OBAMA-BIDEN TRANSITION PROJECT

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You *Can* Get There from Here: Mapping the Way to a Transformed U.S. Health System

THE COMMONWEALTH FUND

President's Message
2008 Annual Report

OBAMA-BIDEN TRANSITION PROJECT

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The Commonwealth Fund's Mission

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.

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President's Message

You *Can* Get There from Here: Mapping the Way to a Transformed U.S. Health System

Karen Davis
The Commonwealth Fund

Where We Stand Today

In a speech he gave nearly half a century ago, John F. Kennedy noted that the Chinese symbol for crisis comprises the characters representing both danger and opportunity. Today, his observation could not be more relevant. The potent combination of recent events in the United States has presented the nation's leaders with a historic opportunity to fix our broken health care system.

With 116 million adults under age 65 reporting health care-related financial issues, the nation's health care crisis and economic crisis have become inextricably intertwined. As unemployment grows, more Americans will join the ranks of the uninsured. States under pressure to balance their budgets are already making cuts in health programs that serve low-income adults and children. Already families—even those with insurance—are struggling to pay their share of premiums and medical expenses. Two-thirds of all adults under age 65 report being uninsured or underinsured, forgoing needed care, or struggling to pay medical bills or accumulated medical debt.[1]

Ours is the only industrialized nation that fails to ensure that all its citizens have access to affordable health care. We are slipping further behind what other countries achieve with their more modest investment in health care: the U.S. now ranks 19th out of a group of 19 major industrialized countries on an important measure of health system performance: mortality amenable to medical care. If we did as well as the best-performing countries, we would have 100,000 fewer deaths each year.[2]

Access is not the only problem. The poor performance of the U.S. health system also adds to the economic crisis. Currently, the United States spends twice as much per person as other major industrialized countries, saddling American businesses—especially those with aging workforces—with high expenses. It adds to burdens on taxpayers and squeezes other public priority needs, from education to the nation's aging infrastructure.

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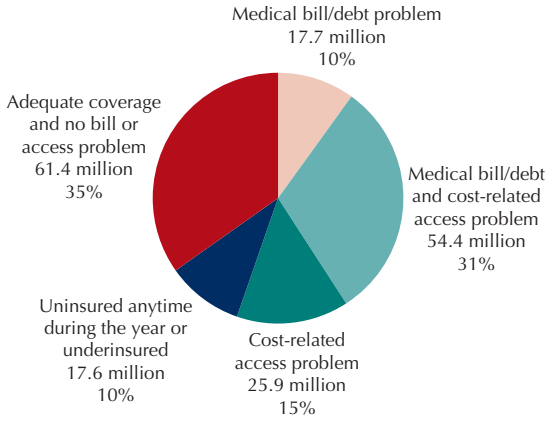
An Estimated 116 Million Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem, and/or Did Not Access Needed Health Care Because of Cost, 2007



177 million adults, ages 19–64

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*, The Commonwealth Fund, August 2008.

An Opening for Change

President-elect Barack Obama has noted, rightly, that health care reform is integral to economic recovery. Investing now in the information technology and other tools needed to modernize our health system, as well as in children's health that will contribute to a healthy workforce in the future, will pay dividends in lower costs and greater productivity in the future.

As we have seen so recently in response to the financial crisis, when government and the business community work together they can creatively address urgent national needs. Reform of our health care system is such a need. Government, business, purchasers, providers, patients—each must be part of the solution. We must all be willing to change—and to put what is in the best interest of patients first—if we want to reap the rewards of a high-value, equitable health care system.

We are fortunate that within our imperfect health care system are examples of all the components that, properly organized, reformed, and financed, can enable the nation to provide high-quality, affordable care to virtually every American. Systematically applying and disseminating what we know works would help put the U.S. on the path to a high-performance health system.

As a nation, we stand today at the threshold of an era ripe with opportunity. A new administration in Washington—one that has promised serious attention to health care reform—gives us hope that providing insurance to all Americans, reducing costs, and improving quality and equity will all soon be in the forefront of our national policy debate.

Leading the Way to a High Performance Health System

The Commonwealth Fund Commission on a High Performance Health System has issued a call to action for health reform.[3] It underscores that a critical step toward achieving a high performance health system is to provide insurance coverage to all Americans. But equally essential are bold actions that simultaneously improve the quality and efficiency of health care delivery—so that we improve the lives of Americans, alter the trajectory of health care costs, and make it easier for patients to obtain the care they need and providers to practice the best of modern medicine.

The Commission calls for the following steps to be taken:

- *Provide affordable health coverage for all.* It is time that all Americans received the security of health care coverage enjoyed by citizens of every other major industrialized country. Providing everyone—regardless of age or employment status—with affordable insurance options, including a comprehensive package of benefits, will enhance access to care. This, in turn, will help reduce

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disparities in care, increase the proportion of people receiving appropriate primary care to prevent illness, and improve the care and health of millions of Americans living with chronic conditions.

