

## THE PATH TO HIGH PERFORMANCE

The policies included in the analysis interact and are mutually supporting. All contribute to the net cumulative effect on potential savings and improvement in value (Exhibit ES-3). Each slows the rate of growth in national health spending compared with current projections. (See summary for policies used for purposes of modeling coverage and cost estimates.)

<b>Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform</b>	
• Net costs of insurance expansion	–\$94 billion
• Reduced administrative costs	–\$337 billion
<b>Payment Reform: Aligning Incentives to Enhance Value</b>	
• Enhancing payment for primary care	–\$71 billion
• Encouraging adoption of the medical home model	–\$175 billion
• Bundled payment for acute care episodes	–\$301 billion
• Correcting price signals	–\$464 billion
<b>Improving Quality and Health Outcomes: Investing in Infrastructure and Public Health Policies to Aim Higher</b>	
• Accelerating the spread and use of HIT	–\$261 billion
• Center for Comparative Effectiveness	–\$634 billion
• Reducing tobacco use	–\$255 billion
• Reducing obesity	–\$406 billion
<b>Total Net Impact on National Health Expenditures, 2010–2020</b>	<b>–\$2,998 billion</b>

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

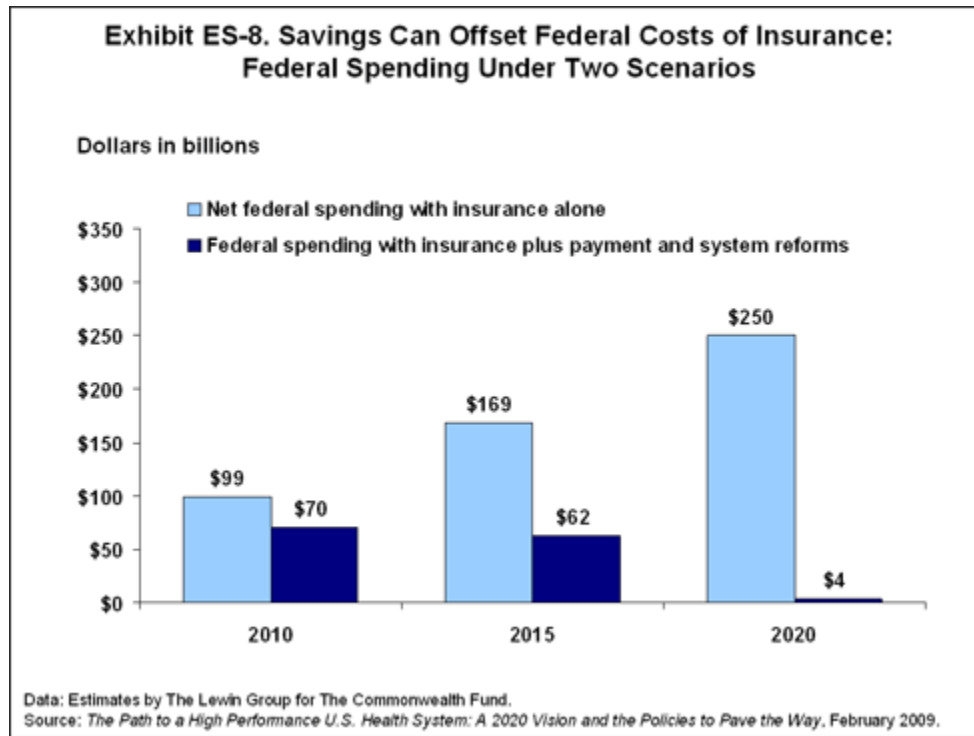
By setting targets and implementing policies that meet and raise benchmarks of top performance, we have the opportunity to save lives, improve the quality of life and care experience, lower safety risks to patients, and prevent the onset of disease and complications. As illustrated by key indicators from the Commission's National Scorecard on U.S. Health System Performance, improving average performance to targets or benchmarks set by current top performers by 2020 would achieve substantial gains in population health and patient experiences (Exhibit ES-5).

