System Performance Assessment and Tracking; and International Health Policy and Innovation.

Within the area of Delivery System Improvement and Innovation, the programs on Health System Quality and Efficiency, Patient-Centered Coordinated Care, and Picker/Commonwealth Fund Long-Term Care Quality Improvement aim to advance the adoption of promising approaches for improving the quality and value of health care services. The Fund will also promote delivery system models that provide population-based, patient-centered, accountable care that is integrated across the full continuum of services, as well as the underlying payment reforms.

Health Reform Policy, which encompasses the Affordable Health Insurance, Payment and System Reform, Federal Health Policy, and State Health Policy and Practices programs, will address health reform policy options at the federal, state, and local level. Together, these programs will foster the identification, development, evaluation, and dissemination of policy solutions that expand access to affordable, high-quality, and efficient care, particularly for vulnerable populations, while reducing the growth of health care spending.

The projects within Health System Performance Assessment and Tracking focus on comparing health system performance, evaluating and monitoring access to care and patients' reports on the quality of their care, and monitoring delivery system change. This work includes the Fund's national

and state scorecards on health system performance, an upcoming long-term care scorecard, analyses of international health system data, and WhyNotTheBest.org, a Web site that offers comparative information on health care provider performance. The Fund also conducts surveys in the U.S. and across countries to provide data that can inform health reform implementation.

Similarly, International Health Policy and Innovation aims to: benchmark U.S. health system performance on costs, quality, access, equity, and efficiency against that of other industrialized

countries; understand the lessons to be learned from other countries' experiences in reforming their health care delivery and financing systems; and showcase international innovations that may be relevant to health reform implementation in the U.S.

Along with the Fund's Commission on a High Performance Health System, the integrated research and analysis that will be conducted within our new programmatic structure will help government agencies, payers, providers, and patients as the country moves toward achieving the goals embodied in the Affordable Care Act.



October 18, 2009

What Is Affordable Health Care?

By Karen Davis

Ensuring that all Americans have access to affordable health insurance and care is one of the major goals of federal health reform, if not the major goal. Under the three bills now before Congress, affordability is achieved through expansion of the Medicaid program, creation of an essential insurance benefit package, and sliding-scale subsidies to make premiums and cost-sharing affordable for low- to moderate-income families. However, the bills recognize that budgetary limitations may still leave some families subject to financial hardship and exempt families from the requirement to purchase insurance if such coverage proves unaffordable.

Determining what is and is not “affordable” for different groups is a challenge that is reflected in the varying levels of coverage and assistance offered across the three bills. In making these calculations, it is important to recognize that affordability is related both to premiums and out-of-pocket costs. If a family’s premium is low but their out-of-pocket expenses are high, their care may ultimately be difficult for them to afford.

Medicaid Expansion. Expanding the safety-net insurance system through Medicaid is critical to reaching a large portion of the nation’s uninsured, low-income working individuals and families. The three congressional bills—the House bill, the Senate Health Education, Labor, and Pensions (HELP) bill, and the Senate Finance bill—all provide for this essential floor of coverage. The House and Senate Finance bills expand Medicaid up to 133 percent of the federal poverty level (approximately \$30,000 for a family of four in 2009), and the HELP bill expands coverage up to 150 percent of poverty. These expansions include previously ineligible populations, such as childless adults. According to estimates from the Congressional Budget Office, as a result of these expansions, the number of people under age 65 covered by Medicaid in 2015 would increase from 34 million to 43 million under the House bill and 44 million under the Senate Finance bill.

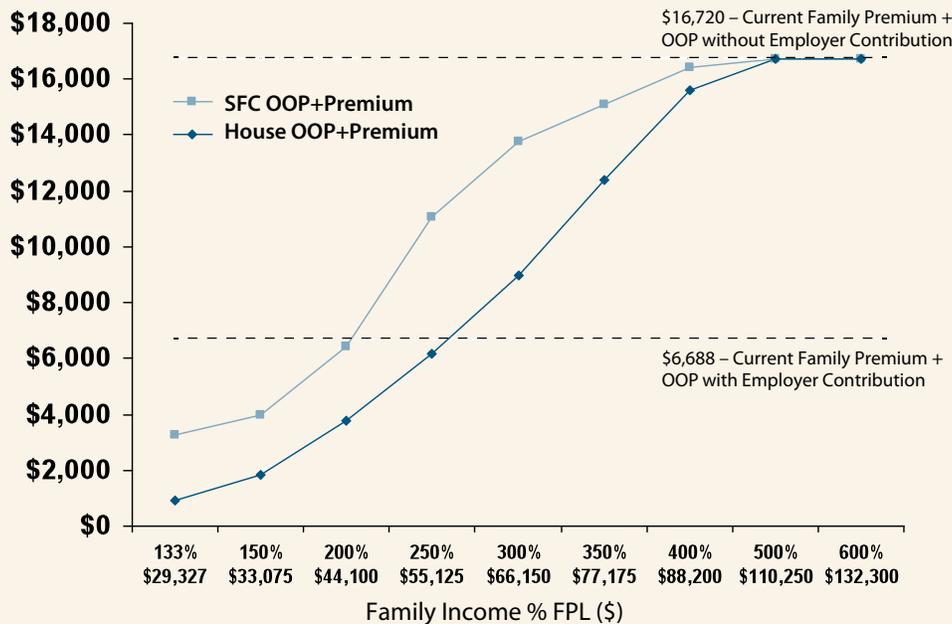
Those covered by Medicaid would not face premiums or significant cost-sharing for medical bills.

Insurance Exchange and Insurance Regulation. Each bill would create a new health insurance exchange, or a marketplace managed and regulated by the government, through which eligible individuals and small businesses could choose among private plans or, in the case of the House bill and Senate HELP bill, a public health insurance plan. Requiring individual and small business health plans to cover everyone and charge the same premium regardless of health status increases affordability for those with serious health problems—a major concern in the current system. All plans would have to meet requirements of participation set by the exchange. Participants in the exchange with incomes up to four times the poverty level would be eligible for subsidies to offset the cost of premiums. A public plan would lower the cost of federal subsidies by an estimated \$80 billion over 10 years, generating savings to help finance premium subsidies for low-income families.

Benefit Standard. To guarantee an adequate level of coverage, an “essential benefit package,” with varying levels of cost-sharing, would be offered through the exchange. All three congressional bills call for such a package, including hospital, physician, and preventive care, prescription drugs, and pediatric dental and vision services, among other services.

While keeping the benefits constant, the three congressional bills define three to four levels of cost-sharing tiers by actuarial value, or the average share of medical expenses covered by a health plan. The lowest-tier plans in both the House and Senate proposals cover less than what is covered by the typical insurance plan for workers and members of Congress. In the House bill, the actuarial value of the basic plan covers 70 percent of medical expenses and rises to 95 percent in the highest

Family Premiums and Out of Pocket Expenses Under House and Senate Finance Proposals*



* For a family of four in 2009.

Source: Commonwealth Fund. For more detail on legislative provisions, see S. Collins et al., *Provisions of Comprehensive Health Reform Bills of 2009: Health Insurance, Delivery System, and Financing*, (New York: The Commonwealth Fund, October 2009).

tier. In the Senate Finance proposal, the lowest-tier plan has an actuarial value of 65 percent and rises to 90 percent. By comparison, the average actuarial value in employer-based plans is an estimated 80 percent. The average actuarial value in the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program, the typical plan for members of Congress and federal employees, is about 84 percent to 87 percent.

The bills also cap out-of-pocket spending. Spending is capped at \$5,000 and \$10,000 annually for individuals and families in the House bill. The Senate Finance bill caps spending at a higher limit, tied to the cap for health savings account/high-deductible health plans—which require that families spend more out-of-pocket. The limit is \$5,950 for individuals and \$11,900 for families, with reduced amounts for lower-income families.

Subsidies for Premiums and Cost-Sharing. The House and two Senate bills all provide assistance in paying premiums for families with income up to four times the federal

poverty level (about \$88,000 for a family of four). The House and Senate bills would set a maximum on the most that any family in this income bracket would pay for health insurance at 12 percent of income for higher-income families; the maximum is 12.5 percent of income under the HELP bill. Individuals with lower incomes or those covered by employer plans would pay less.

The House and Senate Finance bills provide sliding-scale subsidies that increase the actuarial values of the lowest-tier plans to make them more affordable. The House bill is somewhat more generous than the Senate Finance bill: for people with incomes under 350 percent of poverty, subsidies raise the actuarial value of the basic plan to 97 percent for those with incomes of 133 percent of poverty; the value slides down to 72 percent for those with incomes at 350 percent of poverty. The Senate Finance bill provides cost-sharing credits for those with incomes between 100 percent and 200 percent of poverty, raising the actuarial value of the lowest-tier plan to 90 percent for people with incomes up to 150 percent of poverty and

80 percent for those with incomes between 150 percent and 200 percent of poverty.

The chart illustrates how the premium and average out-of-pocket costs would vary across income levels. Our analysis shows that total net premiums and out-of-pocket expenses would be higher at each income level in the Senate Finance bill, compared with the House bill. Reflecting this difference in subsidies, the Congressional Budget Office estimates that the cost of subsidies would be \$773 billion from 2010 through 2019 in the House bill and \$461 billion in the Senate Finance bill.

Employer Contributions. Requiring employers to contribute a share of an employee's premium and setting standards on benefits will ensure affordability for most workers. The House proposal requires firms with more than \$500,000 in payroll to contribute a minimum of 72.5 percent to individuals' premiums and 65 percent to families' premiums. If employers do not meet the standard, they must pay up to 8 percent of payroll into a health insurance fund. The Senate Finance bill does not require employers to provide coverage or contribute to a fund, but rather requires employers with more than 50 employees to pay a flat fee for workers who receive a federal premium subsidy for coverage purchased through the exchange. The Senate HELP bill requires firms with more than 25 workers to pay at least 60 percent of employees' premiums or pay a penalty of \$750 per uncovered full-time employee or \$375 per uncovered part-time employee.

Having employers contribute to coverage—as they now do for 162 million people—is extremely important to ensuring affordability. As shown in the chart, an average family with employers contributing to coverage could expect to pay \$6,700 a year in premiums and out-of-pocket costs, while a family without employer contributions could expect to pay \$10,000 more—or a total of \$16,700.

Hardship Exemption. Finally, both the House and Senate Finance bills include hardship exemptions from the requirement that individuals purchase coverage to avoid penalizing those who can't afford coverage. The Senate Finance bill exempts those for whom premiums exceed 8 percent of income, effectively setting an "affordability" standard for coverage. The House bill has unspecified exceptions. The Congressional Budget Office estimates that 25 million Americans will remain uninsured under the Senate Finance proposal, compared with 17 million under the House bill.

Though these issues will be difficult to resolve, reaching consensus on what constitutes affordability and committing the necessary funds to achieve it are crucial in securing access to essential care for all and protection from the financial hardship that illness can now bring. Ensuring affordable health care for all will ultimately pay national dividends in terms of improved health and productivity of the workforce and economic growth.

August 18, 2009

Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums

By Karen Davis

As health reform advanced through congressional committees this summer, much attention was given to trimming the federal budget cost and slowing the growth in Medicare outlays. But equal attention needs to be focused on provisions to address the rising costs of health insurance premiums for employers and families. Health system reform will be effective only if the legislation considers the financial well-being of all participants, not just that of the federal government. It is time to ask what effect health reform will have on the cost of insurance for businesses and families—and to remember what will happen if we do nothing. Without reform, projected premium increases will put the country at high risk for having health insurance costs absorb all of the average family's future wage increases, eventually pricing middle-income families out of insurance altogether.

Health insurance is already becoming unaffordable for families and businesses, with premium inflation outpacing wage increases. Between 1999 and 2008, employer family health insurance premiums rose by 119 percent, while the median family income rose by less than 30 percent. As a result, average family premiums for group policies have risen from 11 percent to 18 percent of median family income. And if Congress fails to pass health reforms that control health care costs, premiums are projected to rise to 24 percent of a family's income by 2020. In any economic climate, but especially in today's recession, most families cannot afford to devote a fourth of their income to insurance coverage, nor can businesses afford their share of insurance premiums in addition to raises for employees.

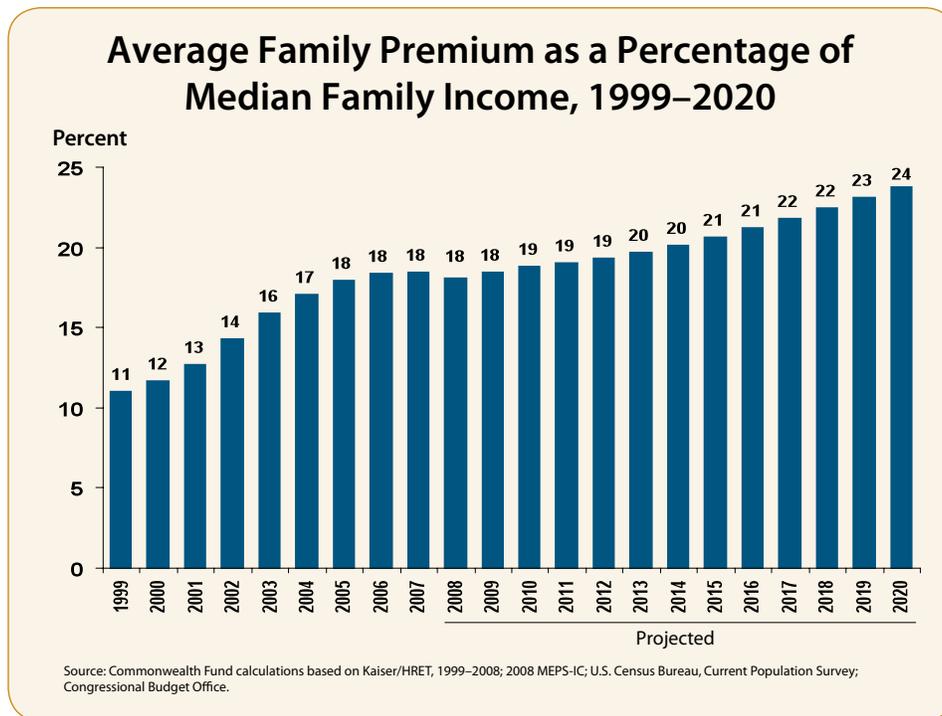
In light of this reality, it is important to remember the principal goals of comprehensive health reform: 1) to cover the uninsured, 2) to enhance the affordability of

insurance coverage for everyone, and 3) to slow the rise in health care costs. Achieving the first goal without the second and third is a recipe for long-term failure.