- *Reform provider payment.* Our open-ended fee-for-service payment system must be overhauled to reduce wasteful and ineffective care and to spur innovations that can save lives and increase the value of our health care dollars. We need to revamp our system for paying health care providers—reform that will reward high-quality care and prudent stewardship of resources, move toward shared provider accountability for the total care of patients, and correct the imbalance in payment whereby specialty care is rewarded more than primary or preventive care.
- *Organize our care delivery systems.* We need to reorganize the delivery of care, moving from our current fragmented system to one where physicians and other care providers are rewarded for banding together into integrated or virtual organizations capable of delivering 21st-century health care. Patients need to have easy access to appropriate care and treatment information, and providers need to be responsive to the needs of all their patients. Providers must also collaborate in delivering high-quality, high-value care, and they should receive the support needed for continuous improvement.
- *Invest in a modern health system.* The U.S. lags behind other countries in the adoption of health information technology and a system of health information exchange. In such a system, patient information would be available to all providers at the point of care, as well as to patients themselves through electronic health record systems, helping to ensure that care is well coordinated. Early investment in the infrastructure of a high performance health system—including information technology, research on comparative effectiveness of drugs, devices, and procedures, data on provider performance on quality and affordability, and a workforce that ensures a team approach to care—is an essential building block.
- *Ensure strong national leadership.* None of the above will be possible if government does not take the lead. The federal government—the nation's largest purchaser of health care services—has tremendous leverage to effect changes in coverage, care delivery, and payment. National leadership can encourage the collaboration and coordination among private-sector leaders and government officials that are necessary to set and achieve national goals for a high performance health system. It can also help set priorities and targets for improvement, create a system for monitoring and reporting on performance, and issue recommendations on the practices and policies.

Coverage for all Americans should be pursued simultaneously with the initiation of reforms aimed at improving the quality of care and efficiency of the health system. Universal coverage should not be held hostage until a more efficient health system is achieved. At the same time, coverage should not be expanded without at least beginning to make the system changes necessary to achieve a level of value that is commensurate with the nation's investment in health care.

Coverage: Building Toward Universal Coverage

The Obama Campaign Proposal

A transformed health system must start with health insurance for all. The Obama presidential campaign laid out a strategy for achieving affordable coverage

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for every American that relies on a mixed system of private and public insurance options. Building on the best of what works, the plan would retain employer-sponsored health insurance, which now covers nearly 160 million Americans, and permit people who want to continue their current coverage to do so.[4] It would also retain Medicaid and the State Children's Health Insurance Program (SCHIP), and offer them as coverage choices to all low-income adults and children. Medicare, too, would continue to cover older and disabled adults.

But the Obama proposal would also provide small businesses and individuals with a choice of new affordable coverage options made available through a national health insurance exchange, modeled on the Massachusetts health reforms and the Federal Employees Health Benefits Program (FEHBP). In addition to private plans, there would be a new public health plan option.

A key question is how expanded coverage will be financed, especially premium assistance for low-income and moderate-income households. The Obama campaign proposal embraced shared financial responsibility for health care—with contributions from federal and state government, employers, and households. All except small businesses would be required to either cover their workforces or contribute to a fund for coverage. Households would also contribute to coverage, with premium assistance available to ensure affordability. Tax breaks for higher-income households, enacted during the Bush administration, would be repealed or allowed to expire to fund coverage expansions.

Depending upon a number of specific critical design decisions, these funds may not be sufficient to cover the federal budget cost of the plan. In a time of economic crisis, expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. Deficit financing in the early years can be justified as part of an economic recovery program. But financing sources in out-years are needed to ensure long-term fiscal soundness. Savings offsets are possible from payment and system reforms—these investments and changes should receive priority attention in the first phase of health reform as their impact is greater in out-years.

Still, other sources of long-term financing will need to be identified and assessed. These might include higher taxes on high-income households, or a redirection of funds "within the system," such as indirect subsidies for care of the uninsured. Taxes on harmful health products—such as sugared soft drinks and tobacco products—should be among the financing options considered.

The "Building Blocks" Approach

A health care reform framework developed by staff at The Commonwealth Fund shares many essential features with the Obama campaign proposal.[5] Known as "Building Blocks," it would retain our mixed private–public system of coverage, require employers to provide health insurance to employees or contribute to a fund, and establish a national health insurance exchange, or connector, to offer private plans as well as a public plan modeled on Medicare to small businesses and individuals. Combining a requirement for coverage under either a public plan or private plans with selected provider payment and health system reforms would make it possible to cover nearly everyone—at minimal cost to the federal budget and with total net savings to the health system.[6]

The Building Blocks framework, however, differs from the Obama campaign proposal in some important respects: it requires everyone to obtain health insurance coverage; it does not include tax subsidies

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for businesses; and it improves benefits and financial protection for Medicare beneficiaries comparable to those under age 65.

Because it includes details on the amount of premium assistance that would be made available to lower-income families, the amount of employer contributions, and other features, it is possible to estimate the impact Building Blocks would likely have on total health system spending and on the federal budget. According to calculations by the Lewin Group,[7] public plan actuarial premiums would be 20 percent to 30 percent lower than premiums typically charged for employer-sponsored plans, especially those in the small-group market—largely because of Medicare's lower administrative costs and payment rates for providers. Overall, the Building Blocks framework could not only help ensure that affordable coverage is available to the uninsured, but it could ensure improved coverage at lower costs for many employers, the self-employed, and insured individuals who now buy coverage on their own.

