



COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Framework for a High Performance Health System for the United States

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The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

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



FRAMEWORK FOR A HIGH PERFORMANCE HEALTH SYSTEM FOR THE UNITED STATES

The Commonwealth Fund Commission
on a High Performance Health System

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ABSTRACT: Despite spending the most on health care, the United States lags behind other industrialized nations on many dimensions of health system performance. Formed in July 2005, The Commonwealth Fund Commission on a High Performance Health System seeks to chart a course for a U.S. health care system that provides significantly expanded access, higher quality, and greater efficiency for all Americans, especially those who are most vulnerable. In this consensus statement, the Commission defines “high performance” and outlines its vision of a uniquely American, high performance health system. It then identifies the most critical sources of our current system’s failures and offers a strategic framework for addressing them through specific actions.

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FRAMEWORK FOR A HIGH PERFORMANCE HEALTH SYSTEM FOR THE UNITED STATES

INTRODUCTION

The United States has some of the best-equipped hospitals and best-trained physicians in the world. With much dedication to helping patients, they often provide extraordinary care. Nevertheless, the evidence clearly shows that, overall, the performance of the U.S. health care system falls far below the level it can and should achieve. On many dimensions of performance—from timely access to needed services to the deployment of health information technology—we lag behind other industrialized nations. Within our own borders, there are wide disparities from region to region and from state to state.

We spend more on health care than any other country. But we allocate our resources inefficiently and wastefully, failing to provide universal access to care and failing to achieve value commensurate with the money spent.¹ In the U.S., many patients receive treatments and procedures known to be ineffective, while other effective treatments are vastly underused. Tens of thousands die annually from preventable errors. Nearly half of all adults worry they will not be able to pay their medical bills if they become seriously ill, will not get high quality care, or will experience a medical error.²

At the same time, we also know that throughout the country there are examples of health care providers and health plans, and innovative policies and programs, that perform much better than the national average.^{3,4}

The Commonwealth Fund Commission on a High Performance Health System seeks to chart a course for a health care system that provides significantly expanded access, higher quality, and greater efficiency for all Americans, especially the most vulnerable members of society. Chaired by James J. Mongan, M.D, the 18-member Commission draws from all parts of the health care system—from health care delivery to health insurance—as well as the state and federal policy arena, the business sector, professional societies, and academia. The Fund’s Board of Directors established the Commission in July 2005, recognizing the need for leadership in advancing promising strategies for health system improvement.

In this statement, the Commission first defines “high performance” and outlines its vision of a uniquely American, high performance health system. It then identifies the most critical sources of system failures and offers a strategic framework for addressing those

failures. While the Commission's work has only begun, this consensus statement represents a significant first step, as it will guide future recommendations for specific actions.

The Commission anticipates that realizing its vision will require significant departures from current practice. Moreover, it demands an accelerated rate of innovation and improvement. The health, social, and economic costs of maintaining the status quo, or moving slowly, are far too great. Failure to improve the health care system will result in needless mortality and morbidity, excess costs and unnecessary expenditures, and, potentially, significantly diminished economic output at a time when the nation urgently needs a healthy and productive workforce. Our nation is both capable of and obligated to improving the health and well-being of all who live here.

ENVISIONING A HIGH PERFORMANCE HEALTH CARE SYSTEM

A nation's health care system is defined by the ways in which health care services are financed, organized, and delivered to meet societal goals for health. It includes the people, institutions, and organizations that interact to meet the goals, as well as the processes and structures that guide these interactions.

- *People* include consumers seeking health care or insurance coverage; patients under the care of a provider; people self-managing their care and making choices that affect their health; the health care delivery workforce; employee benefits managers, insurance brokers, and other members of the health care administrative workforce; public and private program managers and staff; and federal, state, and county officials.
- *Institutions and organizations* include hospitals, clinics, nursing homes, physician practices, and home health agencies; health plans and insurers; businesses that purchase insurance for their employees; health benefit consulting firms; pharmaceutical and medical device industries; federal, state, and local governments and agencies; and public health and social service agencies and other community organizations.
- *Processes and structures* include health care organization and delivery; information provision; payment mechanisms; quality monitoring and improvement; deployment of human and capital resources; information technology; private certification and accreditation; enrollment and billing systems; and public policies.

Nations vary in the degree to which their health care system components are coordinated or integrated, as well as the degree to which the people involved work toward common goals. At one end of the continuum are those systems that are governed by a coherent national strategy and that, from the patient's perspective, achieve full coordination or integration across all aspects of care throughout a person's lifespan. At the

other extreme are those systems with numerous, loosely connected components, where common incentives and mechanisms for strategic integration are lacking. Across the continuum, the degree to which market forces play a role in the financing and delivery of care varies. Neither extreme represents an ideal; health care systems all along the continuum currently fall short on various dimensions of performance.

