



CONFRONTING COSTS

Stabilizing U.S. Health Spending While Moving
Toward a High Performance Health Care System

The Commonwealth Fund Commission
on a High Performance Health System

January 2013

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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

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



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ABSTRACT: The Commonwealth Fund Commission on a High Performance Health System, to hold increases in national health expenditures to no more than long-term economic growth, recommends a set of synergistic provider payment reforms, consumer incentives, and system-wide reforms to confront costs while improving health system performance. This approach could slow spending by a cumulative \$2 trillion by 2023—if begun now with public and private payers acting in concert. Payment reforms would: provide incentives to innovate and participate in accountable care systems; strengthen primary care and patient-centered teams; and spread reforms across Medicare, Medicaid, and private insurers. With better consumer information and incentives to choose wisely and lower provider administrative costs, incentives would be further aligned to improve population health at more affordable cost. Savings could be substantial for families, businesses, and government at all levels and would more than offset the costs of repealing scheduled Medicare cuts in physician fees.

This report was prepared for The Commonwealth Fund Commission on a High Performance Health System by Cathy Schoen, Stuart Guterman, Mark Zizza, and Melinda Abrams. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1653.

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ACKNOWLEDGMENTS

The Commonwealth Fund Commission on a High Performance Health System set the goal of stabilizing national health spending growth to no more than long-term economic growth and guided the framework, strategic approach, and key policies that could achieve this goal while also improving health system performance. The report was prepared for the Commission, with review and direction by Commission leadership and members, by Cathy Schoen, Commonwealth Fund senior vice president, Stuart Guterman, Fund vice president and Commission executive director, Mark Zezza, Fund senior program officer, and Melinda Abrams, Fund vice president.

On behalf of the Commission, the Fund contracted with the Actuarial Research Corporation (ARC) to model policy specifications that illustrate the potential of a synergistic approach to reducing cost growth. Jim Mays led the ARC team in preparing estimates.

Editorial and production support was provided by The Commonwealth Fund’s Chris Hollander, Martha Hostetter, Paul Frame, and Suzanne Augustyn.

PREFACE

Growth in public and private health spending is putting increasing pressure not only on federal, state, and local budgets but on business and families as well. Moreover, the U.S. health system falls short of producing the quality and outcomes that should be possible given the current level of spending. To address these systemwide issues, The Commonwealth Fund Commission on a High Performance Health System presents *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*. This report offers a comprehensive set of policies aimed at holding health spending growth to no more than the rate of long-term growth in the economy while improving health care quality and outcomes.

The Commission recommends a synergistic strategy that reflects the need to address health spending in both the public and private sectors, and to involve providers, consumers, and payers in improving system performance. To illustrate the potential of concerted action to accomplish these goals, we provide estimates of the impact of policies that follow this approach. This analysis indicates it would be possible to reduce projected spending by a cumulative \$2 trillion over the next 10 years, with substantial savings accruing to the federal government, state and local governments, private employers, and households. These impacts are contingent on timely enactment of the policies, their effective implementation, and coordinated efforts across the public and private sectors to achieve the goals of better care, better health, and lower costs.

The Commission on a High Performance Health System offers these recommendations knowing that they will not be easy to enact and implement. Inaction, however, will only exacerbate the problems we currently face. Putting off difficult solutions, or pursuing policies that offer short-term solutions without addressing the underlying factors that drive health spending growth, will only make it more difficult to deal with these factors in the future and will threaten the viability of the health care system. The Commission therefore urges that policymakers act now to move toward a high performance health system.

David Blumenthal, M.D., M.P.P.

Chairman

Stuart Guterman

Executive Director

The Commonwealth Fund Commission on a High Performance Health System

EXECUTIVE SUMMARY

Health spending as a share of U.S. gross domestic product (GDP) has climbed steadily over the past half-century. Today, it constitutes 18 percent of GDP, up from 14 percent in 2000 and 5 percent in 1960, and we are well on our way to 21 percent by 2023, based on current projections. This increased dedication of economic resources to the health sector, however, is not yielding commensurate value in terms of improving population health or patients' experiences with care.

On average, the U.S. spends twice as much on health care per capita, and 50 percent more as a share of GDP, as other industrialized nations do. And yet we fail to reap the benefits of longer lives, lower infant mortality, universal access, and quality of care realized by many other high-income countries. There is broad evidence, as well, that much of that excess spending is wasteful. Stabilizing health spending and targeting it in ways that ensure access to care and improve health outcomes would free up billions of dollars annually for critically needed economic and social investments—both public and private—as well as higher wages for workers.

In this report, The Commonwealth Fund Commission on a High Performance Health System endorses the goal of holding future growth in total health spending to a rate no greater than that of long-term growth in GDP, while simultaneously moving toward a high performance health care system. This is an ambitious goal, to be sure, particularly given our aging population and the commitment to access for all. But with such a high proportion of our economic resources already devoted to health care, and with abundant evidence that we can do better, such a target should be achievable. It is also a key to enabling broader economic growth and a more affordable health care system for businesses, families, and federal, state, and local governments.

The policies described below should produce substantial reductions in health spending. But if spending growth targets are not met, further action should be taken to address areas in which spending growth is excessive. This should include more aggressive implementation of those policies, focusing particularly on both geographic areas and types of services that are found to be drivers of excessive spending and spending growth. The establishment of targets, then, can serve both as a metric to guide policy development and as an incentive for all involved parties to act to make them effective.

To show how future health spending growth could be held to a national target and stabilized while moving toward a high performance health care system, this report lays out a synergistic strategy relying on three broad thrusts:

- Provider payment reforms to promote value and accelerate health care delivery system innovation.
- Policies to expand options and encourage high-value choices by consumers armed with better information about the quality and cost of care.
- Systemwide action to improve how health care markets function, including reducing administrative costs and setting national and regional targets for spending growth.

The set of policies the Commission has identified in these three areas would interact with each other in mutually supportive ways to address market forces that contribute to high and rising costs but are failing to produce value. By applying these policies collectively—with the public and private sectors working in concert—the nation would be able to benefit from their synergy. Analysis of specific policies consistent with these approaches indicates that they could slow growth in national spending by a cumulative \$2 trillion through 2023. Achieving

these potential savings depends on starting now and acting together.

Strategic Approach

This report translates these three broad thrusts into 10 policies to illustrate our comprehensive approach to stabilizing spending growth. The policies reinforce each other to address concerns about both public and private health care costs while also improving health outcomes and patients' care experiences.

Provider Payment Reforms to Promote Value and Accelerate Delivery System Innovation: Create incentives to coordinate care, lower costs, and improve outcomes.

- 1. Revise Medicare physician fees and methods of updating payment so that we pay for value.* Replace Medicare's current system for determining physician fees (and the resulting reductions called for under current law) by holding fees constant at their current level, while adjusting relative payment rates for services that meet specified criteria as "overpriced." Provide increases in future payments only for providers that participate in payment and delivery system innovations that are accountable for the populations they serve. Institute competitive bidding for medical commodities such as drugs, equipment, and supplies.
- 2. Strengthen primary care and support care teams for high-cost, complex patients.* Promote patient-centeredness and better outcomes by changing payment for primary care to reward care management, coordination, and a team-based, systemic approach to treating patients who are covered by Medicare, Medicaid, other public programs, and by private plans participating in the new health insurance exchanges.

- 3. Bundle hospital payments to focus on total costs and patient outcomes.* Accelerate the implementation of provider reimbursement approaches in which a single payment is made for all services provided during an episode of care involving a hospital stay, including postacute services for specified procedures and conditions, for patients in Medicare, Medicaid, other public programs, and private plans participating in the new health insurance exchanges.
- 4. Adopt payment reforms across markets, with public and private payers working in concert.* Align payment incentives across public and private payers to enable and support care systems that are more accountable for providing high-value care. Require private plans participating in health insurance exchanges to incorporate alternative payment approaches to support delivery system innovation, such as payment for primary care medical homes, care teams, bundled payment for episodes involving hospital care, and shared savings or global payment arrangements with networks of providers. Encourage private insurance plans in each state to negotiate health care prices that are consistent with value and efficiency—and not just pass on higher prices to consumers.

Policies to Expand Options and Encourage High-Value Choices by Consumers: Create incentives for consumers to choose high-value care and high-performing care systems based on comparative information about quality and costs.

- 5. Offer Medicare beneficiaries a new "Medicare Essential" plan that provides more comprehensive benefits and better protection against catastrophic costs and includes provider and enrollee incentives to achieve better care, better health, and lower costs.* Develop a value-based benefit design that encourages beneficiaries to obtain care from

- high-performing care systems. These incentives would be aligned with payment reforms that give providers incentives to develop and join innovative care systems that improve patient outcomes and care experiences.
6. *Provide positive incentives for Medicare and Medicaid beneficiaries to seek care from high-value, patient-centered medical homes, care teams, accountable care organizations, and integrated delivery systems.* Work with local employer coalitions to spread the same value-based approach, with positive incentives for patients in private plans.
7. *Enhance information on clinical outcomes of care and patient experiences to inform treatment decisions and choices of providers and care systems.* Accelerate the “meaningful use” of health information technology to assess and compare clinical outcomes over time from alternative treatment choices and, through use of patient registries, to enable post-marketing surveillance of safety and care outcomes. Provide consumers and clinicians with transparent information on costs and prices to further inform choices.
- Systemwide Action to Improve How Health Care Markets Function:** Reduce administrative costs, reform malpractice policy, and set targets for total spending growth nationally and at other geographic levels.
8. *Simplify and unify administrative policies and procedures across public and private health plans to reduce provider and plan administrative costs and complexity.*
9. *Reform medical malpractice policy and link to payment in order to provide fair compensation for injury while promoting patient safety and adoption of best practices.*
10. *Establish spending targets.* Target total combined public and private spending to grow at a rate no greater than economic growth per capita. Set targets for the nation (long-term GDP growth per capita), as well as for states, regions, or localities, and adjust policies as appropriate based on progress in meeting targets. Collect data to inform and enable state and local action to develop focused policies if growth exceeds targets.
- Setting a target for overall spending growth—across all payers, public and private, and across all providers in all areas—of no greater than economic growth per capita would provide guidance for these policies and any further policy action that is needed. Collecting data on total spending and sources of spending growth at the national, state, and local levels would enable state and local governments to set their own targets and develop focused policies to meet them.
- More consistent payment approaches across payers also could help counteract the concentration of market power among providers. Allowing multiple payers to negotiate jointly to employ similar payment methods and more consistent pricing under state or federal government auspices and aligning payment with efficient care and value, rather than simply passing on higher prices in consolidated markets, could lower private insurance premium costs for businesses and families. Joint negotiations among health care purchasers would need to take place under public auspices to ensure accountability.
- Over time, the policies described in this report should generate evolutionary forces that lead to the formation of health care delivery organizations that are held accountable for the costs of care as well as health outcomes and care experiences. By assessing system performance continually relative to the spending target, flexible policies could be calibrated to address areas in which there is excessive cost growth.