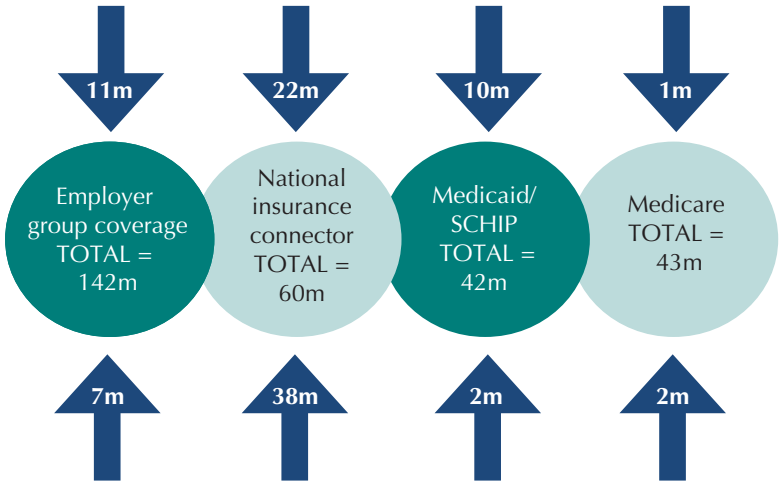
Gains in coverage. Near-universal coverage could also be achieved using the Building Blocks framework, according to the Lewin Group. Forty-four million people in the United States who are currently uninsured would have health insurance, or 99 percent of the total U.S. population. Premiums would be limited to no more than 5 percent of income for lower-income families, and 10 percent of income for other households.

The requirement that employers cover employees or contribute to coverage would persuade more employers to offer coverage. Premium assistance based on income would also make it possible for more low-wage workers to take up their employers' offers of health coverage.

In addition, under the Building Blocks framework all Medicare beneficiaries would have improved benefits and adequate financial protection, with premiums capped as a percentage of income. Elimination of the two-year waiting period for coverage of the disabled under Medicare would add an additional

Building Blocks for Automatic and Affordable Health Insurance for All

New coverage for 44 million uninsured in 2008



Improved or more affordable coverage for 49 million insured

Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May/June 2008 27(3):646–57, from Lewin Group modeling estimates.

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1 million people to Medicare, enabling them to get the early care needed at the onset of disability from serious conditions, such as cancer. Letting older adults and early retirees buy into Medicare would ensure them affordable coverage at a premium that reflects far better value than health plans offered in the individual insurance market—if they are available at all to people with health conditions.

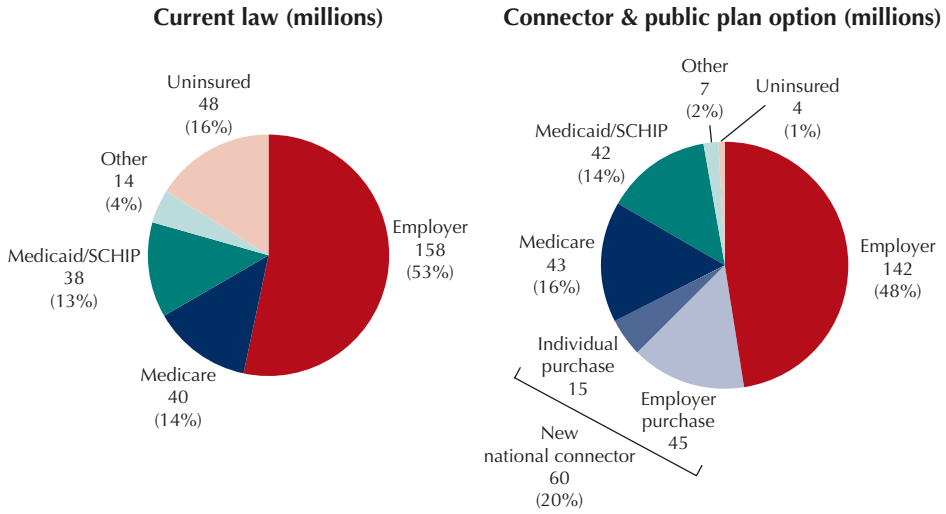
Better quality of coverage. For the 49 million people with insurance who change coverage, their health coverage would improve or their premiums would be lower. Small businesses (with fewer than 100 employees), in particular, would likely respond to the possibility of improved, lower-cost coverage by buying coverage through the national insurance connector instead of directly in the private market.

Altogether, total employer-based coverage—sponsored either directly by employer health plans or financed by employers through the connector—would increase from 158 million people to 184 million, or from 53 percent of the population to 63 percent. The change in coverage reflects decisions made by employers or, in some cases, by individuals, to switch to better health coverage—rather than a requirement that people change their current coverage.[8] Given that many Americans are satisfied with their current coverage, offering choices is likely to garner greater support than radical changes made to existing insurance.[9]

An estimated 60 million Americans would be covered through the national insurance connector, including those individuals whose employers purchase insurance through the connector. Approximately three-quarters, more than 45 million people, would obtain coverage through the new public plan option, and the remaining 15 million people would be in private plans.

Lower costs, more competition. The attraction of the public plan option modeled on Medicare is its lower premiums—an average of 20 to 30 percent lower—compared with private plan offerings.[10] Medicaid provider payment rates, which are substandard in

Building Blocks with Connector and Public Plan Option, 2008



Total population = 298 million

Source: Based on analysis in C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May 13, 2008 27(3):646–57, from Lewin Group modeling estimates.

