PUBLIC PROGRAMS: CRITICAL BUILDING BLOCKS IN HEALTH REFORM

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EXECUTIVE SUMMARY

As the nation begins serious consideration of health reform, it is instructive to review the contributions of Medicare and Medicaid over their 40-year history in covering the sickest and poorest Americans—those who typically do not fare well in private insurance markets. These programs have improved access to health care for many of our most vulnerable citizens, and warrant serious consideration as building blocks in a system of seamless coverage for America's 47 million uninsured people.

Currently, most Americans either have group health insurance through employers (55 percent) or are covered by Medicare or Medicaid (22 percent). Building on the strengths of these sources of coverage has many advantages: it minimizes disruption in current coverage, it builds on what works, and it requires minimal new administrative mechanisms. Both have low administrative costs. Medicare is an ideal coverage source for older and disabled adults who are currently uninsured. Beneficiaries report high satisfaction with their coverage, and their ability to access health care services. Medicaid and the State Children's Health Insurance Program (SCHIP) are also ideal coverage sources for low-income adults.

There are steps that Congress can take to prepare these programs to cover a share of the uninsured under health reform. Medicare can be a leading force for change in the health care system, serving as a model for private insurers in public reporting, rewarding quality, requiring evidence-based care, and encouraging use of modern information technology. Medicare has broad physician and hospital participation at prices below those available through private insurance. Medicaid's provider payment rates are undoubtedly below market prices and limit provider participation; they would need to be brought up to Medicare levels.

Further reforms to Medicare's payment system can stimulate innovation in the private sector—as has been accomplished previously with the development of prospective payment methods—and help shape a more organized, high performance health system. With more integrated benefits and innovative payment policies, a

Medicare-sponsored public plan could also be offered as an option to small businesses and individuals who now have few affordable options for coverage in the private market. Medicaid programs could be strengthened by studying concepts and strategies like state innovations in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

If initiated early, these reforms could help generate savings to "bend the curve" in national health expenditures and help offset the budgetary outlays required for health insurance coverage for all. In doing so, a mixed private–public system of universal coverage with seamless coordination across sources of coverage could transform both the financing and delivery of health care services. Such a system would build on the best that both private insurance and public programs have to offer and also achieve needed savings and ensure access to needed care for all.

Recently, my colleagues at The Commonwealth Fund and I set forth a "Building Blocks" approach to achieving universal coverage through a seamless system of private and public health insurance that builds on what works best in our current health insurance system. We set forth a framework for health coverage reform that features a new public offering—Medicare Extra, which includes elements from Medicare and the Federal Employees Health Benefits Program. Medicare Extra would be available, along with private insurance plans, through a national "insurance connector." We then estimated the changes in insurance coverage, access to care, and costs under a framework founded on the building blocks of private group insurance and this new comprehensive publicly sponsored health plan.

The Building Blocks framework for expanding health insurance coverage has six core components:

1. A structured choice of private plans and an enhanced Medicare-like plan (Medicare Extra) made available through a new national insurance connector; insurance would be available to all at community-rated premiums that would not vary with health risks. The same premium rating provisions would apply inside and outside the connector.
2. A requirement that all individuals obtain health insurance coverage, with automatic enrollment of uninsured tax-filers through the personal income tax system.

3. Financial responsibility shared between employers and employees, with a requirement that all firms cover their workers or else contribute 7 percent of workers' earnings (up to $1.25 per hour) to a pool to help finance coverage.
4. An expansion of Medicaid and SCHIP that would allow coverage of all low-income adults and children below 150 percent of the federal poverty level, with modest copayments for health care services, no premiums, and enhanced federal matching to cover additional costs to states.
5. Tax credits that offset premium cost in excess of 5 percent of income for lower-income tax filers (15 percent-or-lower tax bracket) and 10 percent of income for higher-income tax filers (benchmarked to premium of the Medicare Extra plan).
6. Extension of the option to buy improved Medicare Extra benefits to current Medicare beneficiaries; elimination of the two-year waiting period for Medicare coverage for people with disabilities; the ability of adults age 60 or older to buy in to Medicare; and the same financial protection on premiums as a percentage of income for Medicare beneficiaries as for nonelderly households.

The Lewin Group estimated Medicare Extra premiums at rates that would be more than 30 percent lower than premiums typically charged for employer-sponsored plans, especially those in the small-group market—a result 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 also ensure improved coverage at lower costs for many employers, the self-employed, and insured individuals currently buying coverage on their own.

Simultaneously, coverage expansions could be linked to other health system reforms. These 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. This analysis illustrates that such a strategy has 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. Broader system reforms, if combined with coverage expansion, would also achieve federal budget savings that largely offset the cost of achieving universal coverage by years five to 10.

This analysis should help dispel the conventional wisdom that universal coverage is beyond our means. Our analysis shows that it is possible to cover nearly everyone with

affordable and comprehensive insurance, expand access to essential care, and improve informed decision-making by patients, clinicians, and payers—all while reducing spending on health care. Buying more effective, higher-value care has significant benefits for patients and will help move the U.S. health system toward higher performance. Indeed, more coherent, integrated affordable insurance that covers the population is critical and essential to enable and stimulate nation-wide efforts to slow cost growth and improve value. Fragmented insurance and coverage gaps stand in the way of a path toward more effective, efficient and equitable care, and undermines the nation's health and economic security.

No single element of reform—no silver bullet—will be able to achieve the results described here. The framework explored in this paper is uniquely American: it leaves intact coverage for those who are insured; it does not abolish private insurance, as advocated by some who favor government solutions; and it does not abolish public programs like Medicaid and SCHIP, as advocated by some who favor private insurance markets. The question for the nation should not be "public" or "private," but what creative mix will move us toward more accessible, patient-centered, high performance health care system.

The major innovation of our framework is that it builds on what currently works by offering Medicare not just to the elderly and long-term disabled but also to individuals and small firms. It keeps market competition in place, but adds a new competitive dynamic. Private insurers, rather than competing to attract the healthiest patients, would need to add value, flexibility, and innovation to the products they offer.

The most encouraging message from the estimates presented here is that it is possible to aim for a high performance health system that simultaneously achieves better access, improved quality, and greater efficiency. Other nations have long since adopted many of the reforms we have set forth here. The U.S. can learn from their experience, as it can from states like Massachusetts and Vermont that have recently enacted reforms. Our future is up to us.

PUBLIC PROGRAMS: CRITICAL BUILDING BLOCKS IN HEALTH REFORM
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Thank you, Mr. Chairman, for this invitation to testify regarding the role of public programs in health reform. As this Committee knows well, public programs today cover one of four Americans, including the elderly and disabled under Medicare; low-income families, elderly, and disabled under Medicaid; and low-income children under the State Children's Health Insurance Program (SCHIP). These programs have improved access to health care for many of our most vulnerable citizens, and warrant serious consideration as building blocks in a system of seamless coverage for America's 47 million uninsured people.

As the nation begins serious consideration of health reform, it is instructive to review the contributions of these public programs over their 40-year history in covering the sickest and poorest Americans—those who typically do not fare well in a private insurance market. Medicare was created in 1965 because elderly Americans lost their private insurance when they retired. Medicare is a natural source of coverage for uninsured older adults and disabled people who qualify for Medicare. Medicaid/SCHIP is similarly a natural source of coverage for low-income adults whose children are covered by Medicaid or SCHIP.

There are steps that Congress can take to prepare these programs to cover a share of the uninsured under health reform. Medicare can be a leading force for change in the health care system—serving as a model for private insurers in public reporting, rewarding quality, requiring evidence-based care, and encouraging use of modern information technology. Reforms to Medicare's payment system can stimulate innovation in the private sector—as has been accomplished previously with the development of prospective payment methods—and help shape a more organized, high performance health system. With a new benefit and payment structure, Medicare could also be offered as an option to small businesses and individuals who now have few affordable options for coverage in the private market. Medicaid programs could be strengthened by studying strategies and concepts like state innovations in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

If initiated early, these reforms could help generate savings to "bend the curve" in national health expenditures and help offset the budgetary outlays required for health

insurance coverage for all.[1] In doing so, a mixed private–public system of universal coverage with seamless coordination across sources of coverage could transform both the financing and delivery of health care services. Such a system would build on the best that private insurance and public programs have to offer and achieve needed savings and ensuring access to needed care for all.[2]

Overview of Current System of Health Insurance

The U.S. has a mixed private–public system of health insurance coverage. Moving to either a single payer public system or a predominantly private insurance system would require millions of Americans to change their current coverage, including the large majority who are satisfied with their current coverage and apprehensive about losing it.[3] About 160 million people, or 55 percent of all Americans, are covered by employer health insurance. Only 5 percent of Americans are covered through the individual insurance market, often transitional coverage for older adults waiting to become eligible for Medicare or young adults waiting for their first job with health benefits. Almost one of four is covered by Medicare, Medicaid, or SCHIP, while 16 percent—47 million—are uninsured.[4]

Public programs including the Veterans Administration, as well as Medicare and Medicaid, cover the highest-cost populations: the elderly, disabled, and other high-risk individuals. As a consequence, these programs account for about 45 percent of all health care outlays, while private insurance accounts for about 35 percent of outlays. Each of these sources of coverage plays an important role in our current system.