The Public Plan: The Leverage to Set Rates

Although the Obama Administration may be scaling back its support for a public plan, Commonwealth Fund and Congressional Budget Office (CBO) analyses show that offering a strong public health insurance choice as well as private plans through a health insurance exchange will help all Americans, not just the uninsured, by slowing the growth in premiums. A recent Fund analysis found that offering a public plan alongside private plans to all individuals and employers is our most effective weapon in combating health care costs. The study found that cumulative health system savings between 2010 and 2020—compared with projected trends for that period—could be as high as \$3 trillion if reform includes a public plan that adopts innovative payment methods that reward value and uses its purchasing leverage, along with a reformed Medicare program, to control costs. The annual growth rate in health system spending would fall from 6.5 percent to 5.2 percent—consistent with an industry coalition pledge to slow spending by 1.5 percentage points annually over the next decade.

The CBO estimates that a public plan premium would be 10 percent lower than that of typical private plans offered in an insurance exchange—a cost break that would provide much-needed relief to families and businesses in every state in the country. The average family would save \$2,200 per year by 2020 with reforms that include a public plan. President Obama pledged during the presidential campaign to save American families \$2,500 a year through health reform. This goal needs to be on par with a deficit-neutral health reform plan.



The public plan would achieve these savings because it would use the federal government’s power to set prices for health care providers and control the rate of increase in these prices over time. It would be most effective if it were linked to Medicare, either paying at or somewhat above Medicare rates. Today, nearly all hospitals and physicians choose to participate in Medicare, rather than lose the 20 percent to 30 percent of revenues or more they derive from such participation. This leverage prevents providers from obtaining prices far in excess of their costs—as they often do under private insurance “negotiations” based on their dominant market position. When providers refuse to participate in private insurance networks and simply charge patients whatever they choose, patients are left uninformed and unprotected from the financial consequences.

By using its substantial purchasing power, a public plan that links payment and participation to Medicare could provide relief to employers and households by offering a lower premium. Such a premium would challenge private insurers to bring more value to the insurance market by using tools such as utilization management; creating networks of providers that offer real value for the care they provide; and rewarding accountable care organizations and integrated delivery systems for preventing and controlling chronic conditions.

Private insurers have opposed the creation of a public plan, arguing that Medicare payment rates under a public plan would lead to a “cost-shift” of higher prices to private payers. Instead of proposing an alternative solution that would work to control costs, insurers have simply insisted that there be no public plan option.

It is certainly reasonable to demand that a public plan meet the same market conditions as private plans, for example by requiring it to be self-sustaining, with premiums sufficient to cover projected medical outlays and administrative overhead, and ensuring that public and private plans are held to the same standards for adequate financial protection and access for enrollees. But abandoning a public plan without proposing an alternative that would achieve real value and slow the growth in health spending undermines the long-term success of health reform and puts our economy at risk.

Unfortunately, as legislation has worked its way through congressional committees, the potential power of a public plan has been substantially eroded in three ways: by dropping the requirement that providers that receive Medicare payment also participate in the public plan; by requiring the U.S. Health and Human Services Secretary to negotiate provider payments rather than base prices on

Medicare rates; and by restricting access to a public plan option to individuals and small firms. As a result, a strong public option is no longer a component of several bills now being debated in Congress.

The Senate Finance Committee is considering nonprofit health care cooperative plans as an alternative to a public plan. While the details of this proposal are unclear, it is unlikely that such organizations would have sufficient purchasing power to control costs over time and would take years to evolve. Whether we are considering a public health insurance plan or nonprofit cooperative plan, if the plan does not link payment to Medicare rates, it loses the advantage of representing the share of enrollees, and therefore provider revenues, needed to obtain lower prices. The Congressional Budget Office estimates that only 9 million to 12 million people would be enrolled in these plans as currently designed. Negotiating provider payments for the 10 million or so people estimated to enroll in a public plan or private co-op plan is unlikely to yield significant savings.

In response to the increasing concentration of the insurance industry, the health care provider industry has formed its own large organizations that can command high payment rates. In many markets, one to four large hospital systems dominate. Such systems can easily decline to participate with a weakened public plan or private co-ops, knowing it will not affect a substantial share of their revenues. With only a limited number of individuals covered and restrictions on the ability to set payment rates, a public or nonprofit cooperative plan will be unable to counter the concentrated market powers of providers in a given geographic area. As a result, we are likely to continue on the current course, with employers and families seeing premiums continue to rise far faster than incomes.

Other Options for Cost Containment

To truly contain costs, health reform needs to include some mechanism for controlling both medical outlays and insurance administrative overhead. A strong public plan is one effective option; there are certainly others. For example, one approach would be to negotiate provider payments under all plans—public or private. This is the model followed by most industrialized countries that leverage purchasing power by having a single entity—either a government agency or a nonprofit entity acting in the public interest—negotiate provider payment rates and methods on behalf of the entire population.

Another option would be to charge states with designing and implementing all-payer methods of provider payment. States with a plan that ensures fair and reasonable payment rates and methods that reflect value, harmonizes payment under public programs and private insurance, and effectively controls the growth in costs over time could be permitted to establish their own systems.

Still another course would be to extend Medicare payment innovations to private insurers. The health reform bills in the House and Senate go a long way toward improving Medicare's payment system. They would establish a Center on Payment Innovation with the authority to test new methods of payment that reward value rather than the volume of services, and to rapidly spread the most successful payment methods. The bills call for in-depth analyses of ways to eliminate geographic disparities in Medicare payment. They also create strong independent authorities to establish Medicare payment rates and methods with requirements on Congress to act expeditiously or, failing action, for the recommended changes to take effect.

A broader charge to harmonize Medicare payment and private insurer payment—and to engage in multipayer payment innovations—could spur more rational payment methods throughout the health system, enhance their impact, and lower administrative costs and complexity. What should be unacceptable is to continue with our current system of provider payment—one that lacks leverage and coherence, results in an ever-rising share of economic resources going to the health sector without commensurate value, and has high administrative costs due to fragmented and inchoate payment mechanisms all pulling in different directions.

Health care, simply put, costs far more than it should. There is no justification for the prices and premiums our businesses and workers now pay for health care, which are the highest in the world. We should not accept a health reform plan that focuses only on coverage and savings in public programs. It should be unacceptable to continue with employer health insurance premiums that rise three to four times as fast as wages. The onus must be put on those who oppose a public plan to suggest an equally effective alternative that reforms payment methods, promotes delivery reform, and achieves value for health spending that is in the best interests of the American people.

December 21, 2009

The Costs of Failure: Economic Consequences of Failure to Enact Nixon, Carter, and Clinton Health Reforms

By Karen Davis and Kristof Stremikis

The U.S. Congress is on the threshold of historic change that will usher in a new era in American health care. In the last 50 years, three presidents—Nixon, Carter, and Clinton—have made a serious effort to enact reform and failed. The nation simply cannot afford to fail again—too much is at stake for those Americans who fail to get the life-saving care they need and for those who pay the bills of the ever-rising cost of health care. History makes clear that failing to act on health reform has serious and far-reaching economic ramifications. An examination of trends in health spending over the past 50 years shows that if health reform measures proposed by previous presidents had been enacted and slowed the growth in spending by as little as 1.0 or 1.5 percentage points annually, spending trends in the U.S. would have been closer to those seen in other major industrialized countries and fewer adverse health consequences and economic burdens would have been borne by American families, businesses, and government.

Learning from Past Efforts

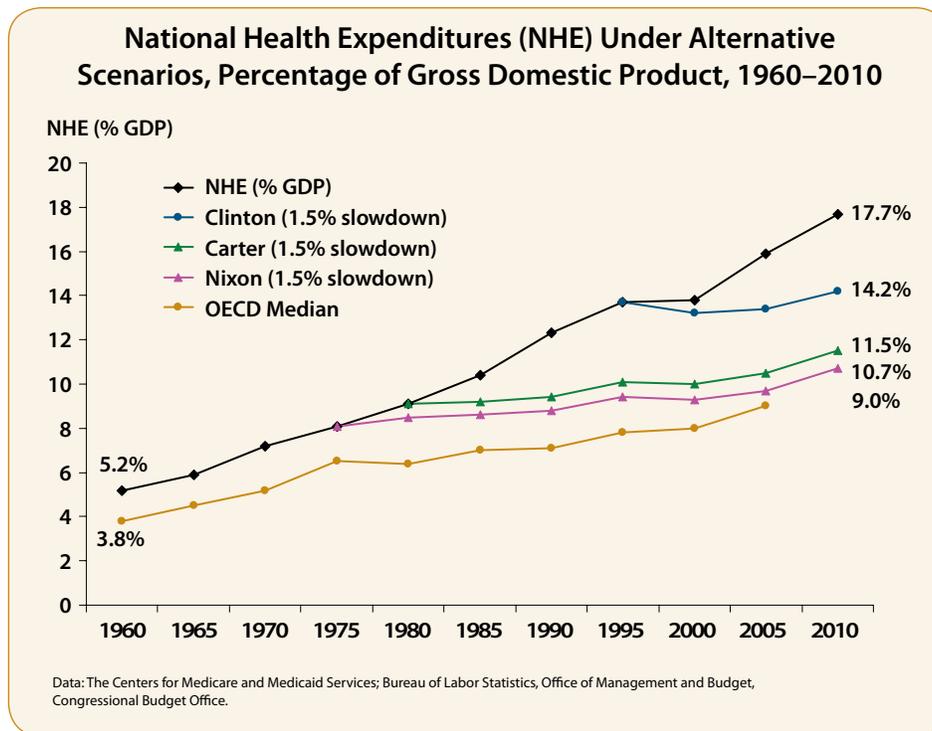
Over the last half-century, the nation has made several serious attempts to ensure health insurance coverage and control health care spending, either as part of comprehensive legislation or through companion measures.

President Richard Nixon imposed wage and price controls on the entire economy in 1971 in the wake of Vietnam War era inflation, with special mechanisms developed for controlling health care costs. He then proposed a Comprehensive Health Insurance Plan that received serious legislative consideration in 1974. The central features of the plan were employer-mandated private insurance coverage for workers and their

families in firms with 25 or more employees, a plan for low-income families that would replace and improve Medicaid, and a federal health insurance plan that would replace and improve Medicare.¹ Reform efforts died when Nixon was removed from office, as proponents hoped to enact stronger legislation in the political aftermath of his impeachment. The Nixon health care cost controls were lifted in 1975 when the industry pledged to control costs voluntarily.²

President Jimmy Carter proposed hospital cost containment legislation in 1977. In 1979, he introduced a national health plan that included minimum standards on benefits and required employer contributions, as well as a new federal HealthCare program to replace Medicaid and Medicare and cover all low-income individuals, in addition to the elderly and disabled. The Carter hospital cost containment legislation, a response to the explosion in health care costs following the lifting of Nixon's health cost controls, was defeated when the industry mounted an alternative "Voluntary Effort." Unfortunately, this voluntary approach to cost control also quickly dissipated once the threat of legislation was removed.³ Inflation in health care spending and a deteriorating economy contributed to the demise of the Carter national health plan in 1980.

President Bill Clinton introduced legislation in 1993 with cost containment measures built into health reform. In particular, his proposal called for controls on the rate of increase in health insurance premiums. The Health Security Act included an employer mandate that required employers to pay 80 percent of the premium (up to a maximum of 7.9% of payroll), with the family share of premiums not to exceed 3.9 percent of income.⁴ The plan



was to be financed by substantial Medicare and Medicaid savings, an increase in tobacco taxes, and cross-subsidies among employers within risk pools. [President Clinton's health reform](#) ran into major opposition from small businesses and insurers, and the legislation stalled out in Congress.

U.S. Health Spending Trends and Projections

The federal government's repeated failure to enact health reform has had serious consequences for American families, businesses, and governmental budgets. The U.S. spent 5 percent of gross domestic product (GDP) on health care in 1960; health care now consumes 17 percent of the nation's economy and will reach 21 percent by 2020, if trends continue. [While investment in health care](#) has contributed to improved health and productivity, other countries have devoted a far lower share of GDP to health care and achieved comparable or better health outcomes.

Ever-higher health spending has directly contributed to stagnating incomes and rising health insurance premiums for middle-class families and workers. [Commonwealth Fund analysis](#) has shown that premiums have risen from 11 percent of family income in 1999 to 18 percent in 2009. If current trends continue, average family premiums will reach 24 percent of median income by 2020.

Rising health care costs—and the subsequent rise in health insurance premiums—have fueled an increase in the number of Americans without insurance over the past three decades. Nearly 50 million Americans are expected to be uninsured in 2010. [Cost growth](#) also has placed enormous pressure on employers' ability to provide comprehensive benefits, leading many to shift to less generous policies or drop coverage altogether. Employees of small businesses, which are much less likely to offer coverage, are at particularly high risk.

It is difficult to estimate with precision what would have happened had earlier proposed reforms been enacted. Still, it is instructive to consider where we would be today if those efforts had succeeded. Each included provisions designed to provide health insurance coverage for all.⁵ Each set out regulatory restraints on the growth in provider payment or insurance premiums, or both. All had significant mechanisms to control costs, including changing provider payment, increasing competition in the insurance market, and controlling the growth in private insurance premiums.