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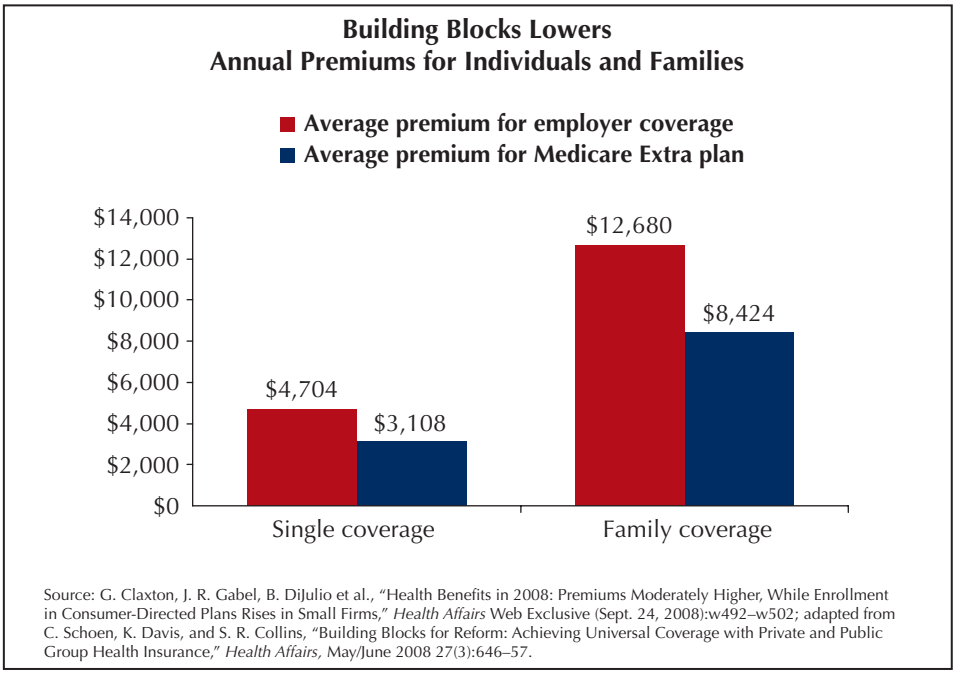
many states, would be raised to Medicare levels to ensure adequate provider participation. Covering the uninsured and underinsured largely through the public plan option and Medicaid/SCHIP is an economical way to expand coverage. Providers under the public plan option are paid at Medicare rates rather than at higher commercial insurer rates.

Private insurers are likely to respond to the competition from a public plan option by forming more highly integrated delivery systems or selecting high-value providers for participation in networks. However, if the public plan continues to be less expensive over time, it might be expected that more people would switch to public coverage. This could lead to further transformation of the private insurance market, as private insurers endeavor to "meet the competition" by lowering overhead and adopting innovative practices in pursuit of higher value or lower premiums. Private plans meeting certain conditions could also be permitted to pay at Medicare rates, with provider participation in Medicare and national health insurance exchange plans conditional on accepting such rates as payment in full.

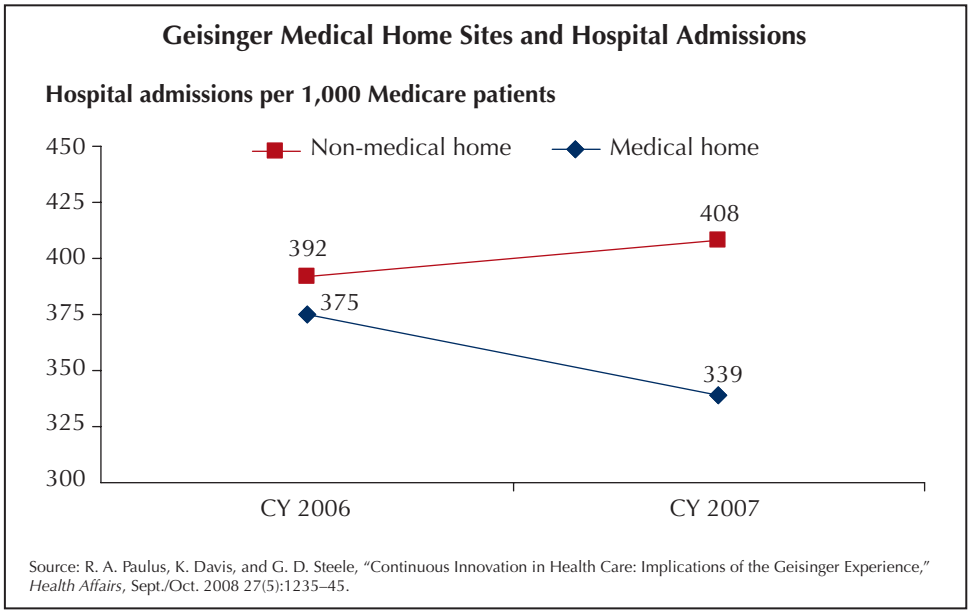
System reforms are a critical part of this plan, and they should include giving providers and patients the information they need to make appropriate health care decisions, revising methods for paying providers to encourage greater accountability for the care delivered, and encouraging preventive care use and health promotion. In a report for The Commonwealth Fund, *Bending the Curve*, The Lewin Group estimated the impact of 15 options to illustrate the potential of multifaceted approaches for addressing projected health care expenditure increases.[11] The most promising of these options are described in more detail below.