Employer Health Insurance

Employer health insurance is the mainstay of coverage for those under age 65. It serves as a source of pooling for good and bad health risks and across the age spectrum since individuals obtain coverage when they become employed. In contrast, people often seek

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[1] 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.

[2] 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; K. Davis, C. Schoen, and S. R. Collins, *The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings*, The Commonwealth Fund, May 2008.

[3] S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform*, The Commonwealth Fund, October 2007.

[4] C. DeNavas-Walt, B. D. Proctor, and J.Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

coverage in the individual insurance market because they are worried about a health condition. Administrative overhead is markedly lower in employment-based coverage than in the individual insurance market.

There are important differences, however, between coverage under large employers and small employers. Nearly all large employers with 50 or more employees offer health benefits to employees. However, less than half of firms with fewer than 10 employees do so, and over the last seven years, coverage in firms with fewer than 50 employees has eroded. Small businesses face many disadvantages because they do not enjoy economies of covering large groups with natural pooling of risks. Small firms are less likely to offer employees a choice of plans. They are charged higher premiums than larger firms for less comprehensive benefit packages and a higher share of the premiums stays with insurance carriers for administrative, marketing, underwriting and other overhead costs.[5]

According to a 2005 Commonwealth Fund survey of health insurance, employees covered by employer plans are, for the most part, satisfied with the coverage their employers provide. Three of four say that employers do a good job selecting quality health insurance plans.[6] In a prior edition of the same survey, workers and family members enrolled in employer-sponsored health insurance were asked whether they would prefer to have their employers offer a set of health plan options or have their employer fund an account they could use to find a health plan on their own.[7] Two-thirds of respondents preferred to have their employer offer a set of options. Surveys by the Employee Benefit Research Institute (EBRI) show that workers value health benefits more than any other non-wage benefit, which makes them a critical recruitment and retention tool for employers.[8]

Rising premiums have weakened the ability of some firms to offer comprehensive coverage and led many to share more of their costs with employees in the form of higher

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[5] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, September 2006.

[6] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, (New York: The Commonwealth Fund) September 2006.

[7] J. Lambrew, *"Choice" in Health Care: What Do People Really Want?* (New York: The Commonwealth Fund) September 2005.

[8] R. Helman and P. Fronstin, *Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey*, EBRI Issue Brief no. 275 (Washington, D.C.: Employee Benefit Research Institute) November 2004.

deductibles and other cost-sharing measures. People with low and moderate incomes are most at risk of lacking coverage through an employer and are the most at risk of being uninsured. Only 22 percent of adults under age 65 in families with incomes of $20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000.[9] Employer-based coverage in the next higher income category—less than $37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006.

Employers have substantial influence in the health care market, spending $420 billion on health care.[10] They have often been innovative leaders in using health benefits to leverage change in the health care delivery system and to encourage greater employee responsibility for their own health. A majority of commercial health plans use methods of payment that reward provider quality and efficiency.[11] Employers also encourage employees to participate in disease management and health promotion programs.[12]

Employer premiums are not counted as taxable income to employees. Tax incentives for employer-sponsored insurance and other medical spending cost about $200 billion in foregone tax outlays.[13] Some proponents have argued that these funds could be better targeted on lower-income households, or used as a revenue source for expanded or universal health insurance coverage. Absent universal coverage, however, this could unravel the current insurance base, leaving the nation with higher costs and less coverage. Any reduced incentive for employers to help finance coverage for employees and dependents could disrupt current sources of group coverage that are highly valued by employees and work effectively to spread risk and lower administrative costs.

Individual Health Insurance

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[9] E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

[10] 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,* The Commonwealth Fund, September 2007.

[11] M. B. Rosenthal, B. E. Landon, S. L. Normand, R. G. Frank, and A. M. Epstein. "Pay for Performance in Commercial HMOs." *New England Journal of Medicine* 355(19):1895–1902.

[12] Debra A. Draper, Ann Tynan, Jon B. Christianson, *Health and Wellness: The Shift from Managing Illness to Promoting Health*, Center for Studying Health System Change, Issue Brief No. 121, June 2008; Ashley C. Short, Glen P. Mays, Jessica Mittler, *Disease Management: A Leap of Faith to Lower-Cost,Higher-Quality Health Care,* Center for Studying Health system Change, Issue Brief No. 69, October 2003.

[13] J. Furman, "Health Reform Through Tax Reform: A Primer," Health Affairs 27:3:620–632, May/June 2008. Furman estimates that the tax exclusion reduces income taxes by $164 billion in FY2008, payroll taxes by $85 billion, but reduce future Social Security benefits by not being counted as income, for a net effect of approximately $200 billion.

The individual health insurance market is the weakest link in the U.S. system of health insurance, covering only 4 percent of all Americans. Except in a few states that require insurers to have open enrollment and community-rated premiums, insurers typically screen applicants for health risks and exclude high-risk individuals from coverage or charge higher premiums.[14] By design, underwriting practices discriminate against the sick and disabled, making coverage often unavailable at any price, or only at a substantially higher cost than incurred by healthier individuals. Nongroup premiums are 20 percent to 50 percent higher than employer plan premiums and more than 40 percent of total premiums are estimated to go toward administration, marketing, sales commissions, underwriting, and profits.[15] Premiums typically climb steeply with age.[16] Benefits are often inadequate, and premiums and risk selection practices are difficult for states to regulate. [17]

The Commonwealth Fund Biennial Health Insurance Survey found that of 58 million adults under age 65 who sought coverage in the individual insurance market over a three year period, nine of 10 did not purchase coverage, either because they were rejected, not able to find a plan that met their needs, or found the coverage too expensive.[18] Nongroup health insurance works least well for those who have limited incomes or serious health problems. More than 70 percent of people with health problems or incomes under 200 percent of the poverty level surveyed by The Commonwealth Fund said that it was very difficult or impossible to find a plan they could afford.

Enrollment is also far more transitional in the individual market than in employer based plans. Klein and colleagues found that only 53 percent of people under age 65 with individual market coverage were still enrolled in the plan two years later, compared with 86 percent of people in employer-based health plans.[19] Although increasing numbers of

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[14] N. C Turnbull and N. M. Kane, Insuring the Healthy or Insuring the Sick? The Dilemma or Regulating the Individual Health Insurance Market, The Commonwealth Fund, February 2005.

[15] D. Bernard and J. Banthin, *Premiums in the Individual Insurance Market for Policyholders under age 65: 2002 and 2005*, Medical Expenditure Panel Survey Statistical Brief #202, Agency for Health Care Research and Quality, April 2008; M.A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, (March/April 2000):173–184; M. V. Pauly and A. M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Policy, Politics and Law*, Feb. 2000 25(1):9–26.

[16] D. Bernard and J. Banthin, 2008.

[17] K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006).

[18] S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[19] K. Klein, S. A. Glied, and D. Ferry, *Entrances and Exits: Health Insurance Churning, 1998–2000* (New York: The Commonwealth Fund, Sept. 2005).

adults lost access to employer-based coverage from 2000 to 2006, there has been virtually no change in the number of people covered by individual market insurance. Loss of employer coverage has led to higher levels of uninsured individuals, not to higher levels of individual coverage.[20] Those who are covered by individual health insurance plans are much less satisfied with their coverage than those covered by employer plans, and are likely to drop such coverage if and when more desirable coverage is available from employers or public programs. Only a third of those with individual coverage rate their coverage as excellent or very good.[21]

Medicare

Medicare and Medicaid have more than 40 years' experience covering the sickest and poorest beneficiaries. Their experience and expertise at enrolling and covering high-risk individuals make them natural candidates for covering a share of the uninsured who are least attractive to private insurers. Two-thirds of the uninsured have incomes below twice the poverty level or are in only fair or poor health. Public programs provide benefit packages well-suited to their needs.

With Medicare's broad risk pooling, the sick are automatically cross-subsidized by the healthy. Administrative costs in Medicare, as well as in the Medicaid program, average less than 2 percent of premiums, while large employer plans expend 5 percent to 15 percent of premiums and nongroup plans 25 percent to more than 40 percent.[22]

In addition, Medicare costs are lower than private coverage because the program pays prices for hospitals, physicians, and other health care providers that are lower than private insurance market prices. Even so, Medicare continues to experience high provider participation rates. Surveys show that Medicare beneficiaries are more likely than those who are privately insured to report that they have never encountered a delay in getting a physician appointment for routine care of an illness or injury.[23] Three-fourths of those covered by Medicare and by private insurance report no difficulties in finding a primary care physician, and Medicare beneficiaries are somewhat more likely than those covered

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[20] C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

[21] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families, The Commonwealth Fund, September 2006.

[22] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M.A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, (March/April 2000):173–184.

[23] MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.

by private insurance to report that they did not encounter problems finding a specialist physician.