As noted by the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, the “purpose of a health care system must be to continuously reduce the impact and burden of illness, injury and disability and to improve the health and functioning of the people. . . .”⁵ In reviewing a wide body of evidence, the Commission finds that the U.S. does not have a system that could be called “high performing,” as will be detailed in our forthcoming national scorecard.⁶ (A description of the specific features of the U.S. health care system can be found in the [Appendix](#).)

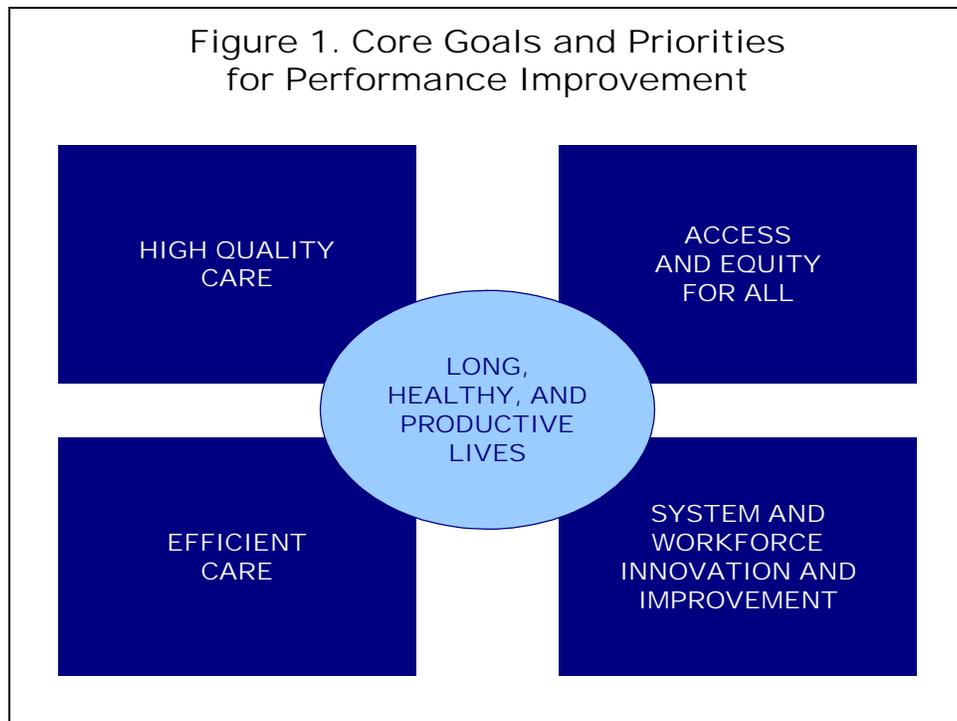
What Is a High Performance Health Care System?

The overarching mission of a high performance health care system is to help everyone, to the extent possible, lead long, healthy, and productive lives. To fulfill this mission, such a system must:

- **Commit to a clear national strategy for achieving the mission and establish a process to implement and refine that strategy.** A national strategy need not imply a unitary national health care system. Rather, it could imply a set of policies aligned to achieve core goals. The process of implementing and refining the strategy can take many forms; what is critical is a mechanism to review data on performance of all stakeholders and make policy changes as appropriate.
- **Deliver care through models that emphasize coordination and integration.** Although such health care delivery models can take a variety of forms, all feature seamless care transitions, decision-support systems for clinicians, and integration at every level of care. Examples include fully integrated health care organizations providing all levels of care, physician group practices or clinics, or smaller independent practices linked as “virtual systems” of care.
- **Establish and track metrics for health outcomes, quality of care, access to care, population-based disparities, and efficiency.** Sound metrics are essential for achieving strategic goals and for identifying and vastly narrowing gaps between top- and bottom-performers. A high performing system values transparency for its role in fostering system improvement and innovation.

The Commission will be identifying models for setting a national strategy as well as the means to establish and track performance metrics. At present, no organization or body, except Congress, can commit to a national strategy. Options could range from relatively modest steps, such as a reorganized committee jurisdiction structure, to more far-reaching steps, such as the devolution of substantial congressional authority to a Federal Reserve–like structure for health care, which would set rules for public and private stakeholders.

To the Commission, a high performance health system is designed to achieve four core goals: 1) high quality, safe care; 2) access to care for all people; 3) efficient, high value care; and 4) system capacity to improve (Figure 1).^{*} The attributes for each are elaborated below.