Cost: Reforming Payment by Leveraging Medicare's Purchasing Power

An essential step in transforming the health care system is changing the financial incentives for hospitals, physicians, and other health care organizations so that they become more accountable for patient health outcomes and the prudent use of resources. Medicare could lead the way by instituting a system for the rapid testing, adoption, and spread of innova-



Source: G. Claxton, J. R. Gabel, B. DiJulio et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises in Small Firms," *Health Affairs* Web Exclusive (Sept. 24, 2008):w492–w502; adapted from C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May/June 2008 27(3):646–57.



Source: R. A. Paulus, K. Davis, and G. D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, Sept./Oct. 2008 27(5):1235–45.

tive payment methods. These should include rewarding high-performing health care organizations for results, not for the quantity of services delivered.

The three most promising changes to provider payment are:

- *Recognizing physician practices or health systems that serve as patient-centered medical homes.* A Commonwealth Fund survey found that patients cared for by physician practices that are accessible and organized are much more likely to receive preventive care and assistance managing their chronic conditions.[12] With Fund support, the National Committee for Quality Assurance has developed standards for physician practices to qualify as patient-centered medical homes. In addition to current fee-for-service payments or a global primary care fee covering all primary care needed by enrolled patients, a medical home fee could also be paid to physician practices that meet medical home standards—that is, they provide accessible and coordinated care to patients and assume responsibility for ensuring patients get all appropriate preventive care and assistance with managing chronic conditions. The Commonwealth Fund is supporting an initiative to help safety-net clinics—which serve low-income and minority patients—transform themselves into patient-centered medical homes. Preliminary evidence from Fund-supported studies suggests that having a medical home can improve patients' experiences and the quality of clinical care while also reducing avoidable hospitalizations.[13] Moreover, estimates from the Fund's *Bending the Curve* report indicate that reforming provider payment to strengthen primary care and improve coordination could generate $194 billion in national health expenditure savings over 10 years.

- *Paying a global fee for acute hospital episodes, including 30-day follow-up care.* A new system of payment for hospital care would make a hospital or health care system accountable not only for the initial hospitalization but any subsequent complications, readmissions, or

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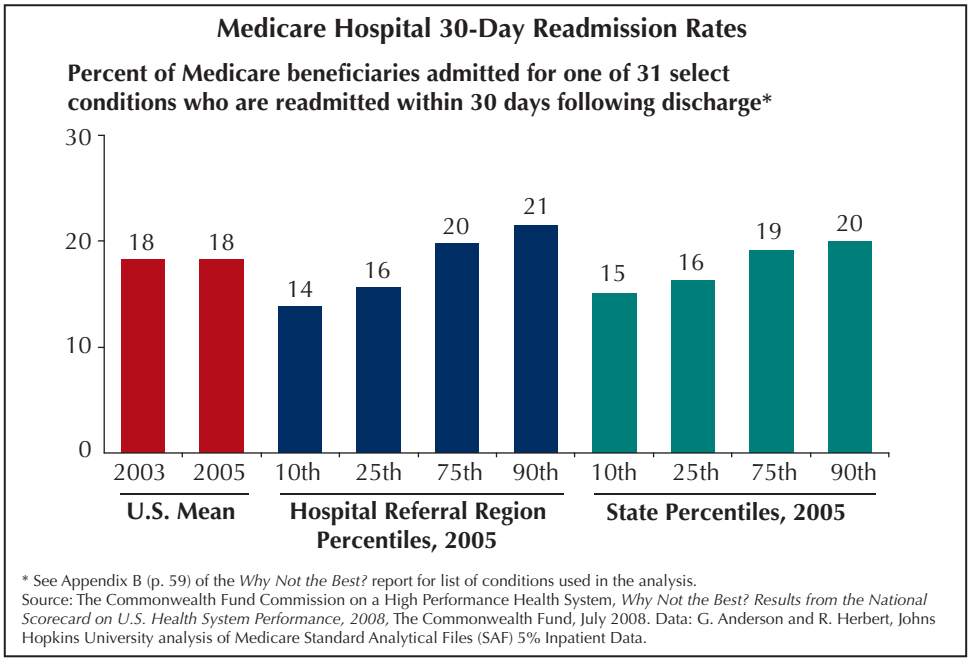

* See Appendix B (p. 59) of the *Why Not the Best?* report for list of conditions used in the analysis.
Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008,* The Commonwealth Fund, July 2008. Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

emergency care. The Commonwealth Fund's State Scorecard on Health System Performance found wide variation in Medicare hospital readmission rates across states.[14] The percentage of Medicare patients readmitted to the hospital within 30 days averaged 18 percent in 2005, but hospital readmission rates varied from 14 percent in some areas to 21 percent in others. The Fund is supporting the Institute for Healthcare Improvement in its initiative to reduce avoidable hospitalizations by providing hospitals with practical guidance on ways to decrease complications during hospital stays, improve patient communications in the discharge process, and monitor patients after discharge.