The exhibit shows the growth in national health expenditures as a percentage of GDP and what we would have spent as a nation if effective measures to slow the growth

in health expenditures by 1.5 percentage points a year had been adopted in 1975, 1980, and 1995. In 1960, we spent 5.2 percent of GDP on health care, compared with the 3.8 percent of GDP median rate in all major industrialized nations. Today, we spend 17.7 percent—nearly twice the rate of 9 percent that is devoted to health care in other industrialized countries.

If President Nixon's health reform plans had been enacted in 1975 and slowed the annual rate of spending by 1.5 percentage points a year, today we would be spending 10.7 percent of GDP on health care. In dollar terms, we would spend only \$1.6 trillion on health care in 2010, instead of projected health spending of \$2.6 trillion. This savings of \$1 trillion in 2010 alone would remove much of the financial burden on families, businesses, and government. Even if Nixon reforms had slowed spending growth by "only" 1 percentage point a year, health spending as a percent of GDP would have been \$1.9 trillion in 2010, or 12.7 percent of GDP—a savings of 5 percent of GDP.

If cost containment measures slowing spending by 1.5 percentage points a year had been enacted in 1980 under President Carter, the trends would be similar, with spending rising to \$1.7 trillion in 2010, or 11.5 percent of GDP. Even if we had acted as late as 1995 under President Clinton, health spending in 2010 would be \$2.1 trillion, or 14.2 percent of GDP.

The federal government would have been a major beneficiary of comprehensive health reform under Presidents Nixon, Carter, or Clinton. Instead of consuming 6.2 percent of GDP in 2010, federal health outlays would have been 3.7 percent in 2010 under Nixon reforms that slowed spending growth by 1.5 percentage points, 4.0 percent under Carter, and 5.0 percent under Clinton.

Bending the Health Care Cost Curve Today

In the current round of health reform, the primary strategy for controlling costs has been legislative changes to Medicare and a public health insurance plan that encourages private insurers to control costs. While enrollment in the public health insurance plan in the House bill has been narrowly targeted on the uninsured and small businesses, the proposal faces an uncertain future in the legislative process.

The House of Representatives has added provisions to negotiate pharmaceutical drug prices, review insurance premium increases, and set standards on the share of premiums devoted to health care. Both the House and Senate have provisions for rapid testing of new methods of provider payment in Medicare. The Senate bill calls for an independent Medicare advisory board to facilitate rapid consideration of recommendations to limit the rate of increase in Medicare outlays.

Several commentators have questioned whether the cost containment provisions in the health reform bills passed by the House and under consideration in the Senate are sufficient. Neither bill includes the aggressive systemwide cost control measures that were part of the Nixon, Carter, and Clinton proposals. But the House and Senate bills would begin to bend the curve in total health spending and encourage the development of mechanisms for extending cost control measures more broadly once experience is gained. A recent analysis by the Council of Economic Advisers estimates that private and governmental spending would be slowed by 1.0 percentage points a year.

History shows that even modest cost-cutting has a significant impact over time and that inaction has a cost. The longer we wait to address the underlying problems in the U.S. health care system, the more health spending will continue on its rapid rise and the more drastic the measures that will be required to right our economy and our federal budget. Congress is right to move ahead. After 50 years of spiraling health care costs and the resulting price paid by American families, business, and government, we can no longer afford to postpone health reform.

Notes

- 1 K. Davis, *National Health Insurance: Benefits, Costs, and Consequences* (Washington, D.C.: The Brookings Institution, 1975).
- 2 K. Davis, G. Anderson, D. Rowland, and E. Steinberg, *Health Care Cost Containment* (Baltimore: The Johns Hopkins University Press, 1990).
- 3 K. Davis, "Recent Trends in Hospital Costs: Failure of the Voluntary Effort," Testimony before the House Committee on Energy and Commerce, December 15, 1981.
- 4 Congressional Research Service, *Health Care Reform: President Clinton's Health Security Act*, (Washington, D.C.: Congressional Research Service, 1993).
- 5 K. Davis, "Universal Coverage in the United States: Lessons from Experience of the 20th Century," *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, March 2001 78(1).

November 5, 2009

Committing to Improvement in All Areas of Health Care

By Douglas McCarthy

The Commonwealth Fund Commission on a High Performance Health System's 2009 State Scorecard shows that in areas of health system performance where we as a nation have made a commitment to reporting and improving performance, we see dramatic results. Since the first State Scorecard was released in 2007, almost all states improved on several indicators of quality of hospital treatment, for example. This change reflects the influence of national consensus on a single set of measures for hospitals, public reporting of results of these measures on the federal Hospital Compare Web site, and widespread hospital participation in reporting following a policy change in which the Centers for Medicare and Medicaid (CMS) linked reporting to Medicare payment updates. Hospital quality has also been the focus of an intense collaborative improvement campaign across the nation.

By contrast, the majority of states failed to improve on multiple indicators of ambulatory care quality and access over most of the two-to-four-year trends captured by the 2007 and 2009 Scorecards. For example, there were only modest improvements seen in preventive care for adults—and this improvement was seen in only half the states. Public reporting on ambulatory care quality is currently limited to a subset of the population enrolled in certain managed care plans that voluntarily publish their results through the HEDIS measurement tools developed by the National Committee for Quality Assurance (NCQA).

Last week NCQA reported that health plan quality stagnated in 2008 after several years of steady gains on key measures. In addition, some areas of quality such as mental health treatment have been consistently lackluster

(an “unacceptable level of mediocrity” according to NCQA). Disturbingly, 2008 marked the third year that quality failed to improve appreciably for Medicaid and Medicare health plans. This plateau in quality might reflect the limits of what managed care plans can achieve without integration of care delivery and support for physicians and patients in improving quality, as well as the absence of a broader commitment to public reporting and improvement by all types of health plans and greater participation in reporting by all physicians. Such reporting will enable all Americans to judge the quality of care that they receive and feel confident that their provider is committed to delivering the best care.

NCQA also examined costs of care for several chronic conditions and found “no clear indication that higher resource use produces better quality results.” This echoes the State Scorecards, which found no systematic relationship between quality and cost of care at the state level. The health plans and states that achieve higher quality at lower cost offer hope that improving health care performance need not cost more.

More widespread adoption of electronic health records and electronic health information exchanges should enable more robust reporting of clinical data in the future. In the meantime there are things that can be done with existing data and tools, such as NCQA's HEDIS measures and the use of registries to track care for patients with chronic conditions. In short, we as a nation need to commit to making the improvements seen in hospital quality the norm across all areas of health care. Patients deserve nothing less.

November 30, 2009

Health Reform: Insights from Around the World

By Cathy Schoen, Karen Davis, Robin Osborn

The United States stands at the brink of a historic change that would remove financial barriers to health insurance coverage and ensure access to essential health care services. Enactment of health reform legislation would enable the U.S. to join the ranks of major industrialized countries that offer their people a system of health insurance coverage. Most of the health reform debate has focused on ways to strengthen our uniquely American private–public system of health financing and expand coverage to those who fall through its cracks. Yet, the debate has also been informed by insights gained from health systems in other countries.

Making Care Affordable

A recent [Commonwealth Fund survey](#) of primary care physicians in 11 countries published in *Health Affairs* underscores just how much is at stake. Many of the shortcomings in the U.S. health system revealed by the survey—pertaining to access, quality, health outcomes, and value—would be addressed by the proposals under consideration by Congress.

Almost three of five U.S. physicians (58%) say their patients often have difficulty paying for care. In sharp contrast, about one of four primary care physicians in the other 10 countries say that costs are often an issue for patients. That's largely because most of these countries have a coverage system with benefits designed to facilitate access to essential services and provide financial protection against burdensome medical bills. Countries such as Norway, Sweden, and the U.K. include little or no patient cost-sharing for medical expenses and cap total financial exposure for the year. Some, such as France, base patient cost-sharing on how essential a particular service is for ensuring good health outcomes. Others, such as Germany, use reference pricing for prescription drugs, with patients paying the difference if they prefer a higher-cost but no more effective medication. Germany

also limits total out-of-pocket costs as a share of income to 2 percent for the general population and 1 percent for sicker patients. France eliminates cost-sharing for seriously ill patients and those with specified chronic conditions on care plans.

Without a seamless coverage system like those offered in these other countries, many Americans cycle in and out of coverage. Nearly [one-third of U.S. adults](#) under age 65 are either uninsured at some point during the year or underinsured, meaning their insurance does not protect them from high medical expenses. Because there is no accepted standard for essential benefits, even the insured can encounter difficulty paying medical bills. Not surprisingly, half of U.S. physicians report that the time they spend helping patients get needed treatment or medications because of insurance restrictions is a major problem. [One study](#) supported by The Commonwealth Fund found that physicians spend \$31 billion a year dealing with insurance companies. On a per-person basis, the U.S. spends more than twice as much as other countries on the net costs of insurance administration. Varying benefit designs, marketing costs, people churning in and out of coverage, underwriting, and insurance profit margins all contribute to higher overhead costs. A recent McKinsey study estimates that such complexity—including multiple reporting requirements—accounts for some [\\$90 billion per year](#) in excess costs.

Insurance reform is fundamental for access to care and financial protection. It also can serve as a base for a more rational payment system and incentives that reward value, not volume. Coherent prices and payment policies that support effective and efficient care are critical for markets to work, as is publicly available information that gives patients comparative information on quality and price to facilitate choice and providers data to improve quality and efficiency.

The U.S. stands out among other countries for the high prices it pays for care. All other industrialized countries leverage their purchasing power to negotiate reasonable provider payment rates and prescription drug prices. Unlike countries with multiple payers and competing insurers—such as Germany, Switzerland, and the Netherlands—the U.S. lacks a mechanism to coordinate payment policies to achieve coherent price signals or use group purchasing power. As a result, the U.S. tends to pay higher prices for specialized services, including prescription drugs, particularly brand-name drugs without generic options. A [recent McKinsey study](#) found the U.S. pays 50 percent more than other countries for comparable drugs and pays for a more expensive mix of drugs than do other developed countries, leading to total costs per capita that are twice as high as other industrialized nations.

Improving Primary Care

Also notable are our nation's weak primary care foundation and poor care coordination. Other countries have insurance systems that promote continuity of care and provide a choice among primary care practices in the community. Many encourage or require patients to identify a “medical home”—a practice that will serve as their principal source of primary care and coordinator of specialist care when needed. With modest financial incentives, more than 90 percent of French adults voluntarily choose to sign up with a medical home. In the Netherlands, after-hours cooperatives take over for primary care physicians at nights and weekends, which explains why [97 percent](#) of Dutch primary care physicians report that they have arrangements for after-hours care of patients. By contrast, only 29 percent of U.S. primary care physicians report any arrangement for the care of their patients after hours.

The U.S. relies on market incentives to shape its health care system, yet other countries are much further along in providing financial incentives to primary care physicians aimed at improving quality of care. The U.K. has had [substantial success](#) in improving quality of care with its pay-for-performance rewards to primary care physicians. [Eighty-nine percent](#) of U.K. primary care doctors report they can receive financial incentives for quality improvement. By contrast, only

36 percent of U.S. primary care physicians report that they can receive financial incentives based on meeting quality targets, delivering recommended preventive or chronic care, or meeting other care goals as of 2009. Incentives and targeted support for primary care in other countries include extra payments to add nurses to care teams, payment for e-mail consultations, and enhanced payments for after-hours care. Providers also receive extra payments for enrolling patients in disease management programs and for offering chronic care services such as patient self-management education. Several countries pay physicians in a way that narrows the spread between primary care physicians' and specialists' income—making a stark contrast to the widening gaps between primary and specialty providers in the United States. Countries that have traditionally paid for care on a fee-for-service basis are increasingly moving toward a mixed payment method, including per-patient monthly allotments for providing access, coordination, teams, and serving as a medical home as well as fees for visits or incentives for quality. In most other countries, hospital and inpatient physician services are “bundled” into a single system of payment, either as global fees based on diagnosis or hospital budgets including salaries of physicians caring for hospital patients.

Investing in advanced clinical information systems is instrumental to inform, guide, and drive innovation. Despite its reputation for use of technology, the U.S. lags way behind other countries in adoption of health information technology and creation of health information exchange networks that facilitate access to all of a patient's pertinent medical information for physicians and other health professionals, authorized by patients. In some countries, patients have direct access to their own medical records. [Less than half of American primary care physicians](#) report use of electronic medical records, compared with nearly all of their counterparts in the Netherlands, New Zealand, Norway, and the U.K. Other countries have invested to spread the adoption and use of health information technology, with the capacity for information exchange. The wide differences across countries reflect national efforts to standardize and promote use, often with financial incentives. The American Recovery and Reinvestment Act enacted earlier

this year should help speed adoption of information technology in the U.S.

Countries are also investing in assessing comparative clinical effectiveness to inform patient and physician decisions as well as pricing and benefit designs. Such assessment promotes innovation and enables reference pricing of medications and brings downward pressure on higher-cost alternatives. In addition, several countries are developing rich comparative information systems on performance. In Germany, peers visit hospitals where the quality of care is substandard and enter into a “dialogue” about why that is the case. The Netherlands and the U.K. are investing in transparency in reporting performance data, including data on patient experiences. In both countries, this information is posted on public Web sites as well as fed back to clinicians. The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

Overall, what most differentiates the U.S. from other countries is the leadership shown by government in setting coherent policies that drive health systems to high performance. This includes setting goals, measuring performance, and rewarding improvement. Over the last decade, a focused strategy and quality outcomes

framework have helped transform the National Health Service in England. When other countries rely extensively on markets, government sets market rules in the public interest to focus competition on quality and efficiency and provide information to spur improvement and innovation. In countries with multiple payers and competing insurers, this includes provisions for public and private participation in a common set of policies that work in the same direction.