Synergistic Policies

Our synergistic approach is intended to build on the substantial movement already afoot to improve health system performance. The policies would interact to accelerate and focus that momentum to achieve the goals of better health, better health care experiences, and lower costs.[†]

The need for action applies not only to the federal government, but also to state and local governments, businesses, and households—all of which are under increasing financial pressure from rapid health spending growth. The overarching goal should be moving the U.S. health system toward a higher level of performance, one marked by access to affordable care for all, improved quality and patient-centeredness, greater accountability for both health outcomes and treatment costs, and enhanced population health. A high performance health system is not only consistent with stability in health care spending, it is essential for it.

To examine the potential of our proposed synergistic policies, The Commonwealth Fund contracted with Actuarial Research Corporation (ARC) to estimate the cumulative impact on health care spending by 2023 if an illustrative set of policies were to take effect in 2014, assuming the policies are enacted in 2013. The analysis examined the net impact on spending by the federal government, state and local governments, private employers, and households as well as total health spending.[‡]

[†] D. Berwick, T. Nolan, and J. Whittington, “The Triple Aim: Care, Health, and Cost,” *Health Affairs*, May/June 2008 27(3):759–69.

[‡] For details regarding data used and modeling assumptions see J. Mays, D. Waldo, R. Socarras et al., *Technical Report: Modeling the Impact of Health Care Payment, Financing, and System Reforms* (prepared for The Commonwealth Fund by Actuarial Research Corporation, Jan. 2013).

The estimates suggest the policies consistent with the strategic approach could reduce projected health spending by a cumulative \$2.004 trillion over the first 10 years (2014–2023). The savings would accrue to the federal government (\$1.036 trillion), state and local governments (\$242 billion), employers (\$189 billion), and households (\$537 billion) (Exhibit ES-1).

For the federal government, the analysis indicates net savings well beyond the level necessary to offset the 10-year costs of replacing current Medicare policies that call for steep cuts in payments to physicians under the sustainable growth rate (SGR) formula. By instituting broader Medicare payment reforms and ensuring these spread to Medicaid as well, the pace of delivery system reform would be accelerated without resorting to across-the-board reductions in provider payments and would produce substantial net savings for federal programs. Targeted policies to lower administrative costs for providers could furthermore support growth in clinician incomes.

U.S. households would be the major winners over time from the strategic approach we describe here, with the potential for better care and health outcomes as well as an estimated \$537 billion in direct savings over 10 years. These savings result from lower future insurance premium and out-of-pocket costs resulting from more efficient insurance markets serving Medicare beneficiaries, and from slower growth in the underlying costs of care as the delivery system responds to new incentives for enhanced, high-value care and care systems. In the end, reduced health spending by federal, state, and local governments and private employers also would accrue to households, which ultimately bear the burden of health spending through higher taxes, reduced wages, and direct out-of-pocket costs.

Exhibit ES-1. Synergistic Strategy: Potential Cumulative Savings Compared with Current Baseline Projection, 2013–2023

Net impact in \$ billions*

	Total NHE	Federal government	State and local government	Private employers	Households
2013–2018	-\$686	-\$345	-\$84	-\$66	-\$192
2013–2023	-\$2,004	-\$1,036	-\$242	-\$189	-\$537

Note: NHE = national health expenditures.

* Net effect does NOT include potential impact of spending target policy.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

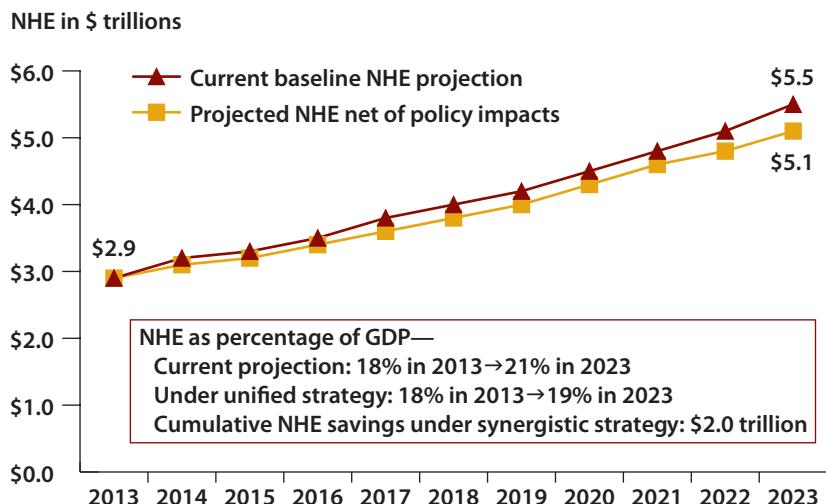
It is important to note that, even with these savings, the health sector would continue to grow. This growth would provide resources to innovate and develop new medical breakthroughs, as well as allow us to meet the needs of an aging population (Exhibit ES-2).

Notably, the bulk of the estimated \$2 trillion in savings comes from pay-for-value reforms that accelerate delivery system innovation and from lowering insurance-related administrative costs by simplifying and standardizing reporting and other policies (Exhibit ES-3). Administrative simplification

savings would largely accrue to providers, freeing up physicians and their staff to spend more time on patient care.

The analysis indicates that such a comprehensive and synergistic approach, with all payers pulling together in the same direction, would stabilize health care spending and bring it more in line with growth of the economy. The percentage of GDP spent on health care by 2023 would be an estimated 19 percent—similar to the 18 percent projected in 2013 (before the policies begin to take

Exhibit ES-2. Projected National Health Expenditures (NHE), 2013–2023: Potential Impact of Synergistic Strategy



Note: GDP = gross domestic product.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

Exhibit ES-3. Cumulative Net Impacts of Payment, Engaging Consumers, and Systemwide Policies, 2013–2023

Net savings in \$ billions

	2013–2018	2019–2023	Total 2013–2023
Payment reforms to pay for value to accelerate delivery system innovation	-\$442	-\$891	-\$1,333
Policies to expand and encourage high-value choices by consumers	-\$41	-\$148	-\$189
Systemwide actions to improve how health care markets function*	-\$203	-\$279	-\$481
Cumulative NHE impact**	-\$686	-\$1,318	-\$2,004

Note: NHE = national health expenditures. Totals may not add because of rounding.

* Net savings do NOT include the potential impact of the spending target policy. Malpractice savings included in impact of provider payment reforms.

** Cumulative NHE impact adjusted for potential overlap of component policy impacts.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

effect) and considerably lower than the 21 percent projected under current law.

The growth in Medicare spending per beneficiary would be below GDP growth for most of the decade, with substantial net savings compared with current projections. In contrast with Medicare, however, although private spending per enrollee would slow, it would continue to exceed GDP growth as it has in recent years. If focused policies at the local, state, regional, or national level slowed private per-person spending growth to bring it more in line with economic growth, the estimates indicate that national health expenditures (NHE) as a share of GDP by 2023 would be near the 2013 level.

Spending growth targets and data for assessing change will be instrumental to inform future action. At the state or local market level, it will be particularly important to have reliable information on baseline total spending and trends so that policies can be developed as needed, since patterns would likely vary in different parts of the country. Policies

could be adjusted over time to achieve targets by the end of the decade.

To get these results, it will be necessary to act quickly and for major payers to pull together with a sense of urgency. As illustrated in Exhibit ES-1, the net impact of these policies accelerates over time as the health care delivery system and markets respond to new incentives and as the policies spread across the public and private sectors.

The Commonwealth Fund Commission on a High Performance Health System offers this synergistic set of policies as a way forward for federal and state policymakers and private-sector health care leaders confronting escalating health care costs. We also offer criteria to guide national discussions related to the federal deficit and federal health programs. Building on the three pillars of payment reform, high-value choices, and other market reforms, the United States has the potential to accelerate health care innovation while ensuring access for all.

CONFRONTING COSTS: STABILIZING U.S. HEALTH SPENDING WHILE MOVING TOWARD A HIGH PERFORMANCE HEALTH CARE SYSTEM

RISING HEALTH CARE COSTS: A NATIONAL CONCERN

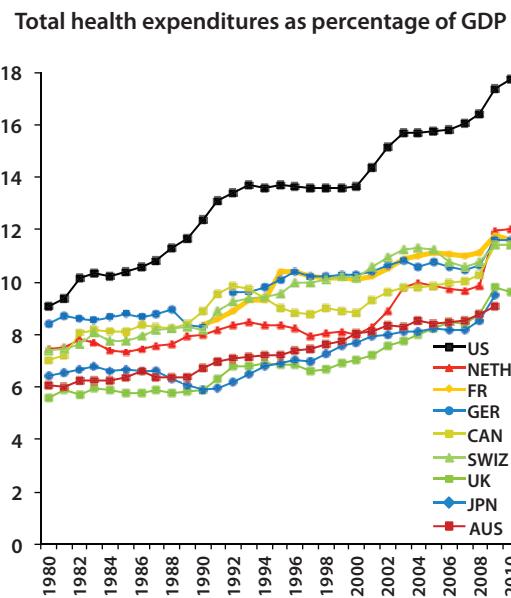
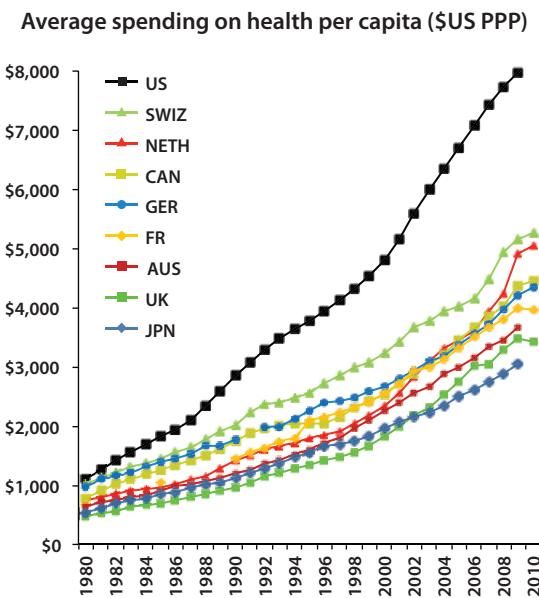
Health spending as a share of the gross domestic product (GDP) has climbed steadily in the United States over the past half-century. Today, health care constitutes 18 percent of GDP, up from 14 percent in 2000 and 5 percent in 1960. On average, the U.S. spends twice as much per capita—and 50 percent more as a share of GDP—on health care as other industrialized nations do (Exhibit 1). But other wealthy nations achieve longer lives, lower infant mortality, better access to care, and higher care quality while spending far less.¹ Total U.S. spending on health care was \$2.7 trillion at the end of 2011; under current policies, it is expected to more than double by 2023, rising to \$5.5 trillion.

For decades, U.S. health care spending has grown far faster than incomes and consumed resources that might otherwise have been spent on other pressing needs. The high and rising portion of

national resources spent on the health system means less for education, infrastructure (such as roads, updated electric power systems, and trains), non-health care jobs, wages, and investments necessary to compete in a global economy. Moreover, we have broad evidence that a substantial share of this spending is wasted on duplicative services, excessive administrative costs, and poorly coordinated, ineffective, or unsafe care. This excess spending has put pressure not only on federal, state, and local government budgets, but also on businesses and households across the country.