Compared with health insurance coverage for those under age 65, Medicare beneficiaries report better access to health care services and financial protection from burdensome medical bills. Medicare beneficiaries age 65 and over are less likely to report going without needed care in the past year due to costs.[24] In particular, Medicare beneficiaries are less likely than nonelderly adults covered by employer plans or individual coverage to report access problems due to cost, such as not going to a doctor when needed medical attention, not filling a prescription, skipping a medical test, treatment, or follow-up visit recommended by a doctor, or not seeing a specialist when a doctor thought it was needed. Medicare's cost-sharing, however, can be a deterrent to care for lower-income beneficiaries or those without supplemental coverage.[25]

Medicare originally did not cover preventive services, but preventive care was gradually added, beginning in the 1990s and now covers women's preventive services, pneumococcal pneumonia and influenza vaccine, among other services. Gaining Medicare coverage greatly improves access to preventive services for those who were uninsured prior to becoming eligible.[26]

In addition to ensuring access to needed care, Medicare's other major goal was to provide financial protection to beneficiaries. Studies have documented that Medicare beneficiaries are less likely than adults under age 65 to report problems paying medical bills.[27] Medicare beneficiaries are less likely than those under age 65 to report times when they had difficulty paying or were unable to pay their bills, were contacted by a collection agency concerning outstanding medical bills, or had to change their way of life significantly in order to pay their bills.

Despite these reports from beneficiaries, elderly beneficiaries spend an average of 22 percent of income on premiums and out-of-pocket health care costs. This is projected

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[24] Karen Davis and Sara Collins, "Medicare at Forty," *Health Care Financing Review*, (Winter 2005–2006):53–62; Karen Davis, Cathy Schoen, Michelle Doty et al., "Medicare vs. Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (October 9, 2002): W311–324.

[25] Rice, T. and Matsuoka, K.Y.: The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors. *Medical Care Research and Review* 61:415–452, December 2004.

[26] McWilliams, J. M., et al.: Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults. *Journal of the American Medical Association* 290(6):757–64, 2003.

[27] S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans*, Commonwealth Fund, June 2005.

to grow to 30 percent by 2025.[28] Few older adults going into retirement have substantial savings from which to draw to meet these expenses.[29]

Medicare beneficiaries are much more likely to rate their insurance as excellent or very good than are those covered by employer plans or individual coverage.[30] Two-thirds (68%) of elderly Medicare beneficiaries rate their insurance as excellent or very good, compared with 44 percent of those with employer coverage, 41 percent of those with individual coverage, and 54 percent of those with Medicaid coverage.

Medicare beneficiaries are also more likely than those under age 65 and covered by private insurance to report being very or somewhat confident that they will get the best medical care available when they need it. Aged Medicare beneficiaries report more choice in where to go for medical care, compared with nonelderly adults.[31]

The high satisfaction of beneficiaries with coverage is also reflected in the importance beneficiaries attach to qualifying for Medicare coverage. The Commonwealth Fund Survey of Older Adults found that almost three-fourths of Medicare beneficiaries ages 50 to 70 said it was "very important" to become eligible for Medicare.[32] This was particularly true of disabled Medicare beneficiaries ages 50 to 64, 84 percent of whom said it was very important to become eligible for Medicare.

Medicare has often been an innovative leader in provider payment reform. Its DRG (diagnosis-related-group) method of hospital payment introduced in 1983 shortened hospital lengths of stay by 10 percent. Its RBRVS (resource-based relative value schedule) method of physician payment introduced in 1992 has been widely used by private insurers, and facilitated the growth of managed care discounted networks in the mid-1990s. Medicare has had some success with demonstrations of new payment methods, and is launching others (e.g., a newly announced acute episode of care bundled

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[28] Maxwell, S., Storeygard, M., and Moon, M.: *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures*, The Commonwealth Fund, November 2002.
[29] Collins, S. R., Doty, M. M., Davis, K., Schoen, C. Holmgren, A. L., and Ho, A.: *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey*. The Commonwealth Fund. New York, NY. March 2004.
[30] K. Davis and S. Collins, "Medicare at Forty," *Health Care Financing Review*, (Winter 2005–2006):53–62; Karen Davis, Cathy Schoen, Michelle Doty et al., "Medicare vs. Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (October 9, 2002): W311–324.
[31] K. Davis and S. R. Collins, "Medicare at Forty," *Health Care Financing Review*, Winter 2005–2006 27(2):53–62.
[32] Collins, S. R., Davis, K., Schoen, C., Doty, M. M., How, S. K., and Holmgren, A. L.: *Will You Still Need Me? The Health and Financial Security of Older Americans: Findings from The Commonwealth Fund Survey of Older Adults.* The Commonwealth Fund. New York, NY. June 2005.

payment method for hospitals and physicians).[33] However, both Medicare and private insurers could move much more quickly to offer new methods of payment for patient-centered medical homes, physician group practices, hospital systems that employ hospitalist physicians, and integrated delivery systems that are willing to be accountable for the total care of patients and willing and able to assume financial risk for a broader continuum of care over time.[34]

Medicare, as the largest single payer for health care, could also use its purchasing leverage to require provider user of electronic information technology and evidence-based medicine. It has begun a major effort to report quality information at the provider level publicly, but these initiatives could be accelerated. It could also be granted greater flexibility to translate lessons learned from its demonstrations on rewarding providers for excellence into payment policy more rapidly.

Medicaid

Medicaid, the nation's safety net health insurance program, covers more than 50 million people, including 41 percent of all births, nearly two-thirds of nursing home residents, 44 percent of persons with HIV/AIDS, and one of five people with severe disabilities.[35] Without Medicaid, we would have far more than 47 million uninsured.[36] In particular, state expansions in eligibility in Medicaid and SCHIP over the last decade have helped offset the declines in health insurance for children. The number of states in which 16 percent or more of children under age 18 were uninsured fell from nine in 1999–2000 to five in 2005–2006. In contrast, the number of states in which 23 percent or more of the adult population under age 65 was uninsured jumped from two in 1999–2000 to nine in 2005–2006.[37] Coverage eligibility for parents and adults without children in Medicaid and SCHIP varies greatly across states: 14 states cover parents with incomes up to 50

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[33] S. Guterman and M. P. Serber, Enhancing Value in Medicare: Demonstrations and Other Initiatives to Improve the Program, The Commonwealth Fund, January 2007; J. Reichard, "Medicare Hopes to Bundle Way to Better Hospital Care," *CQ HealthBeat*, May 16, 2008.

[34] K. Davis and S. X. Guterman, 2007. "Rewarding Excellence and Efficiency in Medicare Payments." *Milbank Quarterly*, vol. 85, no. 3 (September 2007), pp. 449-468; K. Davis, 2007. "Paying for Episodes of Care and Care Coordination," *NEJM*, vol. 356, no. 11 (March 15) pp. 1166-1168; A. Mutti and C. Lisk, "Moving Toward Bundled Payments Around Hospitalizations," presentation to Medicare Payment Advisory Commission, Washington, DC, April 9, 2008.

[35] Kaiser Commission on Medicaid and the Uninsured.

[36] Rowland, D. Medicaid—Implications for the Health Safety Net. *New England Journal of Medicine*. October 6, 2005; 353(14):1439–41.

[37] 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, June 2007). Updated Data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

percent of poverty, approximately equivalent to an annual income of just over $10,000 for a family of four.[38] Thirty-four states provide no Medicaid coverage at all for adults who do not have children.

Elderly and disabled Medicaid beneficiaries account for one-fourth of Medicaid enrollees, but 70 percent of Medicaid medical care outlays. Medicaid provides many services needed for patients with complex medical problems not typically covered by private plans. For example, 35 percent of Medicaid spending goes for long-term care. Medicaid is also a major source of support for safety net providers, accounting for 39 percent of the revenues of public hospitals and 37 percent of the revenues of safety-net clinics.[39]

Medicaid has been successful in improving access to care for both low-income adults and children.[40] Compared with uninsured adults, adults covered by Medicaid are much more likely to have a regular source of care, less likely to have postponed seeking care because of cost, or report that there was a time when they failed to receive needed care or not being able to afford a prescription drug.[41] Similarly, children covered by Medicaid are more likely to have a usual source of care than uninsured children, more likely to have seen a physician in the last two years, and more likely to have had a dental visit in the last two years.[42]

States have the chance to test-drive promising approaches designed to suit the needs of their populations. Iowa has reduced the growth in its Medicaid outlays by 3.8 percent over eight years through primary care case management, similar to patient-centered medical homes.[43] North Carolina has improved care, reduced pediatric hospitalization rates, and saved money in its Medicaid program through Community Care of North Carolina, an enhanced primary care case management system and patient-

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[38] Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs, 2006" and "Income Eligibility for Parents applying for Medicaid, 2006" available online at http://www.statehealthfactsonline.org.

[39] Kaiser Commission on Medicaid and the Uninsured, based on *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, October 2006. KCMU Analysis of 2006 UDS Data from HRSA.

[40] Diane Rowland and Jim Tallon, "Medicaid: Lessons Drawn from a Decade," *Health Affairs*, (January/February 2003): 138–144.

[41] Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data.

[42] Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC. 2007 and Summary of Health Statistics for U.S. Children: NHIS, 2006.

[43] E. T Momany, S. D Flach, F. D. Nelson, and P. C. Damiano,"A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Research and Educational Trust* 41:4, Part I (August 2006): 1357–1371.

centered medical home model of care.[44] Vermont is using state-employed nurses to assist physician practices with chronic care management. Yet, more could be done to share best practices and accelerate the spread of these innovative models to other states.