But today, the national leadership in the U.S. is working to put in place the coverage and delivery reforms that our country desperately needs to ensure the health and economic security of current and future generations. We have the benefit of multiple examples of international strategies as well as care systems in the U.S. that achieve high-quality care at lower costs. We can learn from the experiences of other nations as they continue to innovate to meet current and future needs for accessible, high-quality, and efficient care. By enacting national reforms that take steps to put the United States on a path to a high performance health system, there is the opportunity to reap a high return for the health of the population and the economy.

July 8, 2009

National Leadership to Achieve a Performance-Driven Health System

By Karen Davis & Stephen C. Schoenbaum

What is largely missing from the congressional health reform proposals is an overarching framework that establishes goals for a high-performance health system and includes a coordinated set of public policies and private sector actions that would ensure the U.S. reaches benchmark levels of performance by 2020. Without a mechanism for setting long-range goals as well as immediate priorities for performance improvement, we could fail to realize the enhanced impact and economies possible from concerted action.

Setting Health Goals and Priorities for Performance Improvement

The Commonwealth Fund's Commission on a High Performance Health System has [documented](#) that the U.S. is not achieving the health outcomes, quality of care, and access to care that could be achieved with the resources the country commits to health care. The lack of accountability for results at the national, state, and local health care delivery levels reflects an absence of goals, priority improvement targets, incentives, and support required to meet performance targets—as well as the lack of consequences for performance that does not meet such targets.

A major reason for this lack of accountability, and for highly variable, often poor performance, is the fragmentation of the health care financing and delivery system. Decisions shaping the U.S. health care system are made by thousands of private and public stakeholders, largely acting independently and often with a goal of shifting costs to other parties rather than achieving the best results for the system as a whole. What is needed is national leadership to coordinate the now-disparate components of the health care system.

There are a number of national health initiatives with defined objectives, including the U.S. Department of Health and Human Services' "Healthy People 2010," the National Quality Forum's "National Priorities Partnership," and the Institute of Medicine's priorities for comparative effectiveness research. The Commonwealth Fund's Commission on a High Performance Health System has developed and published a [national scorecard](#) on U.S. health system performance that includes achievable benchmarks across the domains of health outcomes, quality, access, equity, and efficiency.

Health reform proposals under consideration in the House and Senate include requirements for the development of national priorities for quality improvement and reports to Congress outlining national priorities and strategies for health care quality improvement. A Republican-sponsored alternative proposal calls for a new forum on the quality and effectiveness of health care, to be comprised of private-sector representatives. But these proposals focus primarily on health care quality, falling short of a comprehensive set of goals for health system performance that includes access to care, equity, and efficiency.

The U.S. health system will not reach its potential until we have an agreed-upon set of national performance goals and improvement targets with the government's imprimatur, along with supporting policies, resources, and actions. One process for establishing these goals, targets, and supports could be an annual "Health Performance Report," submitted to Congress by the president. This publication would report on health system performance, including:

- health outcomes across geographic regions of the U.S. and population subgroups;

- access to care;
- quality of care;
- efficiency; and
- capacity to innovate and improve.

Such a report would help create a clear picture of the state of the health system and complement the “Economic Report of the president” and data reports on economic growth and employment. Most important, it would include the president’s 2020 goals for health system performance, priority targets for improvement, and recommended policies and private sector actions required to meet them, all based on consultation with the public and health care stakeholders. Congress would act annually to accept or modify these goals and priorities, and make the policy changes needed to help achieve them.

The power of driving performance improvement through presidential, Congressional, and private sector leadership might best be understood by considering the illustrative health system performance goals for 2020 and target indicators for improvement outlined in the exhibit below. These examples highlight the many components of health system performance, which encompasses health outcomes, delivery system organization, quality and safety, disparities, insurance coverage, and incentives to bend the cost curve.

A Whole-System Strategy

Once agreement on the long-range goals and shorter-term improvement targets is achieved, the president could oversee the development of an implementation plan and submit it to Congress for review; the plans would be updated each year. The president also could ensure that the public agencies or private organizations responsible for the key components of a high-performance health system had a clear mandate based on the goals and targets, and would be held accountable for fulfilling that

mandate. For example, the goals and targets would shape priorities within the following areas:

- **Comparative effectiveness.** Priorities for the \$1.1 billion allocated to various agencies within the U.S. Department of Health and Human Services by the American Recovery and Reinvestment Act for comparative-effectiveness research would be based on these goals and targets.
- **Health information technology.** Meaningful use of health information technology and design of health information exchanges provided for under the American Recovery and Reinvestment Act would be consistent with achieving these goals and targets.
- **All-population/all-payer database.** An all-population/all-payer data system would be developed and used to monitor and track performance on these goals and targets. Public reporting would be developed to ensure transparency and support improvement efforts.
- **Quality improvement.** Professional bodies and state agencies that set standards for quality, accreditation, certification, and licensure of health care providers and organizations would agree to align their processes with actions to achieve these goals and targets.
- **Workforce planning and development.** Public agencies charged with workforce planning and development would develop policies to address gaps in accessibility of services and in preparation of teams of health care professionals required to meet these goals and targets.
- **Public health.** Achieving population-oriented health goals and the best possible health outcomes would become the guiding principle for investment in public health activities and adoption of policies such as taxing products related to unhealthy behaviors.

- **Insurance exchange.** Health insurance exchanges or connectors at the national, state, or regional level would set standards for qualified health plans that would help meet these goals and targets.
- **Payment reform.** Perhaps most important, Medicare, Medicaid, and private and public plans participating in health insurance exchanges would be held accountable for payment policies that reward providers based on these goals and targets. The design and rapid testing of new incentives would be facilitated by creation of a Medicare Payment Board within the executive branch whose decisions would be reviewed periodically by Congress.

Coordinating national leadership for all of these components of the health system would enable the federal government to: 1) assign clear responsibility and authority for the key aspects of the health system singly and jointly, and 2) provide the necessary capacity to enable agencies and organizations to act to secure access for all, better health outcomes, and slow the rate of cost growth. The new leadership roles needed to provide a coordinated and systemic approach to improving population health and wresting better value from health spending should be addressed as part of health reform legislation.

A Gain for the Nation

To illustrate the potential gain for the nation of a comprehensive, integrated approach to health reform, the *Path to a High Performance U.S. Health System* report published in February 2009 by the Commonwealth Fund Commission on a High Performance Health System outlined specific reforms related to provider payment, information systems, population health, and coverage that—in combination—could ensure affordable coverage for all, achieve savings, and improve population health.

The U.S. must establish a process for reaching national agreement on long-range goals and priorities for improvement in order to accomplish comprehensive, integrated health reform. This will require national leadership and a mechanism for the federal government to consult with the public as well as private health care stakeholders. The recommendations outlined here would take us a long way toward ensuring that the U.S. has a high-performing health system that simultaneously ensures better access, improved quality, and greater value. The importance of goal-setting, coordinated policies, and leadership must be considered as health reform legislation takes shape in Congress.

**Health System Performance Goals for 2020 and Shorter-Range Target Indicators:
Illustrative Examples**

2020 Health System Performance Goals	Shorter-Range Target Indicators
<p>1. The U.S. is in the top five countries in achieving desired health outcomes for its population.</p>	<ul style="list-style-type: none"> • Percent of population receiving key preventive services or screening • Percent of population with chronic conditions controlled
<p>2. Every American has the opportunity to enroll in a patient-centered, primary care practice that is accountable for ensuring that patients receive accessible, coordinated care, including all recommended preventive, acute, chronic, and end-of-life care.</p>	<ul style="list-style-type: none"> • Percent of adults and children enrolled in a patient-centered primary care practice • Percent of physicians practicing in accountable care organizations
<p>3. All providers reach attainable benchmarks of performance on indicators of health care quality and safety, and racial and ethnic disparities in quality of care are eliminated.</p>	<ul style="list-style-type: none"> • Percent reduction in gap between benchmark levels of quality and safety and 2009 levels • Percent reduction in disparities in quality by race and ethnicity
<p>4. All Americans have the opportunity to be covered by an affordable health plan that ensures that premiums and out-of-pocket expenses do not exceed an affordability standard (e.g., 10 percent of income for median-income families, and less for those with incomes below the median).</p>	<ul style="list-style-type: none"> • Percent of population insured • Percent of population with premiums and out-of-pocket expenses within an agreed-upon affordability standard
<p>5. Health spending over 2010–20 is slowed by 1.5 percentage points a year from 2009 rate of increase.</p>	<ul style="list-style-type: none"> • Percent of provider revenue that replaces fees-for-services with value-based payment for bundles of care, including per-patient fees for chronic care, medical home, acute care case rates, partial or full capitation, or pay-for-performance • Percent of physicians and hospitals with “meaningful use” of health information technology • Percent reduction in duplicative, avoidable, or ineffective services, and administrative overhead

September 30, 2009

Forging Health Reform Consensus

By Karen Davis

Cooler weather has arrived and, with it, cooler heads are moving forward with health reform. Despite the summer demonstrations against congressional health care legislation, there is widescale recognition that the U.S. health system cannot continue on its current course. Ever-rising numbers of uninsured, insurance premiums that are out of reach of even middle-income families, and the strain on businesses and government budgets from a health sector consuming a greater and greater share of the nation's economic resources make the status quo untenable.

Still, most Americans remain perplexed by the different versions of health reform presented in legislation from three committees in the House of Representatives and two committees in the Senate. The daily headlines highlighting differences in opinion on specific provisions suggest bipartisan and even Democratic party agreement is elusive. Yet, even though the Senate Finance Committee is still considering legislation and the final bills going to the House and Senate floors have yet to be formed, there is, in fact, significant consensus on the framework for reform across all the bills moving through Congress. It includes: affordable health insurance coverage for all; increased choices; incentives for accountability; greater transparency; shared responsibility; redirected resources; and opportunities for learning and acting as reform is implemented.

Affordable Coverage for All

On the key goal of ensuring affordable coverage for all, the proposals under consideration include four common elements: expansion of the Medicaid program to all of the lowest-income individuals and families; provision of income-related assistance to make premiums affordable for moderate-income families; an essential benefit package to ensure financial access to health care; and

an affordability standard to ensure that no family faces serious financial hardship as a result of illness or injury.

The House proposal and Senate Finance Committee Chairman's Mark include expansion of Medicaid up to 133 percent of the federal poverty level (almost \$30,000 for a family of four), while the Senate Health, Education, Labor, and Pensions (HELP) proposal would raise the bar to 150 percent of poverty. Both the House and the two Senate versions would provide assistance in paying premiums for families up to four times the federal poverty level (about \$88,000 for a family of four). Each bill would set a maximum on the most that any family in this income bracket would pay for health insurance at about 12 percent of income for higher-income families. Individuals with lower incomes or who are covered by employer plans would pay less. While the differences in the subsidy amounts for different incomes across the House and Senate bills are important, all of the bills recognize that, with premiums now exceeding \$13,000 a year, even average-income families cannot afford health insurance on their own.

All of the proposals also call for creation of an essential benefit package that covers hospital, physician, prescription drugs, preventive care, and other services, with the details left to those responsible for implementing the legislation. Different options would be available, with individuals able to make trade-offs between lower premiums and higher out-of-pocket costs. But all plans would be required to cover a minimum "actuarial value," or share of all expenses, ranging from 65 percent to 95 percent. This range is comparable to the share of expenses covered by the plans typically held by working families and members of Congress. The House bill and Senate Finance Committee Chairman's Mark ensure that lower-income families have affordable out-of-pocket costs.

Again, the differences among proposals on the table are important but there is consensus on the basic structure.

Increased Choices

The most contentious issue is whether a new public health insurance plan would be offered through a health insurance exchange or the marketplace. What is lost in this debate is that all of the proposals would establish such an exchange and set rules on participating plans, including their availability to all on the same terms regardless of health status. These rules would dramatically increase the availability and affordability of coverage for those who have been excluded from the insurance market because of serious health conditions.

The proposals also would expand people's insurance plan choices. The House would include a public health insurance option, which would be sponsored by the government. The Senate HELP proposal includes a community health insurance plan offered by the government but with claims administered by private parties, and the Senate Finance Committee Chairman's Mark includes a nonprofit, consumer-controlled private plan. The structure of the plans and potential premium savings differ, but there is shared recognition that the private insurance market needs to change—and that change can best be accomplished by offering new affordable public or nonprofit plan choices in the marketplace.

Incentives for Accountability

An important aspect of the reform bills that has remained under the radar screen is that all seek to transform the health system from one that rewards doing more to one that rewards getting better health outcomes for patients. Both the House and the Senate Finance Committee Chairman's Mark would improve the coverage of preventive services. Today, only half of adults are up to date with preventive care. No single provider takes responsibility for reminding patients of screenings and ensuring that such services are offered on a timely basis, and financial barriers lead many patients to put off care as long as possible. Likewise, many chronic conditions go uncontrolled because there is no system of accountability for monitoring care over time.

Both the House and Senate Finance Committee Chairman's Mark would establish a Center on Payment Innovation that would reward physicians, hospitals, and health care organizations that agree to be held accountable for ensuring their patients get the best care. This change in accountability for health outcomes, quality of care, and prudent stewardship of resources is a seismic shift from the current system, which simply pays for units of services—each test, each procedure, each face-to-face visit with a physician, each emergency room or hospital encounter. Instead, patients would be encouraged to identify a physician, nurse practitioner, or clinic as their principal source of care. That provider or practice would be responsible for that patient and rewarded for focusing on providing accessible, coordinated, patient-centered care delivered through interactions by telephone, telemedicine devices, or the Internet; during the day or on evening and weekends; and by a physician or a care team that includes nurses, pharmacists, and other health professionals.