The growth of U.S. health spending also contributes to upward pressure on the federal budget. Our national commitment to providing health insurance to the elderly and disabled through Medicare and to low-income families, the disabled, long-term care residents, and children through Medicaid and the Children's Health Insurance Program—combined with our commitment to

Exhibit 1. International Comparison of Spending on Health, 1980–2010



Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

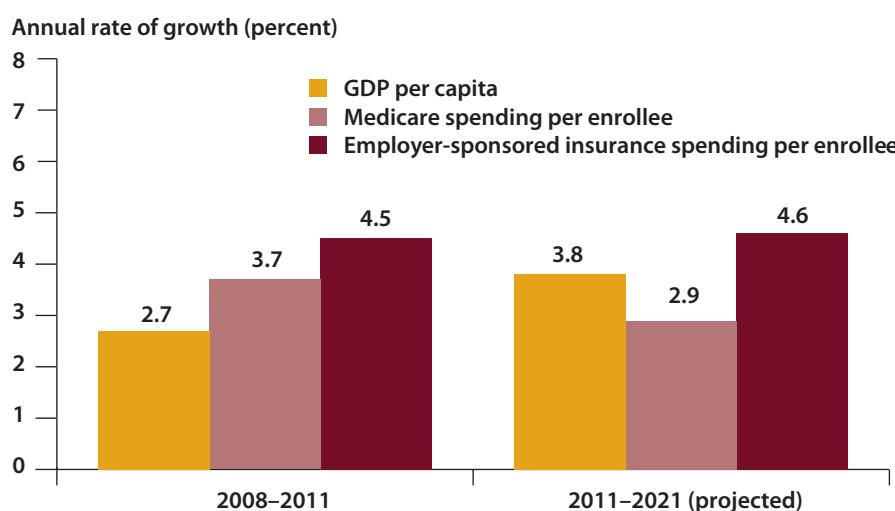
reaching near-universal coverage under the Affordable Care Act—means that a growing share of the population looks to government programs for help in ensuring affordable access to the health care system. This includes an increase in the number of Medicare beneficiaries from 48.7 million in 2011 to 65.8 million in 2021 as those born following World War II reach age 65.² The Congressional Budget Office (CBO) projects that, under current law, federal spending on Medicare, Medicaid, the Children's Health Insurance Program, and tax credits for low- and modest-income families to help offset the cost of private insurance in state exchanges will rise from 24 percent of the federal budget in 2012 to 32 percent in 2022 and 38 percent in 2037.³

Policies enacted as part of the Affordable Care Act helped ease the pressure somewhat by slowing the growth of Medicare spending per person—saving an estimated \$716 billion from what Medicare would otherwise have spent over the next decade while improving benefits for beneficiaries.⁴ This action extended the solvency of the Medicare Trust Fund for hospital care by seven years.⁵

While spending on publicly funded programs is currently a focal point of federal budget debates, for the past several years both Medicare and Medicaid spending per enrollee have been growing at rates well below spending for those who are privately insured.⁶ And the slower rate of growth for public programs—particularly Medicare—is projected to continue over the next decade (Exhibit 2). On a per capita basis, Medicare spending is projected to increase at a rate of 2.9 percent per year between 2011 and 2021, compared with 4.6 percent for private employer-based insurance.⁷ In fact, Medicare spending per enrollee is projected to grow more slowly than GDP per capita as a result of reforms put in place in recent years.⁸

Indeed, businesses and families have faced rapid increases in private health insurance costs for more than a decade, with average premiums rising almost four times as fast as wages and general inflation since 1999. Total employer-based premiums are up by 172 percent and employee shares of premiums by 180 percent (Exhibit 3).⁹ The full annual cost of

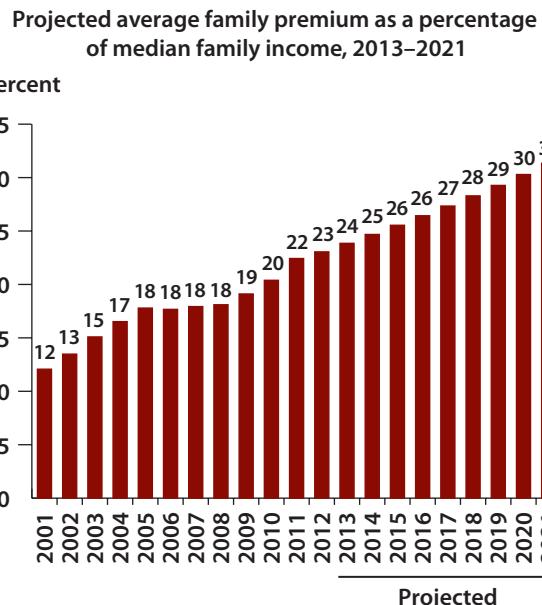
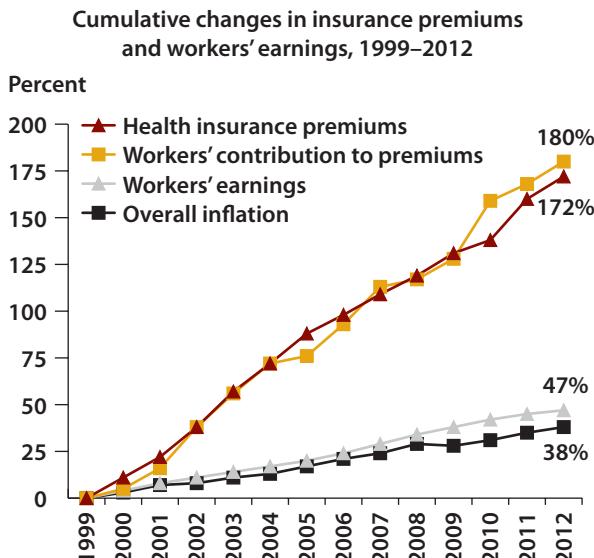
Exhibit 2. Medicare Spending per Enrollee Projected to Increase More Slowly Than Private Insurance Spending per Enrollee and GDP per Capita



Note: GDP = gross domestic product.

Source: CMS Office of the Actuary, National Health Expenditure Projections, 2011–2021, updated June 2012.

Exhibit 3. Premiums Rising Faster Than Inflation and Wages



Sources: (left) Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits Annual Surveys, 1999–2012; (right) authors' estimates based on CPS ASEC 2001–12, Kaiser/HRET 2001–12, CMS OACT 2012–21.

health insurance premiums already amounts to 23 percent of median family income, on average, for the working-age population. If projected trends continue, the average premium for a family plan would exceed \$24,000 by 2021—the equivalent of 31 percent of median family income, intensifying pressure on family budgets across the country.¹⁰ With deductibles up sharply and premiums already representing a high share of income for even middle-class households, affordability is of intense concern to working-age adults and their families.¹¹ If we could succeed in slowing the growth rate by 1 percent to 1.5 percent per year compared with historic trends while preserving coverage, it would mean \$2,000 to \$3,000 in premium savings by the end of the decade for families insured through employers—freeing up funds that could then be available for wages.¹²

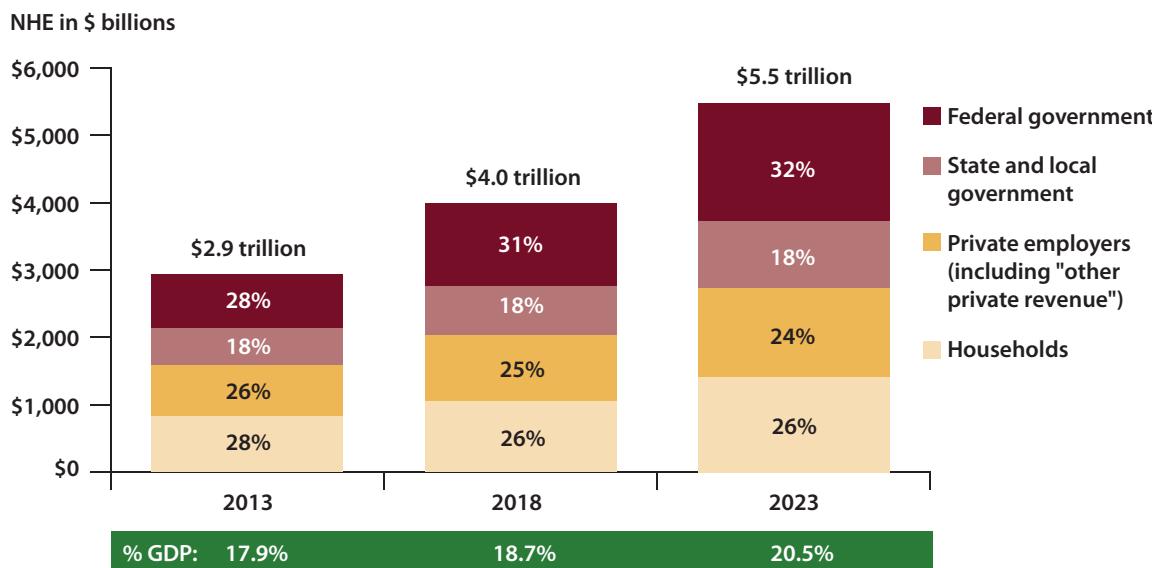
Thus, the rising costs of health care are a shared concern. Total business and household spending on health, as well as federal health spending, are projected to increase sharply between 2013 and 2023 as national health expenditures increase from

\$2.9 trillion to \$5.5 trillion (Exhibit 4). Businesses and households are projected to pay half of total national health care costs in 2023, while the federal government will pay 32 percent and state and local governments will pay 18 percent. Although the business share will be somewhat smaller in 2023 than in 2013 as a result of the aging of the population, total business spending on health benefits is projected to increase by 60 percent over the decade.

The challenge for national policy leaders and the federal government, then, is how to further stabilize and slow the increase in Medicare and Medicaid spending per enrollee, given already relatively low projected rates of growth. To secure further reductions in the growth rates, federal programs will need to work in concert with private payers to address the underlying factors that are driving up the costs of care across the health system.

At the same time, as pressure mounts to address the federal deficit and puts greater focus on federal health spending, it is imperative to act in ways that are consistent with the goals of a high

Exhibit 4. Projected U.S. National Health Expenditures (NHE) by Source, 2013–2023



Note: GDP = gross domestic product.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

performance health system. The current situation presents both a crisis and an opportunity to accelerate movement to a high-quality, innovative system that is accessible for all—while stabilizing health care costs.

With the goal of informing national policy, this report provides a framework, sets criteria, and outlines actions that could reduce future federal health care spending primarily by accelerating delivery system reform and innovation. If implemented soon and effectively, the policies described here have the potential to produce significant savings for state and local governments, businesses, and households as well as the federal government, while improving health system performance.

These policies target the underlying factors contributing to rising health care costs while continuing to support the overarching goal of a high-performing health system. As background for these policies, the following two sections: 1) summarize key factors contributing to rising costs for private

and public payers; and 2) present a framework and criteria to guide and inform policy choices.