States are also investing in electronic medical information capacity to ensure that information travels with patients, provide physicians with decision support to enhance outcomes, and reduce the risk of errors and duplication of effort. Other state initiatives aim to directly reduce preventable hospitalizations and re-admissions. New York recently implemented recommendations of a Commission to close excess hospital capacity. State governments in Massachusetts, Minnesota, Washington, and Wisconsin are employing value-based purchasing in their state public employee or Medicaid programs and joining with other payers to improve quality, reduce administrative cost, provide financial incentives, and leverage health system change.[45]

Public Programs and Private Insurers

It is important to note that public insurance programs work hand-in-hand with—not to the exclusion of—the private market. While funded by the government, Medicare and Medicaid use private insurers when it is efficient to do so. Medicare and Medicaid purchase services from private managed care plans and make extensive use of private insurers as administrative claims payment agents. By utilizing the private market as appropriate, public programs are able to offer beneficiaries a wide array of options.

Public programs lower the cost of private coverage because they enroll everyone who meets statutory age or income criteria, regardless of health status. A study for The Commonwealth Fund found that if the sickest 2 percent were excluded from the nongroup private insurance market, the average cost of coverage would drop by more than 20 percent.[46] Clearly, Medicare and Medicaid help private markets work by covering the elderly, disabled, special needs children, persons with HIV/AIDS, and those with serious mental illnesses. Expanding public programs to cover the sickest and poorest of the uninsured would help ensure affordable private insurance premiums for many of the remaining uninsured. By reducing bad debt and the burden of charity care, expanding public programs would also enhance the financial stability of rural and inner city hospitals, academic health centers, community health centers, and other safety net

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[44] L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007.
[45] S. Silow-Carroll and T. Alteras, Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve, The Commonwealth Fund, August 2007.
[46] Sherry A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, The Commonwealth Fund, January 2001.

providers—many of which have experienced an increased uninsured patient load in recent years.

Medicare and Medicaid have also incorporated private managed care plan offerings with the belief that such organizations have more flexibility to manage utilization of services and create high-value provider networks. However, there is considerable evidence that rather than establishing a level playing field, Medicare is paying more for the care of beneficiaries enrolled in Medicare Advantage plans. Plans are required to share surpluses with beneficiaries in the form of lower premiums or enhanced benefits. As a result, Medicare beneficiary enrollment in such plans, especially Medicare private fee-for-service plans, is climbing sharply. Leveling the playing field between Medicare's "self-insured" coverage and Medicare Advantage is essential if the strengths of both direct public coverage and private plans are to be realized and both parts of Medicare are to bring value-added to providing coverage for elderly and disabled beneficiaries by coordinating care, instituting payment methods that reward quality and efficiency, and lowering administrative overhead. Benefits may need to be standardized to inform enrollee decisions on the value of different offerings. The current complexity and lack of transparency in Medicare Advantage plans currently makes informed choices difficult.

Major Health System Challenges

The U.S. health system is under serious stress from eroding health insurance coverage, missed opportunities to help Americans live healthy lives, and rising costs. The single most important determinant of access to needed health care and the quality of care received is health insurance coverage. Health insurance coverage has deteriorated markedly over the last six years. In 2006, 47 million Americans were uninsured, up from 39.4 million in 2000.[47] Most of the loss of coverage comes from an erosion of employment-based coverage, especially for lower-wage workers.

There are very different trends for adults and children. Rates of uninsured adults increased over the past six years in nearly all states (from 17.8 percent to 20.0 percent overall), while rates of uninsured children declined in the majority of states (from 12.0 to 11.3 percent overall).[48]

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[47] S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, A Roadmap to Health Insurance for All: Principles for Reform, The Commonwealth Fund, October 2007.
[48] Ibid.

The explanation for this differential pattern lies in the SCHIP program. Offering states federal matching funds to expand coverage to low-income children has worked and has encouraged states to design programs to expand much needed coverage to low-income uninsured children. As a result, the percentage of low-income, uninsured children dropped from 22.3 percent to 14.9 percent between 1997 and 2005. SCHIP is a major success story—improving access to care and health outcomes for 6 million low-income children.[49] Relative to uninsured children, children enrolled in Medicaid or SCHIP reported much lower unmet health care needs (2% vs. 11%). Uninsured children who gained coverage through SCHIP received more preventive care; in addition, their parents reported better access to care and better communications with providers. One evaluation found that children who were uninsured and gained coverage through Medicaid or SCHIP had fewer asthma-related attacks after enrollment (3.8 versus 9.5 attacks), with significant improvements in quality of care.[50]

Deterioration in insurance coverage and access to care is not limited to the uninsured. Even individuals with insurance coverage are increasingly at risk of being underinsured, defined as deductibles exceeding 5 percent of income or out-of-pocket expenses exceeding 5 percent of income for low-income families or 10 percent of income for higher-income families.[51] As of 2007, there were an estimated 25 million underinsured adults in the United States, up 60 percent from 2003. In terms of access problems and financial stress, underinsured people—even though they have coverage all year—report experiences similar to the uninsured. More than half of the underinsured (53%) and two-thirds of the uninsured (68%) went without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment. Only 31 percent of adequately insured adults went without such care.

Much of this growth comes from the ranks of the middle class. While low-income people remain vulnerable, middle-income families have been hit hardest. For adults with incomes above 200 percent of the federal poverty level (about $40,000 per year for a family), the underinsured rates nearly tripled since 2003. Other studies have also documented that most of the increased financial stress is on lower-wage and middle-

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[49] J. M. Lambrew, *The State Children's Health Insurance Program: Past, Present, and Future*, The Commonwealth Fund, February 2007.
[50] Ibid.
[51] C. Schoen, S. R. Collins, J. L. Kriss, M. M. Doty, How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007, *Health Affairs* Web Exclusive, June 10, 2008.

income families, where the proportion of families spending more than 10 percent of income on premiums and medical bills has increased.[52]

About half of the underinsured (45%) and uninsured (51%) reported difficulty paying bills, being contacted by collection agencies for unpaid bills, or changing their way of life to pay medical bills. Many reported that they took on a loan, a mortgage against their home, or credit card debt to pay their bills, suggesting that these financial difficulties had the potential to linger into the future. In contrast, only 21 percent of insured adults reported financial stress related to medical bills.[53]

Inadequate coverage can also lead to more costly use of emergency rooms and hospitalizations that could have been avoided with better primary care. Uninsured people with chronic conditions, for example, are less likely to report managing their chronic conditions, not filling or skipping taking prescription drugs, and more likely to experience emergency room use and hospitalization.[54]

A system of universal health insurance coverage with comprehensive benefits is needed to address the shocking disparities in care and unbearable financial burdens a growing number of Americans face. In fact, states that do a better job on ensuring health insurance coverage and access to care also experience higher-quality care.[55] Yet, real progress will only come when the U.S. also implements measures to enhance the value achieved for the dollars we invest in health care.[56]

Health spending is rising faster than the economy as a whole and faster than workers' earnings. The U.S. spends 16 percent of gross domestic product (GDP) on health care, compared with 8 percent to 10 percent in most major industrialized nations.[57] The Centers for Medicare and Medicaid Services (CMS) projects that growth in health spending will continue to outpace GDP over the next 10 years. Wide variations in cost

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[52] Jessica S. Banthin, Peter Cunningham, Didem Bernard, "Financial Burden for Health Care, 2001–2004," forthcoming in *Health Affairs* January 2008.
[53] Schoen, Collins, Kriss, and Doty, "How Many are Underinsured?," 2008.
[54] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund, Apr. 2006).
[55] 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, The Commonwealth Fund Commission on a High Performance Health System, June 2007.
[56] Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, The Commonwealth Fund, November 2007.
[57] B. Frogner and G. Anderson, Multinational Comparisons of Health Systems Data, 2005 (New York, NY: The Commonwealth Fund, 2006).

and quality across the U.S. underlie these national trends, indicating opportunities to increase efficiency. In recent years, insurance administrative overhead has been rising faster than other components of health spending, while pharmaceutical spending has increased more rapidly than spending on other health care services.

From a public perspective, the most desirable strategies to address high and rising health care costs would involve: 1) eliminating duplicative or unnecessary care and reducing administrative overhead; 2) preventing illnesses or complications and detecting conditions at an early stage; 3) avoiding unneeded hospitalizations; and 4) enhancing productivity and efficiency in the provision of care. Although there may come a time when the nation is compelled to make a tradeoff between spending on health care and other high priorities, there is currently ample evidence that we can achieve savings and efficient payment, insurance, and care delivery systems and still improve health outcomes, quality of care, and access to care.

Health care costs vary substantially across the U. S. For example, the *Dartmouth Atlas of Health Care* shows that Medicare outlays per beneficiary adjusted for area wage costs ranged from $4,530 in Hawaii to $8,080 in New Jersey in 2003. Yet studies find no systematic relationship between spending more and achieving longer lives or higher quality of care for Medicare beneficiaries. Evidence of extensive variations in costs and quality and studies documenting provision of duplicative, inappropriate, and unnecessary care have led the Institute of Medicine and other experts to conclude that the U.S. health care system could improve quality, access, and cost performance. For example, the Commonwealth Fund State Scorecard on Health System Performance found a high correlation between Medicare spending per beneficiary across states with Medicare hospital readmissions with 30 days of initial discharge.[58] It is clear there are opportunities to improve the yield we reap given the resources we invest in health care.