Greater Transparency

One of the reasons the U.S. has the costliest health system in the world is that information on the quality and cost of care is not readily available to consumers in a system where profit on the provision of health care is accepted. What may turn out to be the sleeper in health reform are various provisions that would shine more sunlight on economic transactions, such as the profit margins and administrative expenses of insurance companies, the content of insurance policies purchased by consumers, and the financial relationships between physicians and medical device manufacturers and pharmaceutical companies.

Under the reforms, patients would have more information on the quality of care and prices. The gradual shift to global fee systems of payment for total care of a condition—like a hip fracture or heart surgery—would help patients know what to expect before selecting a source of care, as well as help physicians and hospitals benchmark their performance against their peers. The Commonwealth Fund Commission on a High Performance Health System National Scorecard found that performance improves on quality measures that are publicly reported. Even though the Congressional Budget

Office does not attribute significant savings from changes in provider behavior, greater transparency on quality and total fees could lead to substantial shifts in both provider and patient behavior and lower costs over the long term.

Shared Responsibility

It is not surprising that everyone is worried about who will pay for health reform. But the truth of the matter is that coverage for all is affordable if everyone does their part. Those without coverage are being asked to contribute to premiums on an affordable sliding scale based on income, whether they are young and healthy or older with complex health conditions. Young adults would pay lower premiums than older adults, and some proposals add options for young adults to continue coverage under their parents' plans up to age 26.

Employers are also expected to do their part, which will level the playing field between those companies that provide coverage and those that don't. Exceptions and special treatment will exist for very small businesses struggling to meet payroll and for workers whose share of the premium offered by employers is still burdensome.

Redirected Resources

The federal budget price tag for expanded health coverage seems staggering—\$900 billion to over \$1 trillion over a 10-year period under the House and Senate bills. Yet it's important to keep in mind that over the next decade the U.S. will spend \$40 trillion on health care—and the new federal outlays represent about 2 percent to 3 percent of total health spending. To finance this expansion of coverage, about half of the resources will come from slowing growth in provider payment rates under public programs by about 1 percent a year—which hospitals and other health care providers have agreed is possible given savings that will be generated by efforts to improve productivity and eliminate waste. Pharmaceutical manufacturers have offered to cut the price of brand-name drugs in half for seniors hitting a gap in their Medicare drug plan, called the “doughnut hole.” Other savings will come from eliminating overpayments to Medicare managed care plans and levying fees on insurers and device manufacturers. Under the House bill, additional revenues may be generated by reversing some of the tax cuts of the last three decades for the wealthiest

households or, under the Senate Finance Chairman's Mark and possibly the revised House bill, by taxing nonessential insurance benefits or certain health industry suppliers.

Learning and Acting as Reform Is Implemented

Some have called for proceeding at a slower pace, cautioning that the reforms represent a major redirection in the health system and that not all of the consequences are known with certainty. But the proposals in the House and Senate have numerous provisions that call for phasing and monitoring and provide opportunities to make adjustments as reform is implemented. The health insurance exchange, for example, would be established in 2013, and initially open only to individuals and very small firms. This would provide ample time for planning and addressing design issues, and would give discretion to those operating the exchange to decide when to expand to larger firms. As the exchange goes into operation, new transparency on insurance administration and review of premiums would assess whether intended efficiencies are occurring.

The Center for Payment Innovation would implement new methods of payment for physicians, hospitals, and health care organizations ready and willing to participate, with discretion for the Secretary of Health and Human Services to spread successful innovations more broadly. A new commission has been suggested in the Senate to monitor trends in federal budget spending and identify areas of waste and potential additional savings and to expedite the implementation of remedies. This might reasonably be extended to system-wide review of health expenditures for employers and working families. Based on the system reviews, Congress could act to modify reforms, including phasing in various provisions more slowly or quickly, or adding additional safeguards or savings.

A Consensus-Minded Approach

All of the provisions described—in combination with those in the American Recovery and Reinvestment Act of 2009 that are investing in health information technology and comparative effectiveness research—would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the

long term. Each bill now in Congress would also make sure that Americans with insurance maintain stable, affordable coverage and that uninsured Americans gain coverage.

Focusing on areas of consensus rather than our differences or most preferred solution should help make reform this year a reality. The framework for health care transformation has been laid out—our final task is to work through the remaining issues without derailing our efforts and pass this legislation, which has the power to improve the financial health of our nation and the financial and physical health of its people.

January 28, 2010

The Way Forward with Health Reform

By Karen Davis

In his State of the Union address, President Obama urged Congress to stay the course and enact comprehensive health reform. He reminded us that the problems that health reform is intended to address pose a serious threat to the health of Americans and our economy.

Nearly 50 million Americans are uninsured, as those who lose their jobs often lose their health insurance. And it's not just the uninsured who are at risk: with the rise in health care costs in the last decade, even middle-class families with jobs and coverage are struggling to pay their share of premiums and medical expenses. Seventy-two million working-age adults have difficulty paying medical bills or accumulated medical debt, while rising health care costs force employers to choose between hiring new workers, paying higher wages, and providing adequate health insurance to their employees.

For all that families, businesses, and government spend on health care, the health system fails to deliver reliably safe and high-quality care that is easily accessible to patients. Instead, nearly three-fourths of Americans report difficulty getting a doctor's appointment promptly, reaching their physician by phone, or obtaining care on nights or weekends. Half of patients say they don't receive their test results or their doctors don't have their medical information when needed. One-third of the public undergo duplicative tests or other care that is unnecessary or of little health benefit. And more than one-fourth experience administrative hassles when handling insurance claims or paying medical bills.

The high costs of health insurance and health care also force people to go without needed care, whether it's a doctor's visit or a prescription refill. Because of all of these inadequacies, too many Americans are suffering—even dying—without the care they need. And the health

system will continue to deteriorate if we do nothing to change course.

But misleading claims about the impact of health reform, and lack of understanding of its potential to improve patients' experiences, have undermined public support. What have been obscured are the many aspects of the proposed health reform legislation that would make health care accessible to all Americans and begin to transform the delivery system to improve the quality and coordination of care. Both the House and Senate bills:

- Cover over 30 million uninsured Americans who now fail to get the care they need; improve 24/7 access to doctors and nurses; and provide the information necessary to ensure the best care for patients.
- Provide families who make less than about \$90,000 a year and don't have employer coverage with help in paying their insurance premiums; offer coverage under Medicaid for families with incomes under about \$30,000; and set a ceiling on family out-of-pocket medical expenses.
- Ensure health insurance is available to all, without regard to health conditions and without artificial limits on covered expenses, and establish a standard for essential comprehensive benefits.
- Lower premiums and improve benefits, especially for those buying insurance on their own and employees of small firms, and provide tax credits to small businesses.
- Launch an intensive effort to develop and implement innovations to transform health care delivery to improve quality of care, preventive care, and control of chronic conditions, while

eliminating waste, duplication, and the need for costly hospitalizations and reducing insurance waste and overhead.

- Help ensure Medicare’s fiscal solvency while improving prescription drug benefits for beneficiaries and helping pay for home care and long-term care for tomorrow’s disabled.
- Reduce the federal budget deficit and middle-class families’ expenses.
- Ensure that no one in America is unable to obtain the care they need because of cost—so that the U.S. is no longer the only advanced, wealthy country where losing a good job or taking a major cut in pay means losing access to, and the ability to pay for, health care.

Myths and Reality

One way to move forward is to look at what health reform is and isn’t—to separate myth from reality.

1. **Myth:** Health reform would ration needed care.

Reality: Reform would increase patients’ choice and improve access to care.

The charge that the American health system will be “government-run” or “socialized,” with the government telling doctors what they can do for patients, stirs a deep-seated fear that care will be rationed. The truth is that nothing in the health reform legislation calls for rationing effective care. The law would support research on the comparative effectiveness of diagnostic and treatment services so that physicians and patients know which drugs and treatments work best; it would not, however, limit doctors’ ability to treat patients. The U.S. would retain its largely private system of health care delivery and continue to have a well-resourced system capable of meeting the needs of all. In fact, improved access to affordable coverage through a [national health insurance exchange](#) (in the House bill) or state exchanges (in the Senate bill), as well as proposed expansions of Medicaid, would improve access to care and choice among providers for many Americans.

2. **Myth:** Health reform would raise insurance premiums and fail to reduce future health costs.

Reality: Without reform, many Americans stand to lose their coverage or face higher premiums and medical bills as benefits erode. Health reform would offer a return to rising incomes.

Many American families are living on the edge and hard-pressed to meet their day-to-day expenses. Not surprisingly, they worry that health reform might mean losing the coverage they already have—or even higher costs as uninsured people gain coverage. Yet the reality is that rising health care costs have undermined wage increases over the last decade and increased workers’ premium costs and out-of-pocket health care expenses. Without health reform, those trends will continue unabated.

Between 1999 and 2008, employer family health insurance premiums rose by 119 percent, while the median family income rose by less than 30 percent. As a result, the total average family premiums paid by employers and workers have risen from 11 percent to 18 percent of median family income. If Congress fails to pass reforms that are effective in controlling the rise in health care costs, premiums are projected to rise to 24 percent of the typical family’s income by 2020. In any economic climate, but especially today, families cannot afford to devote one-fourth of their income to maintaining insurance coverage, nor can businesses afford to pay their share of insurance premiums while also giving raises to employees.

Comprehensive health reform would reduce administrative costs for insurers and help modernize the delivery of health care services, both of which would result in reductions in private insurance premiums. A [recent analysis](#) finds that, without reform, family premiums are expected to increase from \$13,649 in 2010 to \$22,535 in 2019. By 2019, family premiums would be \$1,900 lower with reform. Along with reductions in out-of-pocket costs and lower taxes for Medicare and Medicaid, estimated savings for the typical family would be about \$2,500, relative to predicted costs, if we stay the current course.

3. Myth: Health reform would cut Medicare benefits.

Reality: Reforms would improve prescription drug coverage and protect future Medicare benefits by giving doctors and hospitals incentives to improve care and efficiency and reduce costs.

Seniors and the disabled are concerned that health reform would undermine their Medicare benefits. Yet Medicare benefits would actually improve under health reform. For example, the so-called doughnut hole in the prescription drug benefit would be eliminated under the House bill and reduced under the Senate bill. The House bill would give the government the authority to negotiate prices of prescription drugs, a move that would further benefit people with Medicare and reduce their out-of-pocket costs. Additionally, preventive services would be covered in full, without copayments.

Medicare reforms in the bills would also save the federal government money. Hospitals have agreed to shave one percentage point off their annual price increase under Medicare over the next decade, recognizing that coverage of the uninsured would reduce bad debt and other efficiencies would make it possible to improve productivity. Providers also fare well under the reforms. Even with this one-percentage-point price reduction, Medicare payments to providers would be more than adequate, exceeding the growth in our economy overall and increasing by 67 percent by 2019. Most important, a new Innovations Center within the Centers for Medicare and Medicaid Services would pilot innovative payment methods that reward providers who succeed in improving care, reducing the need for hospitalization and cutting waste, duplication, and ineffective services.

The government would stop paying private managed care plans extra for participating in Medicare. These plans were paid \$11.4 billion more in 2009 than what the same beneficiaries would have cost were they enrolled in the traditional Medicare fee-for-service program. Health reform would gradually eliminate this inequity. Some extra benefits financed by these overpayments—received by a minority of beneficiaries but financed by all—would likely be eliminated. But all beneficiaries would continue

to receive the basic Medicare benefits to which they are entitled.

4. Myth: Health reform would raise the average American's taxes.

Reality: Reforms avoid any new broad taxes and instead seek to pay for better insurance by slowing spending growth.

Most Americans agree with the goals of health reform: covering the uninsured, improving the affordability of coverage and care, and cutting costs. But they are concerned that paying \$800 billion to \$1 trillion over 10 years for improved coverage would increase their taxes. They question whether the nation—and taxpayers—can afford such a commitment on top of government expenditures under the stimulus bill that was enacted to bring the economy out of serious financial crisis.

In fact, most middle-class families would not face tax increases. Almost half of the cost of improved coverage is financed by slowing increases in prices paid to health care providers and insurers. The remaining financing comes mostly from payroll taxes on families with incomes over \$250,000 a year (in the Senate bill) and income taxes for families with incomes over \$1 million (in the House bill), as well as fees on insurers, manufacturers or importers of brand-name drugs, and medical device manufacturers. An excise tax on insurers selling plans with premiums in excess of \$24,000 might affect premiums for some workers—although few employees have plans that exceed this threshold, and safeguards could be added to protect workers who pay high premiums because of where they live, their age, or health risk.

5. Myth: Health reform would add to the deficit.

Reality: Reform would reduce the deficit and reduce costs for businesses and families.

Related to the concern about taxes is a concern about red ink and the implications for future generations of unfunded expansions in coverage. The president, however, has made good on his pledge not to add to the federal budget deficit, and the Congressional Budget Office (CBO) estimates a net reduction in the budget deficit of \$132 billion, in the Senate bill, to \$138 billion

in the House bill. CBO also estimates that revenues would exceed expenses in the second decade, from 2020 to 2029.

In short, health reform as designed in the House and Senate would achieve the goals set forth by the president: 1) to ensure the stability and security of insurance coverage for those who have it; 2) to provide coverage for those who don't; and 3) to slow the rise in health care costs for employers, individuals, and government.

Health reform would help all Americans receive the care they need to lead healthy and productive lives, while removing the financial strain of inordinately high health insurance premiums and out-of-pocket medical expenses. Rather than inflicting high costs on those who are sickest, as in the current health system, the legislation's proposed financing is balanced and fair, drawing from households, government, and employers. It changes the incentives in our health system, from rewarding a high volume of

services to rewarding prevention, management of chronic conditions, and the best health outcomes for patients. Health reform preserves the best of American health care, while fixing what doesn't work for patients.

While the way forward politically is not yet totally clear, the president reassured Americans in his State of the Union address that he is not going to walk away from the problem. He urged Congress to enact health reform that will relieve the burden on middle-class families, address the worst practices of the insurance industry, and reduce health care costs and insurance premiums.