The policy section of the report then describes a set of actions that address factors driving up costs while adhering to the proposed criteria. These synergistic policies combine payment reforms, incentives and information for engaging consumers in high-value choices, and other reforms to improve the way markets function. We estimate the potential impact over the next 10 years using illustrative policies consistent with such a strategic approach.

The concluding section of the report discusses the need to act soon and the importance of all payers pulling together to bring cost growth in line with economic growth in ways that also secure access to care and improve health system performance.

FACTORS DRIVING UP HEALTH CARE SPENDING

Health spending, by definition, is the product of the price paid for health services and the volume and intensity of services used. Both prices and utilization

have contributed to high levels of and increases in health spending in the public and private sectors. Moreover, there is considerable overlap between key factors influencing prices and volume.¹³ Although the specific contribution of each factor to total costs is debatable, most are amenable to policies that address high or rising costs and the gap between costs and value.¹⁴

Prices

The U.S. pays much higher prices for health services than do other countries, whether for drugs, medical devices, diagnostic tests, or other services.¹⁵ There is also wide variation in the prices paid by different payers for the same services. Even more striking, a single insurer in the private sector may pay widely different prices for the same service, depending on the provider, and different insurers pay very different prices for the same service from the same provider.¹⁶ Such incoherence appears to be the norm rather than the exception.¹⁷ Studies indicate that prices tend to be highest for services delivered by providers that dominate the market or that are regarded as “must have” by insurers, and thus have market power.

In recent years, higher prices paid by private insurers have accounted for most of the increase in health insurance premiums.¹⁸ Yet a lack of transparency makes it difficult to see, much less address, price concerns.¹⁹ Critical factors contributing to high and rising prices include:

- *Concentration of market power.* Both the private health insurance industry and the health care delivery system have become more concentrated over time, although the degree of concentration varies across geographic areas. As a result, the relative market power of some providers to charge more, and payers to pass on these costs to business and households, have emerged as central concerns.²⁰

- *Administrative costs.* Administrative costs in the U.S. are considerably higher than in other countries.²¹ Monitoring and complying with the myriad regulations promulgated as a result of the fragmentation of the health care financing and delivery systems adds substantial overhead costs to private insurers and public payers as well as internal costs to providers. The costs to providers include the time that physicians and their staff members spend interacting with health plans that could otherwise have been devoted to patient care.²² Higher administrative costs drive up prices in the health care market with minimal contribution to quality or access to care.

Volume and Intensity

Current fee-for-service payment in both the public and private sectors rewards the provision of more health services and procedure-based treatments, regardless of their contribution to better patient outcomes.²³ Although volume and intensity vary across geographic areas and category of service, the overall trend has been one of upward pressure on total health spending.²⁴ This trend is driven by several key factors:

- *Fragmented care and care systems.* Health care is too often fragmented as a result of failures to share information and develop a treatment plan among the various clinicians who may care for a particular patient, especially for patients with multiple or complex conditions. Several studies indicate the potential benefits of primary care teams that include nurses and other clinicians in addition to doctors, especially for care for high-risk patients.²⁵ These gains are enhanced by more integrated care systems, in which specialists and primary care clinicians work together supported by systems that provide key information across

- sites of care, including during transitions from a hospital to community or home care.
- *Medical technology.* Unlike in most industries, in health care the availability of new technology has tended to add to costs rather than lowering them.²⁶ Although new technology may contribute to better health in specific applications, the frequent lack of connection between the value and the price of new drugs, devices, and treatments is a symptom of market failure.²⁷ Conversely, technology with the potential to yield social benefits that accrue beyond an individual practice or facility—such as health information technology—is slow to spread without targeted policies that provide incentives for adoption and use across markets.²⁸
 - *Malpractice liability.* Estimates of the impact of the current malpractice system on excessive screening and other tests in reaction to fear of lawsuits range from minimal to more substantial.²⁹ But whatever the contribution to costs, malpractice reforms that reward best practices, provide fair compensation for injury, and encourage patient safety would be more effective in mitigating incentives to do more tests and promoting a culture of safety than the current system.³⁰
 - *Increasing prevalence of chronic medical conditions.* Estimates of the contributions of obesity and other chronic conditions to rising health care costs vary.³¹ Still, chronic conditions certainly account for a large and growing proportion of U.S. health spending, especially among the elderly.³² Initiatives that encourage healthier aging and the use of teams to support and manage care for people with multiple chronic conditions offer the potential to slow decline in health or prevent complications, improve care, and reduce cost growth.³³
 - *Changing demographics.* The U.S. population is growing older, as are the populations of most high-income countries. In fact, many countries already have much older populations than the U.S.³⁴ The aging of the population has important implications for health spending because the elderly tend to have greater health care needs. Without innovation in the way we deliver care, it will be difficult to meet the needs of our aging population and hold the line on health spending.³⁵
- Although their impact may differ by geographic area or sector, all of these factors contribute to both public and private health spending, and most are directly amenable to policy. However, policies that target federal programs alone or simply shift costs to states, businesses, or households potentially destabilize the health care system and ignore the underlying market realities. A successful strategy to stabilize health spending will require a multipronged approach, guided by a strategic framework to improve performance across the health system.

CRITERIA FOR STABILIZING HEALTH SPENDING GROWTH AND IMPROVING SYSTEM PERFORMANCE

As national policy leaders consider approaches to slow and stabilize the growth of federal health spending in ways that also benefit all payers (state and local governments, businesses, and households), it is crucial that these approaches be developed and applied to adhere to and further the goals of a high performance health system. These goals include providing affordable access across the nation to high-quality, well-coordinated and patient-centered care with continuous delivery system innovation.³⁶ Achieving the goals of a high performance health system, while stabilizing cost growth, requires a

focus on the total health system and health care markets, not just federal programs.

There is an urgent need to act and to do so strategically within a framework and guided by criteria that promote these overall goals. Otherwise, we risk producing unintended consequences (including harm to vulnerable populations) and/or pursuing self-defeating and ineffective action. For example, approaches that focus only on cutting eligibility and benefits, or slashing payments to providers, may reduce the projected growth of federal spending, but only by shifting costs to individuals and employers while undermining access to care.³⁷ By contrast, innovative federal actions, such as payment reforms through Medicare and Medicaid, as well as those that establish partnerships with private payers, providers, and consumers, have the potential to accelerate the pace of change across communities. Indeed, in the past, private payers have often followed Medicare's lead in implementing innovative payment reform—such as with the introduction of more bundled payments for hospitals using diagnosis-related groups (DRGs) and the implementation of the resource-based relative value scale for determining physician fees. And Medicare has implemented approaches that have been developed in the private sector as well, such as value-based purchasing.

A framework that considers the potential for federal policies to spread through collaboration with

states and private payers—and that takes the best of what private or public sectors have to offer—could align incentives across markets to accelerate delivery system reform. Further, having public and private payers work in concert is critical for sending consistent market signals to hold care systems accountable for innovating to improve population health and add value.

Ensuring that patients have access to high-quality care is fundamental to a high performance health system and to improving population health. Thus, any action addressing costs must preserve access and enhance equity. At the same time, value-based insurance benefit designs that lower or eliminate costs for essential care and provide incentives and information to guide choices of care and care systems—and to choose wisely—could augment and support provider incentives to focus on outcomes and value.

With the aim of making continued progress toward a high performance health system—one that is high-quality, innovative, accessible, and affordable for all—the Commission developed the following criteria to guide the selection and design of policies to control health spending. These criteria adhere to the goals of a high performance health system and guide the selection of policies that have the potential to make a positive difference (Exhibit 5).

Exhibit 5. High Performance Health System Criteria for Developing Options to Stabilize Spending Growth

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- Set targets for total spending growth
 - Pay for value to accelerate delivery system reform for better outcomes, better care, at lower costs
 - Address the systemwide causes of health spending growth—not just federal health costs
 - Align incentives for providers and consumers across public and private payers
 - Protect access and enhance equity, but also engage and inform consumers
 - Invest in information systems to guide action
-

- **Set spending targets.** Set national and regional targets for health spending growth that limit increases in health spending to the rate of growth of the economy as a whole. Such targets would focus attention on growth rates, create accountability for excessive growth and provide a benchmark against which to judge the success of policies. Setting targets and tracking cost trends would inform future actions aimed at addressing problem areas, while allowing sufficient growth to capture the benefits of advances in biomedical science.
- **Pay for value to accelerate delivery system reform.** Hold providers accountable for population health outcomes and high-value care. Changing the way care is delivered, managed, and coordinated is critical to stabilizing health spending and improving outcomes.
- **Focus systemwide.** Policies to control health spending growth should address its systemwide causes and effects, not just federal costs. Federal spending is an imminent concern, but health spending growth also puts pressure on state and local governments, businesses, and households. It will be important to stabilize spending for everyone, not shift costs from one stakeholder to another.
- **Align incentives.** Public and private payers should act in concert, adopting similar payment reforms to send consistent signals and provide support for innovative care teams and accountable care systems. It is essential to align incentives for providers and consumers across public and private payers to advance the “triple aim” of better care, better health, and lower costs.³⁸
- **Protect access to care and enhance equity while engaging consumers.** Access to care and equity must be protected and enhanced, but consumers also should be engaged in the process of improving health and choosing high-value care.
- **Invest in information to guide action.** Invest in better information and information systems on clinical outcomes and costs of care to drive and guide consumer choices, providers’ health care decisions, and policy.

In devising policies to confront health care costs, we can draw on the authority to innovate and the tools that are already available as a result of recent health reform legislation, thus building on the momentum of promising efforts under way across the country. As a result of congressional action and efforts of multiple groups around the country, the nation is investing in the spread and use of health information technology, better information to inform patients about the risks and benefits of treatment choices, and an array of payment and delivery system reforms intended to reduce long-term health spending and improve health system performance.³⁹ (See box on next page, Initiatives and Provisions Currently in Place to Support Health System Reform.)

Federal, state, and private-sector concerns about costs have stimulated joint Medicare and Medicaid initiatives, as well as partnerships among federal and state governments and private payers. We are also seeing new collaboration among providers and between providers and payers around the joint

goals of better quality and lower costs.⁴⁰ This momentum includes several physician specialty groups' actions to identify treatments and care that are potentially inappropriate or ineffective through the Choosing Wisely campaign to engage and inform patients.⁴¹

As policymakers and the nation confront the urgent need to stabilize health spending, these activities provide a foundation on which to build. However, we need to accelerate the pace of change by implementing policies that can help create a more affordable, better health care system for all.