**Exhibit ES-5. Achieving Benchmarks:  
Potential People Impact if the United States Improved  
National Performance to the Level of the Benchmark**

	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	58%	99%	73 million increase
Percent of adults (age 18 and older) receiving all recommended preventive care	50%	80%	68 million increase
Percent of adults (ages 19–64) with an accessible primary care provider	65%	85%	37 million increase
Percent of children (ages 0–17) with a medical home	46%	60%	10 million increase
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	58%	70%	5 million increase
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	18%	14%	180,000 decrease
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	240	126	250,000 decrease
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	156	49	70,000 decrease
Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)	700	465	640,000 decrease
Deaths before age 75 from conditions amenable to health care, per 100,000 population	110	69	100,000 decrease
Percent of primary care doctors with electronic medical records	28%	98%	180,000 increase

\* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target.  
Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008), with benchmarks from top performance.

As the central source of financing for coverage expansions, the federal government's costs would increase during early years to make coverage affordable. The insurance design specified for modeling also provides federal funding to offset state and local costs of expanding Medicaid and raising Medicaid payment rates to Medicare levels. As a result, there would be an increase in net federal government spending during the decade. With system reform policies in place, however, the net federal cost of insurance expansion and investing in the care system declines rapidly. By 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections (Exhibit ES-8). Over the 2010 to 2020 period, the net federal budget outlays are estimated to be \$593 billion—with most incurred in the first five years.



## Summary of Policy Modeling Specifications for Coverage and Cost Estimates

### *Coverage*

- **National Health Insurance Exchange.** Offers businesses and individuals a choice of private plans and a new public plan, phased in by size of firm with all eligible by 2014. Premium of the public plan would be community rated within broad age bands. Benefits are similar to the standard option in the Federal Employees Health Benefits Program. The plan would use Medicare's claims administrative structure and reformed payment methods and rates.
- **Individual Mandate.** All individuals are required to obtain coverage.
- **Affordability.** Premiums are capped at 5 percent of income for low-income individuals and 10 percent of income for those in higher-income tax brackets.
- **Shared Financial Responsibility.** Employers are required to provide coverage or contribute to a trust fund. The example used in the model included 7 percent of payroll, up to \$1.25 an hour.
- **Medicaid/SCHIP Expansion.** All individuals with incomes up to 150 percent of the federal poverty income level are eligible for Medicaid acute care benefits. Medicaid provider payment rates are raised to Medicare levels. The federal matching rate is increased to offset state costs.

- **Medicare.** The two-year waiting period for coverage of the disabled is eliminated. Medicare beneficiaries are offered a supplement with the same acute care benefits as in new public plan and premium affordability provisions.
- **Insurance Market Reforms.** Require community-rate premiums (age bands permitted) and guaranteed issue and renewal of policies. Premium and insurance information would be publicly available on the Web.

### *Payment Reform: Aligning Incentives to Enhance Value*

- **Enhance Payment for Primary Care.** Increase Medicare payments for primary care by 5 percent and apply differential updates for primary care and other care.
- **Encourage Development and Spread of Patient-Centered Medical Homes.** Provide payment per patient in addition to fee-for-service to practices qualified to provide patient-centered care. Reduced premiums and cost-sharing available to patients who designate a primary care practice as their medical home. Shared savings would be distributed on the basis of performance.
- **Bundled Payments for Acute Care Episodes.** Expand acute care payment to include services during the hospital stay and 30 days post-discharge in a global fee. The policy would be phased in, starting with inpatient services in 2010, then post-acute care in 2013, and hospital inpatient and outpatient physician care in 2016.
- **Correcting Price Signals.** Modify payments by: 1) slowing the rate of Medicare payment updates in geographic areas with high costs; 2) reducing prescription drug costs by having Medicare pay Medicaid prices for drugs used by dually eligible beneficiaries and determining Medicare payments for unique drugs with effective monopolies based on prices paid in other countries; and 3) resetting benchmarks for Medicare Advantage plans in each county to projected per-capita spending under traditional Medicare.

### *Investing in Information Infrastructure*

- **Accelerate the Adoption and Use of Health Information Technology.** Require all providers to report key health outcomes electronically by 2015 to qualify for payment updates. Provide funding to support health information networks and assistance for safety-net providers and small practices through a 1 percent assessment on insurance premiums and Medicare outlays.
- **Center for Medical Effectiveness and Health Care Decision-Making.** Create a mechanism to develop information on the clinical and cost-effectiveness of alternative treatment options. Fund the Center with a .05 percent assessment on insurance premiums and Medicare and Medicaid spending. Use the information in benefit designs with higher out-of-pocket costs or differential pricing depending on comparative effectiveness and include physician-patient shared decision-making.