The odds are that, like President Obama, you, a family member, or a close friend has experienced a problem with health care coverage, medical bills, or care. The health reform legislation is about addressing the problems we all face; we cannot let the opportunity to improve our lives and our livelihoods slip by.

March 22, 2010

A New Era in American Health Care

By Karen Davis and Sara Collins

The historic action by the House of Representatives in passing comprehensive health reform legislation will usher in a new era in American health care—one in which all Americans will be able to get the care they need without incurring financial hardship, and no American will be denied health insurance coverage simply because they have a preexisting medical condition.

Health reform will provide new security for working-age Americans across the income spectrum, increasing access to needed care for millions who are currently uninsured and underinsured. It will cover an additional 32 million people by 2019, or 95 percent of legal residents, by expanding eligibility for Medicaid and by bringing sweeping change to the individual and small group health insurance markets with new premium subsidies. New regulations will prohibit insurers from excluding or charging higher premiums to individuals and small businesses on the basis of health status or preexisting medical conditions, charging excessive premiums to older adults, revoking coverage when people get sick, or setting lifetime and annual limits on what plans will pay. Young adults will be able to remain on their parents' health plans up to age 26 beginning in 2010.

New state-based insurance exchanges will provide structured marketplaces, where small businesses and people without employer coverage may select health plans that will have to meet new standards for comprehensive coverage and consumer information. Families with incomes between \$30,000 and \$88,000 a year will be eligible for premium subsidies for plans purchased through the exchanges (those with incomes up to \$30,000 for a family of four would become eligible for Medicaid). These subsidies would cap premium costs as a share of income at 3 percent for families earning just over \$30,000, and would rise with income to 9.5 percent for families earning \$88,000. In addition, families in that

income range would also have their out-of-pocket costs capped, or would be eligible for cost-sharing subsidies that would reduce their medical bills.

Small businesses, which have suffered from rising health care costs and the recession, will benefit from new market regulations against underwriting and will be able to purchase health coverage through the insurance exchanges, which will reduce the costs they incur in searching for health insurance. In addition, a new tax credit will be available for up to a two-year period starting in 2010 for small businesses with fewer than 25 employees and with average wages under \$50,000, to offset the cost of their premiums. The full credit would be available to companies with 10 or fewer employees and average wages of \$25,000, and would phase out for larger firms. Eligible businesses would have to contribute 50 percent of their employees' premiums. Between 2010–13, the full credit would cover 35 percent of a company's premium contribution. Beginning in 2014, the full credit would cover 50 percent of that contribution.

Health reform will also bring important new benefits to people over the age of 65. It will improve Medicare prescription drug benefits by providing a \$250 rebate to people who reach the coverage gap, or “doughnut hole,” in 2010, and the doughnut hole will phase out completely by 2020. Preventive care will be strengthened in both traditional Medicare and private plans, as the bill eliminates cost-sharing for proven preventive care services, and provides an annual wellness visit for Medicare beneficiaries with no copayment. The new legislation will also help workers finance long-term care should they become disabled or frail.

Many Americans will feel the effect of the reform this year, as significant changes start to go into effect. Within the year:

- underwriting of children in the individual market will be prohibited;
- young adults will be able to stay on their parents' health plans to age 26;
- insurance companies will be prohibited from revoking coverage when people become ill, and from setting lifetime limits on benefits;
- small businesses will be eligible for new tax credits to offset their premium costs;
- people with preexisting conditions will be eligible for subsidized coverage through a national high-risk pool;
- new limits will be set for the percent of premiums that insurers can spend on nonmedical costs and, beginning in 2011, carriers that exceed those limits will be required to offer rebates to enrollees;
- Medicare will provide \$250 rebates to beneficiaries who reach the doughnut hole; and
- Medicare will eliminate cost-sharing for preventive services in Medicare and private plans.

All of these improvements in health benefits for Americans will occur in a way that does not add to the federal budget deficit or accelerate the growth in health care spending.

The Congressional Budget Office estimates that health reform, as passed by the House of Representatives, will reduce the federal deficit by \$143 billion over the next 10 years (2010–19). Congress is making the tough choices to both achieve savings of about \$500 billion in the current federal budget over the next decade, and raise the revenues needed to finance the balance of the federal budget cost of this important reform. The legislation creates a new Center for Medicare and Medicaid Innovation within

the Centers for Medicare and Medicaid Services to test new methods of payment for medical homes, accountable care organizations, and bundled hospital and post-acute care. These efforts will markedly increase incentives to reduce avoidable hospitalizations. It also adjusts provider payments to account for improvements in productivity. And it restructures Medicare Advantage payment rates to make them more reflective of the costs that private plans face with rewards for low-cost areas and high-performing plans.

Commonwealth Fund [estimates](#) indicate that total health spending will slow under this reform—from a 6.6 percent annual rate of increase to less than 6 percent. Employers and workers will also realize savings. Health insurance premiums will be reviewed—preventing increases of 20 percent to 40 percent that have recently been proposed by insurance companies. Reform will save the average American family \$2,500 in 2019.

Most important, the legislation will put the U.S. health system on a path to high performance, by providing for the testing of new ways of paying doctors and hospitals to reward results rather than fees based on the volume of services delivered and for the development of strategies to promote prevention and improve quality. An Independent Payment Advisory Board will be established and charged with issuing recommendations to achieve federal health spending targets, as well as nonbinding recommendations for private payers to harmonize private and public payment and achieve systemwide savings.

The U.S. will now join all other major industrialized countries with a system for ensuring access to essential health care, and we will lay the foundation for a high performance health system that yields access to care for all, improved quality, and greater efficiency. It is a victory for all Americans, who deserve the finest health system in the world.

June 17, 2010

Who Is Helped by Health Reform?

By Karen Davis

This spring—98 years after Theodore Roosevelt first proposed comprehensive health care—the United States joined the world’s other major industrialized nations in providing all its citizens with access to essential health care.

[Commonwealth Fund analysis](#) shows that the Patient Protection and Affordable Care Act will deliver on all three of the goals President Obama set forth when Congress began crafting reform legislation last year:

- expand access to affordable health insurance for those without coverage;
- increase the affordability of insurance for those who already have it; and
- slow the rise in health care costs for individuals, families, and employers while not adding to the federal budget deficit.

Given the complexity of the law, questions linger about how it will affect people’s lives, specifically about what groups of Americans will be helped by health reform and how our experiences with the health care system will change. In this first part of a two-part blog post on the law’s impact, I will explore how different groups will benefit from the new coverage options, benefit standards, and insurance market rules. The upcoming post will look at the benefits for patients of the health system changes contained in the new law.

- Uninsured individuals, whether low- or modest-wage workers or unemployed, will be able to get and afford the coverage and care they need.

The [Congressional Budget Office](#) (CBO) estimates that by 2019 health reform will increase the proportion of the insured population from 83 percent to 94 percent. About half of the 32 million newly insured will be covered by Medicaid, and the other half will receive help in

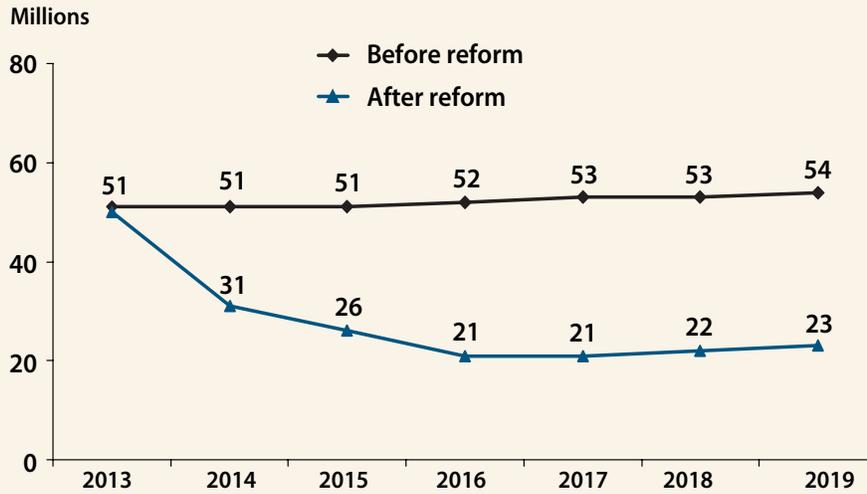
purchasing private coverage. Some will take up employer coverage for the first time. Those without employer coverage can receive federal assistance to purchase qualified health plans through the insurance exchanges; this applies to individuals and families earning between 133 percent and 400 percent of the federal poverty level (between \$29,327 and \$88,200 for a family of four). Within that income range, premium contributions will be limited to between 3.0 percent and 9.5 percent of a family’s income.

- Young adults graduating from high school or college will no longer be uninsured and no longer dependent on emergency rooms for care.

Nearly 30 percent of [young adults](#) are uninsured, often aging out of their parents’ plans and unable to find jobs that offer health insurance benefits. Fifty-three percent report going without needed care in the last year, and four of 10 report difficulty paying medical bills or accumulated medical debt. One-fourth of young adults use emergency rooms during the year, incurring bad debts that may affect their future credit as well as the financial stability of safety-net institutions serving those who cannot pay.

Effective September 2010, young adults will be permitted to stay on their parents’ insurance policies up to age 26, or until they find a job with health benefits. In 2014, about 7 million young adults with incomes below 133 percent of the poverty level (\$14,404 for a single adult) will become eligible for Medicaid; states have the option to cover low-income adults beginning in 2010 at the current federal matching rate. In addition, young adults will be able to purchase coverage through health insurance exchanges in 2014; [85 percent](#) of those young adults (those with incomes below four times the poverty level of \$43,320 for a single adult) will be eligible to receive help paying premiums and medical bills.

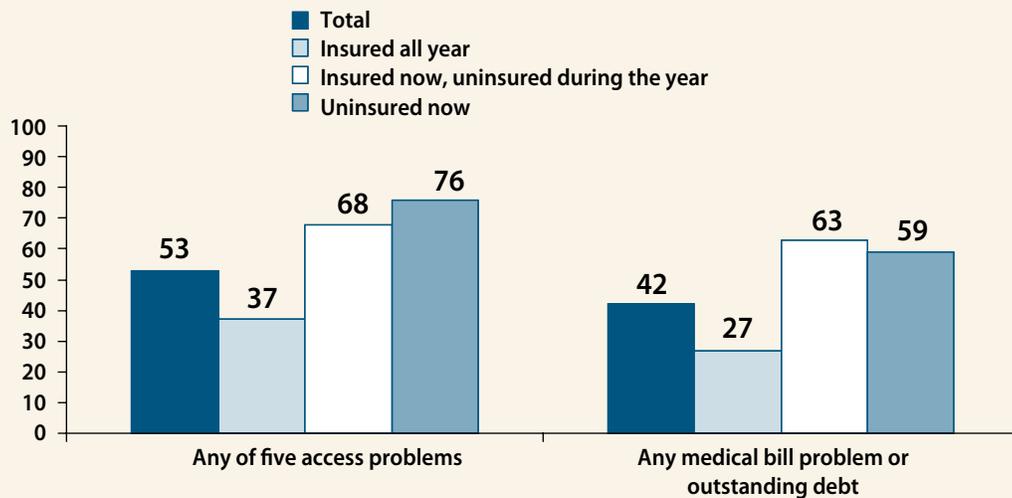
Trend in the Number of Uninsured Nonelderly, 2013–2019 Before and After Health Reform



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% of legal nonelderly residents are projected to have insurance under the new law.
Source: K. Davis, *A New Era in American Health Care: Realizing the Potential*, (New York: The Commonwealth Fund, June 2010).

Uninsured Young Adults Most Likely to Have Cost-Related Access Problems and Medical Bill or Debt Problems in the Past Year

Percent of adults ages 19–29 reporting cost-related access problems or medical bill or debt problems:



Notes: Access problems include not filling a prescription; skipping a medical test, treatment, or follow-up; having a medical problem but not seeing a doctor or going to a clinic; not seeing a specialist when needed; and delaying or not getting needed dental care. Medical debt or bill problems include not being able to pay medical bills; being contact by a collection agency; changing way of life to pay medical bills; and medical bills/debt being paid off over time.
Source: S. R. Collins and J. L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010*, (New York: The Commonwealth Fund, May 2010).

- Workers will no longer lose coverage when changing jobs.