INITIATIVES AND PROVISIONS CURRENTLY IN PLACE TO SUPPORT HEALTH SYSTEM REFORM

- Insurance market reforms: will provide choice, establish essential benefit designs that include preventive care, and create market rules that ensure access, increase transparency, and focus competition among insurers on improving value for their enrollees.
- Health information technology: Policies and funding to encourage physicians, hospitals, and other providers to use electronic health records and exchange information to improve the efficiency and quality of the care they provide.
- Value-based purchasing: Public and private efforts to use financial incentives to improve quality, safety, and outcomes, including reducing hospital infection and readmission rates.
- Medicare Advantage: Revised payment for private Medicare Advantage plans with incentives for efficient provision of care and rewards for high performance.
- Primary care: Enhanced Medicare and Medicaid payment for primary care and new ways of paying for primary care that support medical homes and similar models.
- Bundled payment: Public and private bundled payment initiatives for hospitals to encourage better care in the hospital, better transitions between care settings, and coordination with postacute settings.
- Medicare Shared Savings Program: to foster the development of accountable care organizations, with groups of providers taking broad responsibility for the quality, outcomes, and costs of care and earning rewards for high performance. Multiple initiatives include Medicare as part of multipayer efforts.
- Federal/state Medicaid initiatives: teams and "health homes" to coordinate and provide care for those with multiple chronic conditions, and advanced care teams for ongoing care for high-risk patients.
- Private initiatives: Multiple private insurer initiatives to support patient-centered primary care homes, accountable networks, bundled payments for care, and shared savings agreements.
- Center for Medicare and Medicaid Innovation: authority to develop, implement, assess, and spread promising models of care payment and delivery. The authorization allows the HHS Secretary to extend and expand successful innovations if they reduce costs and/or improve outcomes. Medicare also is provided with authority to partner with state and private-payer initiatives.
- Patient-Centered Outcomes Research Institute: public/private partnership to encourage research on diagnosis and treatment options as well as ways to improve health care systems and accelerate patient-centered outcomes research and methodological research.
- Administrative reforms: more standardized reporting and electronic submissions and standards to lower overhead costs for private insurance.

GETTING AHEAD OF THE CURVE: POLICIES TO STABILIZE HEALTH CARE SPENDING WHILE IMPROVING SYSTEM PERFORMANCE

To address federal and broader national concerns about affordability and health care costs, it is imperative to act, but do so in ways that are consistent with the goals of a high performance health system. Guided by the criteria described above, the Commission set the goal of holding future growth in health spending to no greater than the long-term growth of the economy, and to do so primarily by reforming the way health care is paid for and delivered.

The initiatives described below seek to harness provider incentives, consumer incentives, and market interactions so that all pull in the same direction of better care and care experiences at lower cost. The policies also would allow flexibility for local innovation and provide better, more transparent information for consumers and health system leaders to choose and act wisely. Using a three-pronged approach, these policies would: 1) use payment reform to reward value and accelerate delivery system innovation; 2) engage consumers with information and positive incentives to choose high-value care and care systems; and 3) implement other systemwide reforms to address market forces driving costs, including administrative complexity, malpractice costs, and consolidation of market power. Improving the way markets function also includes setting a target for total spending growth at no more than economic growth to hold care systems and insurers accountable for the overall costs of care in ways that meet the needs of the population.

Provider Payment Reform to Promote Value and Accelerate Delivery System Innovation: Create incentives to coordinate care, lower costs, and improve outcomes.

As a result of an aging population and insurance expansions, over the next decade Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) together will be paying for care for more than 40 percent of the population (150 million people).⁴² It is possible, then, to implement widespread reform by starting with these programs. The following payment policies would use payment reform to accelerate the pace of delivery system innovation and care integration and coordination, while increasing accountability for improving outcomes and reducing cost growth per beneficiary over time. To maximize the impact and ensure consistent signals, the policies would coordinate public programs' payment policies (Medicare, Medicaid, and other public programs) and facilitate spread to private payers to align incentives and reduce administrative complexity for providers.

The net effect of these policies would be to move from our current unfettered fee-for-service payment system into one that pays for value, including more bundled payment approaches that reward efficient care and better population outcomes. These payment changes would accelerate delivery system transformation to improve population health at lower cost, and would promote diverse organizational models that enable providers to better manage the quality and cost of care for their patient populations.

In addition, these policies would strengthen primary care by providing funds for better practice infrastructure (such as health information technology and teams to manage high-cost patients and coordinate care). Policies focused on primary care would include incentives and expanded resources

(including nurses and other clinicians) to improve outcomes, while maintaining or enhancing primary care physicians' income.

Finally, the set of payment reform policies would replace the current Medicare sustainable growth rate (SGR) formula that calls for an across-the-board reduction in payment to physicians. A new Medicare physician payment policy would include incentives to join and develop high-value care networks and care systems while eliminating the scheduled cuts.

The following four illustrative payment reform policies would move away from paying fees for services to paying for value to accelerate delivery system reform while incentivizing and supporting providers to lower costs and improve care.

1. Medicare physician fees: pay for value.

Replace Medicare's current system for determining physician fees (and the resulting reductions called for under current law) by holding fees constant at their current level, while adjusting relative payment rates that meet specified criteria as "overpriced." Provide increases in future prices only for providers participating in payment and delivery system innovations with accountability for the populations they serve. Institute competitive bidding for medical commodities (drugs, equipment, and supplies).

One impediment to using payment policy to accelerate delivery system innovation with a focus on paying for value is the sustainable growth rate (SGR) formula used to set Medicare physician fees.⁴³ This formula was intended to counteract the incentive to increase volume and intensity by imposing across-the-board reductions in fees if Medicare physician spending growth exceeded a predetermined target. Since 2003, however, Congress has intervened to supersede the scheduled reductions temporarily, without changing the formula. Medicare physician

fees were scheduled to be cut by 27 percent across the board—for every service—on January 1, 2013.⁴⁴ Congress postponed the cuts for a year. There is broad consensus on the need to replace the SGR policies.

This policy would repeal and replace the SGR with a Medicare physician payment policy that provides incentives to improve health outcomes and participate in care system innovation. The policy would restructure the Medicare fee schedule to reduce payment rates for services meeting specified criteria as overpriced, and institute a system for future increases tied to performance.⁴⁵ To move more quickly to models of coordinated care with accountability for outcomes, the policy would provide future increases in fees only for providers participating in innovative payment or delivery systems such as patient-centered medical homes (see below), bundled payment, and accountable care organizations. Fees would otherwise remain at 2013 levels. To use the market to drive down costs, Medicare could institute competitive bidding for medical commodities.⁴⁶

2. Strengthen patient-centered primary care and support care teams for high-cost, complex patients.

Change payment of primary care to reward care management, coordination, and a team-based systemic approach to caring for patients under Medicare, Medicaid, other public programs, and private plans participating in health insurance exchanges.

Strengthening the primary care foundation of the nation's health system is critical to providing timely access to care, preventive care, and better outcomes for those with chronic disease. Rich evidence from within the U.S. and abroad attests to the potential of redesigned primary care and care teams to improve care and patient experiences—and to lower costs over time by preventing complications

and reducing avoidable use of hospitals and more specialized care.⁴⁷ By enhancing primary care payment tied to the capacity to serve as patient-centered medical homes with teams for managing care for chronic conditions across sites of care, payment reform would strengthen primary care and overall systems of care. This policy would augment fee-for-service payments with additional payment for care coordination, 24/7 access, and the use of teams for care delivery under Medicare, Medicaid, other federal programs, and private plans. It would include incentives for providers to improve patient outcomes. The policy would complement new Medicare beneficiary incentives that include reduced cost-sharing for those who select patient-centered medical homes and chronic care teams (discussed below).

In addition to providing core support for medical homes, the policy would invest in the development and more intensive use of teams to manage care and improve care coordination by providing enhanced payment to providers that have the team-based capacity to care for high-cost patients with multiple chronic diseases or disability. Such teams would include nurses and other clinicians working with primary care physicians and would provide and coordinate after-hours or at-home care. Care teams responsible for high-risk, high-cost patients would work interactively with hospitals and specialists to ensure patients make smooth transitions across care settings and receive follow-up care after hospitalizations. Such teams would be held accountable for patients receiving timely, safe, and effective care.

New payment incentives and support for comprehensive primary care teams through Medicare and Medicaid would spread efforts already under way that include the use of multidisciplinary teams of doctors, nurses, and others to support and engage patients.⁴⁸ This policy would focus on the highest-cost Medicare and Medicaid patients and extend to

the Federal Employees Health Benefits Program, the military health coverage programs (TRICARE and the Civilian Health and Medical Program of the Uniformed Services), the Veterans Health Administration, and other federal programs. Public programs would partner with private payers where possible to enhance community-wide access to more effective, patient-centered care teams and networks.

3. Bundle hospital payment to focus on total costs and patient outcomes.

Accelerate bundled payment approaches for hospital and postacute care under Medicare, Medicaid, other public programs (including the Federal Employees Health Benefits Program) and private plans participating in insurance exchanges.

Currently, Medicare, Medicaid, and private insurer payments for hospital care typically do not include physician services and do not hold hospitals accountable for readmissions or follow-up care. More-inclusive bundled payments in which a single payment is made for all care provided during an episode of care involving a hospital stay—including physician services—would provide incentives for teamwork and accountability for the total costs of care and outcomes associated with hospital episodes of care. Medicare has begun a pilot to test alternative approaches to bundled payment. One model being tested bundles physicians' services and postacute transition care for selected procedures. Several bundled payment initiatives have been implemented in the private sector as well.⁴⁹ Accelerating bundled payment for hospital and posthospital care under Medicare, Medicaid, the Federal Employees Health Benefits Program, and other public programs and private plans in insurance exchanges would support movement toward high performance, and provide incentives for hospitals to make transitions and follow-up care a priority. Greater use of bundled

payment for hospital care and postacute care also would make it easier for patients as well as payers to compare and assess the total costs of care and quality for certain procedures and conditions such as hip replacement surgery, appendectomy, or heart bypass surgery.

4. Adopt payment reforms across markets, with public and private payers working in concert.

Align payment incentives across public and private payers to enable and support more accountable care systems. Require private plans participating in health insurance exchanges to incorporate alternative payment approaches to support delivery system innovation such as primary care medical homes, care teams, bundled payment for hospital episodes, and shared savings or global payment arrangements with provider systems. Encourage private plans in each state to negotiate prices consistent with efficient care and value and not to just pass on higher prices to consumers.

With federal and state health care programs insuring over 40 percent of the population, including those 65 and older, the disabled, and patients with long-term, complex health conditions, the acceleration of payment policy innovations across federal and state public programs would stimulate change across the country, supporting local care system innovation to achieve the triple aim of better care, better health, and lower costs. This effect would be amplified and benefit private as well as publicly insured families if similar payment methods applied to private as well as public payers. Ensuring that public and private payers employ the same or similar payment methods and reporting requirements would also reduce complexity for physicians and strengthen incentives to transform their practices in ways that improve the value of care. Requiring plans participating in health insurance exchanges to incorporate alternative payment approaches, such as bundled payment and support

for medical homes and high-cost care teams, would further accelerate practice innovation.

More consistent payment approaches across payers could also help counteract the concentration of provider market power. Under state or federal government auspices, allowing multiple payers to negotiate jointly to employ similar payment methods and more consistent pricing that promotes efficient care and value—rather than passing on higher prices in consolidated markets—could lower private insurance premium costs for businesses and families and counteract concentration of market power in some areas of the country. However, such negotiations would likely need to be under some type of public authority to avoid violation of antitrust statutes and to ensure that joint payer action converts savings into lower premiums rather than surplus for dominant private insurers. Antitrust oversight could also enable integration of care systems, as long as the net effect is to lower costs and improve quality.