Quality and Safety

The U.S. health care system should strive to provide care of the highest quality. This means:

- Patients get the **right health care**—care that is known to be effective—as needed for prevention, treatment, or palliation. Underuse of effective care is minimized,

^{*} The Commission’s major goals build on the conceptual frameworks found in the seminal reports of the Institute of Medicine on quality and insurance coverage. We have added several dimensions and used slightly modified language, however, to emphasize attributes we believe are essential for high performance of the entire U.S. health care system.

while overuse and misuse of health care services (e.g., futile treatment at the end of life) are avoided.

- The care provided is **safe**, delivered in a manner that achieves higher reliability in care processes and minimizes medical errors.
- Health care is **coordinated over time**. Each patient has a medical home, with a single primary care physician or group practice responsible and accountable for his or her care. Along the continuum of care and throughout the patient's life, health services are organized, coordinated, and integrated in a seamless manner. Patients can simply and easily obtain care through multiple points of access and through various means, whether telephone management, group visits, nurse visits, or outreach personnel.
- Care is **patient-centered**—provided in a timely way with compassion, effective communication, and excellent service. Pain and suffering are relieved as quickly as feasible. Patients are informed and active participants in their care.

Access to Care

The health system should ensure access to care for all Americans. This means:

- There is **universal participation**.
- Everyone has available to them a minimum level of **financial protection**, as well as **established benefits**.
- Care is **affordable**, from the patient's and the nation's perspective.
- Care is provided **equitably** according to medical need, regardless of race/ethnicity, insurance status, income, age, sex, or geographical location.

Efficient, High Value Care

The health system should provide care of the highest value for the money and resources allocated, striving for the greatest possible health outcomes and benefits possible—all of which are important in a global economy. This means:

- Care delivery and insurance administration are **efficient**.
- Care is delivered at the **right time** and in the **right setting**.
- There is a system whereby new technologies, devices, procedures, laboratory testing, and pharmaceuticals can be **evaluated for both effectiveness and**

value, including defined processes for their introduction, surveillance, retesting, and reevaluation over time.

System Capacity to Improve

A high performance health system should have the capacity to reach and sustain excellence. This means:

- There is significant **investment in innovation and research** on: understanding health and disease; comparative effectiveness of treatment choices; ways to improve delivery processes to maximize quality, safety and efficiency; and ways to expedite the identification, adoption, and dissemination of best practices.
- There is an interoperable **information infrastructure** that supports integration and continuity of care, transparency of information on the price and quality of care, and accountability.
- The **educational system** adequately prepares the next generation of health care providers and leaders, and the nation develops a stable, competent workforce committed to providing all Americans with patient-centered, high quality care.
- The health system **responds quickly, at both the individual and population levels**, to major health threats and disasters.
- There is a **culture of improvement** and professional satisfaction among health care professionals.
- There is an appropriate balance between **autonomy and accountability**.

CURRENT HEALTH “SYSTEM” FRAUGHT WITH SYSTEM FAILURES

The Commission’s framework for a high performance health care system is based on evidence that the nation’s complex web of private/public health care financing, delivery, and quality assurance structures produces vast inefficiencies in the provision of care—including waste due to duplication, poor processes, the provision of care that is known to be ineffective, and unacceptable variation in quality and safety. Our nation can no longer afford this lack of “systemness.” Although decentralization can spur innovation and allocate resources, the United States would benefit from greater integration and coordination among the components of health care delivery, financing, and regulation. There is strong public support for well-coordinated care: in a recent survey, 75 percent of adults said that it was very important that they have one place or doctor responsible for providing their primary care and coordinating all care.⁷

The Commission recognizes that there are many ways to achieve its goals for the nation's health care system. But first, the sources of system failures must be addressed. Key sources of failure include:

- *General support within the health care sector for maintaining the status quo, despite acknowledgment that some level of change is necessary.* This results in part from recognition that transformative change entails disruptions in revenue flows, professional backlash, and “winners and losers.” In addition, there is a lack of consensus on which mechanisms and policies should drive transformation.
- *Misaligned payment incentives across the board.*
 - The high degree of fragmentation in the insurance system leads to significant cost-shifting, inefficient administration, and rewards for avoiding sick, high-risk patients.
 - Rewards for providing specialty care are greater than those for primary care; for example, there is no incentive for establishing a medical home for primary care and coordination of specialty care.
 - Payment incentives within the fragmented delivery structure encourage the provision of more, and progressively more fragmented, care, especially for chronically ill patients. These incentives also encourage overuse and misuse of care, while failing to reward the prevention of illness and complications.
 - Consumers lack incentives to use high performing providers and to be active managers of their own health.
- *Inadequate information systems.*
 - Electronic medical records and decision support systems are vastly underutilized; patients lack access to their own medical records; and there is insufficient interoperability across information systems to allow medical records to follow patients across sites of care, institutions, and payment systems.
 - Valid, useful data on quality and costs are missing, as are adequate systems for evaluating new technology, devices, procedures, tests, or drugs for effectiveness and value.
- *A system of regulatory oversight that is duplicative and costly.*
- *An inappropriate balance between autonomy and accountability.* Across all stakeholders, our traditions and culture foster autonomy; while this has many benefits, it can impede the accountability and teamwork needed for achieving high performance.