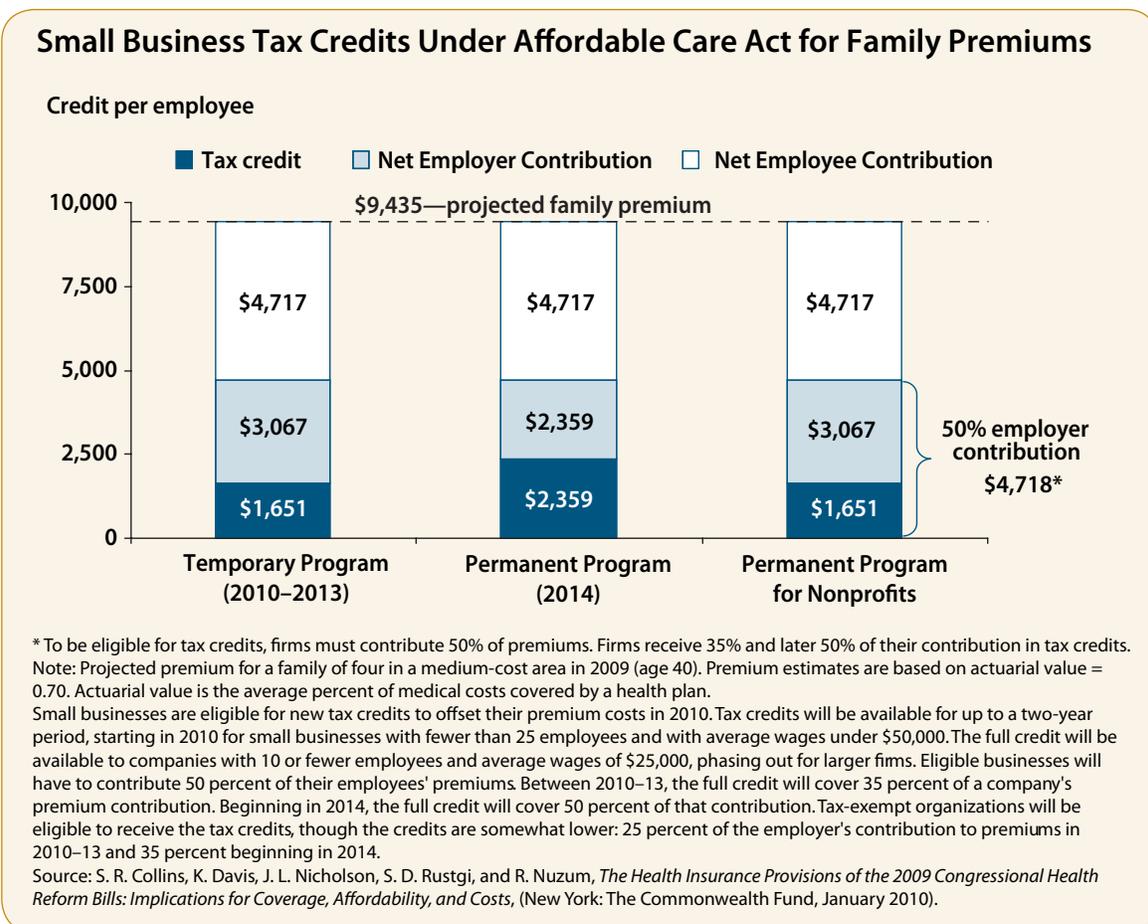
Thirty-two percent of adults report at least one change in their health plan in the past three years. These changes in coverage often result in spells without any insurance, loss of certain benefits, or the need to change doctors. Such changes can have serious consequences for continuity of care and proper management of chronic conditions.

The new health reform law will help workers at every income level keep their insurance coverage if they already have it, or purchase coverage if they don't. Beginning in 2014, workers in small businesses or those buying insurance in the individual market will be able to purchase coverage through insurance exchanges that more efficiently pool risk and reduce administrative costs. After 2017, states have the option of opening the exchange to businesses of any size.

- Small business owners will be able to offer health coverage and afford premiums.

About 78 percent of firms with 10 to 24 employees and 49 percent of businesses with three to nine employees now offer coverage to their workers—even though insurance premiums for small businesses tend to be higher than premiums for larger businesses for health plans with similar benefits. These percentages may increase as workers seek to fulfill their obligation to carry health insurance. In Massachusetts, for example, the share of workers with employer coverage increased from 80 percent to 84 percent under health reform, as more employers offered coverage and some workers who had been eligible for coverage opted to take it up.

As an added incentive for employers to offer coverage, tax credits will be available to offset up to 35 percent of employers' premium contributions for two years for low-wage businesses with fewer than 25 employees.



More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults ages 19–64 with medical bill problems or accrued medical debt

Percent of adults reporting:	Total	Insured All Year		Uninsured Anytime During Year	
		No underinsured indicators	Underinsured	Insured now, time uninsured in past year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	29%	42%	40%
Used up all of savings	39	26	46	46	47
Took out a mortgage against your home or took out a loan	10	9	12	11	11
Took on credit card debt	30	28	33	34	26
Insured at time care was provided	61	80	82	46	24

Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. 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*, (New York: The Commonwealth Fund, August 2008).

A temporary program is slated to begin in 2010; the permanent program, scheduled to start in 2014, will provide up to a 50 percent credit for two years.

In 2014, small employers can elect to purchase coverage for their employees through the exchanges, taking advantage of the reduced administrative costs and lower premiums they will bring.

- Families will face fewer difficulties paying out-of-pocket expenses.

Shrinking coverage—the typical employer plan now covers 80 percent of average medical expenses—and increasing deductibles during the past decade have resulted in a sharp rise in the number of Americans who face substantial out-of-pocket costs, rendering them “underinsured.” One-fourth of insured Americans who have difficulty paying their medical bills report using all their savings or taking on credit card debt to pay those bills.

Beginning in 2014, insurance plans must meet essential benefit standards covering hospital care, physician

services, prescription drugs, preventive services without cost-sharing, and pediatric dental and vision care, among other benefits. The benefit requirements do not apply to grandfathered plans or self-insured plans. Plans will be classified into different “tiers” to allow families to understand their out-of-pocket liability. Actuarial values—the proportion of costs actually covered—will range from 60 percent (bronze tier) to 90 percent (platinum tier). The percentage of expenses covered will vary depending on family income, and out-of-pocket expenses will be limited for individuals and families of all income levels.

- Low-income mothers will be able to afford prenatal care and have a healthy baby.

[Work by the Commonwealth Fund](#) shows that many women face problems securing affordable health coverage and care. Women are less likely to have employer-sponsored insurance available to them and often must seek coverage in the more expensive individual market. The practice of gender rating means that women pay substantially more than men for similar or worse

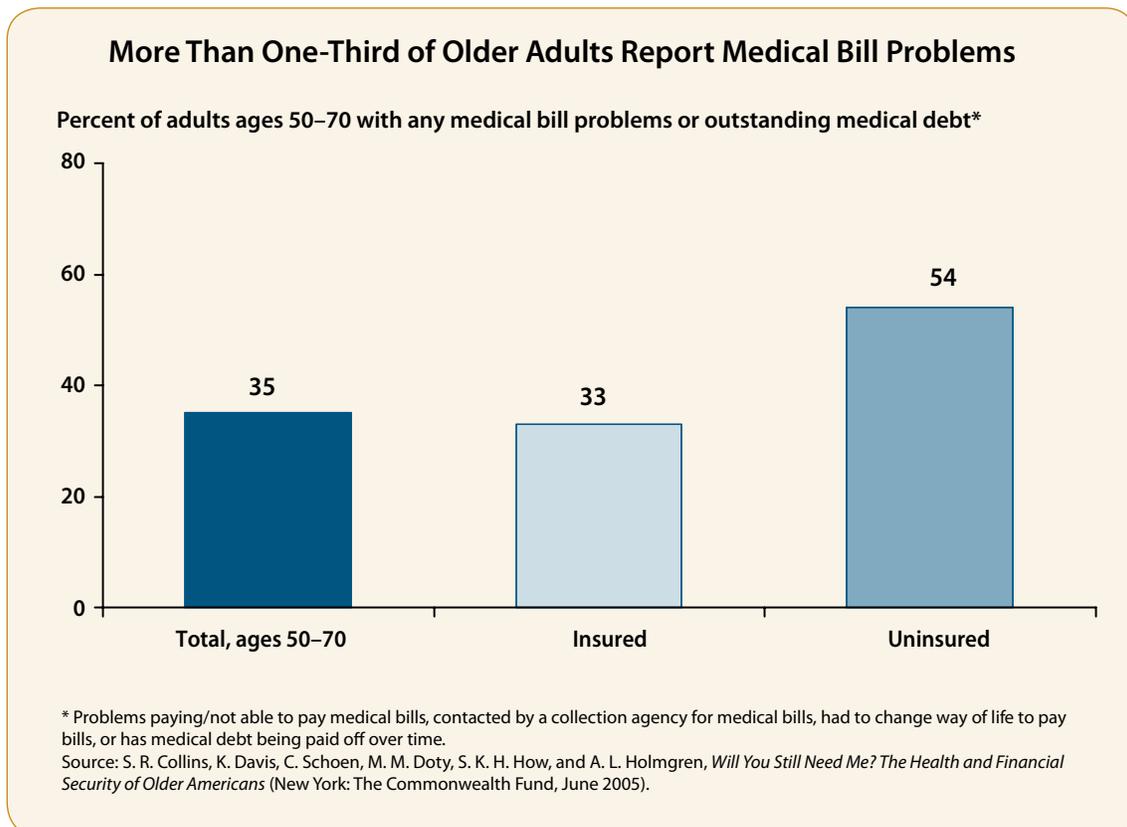
insurance. Pregnant women without employer coverage face particular difficulty securing adequate individual coverage for prenatal care: a [recent study](#) showed that across the country, just 13 percent of individual insurance market plans available to a 30-year-old woman provided maternity coverage.

Beginning in 2014, insurers will be prohibited from charging higher premiums because of gender, health status, or family history. Pregnant women in the Medicaid program will see new coverage options for freestanding birth centers and have access to free smoking cessation programs. The Department of Health and Human Services, meanwhile, is authorized to make grants to states to promote improvements in maternal, prenatal, and infant health. And states are eligible to receive federal funds to provide home visitation services for maternal health and prenatal care.

- Men and women will have access to preventive care and cancer screening for early detection.

Despite significant strides in improving the delivery of preventive services, many adults still fail to receive recommended preventive care and cancer screening. The Commonwealth Fund's [National Scorecard](#) on U.S. Health System Performance finds that only half of all adults, and less than one-third of uninsured adults, are up to date with recommended preventive care and screening services.

Beginning in 2010, all recommended preventive services will be covered without cost-sharing under new individual and group plans (for Medicare beneficiaries, this will begin in 2011). States that expand Medicaid coverage to include approved preventive services with no cost-sharing will receive increased federal funding for these services. This will remove financial barriers to care and save lives.



- Older adults will no longer be denied coverage because of health problems and preexisting conditions.

Older adults seeking health insurance coverage typically face prohibitively high premiums, large deductibles, and troubling exclusions for health problems and preexisting conditions. A [Commonwealth Fund study](#) found that 24 percent of the near-elderly (ages 50 to 70) failed to get health care services because of the cost. More than one-third (35%) had a problem paying their medical bills in the last year or were paying off medical debt they had accrued over the last three years.

Beginning 90 days after enactment of the law, older adults with preexisting conditions who have been uninsured for at least six months will be eligible for subsidized insurance through a national or state high-risk pool. Older adults will pay no more than four times what younger adults pay for coverage.

In 2014, insurance companies will be required to cover all individuals regardless of health status and charge the same premium regardless of preexisting conditions. Premiums may vary based on age, but by no more than a three-to-one ratio. These provisions will greatly increase the affordability and availability of coverage for older adults with health problems.

- Individuals with functional limitations will be able to afford help to continue living at home.

More than 10 million Americans are estimated to need long-term care assistance and support to perform daily activities, but long-term care is simply unaffordable for the majority of the population. While Medicare covers some short-term skilled nursing and home health care, Medicaid is the only program available to finance care for those with long-term disabilities and needs and without significant income or assets. Unfortunately, workers and retirees with functional limitations must “spend down” their savings—essentially impoverishing themselves—before becoming eligible for Medicaid assistance.

The health reform law establishes a national, voluntary insurance program for purchasing community living assistance services and supports in 2012. Known as the CLASS program, it will provide a cash benefit to individuals with limitations, enabling them to purchase nonmedical services and supports necessary to remain at home. After a five-year vesting period, the program will begin to provide benefits to those who need assistance. The program is financed through voluntary payroll deductions—all working adults will be automatically enrolled in the program unless they opt out.

- Medicare beneficiaries will receive free preventive care and no longer face the prescription drug “doughnut hole.”

Medicare prescription drug coverage currently includes a gap—known as a “doughnut hole”—where beneficiaries are required to pay 100 percent of their prescription drug costs between \$2,700 and \$6,154. Under health reform, Medicare beneficiaries entering the coverage gap will receive a \$250 rebate in 2010. In 2011, beneficiaries covered by private drug plans (other than those with high incomes) will receive a 50 percent discount on brand-name drugs. Beneficiaries will then receive additional discounts on brand-name and generic drugs, to close the doughnut hole by 2020. Rather than paying 100 percent of prescription costs in the gap range, beneficiaries will pay 25 percent.

In addition, beginning in 2011, Medicare beneficiaries are eligible for an annual wellness visit and all recommended preventive services, without any cost-sharing.

It’s clear that a majority of Americans stand to benefit from the Affordable Care Act. This law ushers in a new era in U.S. health care—one in which every American has access to affordable health insurance coverage and no one is turned away simply because they have a preexisting condition. The new insurance market protections are designed to work in concert with important payment and system reforms that will improve access and quality and reduce cost growth for everyone; I will address these reforms in my next blog post.

June 29, 2010

How Will the Health Care System Change Under Health Reform?

By Karen Davis

In my last [blog post](#), I discussed the ways the new health reform law improves the affordability of insurance for a variety of populations, including the uninsured and the underinsured and older and younger adults. The Affordable Care Act also includes a host of lesser-known provisions that, together, place a new emphasis on preventive and primary care and reward quality. These key features will ultimately push the health care system to deliver more patient-centered, accessible, and coordinated care. Below, I outline some of the reforms that will change people's experiences in the doctor's office and hospital.

Under the new reforms, patients will be more likely to have:

A physician practice that is accessible 24/7 and helps arrange specialist appointments.

A strong network of primary care physicians is central to a high performance health system that works for everyone. Yet only [two-thirds of American adults](#) under age 65 report having an accessible primary care provider (Exhibit 1). In addition, nearly [three-quarters of all adults](#) were not able to see their doctor quickly 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.

Health reform will test a new model of care that changes the way health care is organized. Patients can enroll in a patient-centered medical home, which is accountable for ensuring that patients get all recommended care. By offering care on nights and weekends, by using information technology and office systems to remind patients about preventive care, and by assisting them with obtaining needed specialty care, medical homes provide high-quality, coordinated care.

Financial incentives will help these practices succeed. New pilot programs will support and reward practices with an extra "medical home fee" paid by insurers and public programs. Moreover, they can earn bonuses for ensuring that their patients receive preventive care and help with managing a chronic illness. Care teams, including physicians, nurses, pharmacists, and other health professionals, will ensure coordination of care and shared accountability for health outcomes. To support provider groups as they reorganize—a challenging task even for large providers—the government will begin to fund regional or state health information exchange networks, and test strategies for ensuring access to after-hours care, case management help, and more.