Improving the way private insurance markets function and pay providers for care is of paramount interest to families as well as employers that sponsor and pay for employee health benefits. With the federal government providing premium tax credits for modest- and lower-income families enrolled through health insurance exchanges, stabilizing private health insurance costs would also mean lower federal outlays in the future.

Policies to Expand Options and Encourage High-Value Choices by Consumers: Create incentives for consumers to choose high-value care and high-performing health care systems, armed with comparative information about quality and costs. Currently, patients and consumers have very little information to guide their care decisions or to choose care or care systems wisely.⁵⁰ The lack of information about different treatment choices, clinical outcomes, prices, total costs, and quality of care

has discouraged efforts to develop insurance benefit designs that provide positive incentives to seek care from high-value care teams or networks. In all communities, annual health spending is highly concentrated among the sickest 10 percent of the population, who account for 65 percent of total health spending.⁵¹ This population includes those with cancer, heart attacks, major injuries, and multiple chronic illnesses. In contrast, the healthiest half of the population accounts for just 5 percent of total spending each year. Given that the bulk of health spending is for the sickest patients, it is important that efforts to engage consumers do not increase the substantial costs already borne by these vulnerable patients. To improve care outcomes and lower costs, policies should instead focus on providing better information and positive incentives to choose wisely based on value.

Engaging consumers requires providing better information on alternative care choices, as well as incentives to choose care systems that provide better patient outcomes and more patient-centered care. With advances in communication and health information technology (HIT), we have the potential to track, assess, and use information about clinical outcomes over time to inform and guide treatment decisions. As HIT spreads, following investments made possible by the 2009 economic stimulus bill, meaningful use and exchange capacity have the potential to provide more timely and longitudinal information on clinical outcomes resulting from different care decisions.

A consumer-friendly, patient-centered approach to providing information and positive incentives to choose wisely would complement payment policies that give providers incentives to innovate and collaborate while being held accountable for population outcomes and the total costs of care. Positive consumer incentives include reducing

cost-sharing or eliminating cost-sharing altogether for essential, highly effective care, and providing patients with comparative cost information for equivalent care choices. To enable such informed choice, there is also a critical need to expand scientific information about the comparative risks and benefits of alternative treatment choices, with assessment of outcomes for existing as well as new medical technologies and practice.

The following three illustrative policies would promote consumer engagement in making informed, high-value choices about providers and treatments.

5. Offer Medicare beneficiaries a new “Medicare Essential” plan that provides more comprehensive benefits and better protection against catastrophic costs, with provider and enrollee incentives to achieve better care, better health, and lower costs.

Use a value-based benefit design that provides positive incentives for Medicare beneficiaries to seek care from high-performing care systems, such as patient-centered medical homes, health care teams, accountable care organizations, integrated delivery systems, and other organized systems of care. These incentives would be aligned with payment reforms that give providers incentives to develop and join innovative care systems that improve patient outcomes and care experiences.

Currently, Medicare beneficiaries who decide to stay in traditional Medicare face a benefit structure that exposes them to unlimited risk for high costs of care unless they buy supplemental “Medigap” coverage and Part D plans to cover prescription medications. The current core benefits also include separate deductibles for hospital care, physicians, and prescription medications. The need for three insurance policies is confusing to beneficiaries and generates high administrative costs and high annual premium costs. Having multiple policies also

makes it more difficult to obtain the data needed to coordinate care effectively and complicates efforts to incorporate appropriate incentives that benefit the patient and ensure essential care (e.g., reduce hospitalizations through improved medication adherence.)

Offering Medicare beneficiaries a competitive Medicare Essential plan with integrated benefits that limit out-of-pocket costs while providing positive incentives to seek care from high-value care networks and teams would engage Medicare beneficiaries while protecting access and affordability. These positive incentives would work in tandem with the provider payment policies described above to encourage physician participation in high-performing health care organizations and payment innovations, including the formation of patient-centered medical homes, high-cost care teams, and high-value provider networks. Beneficiaries could enroll in a modernized Medicare Essential benefit option with deductibles or copayments lowered or eliminated for those who register with a medical home or receive care from a care team. This would involve the designation of a set of essential benefits, including integrated Part A (Hospital Insurance, which covers facility-based care), Part B (Supplementary Medical Insurance, which covers physician services), and Part D (the Prescription Drug Benefit) services and an overall out-of-pocket spending limit for covered services. This option could be designed as self-financing, with beneficiaries paying a premium directly to Medicare.

In estimating the potential premium cost for such a Medicare Essential plan we find it would generally be lower than the amount seniors typically pay for current Medicare Supplements (Medigap policies), in part because of lower administrative costs.⁵² This confirms earlier analyses that similarly found

that the resulting premium could be less than the current premiums paid by beneficiaries with private Medigap policies that provide supplemental coverage.⁵³

The benefit package of a Medicare Essential plan would more closely correspond to that provided by private plans in Medicare Advantage and those available through public and private employers. This would provide beneficiaries with real choices among health plan options. Recalibrating payments to Medicare Advantage plans based on the costs of the new Medicare option, with shared savings for lower-cost, high-quality plans and their enrollees, would encourage plans to operate more efficiently and encourage beneficiaries to select the best plan for them. High-quality plans would be those that perform well (4 or more stars out of the maximum of 5) according to the rating system used by Medicare.⁵⁴

6. Provide positive incentives for Medicare and Medicaid beneficiaries to seek care from high-value, patient-centered medical homes, care teams, accountable care organizations, and integrated delivery systems.

Work with local employer coalitions to spread the same value-based approach with positive incentives for patients in private plans.

To complement provider incentives to strengthen primary care and participate in accountable care networks, both Medicare and Medicaid would offer beneficiaries positive incentives to select care from practices and networks with proven track records of better outcomes. In Medicare, the deductible would be waived for primary care for beneficiaries who register with a practice that is a medical home or for care teams with the capacity to care for high-cost, high-risk patients. Cost-sharing also could be reduced for those patients who agree to receive care from networks that participate in the Medicare

Shared Savings Program or the Pioneer ACO initiative. To spread this approach in Medicaid, high-cost and chronically ill patients who elect to receive care provided by teams would be provided with access to enhanced services. Private plans participating in Medicare Advantage, Medicaid, and insurance exchanges would be encouraged to follow a similar approach and to align incentives across markets to support high-value care teams and care systems. Efforts to align information and provide positive incentives would be particularly important for networks participating as ACOs with multiple payers, including public and private payers.

7. Inform choice.

Enhance clinical information on outcomes of care and patient experiences to inform choice of care and care systems by accelerating “meaningful use” of health information technology to assess and compare clinical outcomes over time from alternative treatment choices and use registries to enable post-market surveillance of safety and outcomes. Promote transparency about health care costs and prices to further inform choices.

Providing better information on the benefits, safety, and cost of alternative high-cost medical treatment choices or technologies would inform decisions by patients and providers. As use of electronic medical records spreads, with enhanced capacity to exchange information across providers, the nation has the potential to reap benefits from its investment in smarter information systems and clinical support. Meaningful use of such systems, however, will require a concerted effort across care systems to pool information on outcomes to track and assess patient experience. The potential to learn from experience would be further enhanced with registries that track experience with medical devices or other high-tech procedures, such as the registry for total joint

replacement maintained by Kaiser Permanente.⁵⁵ Developing a national approach, rather than relying on private systems, would provide information about the safety of devices and other technologies as well as their comparative benefits for patients and doctors.

Having all-payer information on prices, quality, patient experiences, and outcomes of care, at both the state and community levels, would inform consumer choice. It also would inform efforts by providers to improve care by setting benchmarks and targets, and would enable payers (both public and private) to develop more value-based insurance benefit designs.

Policy leaders also may want to consider a ban on direct-to-consumer advertising for medical devices and prescription drugs in favor of providing information from unbiased, scientific sources. This would represent a return to policies in force in the United States before 1997.⁵⁶ Having trusted third-party sources that compare alternatives would further enhance the ability of consumers and physicians to make informed choices. Alternatively, there could be tightened oversight of claims in advertising.

Systemwide Action to Improve How Health Care Markets Function: Reduce administrative costs, reform malpractice policy, and set targets for total spending growth nationally and at other geographic levels.

Currently, health care markets do not function well. Fragmented payment policies and reporting requirements have given rise to an incoherent range of prices paid for the same service and same provider, and added layers of administrative costs for providers and health plans. At the same time, current malpractice liability laws provide incentives to do more testing while failing to address safety concerns.

Within local markets, consolidation of providers that may result in higher-quality and more-integrated care also has the potential to increase

prices, irrespective of value, if a relative imbalance of market power results from the consolidation. In recent years, increasing concentration has been an important factor in driving up costs for care systems and for health insurance. Indeed, increases in prices paid for care by private insurers for “must have” providers or dominant systems have accounted for much of the rise in private insurance premium costs as insurers pass on the higher costs, taking the path of least resistance.⁵⁷ This dynamic puts pressure on public programs to pay more, adding up to a recipe for increases in total spending in excess of economic growth.

As described above, transparency about health care prices, quality, and outcomes would inform consumer choice as well as providers’ efforts to improve. However, transparency alone will do little to address rising prices. Indeed, there is the potential for lower-cost providers to aim for the high end of the range once this is made public. And in communities where markets are concentrated, with few alternative sources of care available, consolidated market power could overwhelm and undermine any incentives for consumers to compare costs.

Given the reality of the current health insurance and delivery system market dynamics and concentration, systemwide efforts will be needed to complement payment reforms and incentives for consumers. This includes systemic efforts to lower the administrative costs that result from having multiple payers and failure to coordinate or standardize insurers’ policies.

To support payment reforms and incentives for consumers to choose wisely, the following policies seek to further improve the functioning of health care markets by reducing excessive administrative costs, reforming malpractice to promote

safety and fair compensation, and enabling multi-payer approaches.

Establishing a spending target and providing data on total spending (by both public and private payers) at national, state, and local levels would further inform policies over time and hold health care markets accountable. The targets, shaped by information on sources of cost increases and comparative data, would enable adjustment of policies to focus on what further action might be needed to achieve the goal of holding health spending increases to no more than the growth of the economy.

8. Simplify and unify administrative policies and procedures across public and private plans to reduce administrative costs and complexity.

Currently, private insurers employ different payment methods, reporting requirements, benefit designs, and regulatory policies. As a result, physicians and hospitals face complex insurance payment, regulatory, and reporting policies with consequently high administrative costs. This complexity also results in insurance administrative costs in the United States that are well above those in other countries, including those with multiple payers and private insurance markets. Recent forums of insurers and providers, and the policy papers they produced, have concurred that the multiple variations add cost without value, and that there is the potential for substantial savings with simplification.⁵⁸ But with variation seen as a potential market niche, each insurer alone has had little incentive to act.