STRATEGY: A FRAMEWORK FOR A HIGH PERFORMANCE HEALTH SYSTEM

According to the Organization for Economic Cooperation and Development (OECD), health care financing and delivery can be organized into the following arrangements:

- The private insurance/provider model, which combines private insurance with private (often for-profit) providers.
- The public contract model, in which public payers (in the form of state agency or social security funds) contract with private or public providers.
- The public integrated model, which combines publicly budgeted financing with public provision of care. Under such a system, the government is responsible for both insurance and care provision functions.⁸

These arrangements are not mutually exclusive; elements of all three can be found in the U.S. For example, the Veterans Health Administration and public hospital systems fit into the public integrated model, while the Medicaid and Medicare programs fall more under the public contract model. Since most care, however, is delivered by private organizations, and a significant amount is financed privately, the first model is the one many use to characterize the current U.S. “system.” Still, in accordance with their preferences and values, Americans have historically embraced the blending of all three models.

The Commission believes that this mix of private and public financing, organization, and delivery will continue, at least for the foreseeable future. Our call for greater integration and alignment of incentives, while retaining pluralism, recognizes that each model responds to different incentives and pressures.

A high performing health system for the U.S., then, will likely combine market forces and public policy to achieve its goals. America’s challenge is to find a way to benefit from what markets can provide while pursuing alternative strategies to achieve what markets cannot. Market forces can promote innovation, efficiency, and responsiveness to heterogeneous consumer demand, but they alone are not likely to overcome the information imbalance, risk fragmentation, and undesirable disparities in access and care that need to be addressed. The provision of better information to consumers, while a critical component of a high performing system, will not be sufficient on its own to overcome the structural and organizational deficiencies that lead to poor outcomes. Public systems and policies, meanwhile, can remedy some of these problems—for example, by promoting population health, social good, transparency, and accountability—but they are not able to replicate the flexibility and responsiveness that markets offer. Government’s

role in a high performance health system is to set the rules for the market and key stakeholders, ensure universal participation, and invest in information and research to improve care and its delivery.

Health care delivery in the U.S. encompasses a range of organizational structures along a continuum. At one extreme, there is full vertical and horizontal integration of providers and services, with patients having access at multiple, connected points. At the other extreme, patients are the only organizing force for seeking, selecting, and coordinating services. Care is more coordinated for patients who seek it from more organized delivery models, such as integrated delivery systems and large physician group practices, or from practices where physicians or community clinicians serve as medical homes and take the responsibility for care coordination. For most patients with complex health problems, however, it is they and their families who must arrange for the care they need.

In a high performing U.S. health care system, it may be possible for numerous delivery models to exist. What is important is that public policy ensures that all Americans have access to the same cost-effective, high quality care. Because evidence shows that greater integration and larger physician groups have, on average, higher clinical quality, policies that promote greater integration will be required. This will likely require providers outside of integrated systems to operate with more accountability than they currently do. It will require all providers, no matter what delivery model, to be held to quality, safety, and efficiency benchmarks. It will also require much greater emphasis on primary care and better coordination throughout the health system. Finally, it will require a health information system in which patients and their providers have ready access to complete, organized information about their health care.

GETTING THERE FROM HERE

As the Commission has defined a high performance health system, it has simultaneously been developing national and state “scorecards” to measure U.S. performance against specific benchmarks. These documents will be instrumental in setting specific targets for improvement. The Commission’s next step is to envision how each stakeholder in the system is to be accountable to others, and how that accountability can be brought about. For example, health plans should be accountable for ensuring that benefits packages include the right care; providers should be accountable to patients and to purchasers for providing the right care; employer purchasers should be accountable for providing employees with the tools to make wise choices among plans, providers, and treatments; and patients should be accountable for actively managing their health and complying with effective treatments. For each stakeholder, there needs to be a balance in which autonomy

and choice foster innovation and efficiency, but also where greater accountability reduces mortality, morbidity, and costs. The Commission will be offering specific ways to achieve this balance.