International Experience

Nothing makes it clearer that something is amiss than the contrast between health spending in the U.S. and health spending in other countries. The U.S. spends $2 trillion, or $7,000 per person on health care—more than twice what other major industrialized countries spend.[59] Even within the context of its substantial economy, the U.S. spends 16

[58] 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*, The Commonwealth Fund Commission on a High Performance Health System, June 2007.

[59] A. Catlin et al., "National Health Spending In 2006: A Year of Change For Prescription Drugs," *Health Affairs*, Jan./Feb. 2008 27, no. 1: 14-29.

percent of GDP on health care, while other countries spend 8 percent to 10 percent. Health spending in the U.S. rose faster than other countries in the last five years, while countries with high spending, such as Germany and Canada, moderated their growth, and countries with low spending, such as the U.K., increased outlays as a matter of deliberate public policy.[60]

All countries face rising costs from technological change, higher prices of pharmaceutical products, and aging of the population. In fact, the population in most European countries already has the age distribution the U.S. will experience in 20 years. Nor is the difference in spending attributable to rationing care. In fact, the U.S. has lower rates of hospitalization and shorter hospital stays than most other countries.[61] One difference is the U.S. tends to pay higher prices for prescription drugs; in other countries governments typically negotiate on behalf of all residents to achieve lower prices.[62]

The U.S. is alone among major industrialized nations in other respects. Over half of health care spending is paid for privately, compared with about one-fourth or less in other countries. Ironically, because the U.S. is so expensive, the government—while it accounts for only 45 percent of all health care spending—spends as much as a percent of GDP on health care as do other countries with publicly financed health systems.[63]

Another striking difference is that the U.S. has fewer physicians per capita than other countries, and many more of those physicians are specialists.[64] Research both within the U.S. and across countries has shown that health care spending is higher and health outcomes worse when there is a lower ratio of primary care to specialist physicians.[65]

Health Outcomes

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[60] Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007).
[61] Frogner and Anderson, *Multinational Comparisons of Health Systems Data*, 2006.
[62] G. F. Anderson et al., "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004):W4-396–W4-404; Gerard Anderson et al., "It's the Prices, Stupid: Why the United States is So Different from Other Countries," *Health Affairs* (May/June 2003): 89–105.
[63] B. Frogner and G. Anderson, *Multinational Comparisons of Health Systems Data, 2005* (New York, NY: The Commonwealth Fund, 2006).
[64] G. F. Anderson, B. K. Frogner, R.A. Johns, and U.E. Reinhardt, "Health Care Spending and Use of Information Technology in OECD Countries," *Health Affairs* (May/June 2006):819–831.
[65] J. S. Skinner, D. O. Staiger, and E. S. Fisher, "Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs* Web Exclusive (Feb. 7, 2006):W34–W47.; B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly*, 2005 83(3):457–502.

The bottom line is that the U.S. is not receiving value commensurate to the resources it commits to health care. Many Americans would gladly pay more for health care if it meant longer lives, improved functioning, or better quality of life. Yet, on key health outcome measures the U.S. fares average or worse. For example, on mortality from conditions "amenable to health care"—a measure of death rates before age 75 from diseases and conditions that are preventable or treatable with timely, effective medical care—the U.S. ranked 19th out of 19 countries, with a death rate 30 percent higher than France, Japan, and Australia.[66] If the U.S. performance were comparable to the best three countries, it could save 101,000 lives a year.

The Commonwealth Fund supported an international working group on quality indicators, an effort that is now being continued and extended by the Organization of Economic Cooperation and Development. On most measures, the U.S. was neither the best nor the worst on clinical quality outcomes. It had the best outcome of five countries on five-year relative survival rates for breast cancer, but the worst outcome on five-year relative survival rates for kidney transplants.[67] For the resources it commits to health care, it should be achieving much better results.

Access to Care

The U.S. is alone among major industrialized nations in failing to provide universal health coverage. This undermines performance of the U.S. health system in multiple ways, but the most troubling is the difficulty Americans face in obtaining access to needed care. Almost 40 percent of U.S. adults report one of three access problems because of costs: not getting needed care because of cost of a doctor's visit, skipping medical test, treatment, or follow-up because of costs, or not filling prescription or skipping doses because of cost.[68] Further, Americans pay far more out-of-pocket for health care expenses and are more subject to financial burdens as a result of either no health insurance or inadequate health insurance.

But aside from the evident failure of the U.S. health system to guarantee financial access to care, the organization of care also fails to ensure accessible and coordinated care for all patients. In fact, the U.S. stands out for patients who report either having no

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[66] E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, *Health Affairs*, January/February 2008, 27(1):58–71.

[67] P. S. Hussey, G. F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs (*May/June 2004).

[68] K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007.

regular doctor or having been with their physician for a short period of time. About half of Americans with health problems have been with the same physician for five years or more, compared with two-thirds to three-fourths of patients in other countries.[69] Managed care plans with restricted networks exacerbate poor continuity of care, as patients may need to change physicians when their employers change coverage. In contrast, many other countries encourage or require patients to identify a "medical home," which is their principal source of primary care responsible for coordinating specialist care when needed.

These differences in care arrangements and the relative undersupply of primary care physicians contribute to more Americans reporting an inability to get care when seeking or needing medical attention—whether in the doctor's office during the day or on nights and weekends. Almost one-fourth of sicker adults in the U.S. and one-third of Canadian adults wait six or more days to get in to see a doctor when sick or need medical attention, compared with only one of seven or less in New Zealand, Germany, Australia, or the UK.[70] The U.S. has short waiting times for elective surgery such as hip replacements or cataract operations, but quick access to primary care is rarer in the U.S.

The U.S. also stands out for difficulty obtaining care on nights and weekends. Three of five sicker adults in the U.S. report that it is difficult to obtain care off-hours without going to the emergency room, compared with one of four in Germany and New Zealand. In a recent survey of primary care physicians, only 40 percent of U.S. physicians say they have an arrangement for after-hours care, compared with virtually all primary care physicians in the Netherlands.[71]

These differences in accessibility of basic primary care are a reflection of policy decisions made by different countries.[72] Most fundamentally, of course, other countries make primary care financially and physically accessible to their residents. In contrast, the U.S. puts substantial financial barriers to primary care including gaps in insurance and significant deductibles that pose obstacles to primary care even for the insured. Other

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[69] C. Schoen, R. Osborn, P. T. Huynh, M. Doty, J. Peugh, and K. Zapert, "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive (Nov. 2, 2006):w555-w571.

[70] Schoen, et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* 24 (2005):w509-525 (published online 3 November 2005; 10.1377/hlthaff.w5.509.)

[71] Davis, Schoen, Schoenbaum, Doty, Holmgren, Kriss, and Shea, *Mirror, Mirror on the Wall*, 2007.

[72] Schoen, et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* 24 (2005):w509-525 (published online 3 November 2005; 10.1377/hlthaff.w5.509.); Schoen, Osborn, Huynh, Doty, Peugh, and Zapert, "On the Front Lines of Care," 2006.

countries provide relatively higher payments to primary care physicians and support physician practices in organizing after-hours care. These policies increase the attractiveness of primary care practice.

Quality of Care

The U.S. faces a major increase in chronic conditions as its population ages. Sicker adults with multiple chronic conditions are particularly at risk for poor quality or uncoordinated care. Coordination of information across sites of care is essential for safe, effective, and efficient care. Measured by patients who said that test results or medical records were not available at the time of appointments or that physicians duplicated tests, one-third of sicker U.S. patients experience breakdowns in coordination, compared with about one-fifth in other countries.

Patient safety has received heightened attention in the U.S. in the last five years. Despite this, patients in the U.S. are more likely to report experiences of medical errors than residents of other countries, including medical or medication errors, hospital acquired infections, or incorrect lab or diagnostic tests or delay in communicating abnormal results to patients. Overall one-third of sicker adults in the U.S. reported such errors in 2005, compared with one-fourth in other countries. The frequency of errors was strongly associated with the number of doctors involved in a patient's care. Almost half of U.S. sicker adults who see four or more physicians reported such errors.

In the U.S., patients face a more fragmented health care system, are cared for by different physicians for different conditions, have poorer care coordination, and take more medications, which contribute to higher rates of medical errors.[73] More things can and do go wrong when care is provided by multiple parties. In 2006, 42 percent of U.S. adults reported one of four experiences in the prior two years: their physician ordered a test that had already been done; their physician failed to provide important medical information or test results to other doctors or nurses involved in their care; they incurred a medical, surgical, medication, or lab test error; or their physician recommended care or treatment that in their view was unnecessary.[74]

Efficiency

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[73] Schoen, et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* 24 (2005):w509-525 (published online 3 November 2005; 10.1377/hlthaff.w5.509.)

[74] C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).

U.S. physicians are highly trained and U.S. hospitals are well-equipped compared with hospitals in other countries.[75] Some of the waste and missed opportunities to provide high-quality, safe care may be attributable to the slower adoption of information technology in the U.S. About one-fourth of U.S. primary care physician report use of electronic medical records (EMRs), compared with over nine of 10 primary care physicians in the Netherlands, New Zealand, and the U.K. These countries often obtain financial support from their governments directly or through reimbursement incentives.