The new law will also establish a Center for Medicare and Medicaid Innovation, effective January 2011, to oversee and test these and other innovative payment methods. Priority will be given to models that both improve quality and reduce costs, such as medical homes, accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, funding for care coordination, and bundled payment for hospital acute and post-acute care.

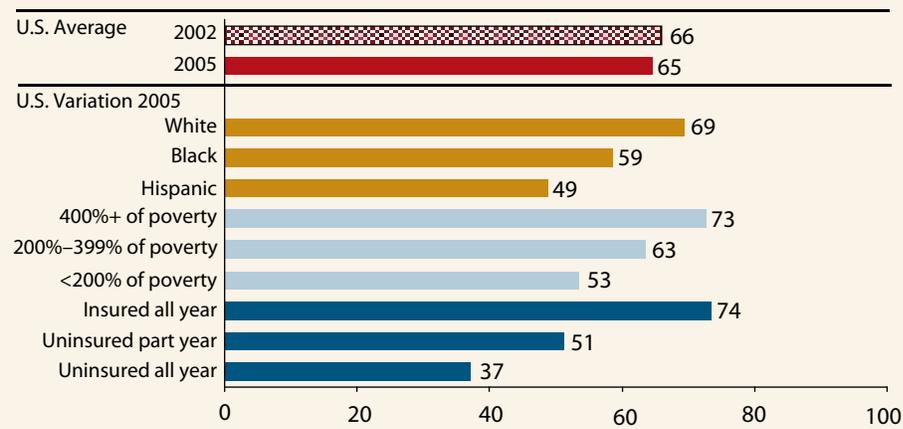
By increasing primary care payment rates, and making low-interest student loans more available, the Affordable Care Act also aims to increase the supply of primary care physicians and advanced practice nurses, making it easier for patients to find a primary care provider.

Better access to community health centers able to serve more patients.

Federally qualified health centers provide comprehensive primary care and mental health services to some of our nation's most vulnerable individuals and families. Recent [Commonwealth Fund analysis](#) shows that of the 16 million patients who received care from health centers

Exhibit 1. Only 65 Percent of Adults Report Having an Accessible Personal Clinician

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.

Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: 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).

in 2007, 90 percent were at or below 200 percent of the federal poverty level, 45 percent had public insurance, and 40 percent had no insurance at all.

The Affordable Care Act expands funding to community health centers by \$11 billion over five years beginning in 2010; provides state grants for health care providers that serve a large percentage of medically underserved populations; and provides for a Medicaid global payment system demonstration project that allows up to five states to make global capitation payments—covering all services provided to a patient during an episode of care—to safety-net hospitals from 2010 to 2012. It also provides grants to assist in development of community-based collaborative care networks, or integrated health care delivery systems, to serve low-income or medically underserved communities from 2011 to 2015.

Electronic medical records that ensure, with the patient’s authorization, complete medical records are accessible when needed.

U.S. health providers have been slow to adopt electronic health information systems, in part because of concerns about the value and the costs of implementation. A 2009 Commonwealth Fund survey of primary care physicians shows that the U.S. is far behind most of its industrialized

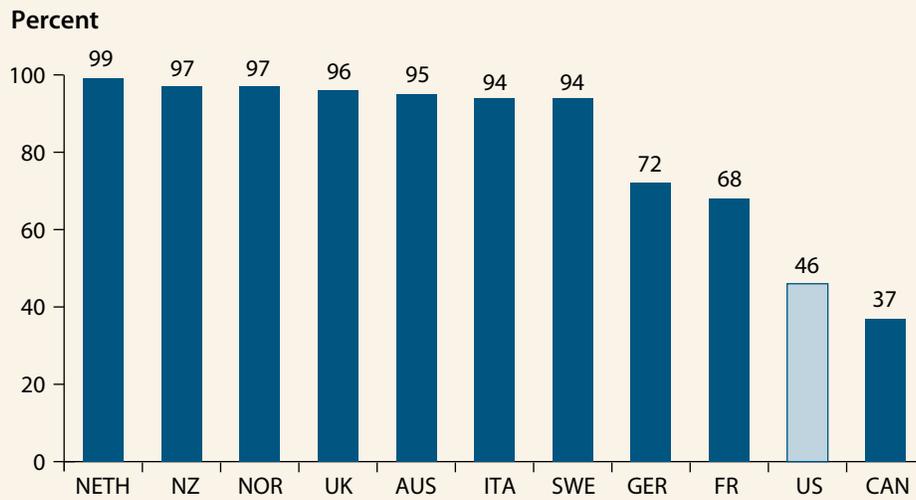
peers in the use of health information technology (IT) (Exhibit 2).

Without an information system that ensures the right information is available at the right time, tests are repeated, appointments with specialists have to be rescheduled, and patients are not informed about abnormal lab tests in a timely manner (Exhibit 3). The American Recovery and Reinvestment Act of 2009 provides financial assistance for physicians and hospitals to adopt health information systems to report quality information, deploy decision support to help providers provide the best care, and improve the quality of care. The Affordable Care Act provides further incentives to establish such information systems: it rewards high-quality care and enables health care organizations that assume responsibility for total patient care to share in the savings.

Doctors and hospitals that are rewarded for higher quality and better patient outcomes.

The prevailing fee-for-service payment system rewards physicians for the volume of care they provide, rather than the value of that care. The U.S. lags behind its counterparts in this regard (Exhibit 4).

Exhibit 2. Doctors Use of Electronic Patient Medical Records



Note: Not including billing systems.
 Source: C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171-w1183.

Exhibit 3. Nearly Half of U.S. Adults Report Failures to Coordinate Care

Percent U.S. adults reported in past two years:



Source: S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund, Aug. 2008).

The new reform law will reward hospitals for achieving benchmark levels of performance in heart attack, heart failure, and pneumonia care, and for preventing surgical infections. Starting in October 2012, hospitals that meet or exceed the designated performance standards will receive enhanced Medicare payments, taken from a pool of money collected from all hospitals. By 2012, the Secretary of Health and Human Services (HHS) is required to submit a plan to Congress on how to move home health and nursing home providers into a value-based purchasing payment system.

The legislation also includes physician payment reforms that encourage physicians, hospitals, and other providers to join together to form accountable care organizations to gain efficiencies and improve quality of care. Those that meet quality-of-care targets and reduce costs relative to a spending benchmark can share in the savings they generate for Medicare. Furthermore, all physicians and hospitals meeting benchmarks for high-quality care will be eligible for bonuses under new value-based purchasing provisions.

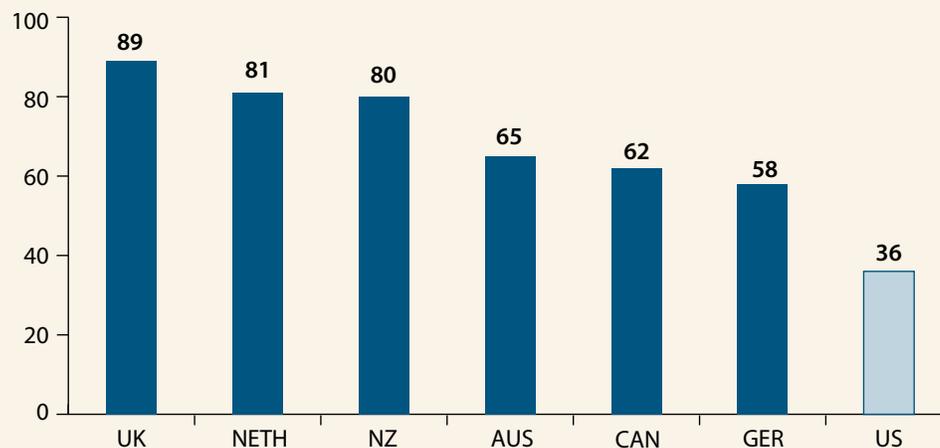
Better information and support when discharged from the hospital.

U.S. [hospital readmission rates](#) for Medicare patients within the first 30 days following discharge range from 14 percent to 21 percent. Inadequate communication during care transitions—when patients are discharged from the hospital to home or to a nursing facility, for example—often contributes to readmissions or avoidable complications. The Commonwealth Fund is working with Massachusetts, Michigan, and Washington State on the [State Action on Avoidable Rehospitalizations \(STAAR\) initiative](#) to test interventions that reduce readmissions, such as making sure patients have the information they need for self-care and have scheduled a follow-up appointment with their physician.

Medicare payments will be reduced for hospitals with high rates of potentially preventable readmissions for certain eligible conditions or procedures, as determined by the HHS secretary. In addition, by 2013, HHS will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to test “bundled” Medicare payment models spanning three days before and 30 days after a hospitalization. If the

Exhibit 4. Physicians in U.S. Less Likely to Receive Incentives for Quality or Meeting Goals

Percent of physicians reporting any financial incentive for targeted care or meeting goals*



* Can receive financial incentives for any of six: high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding non-physician clinicians to practice, and non-face-to-face interactions with patients.
Source: C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, “A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences,” *Health Affairs Web Exclusive*, Nov. 5, 2009, w1171–w1183.

pilot programs improve care and reduce spending, HHS is required by 2016 to submit a plan for expansion.

Hospitals with an incentive to reduce hospital-acquired infections.

The new legislation demands greater transparency and public reporting on hospitals' performance at preventing infection. Later this year, the Centers for Medicare and Medicaid Services (CMS) will begin reporting rates of medical errors and selected hospital-acquired conditions on its Hospital Compare Web site. Starting in 2011, federal payments for Medicaid services related to hospital-acquired conditions will be prohibited. Beginning in 2015, hospitals that have among the highest rates of these hospital-acquired conditions will have their Medicare payments reduced by 1 percent.

More patient information on quality of physicians, hospitals, and health plans.

Physicians who report data on the quality of their care through a qualified program will be eligible for one-half percent Medicare bonus payments. In addition, HHS will develop a Physician Compare Web site by January 2011. Combining Medicare data on quality with that of private insurers should improve the scope and reliability of information on performance. To further this aim, the legislation also authorizes, effective January 2012, the release of Medicare claims data to measure the performance of providers and suppliers in a way that protects patient privacy.

More choice of health insurance plans, including nonprofit plans.

A 2007 Commonwealth Fund survey showed that 42 percent of workers with employer-based coverage had only one choice of health plan. Even when workers have a choice of plans, the plans are often different products offered by the same insurer. Nor do all plans provide adequate benefits or ensure adequate participation of physicians in essential specialties.

Under health reform, state-based health insurance exchanges will increase the choice of high-quality private plans and health care cooperative plans, and will make it easy to compare these choices. In addition, the federal

government will contract with private insurance carriers to offer multistate plans through each exchange. At least one of the new multistate plans must be nonprofit. The government will negotiate contracts, much as it does for the Federal Employees Health Benefits Program.

The new Consumer Operated and Oriented Plan program, meanwhile, will foster the creation of nonprofit, member-run health insurance companies, or cooperatives, that will provide coverage and deliver health services. In making grants, priority will be given to cooperatives that operate on a statewide basis, are organized as integrated care systems, and have significant private support.

The insurance exchanges provide an important avenue for setting quality standards on insurance and care. In overseeing the exchanges, the HHS secretary is charged not only with ensuring a sufficient choice of qualified plans and providers but also with establishing certification criteria for qualified plans, requiring plans to provide the essential benefits package and meet marketing requirements, and ensuring that essential community providers are included in networks and accredited on quality.

Private plans that are rewarded for better care.

Currently, employers and Medicare beneficiaries tend to make choices based largely on premiums, without information showing whether plans are actively trying to ensure high-quality care—either through the way they select participating physicians and hospitals, or through the information and support they offer to providers regarding benchmark quality care.

Under health reform, Medicare private managed care plans that receive a four- or five-star quality designation will receive bonuses. Health plans that operate through the new health insurance exchanges will report on their quality improvement activities, including their efforts to prevent hospital readmissions. By 2015, health plans operating in the exchanges will be allowed to enter into contracts with hospitals with fewer than 50 beds only if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for patient discharge.

Reduced health insurance premiums and health spending.

Between 2000 and 2009, health insurance premiums rose by 108 percent, while workers' earnings rose by just 32 percent. As a result, [average family premiums](#) for group policies have risen from 11 percent to 18 percent of median family income. In the absence of reform, premiums were projected to rise to 24 percent of a family's income by 2020. Under the [new reform law](#), the average family stands to save nearly \$2,000 or more in 2019.

Premiums will be held down by requirements that limit the percentage of premium revenue going to administrative costs, and that require carriers seeking certification as qualified health plans to submit a justification in advance for any premium increase. Premium growth will be monitored and used as a criterion for allowing plans into the exchanges.

The establishment of health insurance exchanges in 2014 will further lower administrative costs and premiums in the individual and small-business markets as transparency, choice among plans with comparable actuarial value, and new nonprofit plans enhance competition, and the requirement for people to obtain coverage broadens the risk pool.

The upward spiral of health care costs will also slow as those that pay for health care begin to adopt innovative payment methods that reward quality and value, rather than volume. For example, the new Independent Payment Advisory Board within the executive branch will have significant authority to identify areas of waste and additional federal budget savings.

A [Commonwealth Fund report](#) found that the impact of health reform on health insurance premiums and health spending will be significant. It estimates that, on net, the combination of provisions in the new law will reduce health care spending by \$590 billion over 2010–19. The annual growth rate in national health expenditures would be slowed from 6.3 percent to 5.7 percent.

All Stakeholders Needed for Success

The Affordable Care Act's important payment and system reforms, along with the new insurance market protections discussed in [my last post](#), will improve access and quality and reduce cost growth for everyone. Reform is a historic victory for all Americans. But it will require the efforts of all stakeholders to make the promise a reality.