At the outset of this statement, we outlined the core goals and priorities of a high performance health system. For some goals, we currently know which policies and practices hold the most promise; for others, we need further research and experience to recommend effective next steps. The Commission is currently identifying those policies and practices that the nation can put in place now as it works through a comprehensive plan to overcome system failures, improve accountability and transparency, and reward quality and efficiency. Below is a list of examples of initial steps that can and should be taken. In each area, there are bold leaders across the country—whether providers, plans, purchasers, states, and other stakeholders—who are currently making measurable progress, while planning for significantly more in the future.

- **Expand health insurance coverage.** Expanding insurance coverage is a necessary, though not sufficient, step toward universal participation in the health system. A variety of strategies are under debate or undergoing testing, especially in the states. Here, public policy must take the lead to achieve significant progress.
- **Implement major quality and safety improvements.** This includes promoting the use of evidence-based medicine, promoting effective chronic care management, “reengineering” delivery within and among provider organizations, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings. To date, innovations have largely taken the form of public/private collaborations, although the investment to date has been limited in relation to need.
- **Work toward a more organized delivery system that emphasizes primary and preventive care that is patient-centered.** Strategies for improving quality and safety focus on creating better systems within and among health care delivery organizations. Innovative, patient-centered care practices should also be emphasized. While appropriate specialty care is essential, there is increasing evidence that a high performance health system needs to focus on primary care. Benefits design, workforce training, and payment policy are key levers for promoting change.
- **Increase transparency and reporting on quality and costs.** Public reporting of information on the performance of health plans and providers can spur improvements in quality and efficiency, primarily by helping consumers make more informed decisions and by stimulating plans and providers to be more

accountable for their results. Much needs to be resolved about who should report, what should be reported, and how the information should be presented, but the general consensus holds that increased transparency will lead to results.

- **Reward performance for quality and efficiency.** Our payment system should be restructured so that providers are reimbursed based on the quality of the care they provide. Purchasers, both public and private, can improve quality and efficiency by building performance standards into health plan contracts and developing “pay-for-performance” programs that reward quality and efficiency in the provision of acute and chronic episodes of care.
- **Expand the use of interoperable information technology.** Computerized order entry systems and electronic health records developed at the organizational level can help to reduce costs and improve safety and efficiency. In order for the health system to maximize benefits from these individual systems, however, innovation must focus on linking all pieces into an interoperable network.
- **Encourage collaboration among stakeholders.** Achieving any improvement requires processes that create a “culture of high performance,” where all parties share a vision of bringing high quality health care to every person. It is particularly critical for the public and private sectors to work together. Good collaborative models for improvement can be found where each sector has taken the lead, and more such efforts should be encouraged.

The Commission will explore alternative models and organizational structures for setting and updating our national strategy and for measuring and tracking our performance. Ultimately, the Commission seeks to define the specific policies and practices that can help the nation attain this vision, and it plans to develop and disseminate recommendations to the nation. The Commission believes that the nation can and must do better, and it is committed to action.

APPENDIX. FEATURES OF THE CURRENT U.S. HEALTH CARE SYSTEM

(Note: This section is adapted from *The Commonwealth Fund* publication, [Toward a High Performance Health System for the United States](#).)⁹

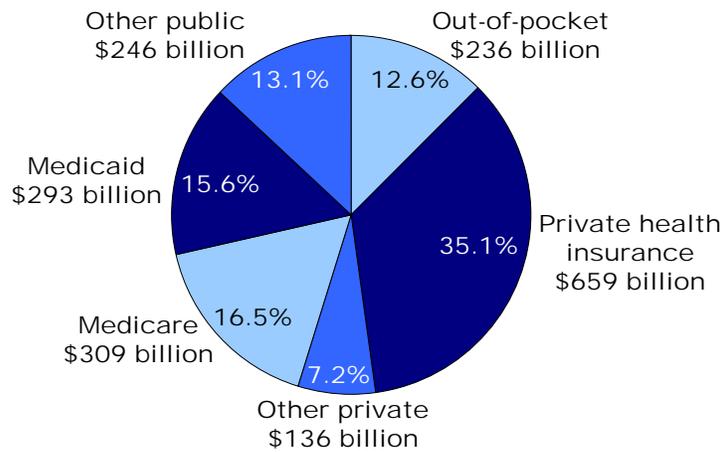
Who Is Covered? Fifty-nine percent of the U.S. population is covered by private health insurance, with nearly 92 percent of this coverage linked to employment.¹⁰ Employee coverage is not mandatory, but the tax system encourages employers to provide the benefit. Twenty-seven percent of the population receives health insurance coverage from the government—through the federal Medicare program, military health care, the state–federal Medicaid program, and the State Children’s Health Insurance Program (SCHIP). Medicare covers people age 65 and older, disabled individuals under 65 who have received Social Security Disability Insurance for two years or more, and those with end-stage renal failure or amyotrophic lateral sclerosis (Lou Gehrig’s disease). Medicaid and SCHIP serve as a safety net for the poorest citizens, those with specific medical conditions and disabilities, poor and near-poor children and their families, and the elderly.