Primary care physicians in other countries not only have basicEMRs but an array of functionality, often facilitated by government-arranged systems of information exchange. Less that one-fifth of U.S. primary care physicians routinely send reminder notices to patients about preventive or follow-up care, compared with over nine of 10 in New Zealand.[76] Nine of 10 primary care physicians in the Netherlands, New Zealand, and the U.K. receive alerts about potential problems with prescription drug dosage or interaction, compared with one-fourth who receive such notices in the U.S. through computerized systems. When assessed against 14 different functions of advanced information capacity (EMR, EMR access to other doctors, access outside office, access by patient; routine use electronic ordering tests, electronic prescriptions, electronic access to test results, electronic access to hospital records; computerized reminders; prescription alerts; prompt tests results; easy to list diagnosis, medications, patients due for care), one of five U.S. primary care physicians—compared to nine in 10 in New Zealand—reported having at least seven out of the 14 functions.

The U.S. relies on market incentives to shape its health care system, while other countries use quality-of-care financial incentives with physicians. Only 30 percent of U.S. primary care physicians report having the potential to receive financial incentives based on quality of care, including potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or quality improvement activities.[77] In contrast, nearly all primary care physicians in the U.K. and more than 70 percent in Australia and New Zealand report such incentives.

The reliance on private insurance and the fragmentation of the U.S. health insurance system—with people moving in and out of coverage and in and out of plans,

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[75] R. J. Blendon, C. Schoen, C. M. DesRoches, R. Osborn, K. Zapert and E. Raleigh, "Confronting Competing Demands To Improve Quality: A Five-Country Hospital Survey *Health Affairs*, 23, no. 3 (2004): 119-135.
[76] Schoen, Osborn, Huynh, Doty, Peugh, and Zapert, "On the Front Lines of Care," 2006.
[77] Ibid.

and changing their usual source of care—all contribute to high administrative costs for insurers and for health care providers.[78] In 2006, the U.S. health system spent $145 billion on administrative expenses, not including administrative expenses incurred by health care providers.[79]

With its mixed public-private system of financing, the U.S. devotes a much higher share of health spending to administration. The U.S. spends 7.5 percent of total health expenditures on insurance administrative expense.[80] In 2005, if the U.S. had been able to lower the share of health care spending devoted to insurance overhead to the same level found in the three countries with the lowest rates (Finland, Japan, and Australia), it would have saved $102 billion.[81]

Innovations in Other Countries: Examples of High Performance

The key question is how the U.S. might achieve improved coverage and greater efficiency while maintaining or improving the quality of care for all. Given its history, institutions, and preferences, the U.S. is unlikely to adopt another country's health system in all its aspects, but it can learn from examples of practices that contribute to high performance. The Commonwealth Fund's has 10 years of experience conducting comparative surveys of the public and health professionals in selected countries and sponsoring annual symposia for top government officials and experts focused on innovations. From this experience, numerous examples of innovative practices and high health system performance stand out. I have also had the opportunity of serving on a team of economists charged with preparing a report for the Danish parliament that critiqes the Danish health system.[82] I'm pleased to share with the Committee selected innovations that stand out as possibilities for the U.S. to consider, highlighting examples of high performance and innovative practices in Denmark, the Netherlands, Germany, and the U.K.

I will begin with Denmark, which I visited again in October 2006. Public satisfaction with the health system is higher in Denmark than any country in Europe.[83] In

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[78] Karen Davis, "Time For Change: The Hidden Costs of a Fragmented Health Insurance System." Invited Testimony, Senate Special Committee on Aging, March 10, 2003.
[79] A. Catlin et al., "National Health Spending In 2006: A Year of Change For Prescription Drugs," *Health Affairs*, Jan./Feb. 2008 27, no. 1: 14-29.
[80] C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457-w47.
[81] Ibid.
[82] K. Davis, 2002. "The Danish Health System Through an American Lens," *Health Policy*, 59:119–132.
[83] E. Moussiapolos reference cited in K. Davis, 2002. "The Danish Health System Through an American Lens," *Health Policy*, 59:119–132.

my view this is related to the emphasis Denmark places on patient-centered primary care, which is highly accessible and has an outstanding information system that assists primary care physicians in coordinating care. Denmark, like most European countries, has a universal health insurance system with no patient cost-sharing for physician or hospital services. Every Dane selects a primary care physician who receives a monthly payment per patient for serving as the patient's medical home, in addition to fees for services provided. Incomes of primary care physicians are slightly higher than those of specialists, who are salaried and employed by hospitals. Primary care physicians own their own practices, which are open from 8 am to 4 pm, and patients can easily obtain care on the same day if they are sick or need medical attention.

This system of primary care contributes to highly accessible basic and preventive care and lower total health care expenditures. Denmark is rated as one of the best countries on primary care as measured by high levels of first-contact accessibility, patient-focused care over time, a comprehensive package of services, and coordination when services must be provided elsewhere.[84]

What most impresses me about the Danish system is its organized "off-hours service." In every county, clinics see patients at nights and weekends. Physicians sit at phone banks in the back office of the clinic and directly take any calls from patients. They sit in front of computer terminals and can access computerized patient records. After listening to a patient's complaint, they can electronically prescribe medications, or ask the patient to come in to see a physician on duty. Physicians are paid for telephone consultations, and paid a higher fee if the problem can be handled over the phone. The patient's own primary care physician receives an e-mail the next day with a record of the consultation.

All primary care physicians (except a few nearing retirement) are required to have an EMR system, and 98 percent do. Danish physicians are now paid about $8 for e-mail consultations with patients, a service that is growing rapidly. The easy accessibility of physician advice by phone or e-mail, and electronic systems for prescriptions and refills cuts down markedly on both physician's and patients' time. Primary care physicians save

[84] B. Starfield, "Why More Primary Care: Better Outcomes, Lower Costs, Greater Equity," Presentation to the Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006.

an estimated 50 minutes per day from information systems that simplify their tasks, a return that easily justifies their investment in a practice information technology system.[85]

Physicians, whether seeing patients through the off-hours service or during regular hours, are supported by a nationwide health information exchange, maintained by a nonprofit organization called MedCom. An assessment of information systems in 10 countries ranks Denmark at the top, and concludes that countries with a single unifying organization setting standards and responsible for serving as an information repository have the highest rates of information system functionality.[86] It is a repository of electronic prescriptions, lab and imaging orders and test results, specialist consult reports, and hospital discharge letters—accessible to patients, authorized physicians, and home health nurses. It now captures 87 percent of all prescription orders, 88 percent of hospital discharge letters, 98 percent of lab orders, and 60 percent of specialist referrals. Yet, its operating cost is only $3 million a year for a population of 5.3 million, or 60 cents per person per year.

Denmark is not the only country with cutting-edge innovations to improve the quality, accessibility, and efficiency of health care. Germany is a leader in national hospital quality benchmarking, with real-time quality information on all 2,000 German hospitals with over 300 quality indicators for 26 conditions. Peers visit hospitals with substandard quality and enter into a "structured dialogue" about why that is the case. Typically, within a few years all hospitals come up to high standards. Germany has instituted disease management programs and clinical guidelines for chronic care, with financial incentives from insurance funds to develop and enroll patients and be held accountable for care with earlier results showing positive effects on quality.[87] Germany is also experimenting with an all-inclusive global fee for payment of care of cancer patients in Cologne.

The Netherlands also stands out. In 2006, it introduced a very interesting system of competing private insurance plans, with half of funding coming from public taxation

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[85] I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.
[86] D. Protti, "A Comparison of Information Technology in General Practice in Ten Countries," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.
[87] Michael Hallek, "Typical problems and recent reform strategies in German health care - with emphasis on the treatment of cancer," Presentation to the Commonwealth Fund International Symposium, November 2, 2006.

funds to equalize risk across plans.[88] It also has a system of public reporting for quality data, as well as its own approach to primary care and "after-hours" care arrangements. Although most Dutch primary care practices are solo practices, they support each other through a cooperative that includes an after-hours nurse and physician call-bank service. The Dutch government funds nurse practitioners based in physician practices to manage chronic disease. Under national reforms implemented in 2006, payments to Dutch doctors now blend capitation, fees for consultations, and payments for performance.

In April 2004, the U.K. General Practitioner contract provided bonuses to primary care physicians for reaching quality targets. Far more physicians met the targets than anticipated, leading to a controversial cost over-run, but amply demonstrating that financial incentives do change physicians' behavior.[89] The U.K. National Institute of Clinical Effectiveness conducts cost-effectiveness review of new drugs and technology. The U.K. also publishes extensive information on hospital quality and surgical results by name of hospital and surgeon.

These are just a few examples of innovative practices that the U.S. might wish to investigate more closely and potentially adopt. Most, however, require leadership on the part of the central government to set standards, ensure the exchange of health information, and reward high performance on quality and efficiency.

Health Reform

Recently, my colleagues at The Commonwealth Fund and I developed a "Building Blocks" approach to achieving universal coverage through a seamless system of private and public health insurance that builds on what works best in our current health insurance system.[90] The framework for health coverage reform features a new public offering—Medicare Extra, which includes elements from Medicare and the Federal Employees Health Benefits Program. Medicare Extra would be available, along with private insurance plans, through a national "insurance connector." We then estimated the changes in insurance coverage, access to care, and costs under a framework founded on

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[88] W. P. M. M. van de Ven and F. T. Schut, Universal Mandatory Health Insurance in The Netherlands: A Model for the United States? *Health Affairs,* May/June 2008 27(3):771–81.