Policies that simplify and require more uniform administrative policies and procedures across public and private plans would reduce an expensive layer of paperwork and make it easier for providers to focus on providing more effective, coordinated, and efficient care. Integrating administrative records systems, electronic submission of claims, shared

provider enrollment and credentialing systems, and common quality reporting would reduce redundancy and complexity that add time and staffing costs for practices and hospitals. The reduced administrative cost burden would largely accrue to physicians and hospitals. Streamlined enrollment processes for Medicaid and new insurance exchanges would also reduce health plan and insurance system administrative costs and promote more continuous enrollment.⁵⁹ Such efforts would build on beginning steps for administrative simplification embedded in the Affordable Care Act.⁶⁰

9. Reform medical malpractice policy.

Malpractice reforms should be linked to payment reforms and should provide fair compensation for injury while promoting patient safety and adoption of best practices.

Like administrative burdens, high premiums for professional liability insurance add to practice costs, especially for some specialties. Yet, despite its expense, the current malpractice system fails to create effective incentives to provide safe or evidence-based care, or to encourage admissions of mistakes or errors to inform corrective action. Reforming the malpractice system to include provisions for fair compensation for injury and medical costs, policies to encourage disclosure of errors, and protection for those adopting evidence-based practice could curb incentives to provide excessive or inappropriate care. Creating an environment that encourages the medical profession to police itself—with information shared across state borders for licensure—would further protect patients. Such an approach would also promote patient safety and evidence-based practice.

Although system savings would likely be modest, coupling such malpractice reform with Medicare payment reform would further focus incentives on value, and avoid liability incentives

that could lead to or be cited as the reason for excessive care.

10. Establish spending targets.

Target total public and private spending (combined) to grow at a rate no greater than economic growth per capita. Set targets at national and other geographic levels and adjust policies as appropriate based on progress toward meeting those targets. Collect data to inform and enable state and local action and allow for focused policy responses if growth exceeds targets.

Starting in 2014, the federal government will be providing tax credits to low- and modest-income families to help them buy insurance through state exchanges. As noted above, private costs per capita (per enrollee) are rising faster than Medicare costs per capita, and they are projected to continue to increase faster through the coming decade. In many markets, private insurers pay more than Medicare for specialized services and hospital care, especially in markets with more provider concentration or “must have” providers. To the extent that Medicare incentives to form ACOs speed up market consolidation across a continuum of care, more integrated care systems could further shift the balance of market power in favor of higher prices.

Rising costs and higher private market prices increase costs to businesses and working families and threaten access for beneficiaries of public programs. Policies that require transparent information on prices, quality, patient experiences, and outcomes of care would inform efforts to reduce excess increases. Enabling multipayer initiatives, including joint negotiations, under public auspices, could further curb increases. With the above strategic payment, consumer, and market policies, it should be possible to make significant progress toward stabilizing health care spending growth to no greater than the growth in the economy.

Establishing such a spending target, and adjusting policies as needed if the target is exceeded, would focus attention on identifying the sources of excessive cost increases. For example, certain geographic regions, more consolidated markets, or specific service areas may be the heart of the problem. Data would be collected to enable state or local communities to establish baselines, set targets, and adjust policies as needed. A spending target would also guide any multipayer negotiations of payment methods and rates.

A policy that includes provisions for adjustment of policies over time and allows for focusing on specific geographic areas or services if trends exceed the target would provide impetus to act and collaborate. A well-designed policy could enable targeted action at the geographic or service area or within local markets, with flexibility to refocus over time as needed.

ESTIMATING THE IMPACT OF THE POLICY OPTIONS

To estimate the potential impact of combining payment reform, positive consumer incentives to make high-value choices, and marketwide policies, we detailed illustrative policies that correspond to the strategies described above. Since the spending target actions would allow for adjustment pending the impact of the other policies, we did not delineate a specific policy to achieve the target of holding health care spending growth to no more than economic growth. In other words, the spending target policy was not scored.

The Commonwealth Fund contracted with the Actuarial Research Corporation (ARC) to estimate the potential cumulative effects if all policies were in place starting in 2013, with first-year impacts in 2014. ARC estimated the incremental

and cumulative spending impact over the 10-year period 2014 through 2023, compared with baseline projections under current policies. To estimate the potential of the combined policies, ARC adjusted estimates for each to reflect potential overlap.

For the baseline projections, ARC started with projections of national health expenditures, including spending and enrollment by major payer categories, from the Centers for Medicare and Medicaid Services Office of the Actuary. In recognition of the fact that Congress has consistently postponed the scheduled SGR cuts in Medicare physician fees, ARC used an alternative baseline that increases fees by 1 percent in 2013 and then holds base physician fees at their 2013 level under the assumption that Congress will continue to postpone the cuts throughout the decade. This would have the cumulative impact of raising total Medicare spending by some \$334 billion dollars from 2014 through 2023, compared with current law. This alternative baseline is similar in concept to the “extended alternative fiscal scenario” presented by the Congressional Budget Office in their annual *Long-Term Budget Outlook*.⁶¹

The ARC estimates draw on existing evidence regarding likely responses to policy changes. As always with estimates of projected changes, actual impacts would depend on the specifics of policy proposals, how rapidly and well policies could be implemented, and behavioral responses across markets.

All estimates assume policies are enacted in 2013 and in place starting in 2014, with accelerating impact over time as they take hold and spread across public and private payers. A [separate technical document](#) provides assumptions and data used to model the potential impact and studies used to inform the specifications.⁶²

THE POTENTIAL IMPACT OF THE COMMISSION'S POLICY OPTIONS

Analysis indicates that the policies consistent with the reforms discussed above offer the potential to slow and stabilize health spending, with significant savings across payers compared with projected spending over the next decade. By combining payment reform to accelerate delivery system innovation, initiatives to engage consumers to make high-value choices, and policies to lower administrative costs and improve the way health care markets function, total national spending could be reduced by a cumulative \$2.0 trillion from 2014 through 2023, if all were enacted together as part of a unified, synergistic strategy (Exhibit 6).

Looking at potential savings by major payer category, the analysis indicates there would be substantial savings for both public and private payers compared with baseline projections as policies spread across markets. The federal government would save an estimated \$1.036 trillion over the decade as a result of slower growth in spending per beneficiary for Medicare (\$528 billion) and Medicaid (federal share: \$369 billion). Households would save an estimated \$537 billion as a result of lower premium and out-of-pocket costs for medical care. State and local governments would save \$242 billion, primarily as a result of slower growth in their share of Medicaid costs (state share: \$236 billion), but also because of

slower growth in public employee health care costs. And private employers would save an estimated \$189 billion as a result of lower costs per person for their employees and retirees.

Analysis by strategic area indicates that the bulk of potential savings would result from payment reform and the resulting delivery system change (Exhibit 7). Together, these policies account for \$1.333 trillion of the estimated \$2 trillion in potential cumulative savings. Engaging consumers to make high-value choices about their care and giving them better information and positive incentives to receive care through high-value care systems and care teams could achieve an additional net savings of \$189 billion over the decade. Enabling consumers to make informed choices would also align incentives with payment reform to provide support and synergy for the development of higher-value care networks.

Focused efforts to improve the way health care markets function would reduce excessive administrative costs and ensure that care systems are held accountable for costs as well as health outcomes across all payers. Enacting strong measures to simplify and reduce administrative costs could potentially reduce net spending by \$481 billion. Although malpractice savings would likely be small, reforms could reduce costs for providers and improve the signals they receive from health care markets.

Exhibit 6. Synergistic Strategy: Potential Cumulative Savings Compared with Current Baseline Projection, 2013–2023

Net impact in \$ billions*

	Total NHE	Federal government	State and local government	Private employers	Households
2013–2018	-\$686	-\$345	-\$84	-\$66	-\$192
2013–2023	-\$2,004	-\$1,036	-\$242	-\$189	-\$537

Note: NHE = national health expenditures.

* Net effect does NOT include potential impact of spending target policy.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

Exhibit 7. Synergistic Strategy: Cumulative Savings, 2013–2023

Payment reforms to accelerate delivery system innovation (\$1,333 billion)

- Pay for value: replace the SGR with provider payment incentives to improve care
- Strengthen patient-centered primary care and support care teams
- Bundle hospital payments to focus on total cost and outcomes
- Align payment incentives across public and private payers

Policies to expand and encourage high-value choices (\$189 billion)

- Offer new Medicare Essential plan with integrated benefits through Medicare, offering positive incentives for use of high-value care and care systems
- Provide positive incentives to seek care from patient-centered medical homes, care teams, and accountable care networks (Medicare, Medicaid, private plans)
- Enhance clinical information to inform choice

Systemwide actions to improve how health care markets function (\$481 billion)

- Simplify and unify administrative policies and procedures
- Reform malpractice policy and link to payment*

Target total public and private payment (combined) to grow at rate no greater than GDP per capita**

Notes: SGR = sustainable growth rate formula; GDP = gross domestic product.

* Malpractice policy savings included with provider payment policies.

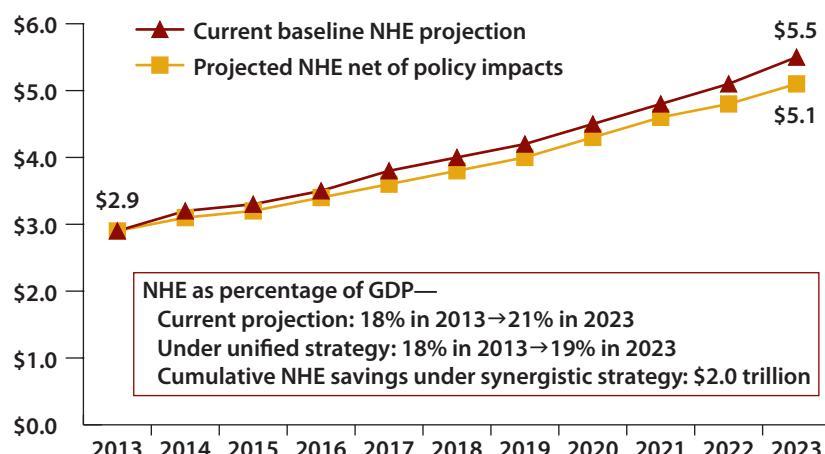
** Target policy was not scored.

The above estimates of potential savings indicate that systemwide payment reforms, positive incentives for consumers to make high-value choices, and concerted efforts to reduce administrative costs could potentially hold spending growth to no more than GDP growth per capita for most of the decade, without resorting to additional policies implemented

specifically to achieve the spending growth target. Together, the policies described above would reduce total national spending by a cumulative \$2 trillion, with health spending amounting to an estimated 19 percent of GDP by 2023 compared with the current projection of 21 percent (Exhibit 8).

Exhibit 8. Projected National Health Expenditures (NHE), 2013–2023: Potential Impact of Synergistic Strategy

NHE in \$ trillions



Note: GDP = gross domestic product.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

The nation is projected to spend about 18 percent of GDP on health care in 2013, the year before these policies are assumed to be implemented. Thus, the synergistic policy approach comes close to the goal of stabilizing spending growth to no more than the growth of the economy, with a significant reduction in the currently projected rate of growth. Analysis indicates there would not be a need for further action to enforce the spending growth and share of GDP target until near the end of the decade (2021) if policies were implemented quickly and effectively.