Based on the most recent national survey, 16 percent of the population is uninsured. Millions more endure a period without insurance during the year: almost one of three civilian, non-institutionalized citizens under the age of 65 was uninsured for a period of at least one month in 2003.¹¹

What Is Covered? There is no defined package of core benefits. Benefit packages often include inpatient and outpatient hospital care and physician services. Many also include preventive services, dental care, prescription drug coverage, and mental health care.

How Is the System Financed? Medicare is administered by the federal government. The program is financed through a combination of payroll taxes, general federal revenues, and premiums. In fiscal year 2004, the total outlay for the Medicare program was \$309 billion, or 16.5 percent of national health expenditures (Figure 2).¹² Medicaid is administered by the states, which operate within broad federal guidelines. The federal government matches states’ Medicaid spending at a rate that is inversely related to state per capita income. In fiscal year 2004, total outlays for the Medicaid program were \$292.7 billion (including federal, state, and local expenditures), or 15.6 percent of total health spending.¹³

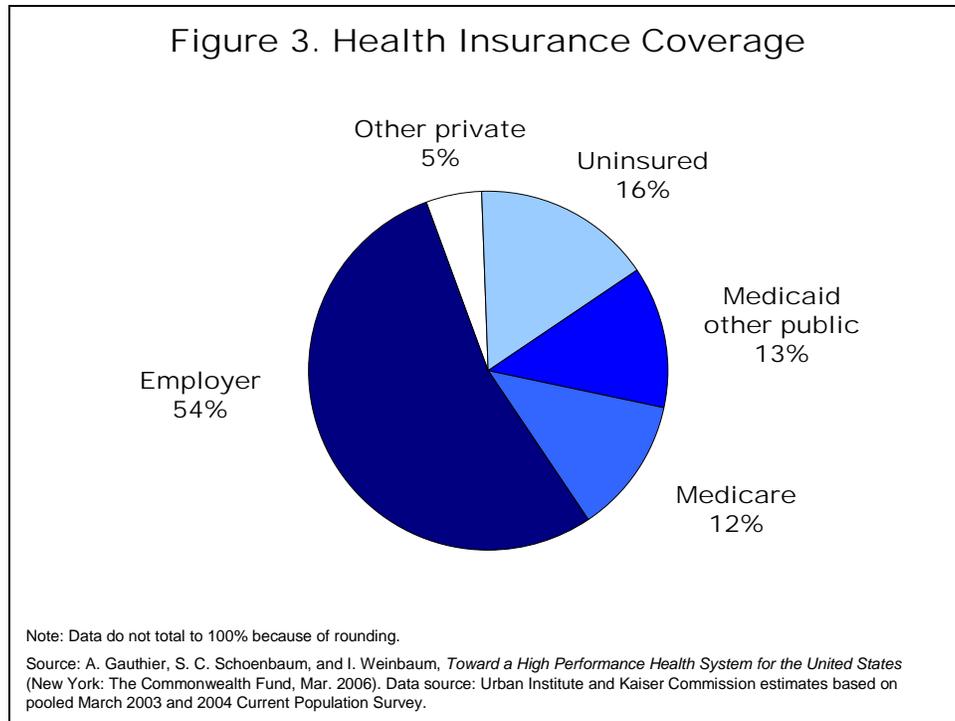
Figure 2. Total National Health Expenditures, \$1.88 Trillion



Note: Data do not total to 100% because of rounding. Data were rounded to the nearest tenth of a percent because rounding to the nearest percent does not reflect the significant difference in spending between Medicaid and Medicare.

Source: A. Gauthier, S. C. Schoenbaum, and I. Weinbaum, *Toward a High Performance Health System for the United States* (New York: The Commonwealth Fund, Mar. 2006). Data source: C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, Jan./Feb. 2006 25(1):186-96.