[89] T. Doran, C. Fullwood, H. Gravelle, D. Reeves, E. Kontopantelis, U. Hiroeh, and M. Roland, "Pay-for-Performance Programs in Family Practices in the United Kingdom," *New England Journal of Medicine,* 2006 355(4):375–384.

[90] 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; K. Davis, C. Schoen, and S. R. Collins, *The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings*, The Commonwealth Fund, May 2008.

the building blocks of private group insurance and this new comprehensive publicly sponsored health plan.

The Lewin Group estimated Medicare Extra rates that would be more than 30 percent lower than premiums typically charged for employer-sponsored plans, especially those in the small-group market. This is a result 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 also ensure improved coverage at lower costs for many employers, the self-employed, and insured individuals currently buying coverage on their own.

Simultaneously, coverage expansions could be linked to other health system reforms. These 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. This analysis illustrates that such a strategy has 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. Broader system reforms, if combined with coverage expansion, would also achieve federal budget savings that largely offset the cost of achieving universal coverage by years five to 10.

Health Insurance for All: The Building Blocks Framework

The Building Blocks framework for expanding health insurance coverage has six core components:

1. A structured choice of private plans and an enhanced Medicare-like publicly sponsored plan (Medicare Extra) made available through a new national insurance connector; insurance would be available to all at community-rated premiums that would not vary with health risks. The same premium rating provisions would apply inside and outside the connector.
2. A requirement that all individuals obtain health insurance coverage, with automatic enrollment of uninsured tax-filers through the personal income tax system.
3. Financial responsibility shared between employers and employees, with a requirement that all firms cover their workers or else contribute 7 percent of workers' earnings (up to $1.25 per hour) to a pool to help finance coverage.
4. An expansion of Medicaid and SCHIP that would enable coverage of all low-income adults and children below 150 percent of the federal poverty level, with

modest copayments for health care services, no premiums, and enhanced federal matching to cover additional costs to states.

5. Tax credits that offset any premium cost in excess of 5 percent of income for lower-income tax filers (15 percent-or-lower tax bracket) and 10 percent of income for higher-income tax filers (benchmarked to premium of the Medicare Extra plan).

6. Extension of improved Medicare Extra benefits to current Medicare beneficiaries; elimination of the two-year waiting period for Medicare coverage for people with disabilities; the ability of adults age 60 or older to buy in to Medicare; and the same financial protection on premiums as a percentage of income for Medicare beneficiaries as for nonelderly households.

Medicare Extra Benefits vs. Current Medicare Benefits

	Current Medicare benefits*	Medicare Extra
Deductible	Hospital: $1,024/benefit period Physician: $135/year Rx: $275/year**	Hospital/Physician: $250/year for individuals; $500 for families Rx: $0
Coinsurance	Physician: 20%	Physician: 10% Rx: 25% Preventive services: 0%
Ceiling on out-of-pocket	No ceiling	$5,000 for individuals; $7,000 for families
Insurance-related subsidies	Medicare Savings Programs Low-Income Subsidy	Ceiling of 5% of income for low-income beneficiary premiums or 10% if higher income

* See http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2488.

** Under "standard" plan. In 2008, only about 10% of national prescription drug plans offer the defined standard benefit. More frequently, plans eliminate the deductible and use tiered, flat-dollar copayments (see http://www.kff.org/medicare/upload/7762.pdf).

Building Blocks' Impact on Insurance Coverage

Based on estimates by the Lewin Group, the Building Blocks framework would achieve near-universal coverage: 44 million of the 47 million people in the U.S. who are currently uninsured would have health insurance, or 99 percent of the total U.S. population. Tax-filers with income above 150 percent of the poverty level who do not verify insurance coverage when filing personal income tax returns would be automatically enrolled in Medicare Extra and assessed a premium based on their income—5 percent of income in households in the 15-percent-or-lower marginal tax bracket, and 10 percent of income for

other households. Uninsured tax-filers with incomes below 150 percent of poverty would be automatically enrolled in Medicaid or SCHIP, with no premium assessed. Those remaining uninsured would largely be low-income non-tax-filers; these individuals could be retroactively enrolled in Medicaid or SCHIP when they seek health care.

Based on the Lewin Group estimates, about half of those individuals gaining insurance coverage under the Building Blocks framework would obtain their coverage through the national insurance connector and the new insurance products it makes available. The other half would be equally split between employer plans and Medicaid or SCHIP. The requirement that employers cover employees or contribute to coverage would persuade some employers to offer coverage. Premium assistance based on income would make it possible for more low-wage workers to take up their employers' offers of health coverage. In most states, healthy, working low-income adults with incomes up to 150 percent of the poverty level would, for the first time, be eligible for state low-income programs. By automatically enrolling tax-filers with incomes below 150 percent of poverty in Medicaid or SCHIP, the number of uninsured low-income adults would drop and the proportion of eligible individuals who participate would increase.

For the 49 million people with insurance who change coverage, their health coverage would improve or their premiums would be lower. Small businesses (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 buying it directly themselves. An estimated 32 million insured people covered by employers would switch and receive coverage through the connector. Enrollment directly through employer plans would also increase, if modestly, since some individuals now covered by Medicaid or SCHIP would switch to employer coverage, as would some who are now covered by individual insurance plans.

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, up from 53 percent to 63 percent of the population. 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. 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.[91] Given that many Americans are satisfied with their current coverage, offering choices is likely to garner greater support than requiring radical changes in existing insurance.[92]

An estimated 60 million Americans would be covered through the national insurance connector, including those individuals whose employers purchase insurance through the connector. Approximately two-thirds, or 40 million people, would obtain coverage through the Medicare Extra fee-for-service plan, and the remaining 20 million people would be in private plans. Combined with the modest increases in Medicare enrollment that would be gained by eliminating the two-year waiting period for disabled adults and by providing a buy-in option for adults ages 60 to 64, Medicare fee-for-service enrollment would increase from about 35 million to approximately 75 million.

The attraction of the Medicare Extra publicly sponsored option comes from its lower premiums compared with private plan offerings. For individuals under age 60, premiums are estimated to be $259 per month for single premiums and $702 per month for families in 2008.[93] In contrast, employer premiums for a single individual were $373 a month in 2007, and for a family were $12,106 a year, or over $1,000 a month.[94]

Premiums for Medicare Extra for individuals under age 60 represent significant savings—more than 30 percent below average employer premiums. If the differential persists over time, it might be expected that more switching would occur. Moreover, larger employers are likely to seek extension of the Medicare Extra option to their choices as well, leading to still further growth in enrollment. This could lead to a transformation of the private insurance market, as private insurers endeavor to "meet the competition" by lowering overhead, adopting a tougher stance in provider payment negotiations, and adopting innovative practices in pursuit of higher value or lower premiums.

For those people ages 60 to 64 who are buying into Medicare, monthly premiums are estimated to be $532 per month—again much lower than policies available to older

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[91] 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, Mar. 2007).
[92] 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 et al., *Listening to Workers: Findings from the Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (New York: The Commonwealth Fund, Jan. 2000).
[93] Schoen, Davis, and Collins, "Building Blocks for Reform," 2008.
[94] 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.

adults on the individual insurance market (if they are available at all, given many insurers' exclusions for preexisting health conditions or risks). As a result of eliminating the two-year waiting period for the disabled and implementing the new option to buy in, an additional 1 million uninsured older or disabled adults under age 65 would enroll in Medicare, and 2 million insured older or disabled adults would switch to Medicare coverage.

Building Blocks' Impact on Health Spending

One of the major barriers to enactment of universal health insurance coverage is the perception that it is extraordinarily costly. In fact, the estimated net effect on national health spending from implementing the Building Blocks framework is an increase of $15 billion, a relatively small amount that works out to less than 1 percent of the $2.4 trillion in estimated national health expenditures for 2008.

The voluntary shift of a substantial number of people into Medicare Extra coverage achieves significant savings, including $15.4 billion in lower administrative costs (after netting out the cost of establishing the insurance connector and administering income-related subsidies) and $22 billion in lower Medicare provider payment rates for individuals switching from private coverage. These savings would be even greater if the option of Medicare Extra were extended to all firms, not just those with fewer than 100 employees.

An increase in the use of health services ($52 billion) by newly insured, and more adequately insured, people is the primary source of greater health system spending. Indeed, a major goal of universal coverage is to reduce existing disparities in health care between the insured and uninsured, improve the receipt of preventive care, and make it more affordable to access services and medications for the control of chronic conditions.

Increasing Medicaid payment rates to the level of Medicare rates and reducing bad debts or discounts for the uninsured also have the effect of increasing outlays. These higher payments to providers are partially offset by an assessment on provider revenues (4% for hospitals, 2% for physicians) and elimination of current disproportionate share hospital payments that the government provides for care of the uninsured.

The Building Blocks framework would result in a reallocation of spending by federal and state governments, employers, and households. While the overall impact on health spending would be relatively minor, some sectors would gain while others would

lose, depending on the specific design and the specific sources of financing coverage. The most significant gainers, not surprisingly, would be uninsured and underinsured households who are relieved of the financial burdens of health care bills; estimated net savings for households in 2008 are $76 billion.