In other words, all estimates in the exhibits represent the net impact of the specified payment, consumer incentives, malpractice, and administrative-cost reforms without resorting to additional actions to reach the spending target. Examining the potential impact by year, the analysis indicates that the combined impact of payment reforms, incentives for consumers, and market reforms would potentially hold the line on national spending as a share of GDP at 18 percent up to 2021. And throughout most of the decade, the growth in Medicare spending per beneficiary would be below GDP growth per capita, with substantial net savings compared with current projections. However, at the end of the decade an aging population would lead to increases in Medicare and Medicaid spending above projected GDP growth without further health system innovation.

Notably, although private spending per insured enrollee would slow, it would continue to exceed GDP annual growth and Medicare per beneficiary growth throughout the decade as it has in recent years. In specifying policies, none of the illustrative policies explicitly aimed at controlling the prices private payers pay for care or limiting the rate of increase. Instead, the policies focused on private payers adopting similar payments through insurance

exchanges. The analysis does not examine what could happen to private payer trends if dominant private payers were better able to leverage their purchasing power by paying for value or through multi-payer initiatives.

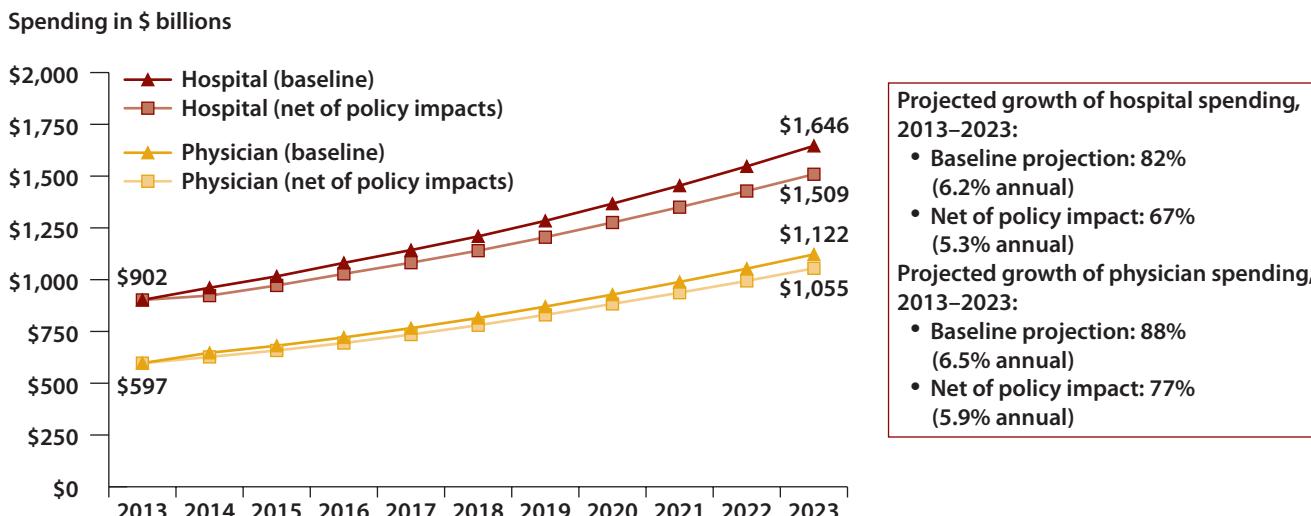
If the pace of delivery system change accelerated and private-payer payment policies spread to slow private per-person spending growth and bring it more in line with economic growth, the estimates here indicate that national health expenditures as a share of GDP by 2023 would be held near the 2013 level of 18 percent.

The analysis further suggests that policies would need to be adjusted or expanded over time to achieve the target at the end of the decade—but the nation would be within reach of the goal. In other words, it should be possible to achieve the target if all sectors pull together and are accountable for the total costs of care, further enhancing the effectiveness of these policies.

It is important to note that despite the substantial savings produced by these policies over 10 years, the health sector would still grow—with adequate resources to adopt innovations in care delivery, introduce new medical breakthroughs, and ensure care for an aging population. Even under these policies, health spending is projected to increase from \$2.9 trillion in 2013 to \$5.1 trillion in 2023—an increase of more than 75 percent over the decade. In particular, national spending on both hospitals' and physicians' services would continue to grow, with the potential for net revenue growth as administrative costs decline (Exhibit 9). This would also be true if total national spending stabilized to a constant share of GDP, as long as the economy continued to grow.

With an aging population, there will be a need in the future for community-based care teams that include nurses and medical assistants to ensure timely access to care. By eliminating duplication,

Exhibit 9. Impact of Synergistic Strategy on Projected Annual Hospital and Physician Spending, 2013–2023



Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

inappropriate care, and excessive administrative costs, and by providing safer care, it should be possible to organize the care system around patients' needs and redirect resources away from waste to essential, high-value care.

The substantial—but slower, more stable, and better targeted—growth in health spending would continue to allow for expansion of services to those who are now uninsured and underinsured, the ongoing adoption of information technology, the introduction of new prescription drugs and medical breakthroughs, and an increase in compassionate care for the most vulnerable, including low-income individuals, the elderly, and the disabled. It also provides for jobs in the health sector, stable incomes for health care professionals, and fiscal viability for efficient hospitals providing essential services.

CONCLUSIONS

The analysis described above indicates that it should be possible to stabilize health care spending growth in ways that achieve substantial savings in federal spending as well as savings for households, businesses, and state and local governments—all the while adhering to the principles and goals of a high performance health care system that is accessible to all. Analysis of potential policy action in the key strategic areas identified by the Commission indicates there is potential to substantially reduce spending growth through a combination of reforming provider payment, engaging consumers to make high-value choices, improving the way health care markets function, and holding markets accountable.

In combination, these policies could lead to wiser and more efficient expenditures of health care dollars, while also enhancing the benefits of health care. Further, the projected savings could be redirected to other essential sectors of the economy. By stabilizing growth, health care would no longer deprive other essential sectors of the economy of the resources required to invest in education, research,

innovation, and infrastructure development, all of which are needed for a thriving economy in the future.

Freeing up \$2 trillion that would otherwise have been spent on the health sector over the next 10 years because of the rising costs of care could also result in positive reverberations across the economy. It would ease burdens on U.S. businesses and potentially raise incomes for the working population through a return to economic growth, while better meeting the needs of an aging population.

Notably, the policies could achieve substantial federal budget savings compared with projected trends while at the same time preserving access to care and affordability and avoiding shifting costs to households, business, or state and local governments. The analysis further indicates that potential federal savings could more than offset the \$334 billion 10-year costs of repealing scheduled Medicare cuts to physicians—yielding substantial net federal savings—while aligning payment more closely with system goals. Achieving these savings, however, requires reforms of current payment policies, with future increases dependent on development of more accountable care systems and high-value care teams. The analysis also assumes that Medicare policy would recalibrate payment rates as appropriate, depending on market trends, especially where prices paid by private payers have moved lower than historic Medicare rates. This would require enabling more flexible payment authority to respond to market changes.

The analysis indicates that families would be the major winners over time from such a strategic approach, with potential for better care outcomes and experiences as well as an estimated \$537 billion in direct savings over 10 years, compared with projected trends. These savings are the result of lower

future premium costs as well as lower out-of-pocket costs, including gains from more efficient insurance coverage of Medicare beneficiaries. The slower growth of medical care costs would reduce out-of-pocket costs as the delivery system responds with enhanced high-value care and care systems. The substantial net savings for Medicare's elderly and disabled beneficiaries depend on the provision of a Medicare Essential option for beneficiaries that would complement provider payment policies and reduce costs for beneficiaries. In the end, reduced health spending by federal, state, and local governments and private employers also would accrue to households, which ultimately bear the burden of rising health spending through higher taxes, reduced wages, or direct out-of-pocket costs.

Overall, the analysis indicates the potential of aiming policy efforts at the forces driving up medical care costs for the nation, rather than a narrow short-term focus on federal programs only. The policy set outlined by the Commission in this report, with its three-pronged strategic approach, would interact synergistically to address the forces that are driving up costs without adding value across the health system and would accelerate progress to a more patient-centered, high-quality, innovative health care delivery system.

The fact that private insurance costs per enrollee have been rising more rapidly than public per-enrollee costs, and that Medicare costs per beneficiary are growing more slowly than GDP per capita, further highlights the need for joint public- and private-payer action. Integrated care systems, which produce better health outcomes at lower costs, have as yet failed to spread because health care markets do not support movement in that direction. With the advent of promising payment initiatives in the private sector, as well as in some states, there is an

opportunity to accelerate this trend by having Medicare, Medicaid, and private payers collaborate to align provider incentives and address market dynamics that are barriers to moving forward.

In summary, analysis of the set of policies identified by the Commission indicates the potential to achieve the goal of stabilizing health care spending growth if policies are applied broadly and effectively and public and private payers act in concert—and if payment reforms accelerate delivery system changes and address market forces that drive up costs without increasing value.

Moving from concept to action, however, will require that national policy leaders reach consensus that health care cost growth is a national concern, not just a federal budget concern. The need for action applies not only to the federal government, but also to state and local governments, businesses, and households, all of which are under increasing financial pressure as a result of the growth in health spending. Ideally, all of these stakeholders would work together toward the same goals: simplifying the health system; reducing administrative waste; changing the way we pay for care to hold care systems accountable for population health while providing flexibility to innovate; and leveraging the impact of policy changes across payers. By pulling together to stabilize health spending, we have the opportunity to reduce the federal deficit, free up resources for state and local governments, and make care and high-value health insurance more affordable for families and employers.

Further, the overarching goal should be moving the U.S. health system toward a higher level of performance, with access to affordable care for all,

improved quality and patient-centeredness, greater accountability for both health outcomes and treatment costs, and enhanced population health. A high performance health system is not only consistent with, but also necessary for, stabilizing health care spending into the future.

As looming federal deficits intensify the call for action, it will be critical that health care spending decisions are guided by the goal of creating a high performance health system. To achieve this goal, policymakers will need to come together to act on behalf of the nation. The federal government is in a unique position to partner with states and private payers. In addition, through Medicare, it plays a critical role for all families across the United States. The analysis of the potential yield to the federal government and the nation if policies that aim to address systemic concerns and accelerate care system innovation are enacted indicates that federal health programs could achieve substantial savings with a unified strategy.

There is the opportunity to act now, spurred by concerns of future federal deficits. But it is essential to act wisely. The Commission offers this unified strategy and exemplary policies as a framework pointing a way forward for federal, state, and private policy leaders as they confront health care costs. Building on the three pillars of payment reform, high-value consumer choice, and improved market function, the nation has the potential to accelerate health care innovation, ensure access for all, and at the same time achieve not only a more affordable, but also a better and higher-performing health system.

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- ⁷ Note that all three of these rates are below the projected rate of increase for overall national health expenditures. This is because the proportions of the population covered by Medicare and Medicaid—who are considerably more expensive than people covered by private employer-based insurance—are expected to rise, increasing overall per capita spending more rapidly than any of its components.
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