Aligning financial incentives to reward hospitals for better transitional care from hospital to home or nursing home could spur such efforts and compensate hospitals for the additional cost of changing processes to improve care. Hospital systems, multi-specialty physician group practices, and integrated delivery systems that are willing and able to assume financial risk for the total care of patients over an episode of illness could be paid a global fee for each episode, starting with the initial hospitalization.[15]

Such a payment change could start with Medicare. For Medicare alone, preventing avoidable hospitalizations could save $12 billion in one year.[16] The Fund's *Bending the Curve* report estimates that such a change would reduce national health expenditures by $229 billion over 10 years.[17]

- *Providing financial rewards for top-performing providers.* Medicare could reward all physicians, hospitals, health systems, nursing homes, and other providers that excel at providing top-quality care. In recent years, the Medicare program has begun publicly reporting mortality rates and quality of care for selected hospitalized patients, including those with heart attacks, congestive heart failure, and pneumonia. Medicare demonstrations are also testing new payment methods

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that peg payment to performance. Providing bonuses to hospitals that ranked in the top 20 percent on quality metrics for major conditions such as congestive heart failure and pneumonia improved quality and achieved savings from reduced readmissions and fewer complications.[18] Similarly, a demonstration of rewards to physician group practices for slowing the growth in Medicare outlays stimulated new ways to avoid hospitalization and achieve savings.[19] The *Bending the Curve* report estimates that spreading the Medicare hospital pay-for-performance demonstration to all hospitals would save $34 billion in national health expenditures over 10 years.

Each of these payment methods provides an incentive for health care providers to improve quality of care, coordinate care across care settings and over time, and prevent avoidable hospitalization and complications. In doing so, they create a dynamic that leads to higher-value care—better outcomes, higher quality, fewer complications, and lower costs.

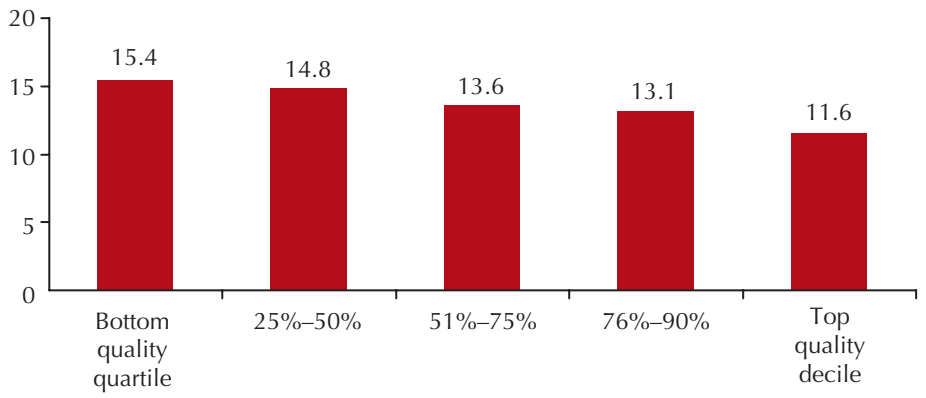
Delivery System Reform: Organizing the Health Care System Around the Patient

Providing modern, high-quality health care requires moving to a more organized delivery system that taps the expertise of a team of health professionals, from primary care and specialist physicians to nurses and pharmacists. As outlined above, Medicare can help lead the transformation of health care delivery by basing its payment policies on health outcomes and results, not on who provides a given medical service.

Medicare can also encourage greater organization of care by recognizing systems of care—from individual clinics to large integrated delivery systems—that reach high standards of care, report their results publicly, and assume accountability for patients. This includes making sure that every enrolled patient is up-to-date with all recommended preventive care, and that all patients with chronic conditions receive the follow-up care necessary to keep their conditions under control.

These principles should apply to the private plans that now serve Medicare beneficiaries. Current methods of payment and reporting for private Medicare

Medicare Experimenting with Pay for Performance
CMS-Premier Hospital Quality Incentive Demonstration:
Higher Quality Hospitals Have Fewer Readmissions



© 2005 Premier, Inc.
Source: Stephanie Alexander, "CMS/Premier Hospital Quality Incentive Demonstration Project: 1st Year Results," Presentation at an Institute of Medicine Pay for Performance Subcommittee Meeting, November 30, 2005.

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Advantage plans do not encourage them to reach high levels of quality and efficiency. Rather, these plans are paid, on average, 13 percent more to care for patients than it would cost under traditional Medicare. Not surprisingly, the "overpayment" of private plans that was authorized by the 2003 Medicare Modernization Act has led to their rapid proliferation and to growth in their Medicare beneficiary enrollment. The *Bending the Curve* report estimates that leveling the playing field between Medicare Advantage plans and traditional Medicare would save $50 billion in national health expenditures over 10 years.