State governments would also see benefits. For 2008, their outlays would drop by $12 billion, as federal health insurance premium subsidies for low-wage workers replace some shared federal–state Medicaid outlays and yield some savings for state employee health insurance coverage. These savings, of course, could be redirected by reducing federal matching rates on Medicaid and making states budget-neutral, on average. However, given the variation in state Medicaid programs, some states would inevitably lose money under such a policy. Permitting certain states "fiscal windfalls," and avoiding state "shortfalls," likely increases the attractiveness of the proposal to states.

Employers that now provide coverage are estimated to save $24 billion in 2008 under the proposal, as the cost of dependents is shared with other employers. On the other hand, employers that do not currently cover employees would experience a cost increase of $45 billion. More employers might experience savings if Medicare Extra were made available to larger firms.

Given these specific design choices, the federal government has a net cost of $82 billion in 2008, stemming largely from the greater use of health services and reduced financial burdens on households. About half of this amount—$43 billion—comes from improved coverage and financial protection for Medicare beneficiaries to provide them with coverage comparable to that of adults under age 65.[95]

Over time, the national connector would give small firms and individual new choices. It would have the potential to stimulate a new, more constructive competitive dynamic, with innovations in private insurance and public systems reforms focused on access, quality and costs. If coupled with payment reforms and information systems, the integrated insurance foundation offers a new foundation to move forward.

Bending the Curve: Coupling Coverage with Health System Reform

If no other steps are taken to reform the way in which care is provided, these expenditures to improve and expand coverage could be expected to grow with the rise in health care costs. The substantial costs to the federal budget estimated for 2008, and the

[95] See Schoen, Davis, and Collins, "Building Blocks for Reform," 2008, Exhibit 4.

inevitable growth in outlays for all payers over time, make it imperative that any proposal to expand coverage be coupled with significant measures to achieve health system savings.

Over a 10-year period, the total impact on health system spending would be an increase of $218 billion. This is modest relative to total health spending currently projected over that period ($33 trillion).[96] But the impact on individual sectors would be significant. The 10-year federal budget cost would be $1.3 trillion, while employers would pay an additional $267 billion over and above current projected outlays. Households and state and local governments would experience significant 10-year savings of $1.2 trillion and $164 billion, respectively.

To offset these costs, it is important that coverage expansions be pursued simultaneously with comprehensive reforms to control costs and improve quality and access.[97] A recent report prepared for The Commonwealth Fund Commission on a High Performance Health System sets out a number of reform options that could be combined with the Building Blocks coverage expansion to achieve considerable savings.[98] With the assistance of the Lewin Group, the report analyzed the impact on national health expenditures of various reform options, including those designed to: ensure that the best-possible information is used for health care decision-making; promote health and enhance disease prevention efforts; align financial incentives with health quality and efficiency; and correct price signals in health care markets.

To illustrate the potential of a multifaceted approach, the report examined what might happen if the Building Blocks approach were combined with policies designed to achieve savings and enhance value in health care. The options selected include:[99]

- promoting health information technology;
- establishing a Center for Medical Effectiveness and Health Care Decision-Making, and linking their recommendations to insurance benefit design;

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[96] See C. Schoen, S. Guterman, A. Shih et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007) for additional details on the spending projections.
[97] Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007).
[98] C. Schoen et al., *Bending the Curve*, 2007.
[99] See C. Schoen et al., *Bending the Curve*, 2007, for additional details on the specifications of these options.

- reducing tobacco use through public health measures;
- reducing obesity through public health measures;
- implementing a provider payment system based on episodes of care (for episodes involving acute hospitalizations only);
- strengthening primary care and care coordination;
- resetting benchmark rates for Medicare Advantage plans;
- allowing Medicare to negotiate prescription drug prices

The Lewin Group estimates illustrate the potential of multifaceted approaches for addressing projected cost increases. In the first year, net national savings are estimated at $31 billion, as savings more than offset the cost of the insurance expansion. In contrast, in the absence of system reforms, there would be an expected net increase of $15 billion. Over the 10-year period, multiple years of savings add up to a $1.6 trillion cumulative difference in expenditures below projected trends. If Building Blocks is implemented without these additional health system reforms, there would be an increase of $218 billion.

The substantial $1.6 trillion reduction in national expenditures represents the cumulative effect of relatively small percentage changes in each year. The cumulative effect on expenditures of the combination of options grows rapidly year by year: the reduction estimated over 10 years is more than 50 times larger than that estimated in the first year.

Every sector that now pays for health care would ultimately benefit from the proposal. By the 10th year, households, employers, and state and local governments would be spending less on health care than they would otherwise spend, with reforms in place that improve the accessibility and quality of care.

The federal government would also ultimately benefit. While additional federal budget outlays would initially be required as an investment in an improved system providing better coverage and care, the Building Blocks framework, when combined with other health system reforms, markedly cuts the federal budget cost of expanding coverage. In the first year, savings options could reduce net federal outlays to $31 billion, compared with $82 billion in the Building Blocks scenario alone. By 2014, the net federal

costs could be negligible—a mere $10 billion—if bundled with options that focus on improving both the effectiveness and efficiency of care.

Within Reach: A Higher-Performing Health System

This analysis should help dispel the conventional wisdom that universal coverage is beyond our means. Our analysis shows that it is possible to cover nearly everyone with affordable and comprehensive insurance, expand access to essential care, and improve informed decision-making by patients, clinicians, and payers—all while reducing spending on health care. Buying more effective, higher-value care has significant benefits for patients and will help move the U.S. health system toward higher performance.

Building Blocks, coupled with other health system reforms, would go a long way toward achieving needed changes in the health care system—universal coverage, better care, and lower health spending over time. Health spending is projected to be 19.8 percent of GDP by 2017 if current trends continue. Combined with the savings generated by additional system reforms, Building Blocks would "bend the curve" to 18.5 percent of GDP by 2017. Savings on this scale—$1.6 trillion—represent significant resources that would be available to address other societal needs or goals, whether related to the health system or to others sectors of the economy.

Achieving needed changes in the way health care is delivered and paid for will be a challenge, even though the "savings" from these policy changes would derive primarily from reductions in the future growth, not the absolute amount, of health spending. Changing how spending is distributed means changing the flow of income to the many groups that currently depend on, and expect, future increases. The Building Blocks option relies on administrative cost savings and the application of Medicare payment rates to a larger share of the insured population. The health system savings options will require moving to a new set of incentives and market signals that require better quality and lower costs and a redistribution of health care payments. The public health initiatives will require policies to effect health behavior change. And enhancements to the health information system will require successful implementation and widescale adoption, which may necessitate substantial investments at the outset.

No single element of reform—no silver bullet—will be able to achieve the results described here. The framework explored in this paper is uniquely American: it leaves intact coverage for those who are insured; it does not abolish private insurance, as

advocated by some who favor government solutions; and it does not abolish public programs like Medicaid and SCHIP, as advocated by some who favor private insurance markets.

The major innovation of our framework is that it builds on what currently works—offering Medicare not just to the elderly and long-term disabled but also to individuals and small firms. It keeps market competition in place, but adds a new competitive dynamic. Private insurers, rather than competing to attract the healthiest patients, would need to add value, flexibility, and innovation to the products they offer. If carriers can offer better benefits or better premiums than Medicare, employers and individuals would stay with private insurance. If the Medicare Extra option demonstrated greater value and lower premiums than plans offered by private insurers, more employers and individuals would undoubtedly find such coverage more attractive. This proposal begins by offering this choice only to firms with up to 100 employees, but if it succeeds in this market niche, the case for extending it more broadly would be compelling.

Medicare will need to change to face the challenge of enrolling a new population of young adults, families, and middle-aged workers. The additional system reform options will also pose challenges to Medicare, as they would fundamentally reform the way the program pays hospitals and physicians to reward primary care and strengthen care coordination and allow prescription drug prices to be negotiated.

In the end, health reform will only work if hospitals, physicians, and other health care professionals see in it the opportunity to provide all their patients with the best care possible. The reforms will help uninsured patients afford medications and recommended specialist care. They will also provide support to providers in the form of modern health information technology and information on the comparative effectiveness of alternative drugs or treatments. But reforms on this scale will mean a significant realignment of financial rewards—with rewards for delivering better care and better outcomes, rather than simply providing more services.

For patients, there are benefits to be gained through more secure and protective health insurance. The set of reforms we describe is intended to improve the accessibility of care, giving all patients a source of care—a medical home—that ensures they receive all preventive and essential care and that assists them in navigating our complex health care system. But patients, too, have great responsibilities—to use the health system appropriately, to work in partnership with their physicians and nurses to manage their chronic conditions, and take responsibility for reducing their health risks.

The most encouraging message from the estimates presented here is that it is possible to aim for a high performance health system that simultaneously achieves better access, improved quality, and greater efficiency. Other nations have long since adopted many of the reforms we have set forth here. The U.S. can learn from their experience, as it can from states like Massachusetts and Vermont that have recently enacted reforms. Our future is up to us.

Thank you for this opportunity to participate in today's Senate Finance Committee retreat and to address questions of the Committee.