### *Promoting Health and Disease Prevention*

- **Reduce Tobacco Use.** Increase federal taxes on tobacco products by \$2 per pack of cigarettes. Use revenues to fund public health programs and insurance expansion.
- **Reduce Obesity and Alcohol Use.** Establish a new tax on sugar-sweetened soft drinks of 1 cent per 12-ounces to finance state obesity prevention programs, and increase the federal excise tax on alcohol by 5 cents per 12-ounce can of beer, with proportionate increases on other alcohol products. Use funds for prevention and insurance expansion.

**Methodology Note:** Modeling the Commission recommendations required detailed specifications for each of the policy approaches. The above specifications were used for illustrative purposes. Recognizing that multiple policy variations are feasible for key policy reforms, the Commission endorses the strategic approaches rather than the specific policy parameters used to model potential effects. The main report provides further detail. The Lewin Group technical report, *The Path to a High Performance U.S. Health System: Technical Documentation*, is available online at [www.Lewin.com](http://www.Lewin.com) for data and parameters used to estimate 2010–2020 impacts.

## Citation

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





- Executive Summary (750K) [\[download\]](#)
- Fund Report (716K) [\[download\]](#)
- Press Release (52K) [\[download\]](#)
- Chartpack (133K) [\[download\]](#)
- Chartpack (670K) [\[download\]](#)

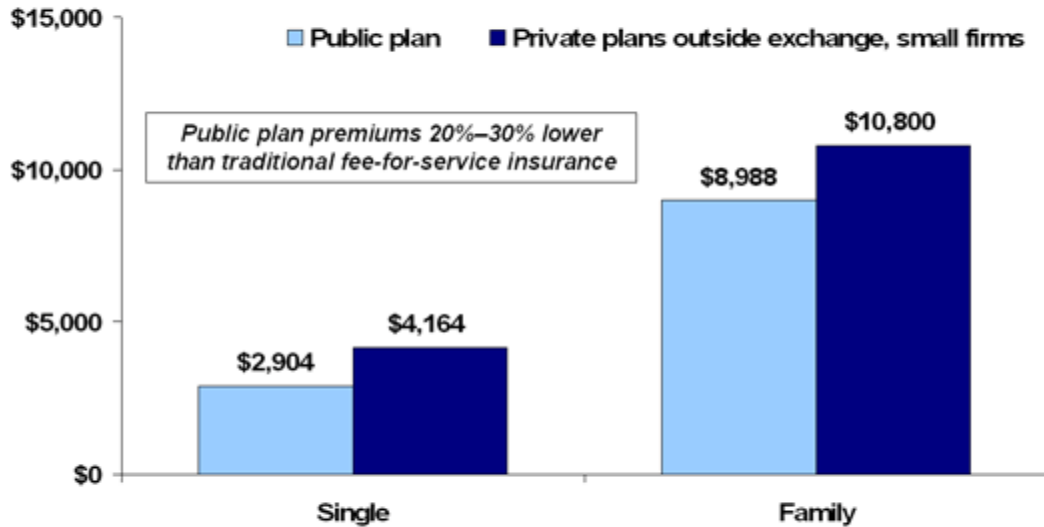
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[Estimated Premiums for New Public Plan Compared with Average Individual/Small Employer Private Market, 2010](#)

## Estimated Premiums for New Public Plan Compared with Average Individual/Small Employer Private Market, 2010

Average annual premium for equivalent benefits at community rate\*



\* Benefits used for modeling include full scope of acute care medical benefits; \$250 individual/\$500 family deductible; 10% coinsurance for physician service; 25% coinsurance and no deductible for prescription drugs; reduced for high-value medications; full coverage checkups/preventive care. \$5,000 individual/\$7,000 family out-of-pocket limit.  
Note: Premiums include administrative load.

Data: Estimates by The Lewin Group for The Commonwealth Fund.

Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