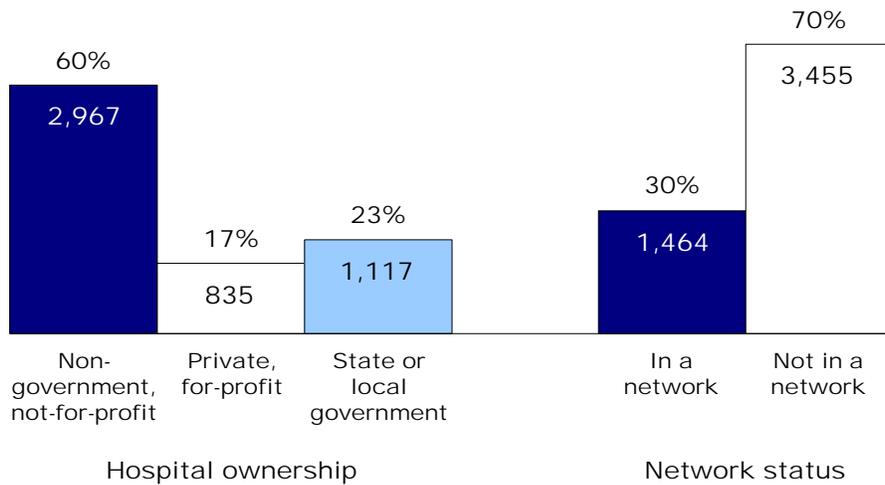
Private health insurance can be purchased by individuals but more often is purchased by an employer on behalf of a group of employees and funded by voluntary premium contributions shared by employers and employees on a negotiable basis. Fifty-four percent of the population is insured through employer-based private insurance, and another 5 percent is insured through other private insurance (Figure 3). On average, employers cover 85 percent of the premium for an individual policy and 75 percent for family coverage.¹⁴ In 2004, expenditures for private health insurance premiums amounted to \$658.5 billion, or 35.1 percent of total health expenditures.¹⁵



Out-of-pocket spending in the form of copayments, deductibles, coinsurance, and payments for services not covered by insurance accounts for 12.6 percent of total health expenditures. Another 7.2 percent of health spending comes from other private funds and the remaining 13.1 percent of expenditures comes from other federal and state programs.¹⁶

How Is the Delivery System Organized? The health care delivery system in the U.S. comprises many types of provider groups and institutions, with limited organization at any level. The majority of hospitals are non-government and not-for-profit, but there are significant numbers of hospitals operated by state or local governments and for-profit, investor-owned institutions (Figure 4). Of the nation's nearly 600,000 physicians who have completed their residency training and clinical fellowship and are not employed by the federal government, only 26 percent are employed by a health care institution. The large majority of physicians work in physician-owned private practices. Less than one-quarter of all physicians work in practices of 10 or more physicians, with nearly 60 percent working in groups of less than five (Figure 5).¹⁷ One-third of physicians work in primary care and the rest are specialists.¹⁸

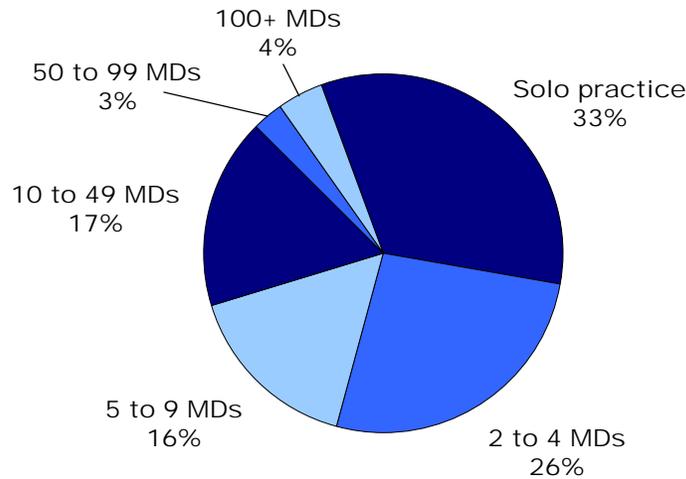
Figure 4. Characteristics of U.S. Hospitals, 2004*
Total Number = 4,919



* Community hospitals are defined as all nonfederal, short-term, general, and other specific hospitals.

Source: A. Gauthier, S. C. Schoenbaum, and I. Weinbaum, *Toward a High Performance Health System for the United States* (New York: The Commonwealth Fund, Mar. 2006). Data source: American Hospital Association Resource Center, http://www.aha.org/aha/resource_center/.

Figure 5. Distribution of Physicians Employed in Physician-Owned Groups by Practice Size, 2001



Note: Data do not total to 100% because of rounding.

Source: A. Gauthier, S. C. Schoenbaum, and I. Weinbaum, *Toward a High Performance Health System for the United States* (New York: The Commonwealth Fund, Mar. 2006). Data source: C. Kane, "The Practice Arrangements of Patient Care Physicians," American Medical Association, Physician Marketplace Report no. 2004-02, Feb. 2004.