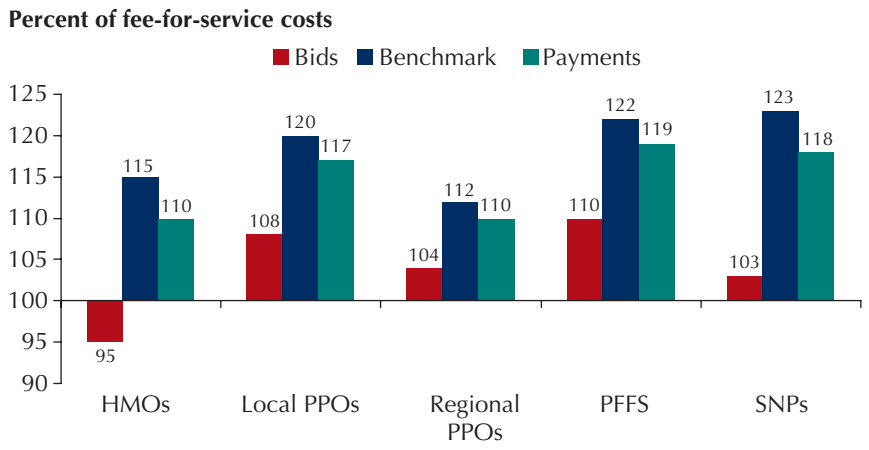
Infrastructure Investment: Meeting and Raising Benchmarks for Care

The federal government can also raise the bar for health system performance and help providers get the tools they need to reach the highest attainable levels of performance. This should start with setting explicit goals and priorities for improvement—including a focus on the most prevalent chronic conditions, which account for a large majority of health care costs.

For example, Medicare could join with private insurers and other payers to develop a database that lets providers and the public know how they are doing relative to what is possible. Having reliable comparative data, adjusted for differences in patient characteristics, is the first step along the path to improvement. Such a database should provide timely feedback on how each and every provider—whether health system, hospital, physician, or long-term care facility—is doing on quality and health outcome metrics that are tied to achievable benchmarks. The Commonwealth Fund is helping to support such a tool through its WhyNotTheBest.org Web site with data and tools to improve hospital clinical quality and patients' experiences.

Medicare, Medicaid, and private insurers can also ensure that the care they cover is based on the best and latest research findings on effectiveness. Insurers should cover all medications, devices, and procedures that have been scientifically shown to improve patient outcomes and quality of life. But insurers also should be prudent purchasers, paying no more for a

Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006



Note: HMOs = health maintenance organizations; PPOs = preferred provider organizations; PFFS = private fee-for-service plans; SNPs = special needs plans.
Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2007).

device or treatment than they would for another that is equally effective. The *Bending the Curve* report estimates that a center on medical effectiveness and health care decision-making could save $368 billion over 10 years, if insurance benefit design and payment were tied to evidence on cost-effectiveness.

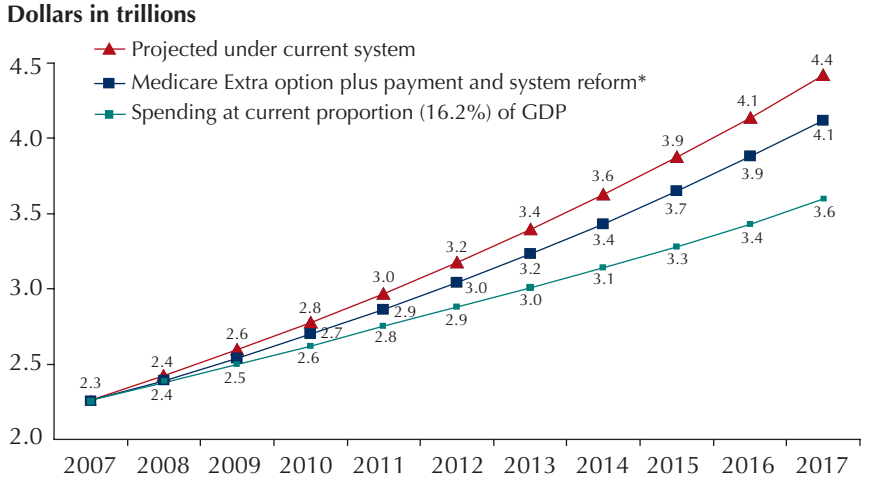
Modern health care also requires replacing antiquated paper-based medical records with systems that take advantage of modern health information technology. Medicare can do its share by joining with private payers in contributing funds to help those who cannot afford to purchase such technology on their own—especially safety-net clinics and hospitals serving uninsured and low-income patients. It can also create incentives for the adoption of information systems meeting approved standards, and help establish "health information networks" that allow patients and the health professionals that care for them to have all relevant medical information available at their fingertips. While such a change requires upfront investment, it would begin to pay dividends after seven years and generate net savings of $88 billion over a decade.

Ensuring Accountable National Leadership and Public–Private Collaboration

While it is clear what the federal government could do to help move the U.S. health system further along the path to high performance, carrying out change is difficult in a highly political environment where consensus must be reached among 535 members of Congress and endorsed by the President. That is why the federal government must assume a much greater leadership role.

Strong, effective leadership, however, requires independence and authority to act quickly to test and spread new ideas. By strengthening Medicare with a "board of directors"—an independent health board or health authority—it would be able to structure an appropriate set of incentives for beneficiaries and health care providers. This would involve setting payment methods and levels, making decisions on

Total National Health Expenditures, 2008–2017, Projected Under Connector with Public Plan Option with Payment and System Reform



* Selected individual options include improved information, payment reform, and public health.
Source: C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, The Commonwealth Fund, December 2007.

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what drugs, devices, and procedures are covered, setting conditions of provider or health care organization participation, and ensuring rapid information feedback to providers and beneficiaries on outcomes, quality, accessibility, and efficiency of care achieved by different health care organizations and providers.