There has been a movement in the U.S. to develop integrated health systems, with one organization providing an array of services. The Veterans Health Administration (VHA) is a public integrated system that provides medical, surgical, and rehabilitative care to veterans and their families. Over 5 million patients are treated every year through the

VHA's network of 137 medical centers (at least one per state) and 1,300 sites of care, including ambulatory care and community-based clinics, nursing homes, residential rehabilitation treatment programs, veterans' centers, and comprehensive home care programs.¹⁹ Kaiser Permanente is the nation's largest integrated health care organization, with over 8 million members. Kaiser Foundation Health Plans offers insurance products to its members and contracts with Kaiser hospitals and medical groups to provide services. This type of organization currently accounts for a relatively small share of the health care market; only about 15 million Americans are enrolled in group, or staff model, health maintenance organizations and only 30 percent of community hospitals (non-federal, short-term hospitals) are part of a network.²⁰

How Are Providers Paid? Hospitals are paid through a combination of methods, primarily based on fee-for-service charges, a set rate for each unit of care provided, or a fixed payment per day of care or per admission, adjusted for diagnosis and severity by the diagnosis-related group system. Physician payment methods vary widely by payer and type of practice. The arrangements include: fee-for-service, with payments coming directly from patients or, more commonly, from insurers based on negotiated fee schedules; capitation, or fixed monthly payments for a specified group of services that have been negotiated with public and private payers; and salary, most common for physicians employed by hospitals or integrated health plans.

How Are Costs Controlled? Payers have attempted to control cost growth through the following methods: selective provider contracting; discount price negotiations; direct utilization controls; risk-sharing payment methods with providers such as full or partial capitation, generally for primary care; and managed care practices such as use of primary care gatekeepers and disease management for high-cost patients. These methods are directed at providers, rather than patients, and seek to encourage efficiency in production of services or lower cost patterns of care.

Because there are relatively few ways to exert direct control over the costs of health care, payers have been turning to patient cost-sharing in the hope that it will reduce consumer demand. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included new provisions for tax incentives for Health Savings Accounts (HSAs) coupled with high-deductible health insurance plans (i.e., plans with deductibles of \$1,000 or more for individuals and \$2,000 or more for families). HSAs permit individuals to save money, tax-free, to use on out-of-pocket health care expenses. Such tax incentives, together with double-digit premium increases, have led to a shift in health insurance benefit design toward higher patient payments. HSAs are an example of a demand-side strategy aimed at making consumers more conscious of costs through

increased cost-sharing and information. Other strategies include benefit designs such as point-of-service plans, in which patients pay more to see out-of-network providers.

How Is Quality Assured? Hospitals and health plans are accredited by private accreditation organizations, while physicians are certified by specialty boards which are independent of the medical societies. States regulate insurance companies, but the federal government regulates self-insured employer benefit plans. Such accreditation is considered to be a proxy for a minimal standard of quality but does not delve into treatment choices or service provision. Medicare has developed pilot programs that will give bonuses to hospitals demonstrating the best performance in treating particular conditions. Medicare, private insurers, and employers are beginning to use pay-for-performance programs to pay hospitals and physicians based on the quality of services provided. Some states, along with private and public insurers, have made performance ratings of hospitals available to the public and a few health plans are beginning to rate physician groups and individual physicians.²¹

Many national, state, regional, and local partnerships have formed to pursue quality improvement goals. Their strategies include increasing the availability of performance data, standardizing performance measurement, increasing public reporting, and using value-based purchasing. Some of these partnerships, such as the Leapfrog Group and Bridges to Excellence, include strictly business groups and coalitions of purchasers, whereas other initiatives bring together various stakeholders, including providers, health plans, consumers, and government.

In July 2005, Congress passed a bill to establish a national database of medical errors. The law encourages health care providers to report errors anonymously to patient safety organizations. In turn, these organizations will compile the information into a national database and use it to analyze trends and make recommendations as to how future errors can be prevented.

How Is Access to Care Assured? Those who have insurance coverage have the greatest access to care. Uninsured individuals are half as likely as insured individuals to receive care for highly threatening conditions, or those deemed by physicians to require medical attention. In addition, uninsured adults are three times less likely than insured adults to have a regular source of care and are more likely to be hospitalized for conditions that could have been prevented with timely care.²² Safety net health care for the uninsured consists of federally funded community health centers as well as state and locally funded clinics and public hospitals that serve all patients, regardless of their insurance status. In addition, professional and legal requirements oblige hospitals to provide emergency care to all individuals in need, regardless of their ability to pay.

NOTES

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