To ensure accountability, Congress would need to establish a framework for operation of the new health board. For example, there might be five-year targets on Medicare spending per beneficiary, along with a requirement that costs cannot be shifted to private payers, states, or beneficiaries. The health board should be required to make an annual report to Congress on the extent to which Medicare is improving outcomes, quality, access, equity, and efficiency of care for its beneficiaries—as well as the health system as a whole—and what key actions it proposes to implement in the coming year.

While Congress could retain the authority to override the proposed plan of action and substitute an alternative that achieves the same overall goals, the health board should be structured to ensure its independence and ability to implement a long-range vision. This might mean that full-time board members are appointed by the President to lengthy terms. Rather than representing the different interests affected by Medicare policy, all board members should have the requisite expertise to carry out the functions assigned to them.

In addition, the health board should be authorized to convene and collaborate with private payers and other parties to streamline and simplify many of the conflicting regulations and processes that burden the health care system. For example, one system of data reporting, one set of performance metrics, and one set of conditions for provider participation should greatly reduce current administrative costs and burdens on providers.

Putting It All Together: A Roadmap to a Transformed Health System

These actions, taken together, have the potential to achieve near-universal coverage, improve quality, and expand access—all while generating health system savings of at least $1.6 trillion over 10 years.[20] Broader health system reforms, if combined with coverage expansion, would also achieve federal budget savings that largely offset the cost of achieving universal coverage after five to 10 years.

On issues of cost, quality and coverage, a transformed Medicare payment system is the key to a transformed health system. As the discussion about reforming health care gathers steam during 2009, The Commonwealth Fund, together with its Commission on a High Performance Health System, will continue to make the case for an integrated approach to system reform, one in which issues of access, quality, and cost are considered concurrently. We will also continue to stress the importance of leadership and collaboration among business, government, insurers, providers, and patients—no matter what path reform takes. By providing information on promising initiatives, assessing the likely impact of proposed policies, and offering new ideas, we hope to assist health care leaders and policy officials who are committed to making the U.S. health system truly the best it can be.

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

Karen Davis

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Notes

1 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, Aug. 2008).

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

3 The Commonwealth Fund Commission on a High Performance Health System, *The Time Has Come for Comprehensive Health Reform* (New York: The Commonwealth Fund, Nov. 2008). The remainder of this section is derived in large part from the statement of the Commission.

4 S. R. Collins, J. L. Nicholson, S. D. Rustgi, and K. Davis, *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America* (New York: The Commonwealth Fund, Oct. 2008).

5 C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs,* May/June 2008 27(3):646–57.

6 K. Davis, C. Schoen, and S. R. Collins, *The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings* (New York: The Commonwealth Fund, May 2008).

7 The Lewin Group is a wholly owned subsidiary of Ingenix which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and the Fund monitors the relationship to assure such independence.

8 Some health insurance bills introduced by members of Congress would require everyone to drop employer coverage and be covered under Medicare or a single-payer public program; others would abolish employer-based insurance and require everyone to obtain coverage on their own through the individual insurance market or a regional insurance connector. See S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005–2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund Commission on a High Performance Health System, Mar. 2007).

9 S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007); L. Duchon, C. Schoen, E. Simantov, K. Davis, and C. An, *Listening to Workers: Findings from the Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (New York: The Commonwealth Fund, Jan. 2000).

10 C. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs* Sept./Oct. 2007 26(5):1407–16.

11 C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund Commission on a High Performance Health System, Dec. 2007).

12 A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From the Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

13 Beal, Doty, Hernandez et al., *Closing the Divide,* 2007; C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007 26(6):w717–w734; R. A. Paulus, K. Davis, and G. D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs,* Sept./Oct. 2008 27(5):1235–45; D. McCarthy, R. Nuzum, S. Mika, J. Wrenn, and M. Wakefield, *The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation* (New York: The Commonwealth Fund, May 2008); M. Lodh et al., "ACCESS Cost Savings—State Fiscal Year 2004 Analysis," Mercer Governmental Human Services Consulting letter to Jeffrey Simms, State of North Carolina, Office of Managed Care, Mar. 24, 2005 (available at: http://www.communitycarenc.com/PDFDocs/Mercer%20SFY04.pdf).

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

[15] K. Davis and S. Guterman, "Rewarding Excellence and Efficiency in Medicare Payments," *Milbank Quarterly,* Sept. 2007 85(3):449–68; K. Davis, "Paying for Care Episodes and Care Coordination," *New England Journal of Medicine*, Mar. 15, 2007 356(11):1166–68; A. Mutti and C. Lisk, "Moving Toward Bundled Payments Around Hospitalizations," presentation to the Medicare Payment Advisory Commission, Washington, D.C., Apr. 9, 2008.

[16] R. Pozen and C. Schoen, "How Rehospitalizations Are Hurting Medicare," *Boston Globe*, Aug. 14, 2008. Available at: http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2008/08/14/how_rehospitalizations_are_hurting_medicare/.

[17] Schoen, Guterman, Shih et al., *Bending the Curve,* 2007.

[18] P. K. Lindenauer, D. Remus, S. Roman et al., "Public Reporting and Pay for Performance in Hospital Quality Improvement," *New England Journal of Medicine,* Feb. 1, 2007 356(5):486–96.

[19] J. Reichard, "Team Play in Medicine Nets Medicare Quality, Savings Gains," *CQ HealthBeat,* Aug. 14, 2008.

[20] Schoen, Guterman, Shih et al., *Bending the Curve,* 2007.

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