Health Care Reform:
The Perils of Inaction and the Promise of Effective Action
Executive Summary

The debate over comprehensive health care reform is at a critical juncture. Fact and fiction are becoming increasingly blurred as the debate moves into the public arena. As the sponsors and purchasers of the bulk of group health plans in America, employers will play an important role in the eventual solution. The status quo is not an option for American business, and meaningful reform must address the delivery system inefficiencies that are driving up health care costs. Expanding health insurance coverage is critically important, but simply adding more people to an ailing system and spending more money will only make the existing cost problems worse.

This report makes a case for the potential benefits of health care reform if it is done wisely. The United States can reduce upward health care cost trends and expand access for most Americans if:

- Health insurance coverage is expanded to as close to universal levels as we can reasonably get;
- Existing sources of employer-based coverage are not disrupted or displaced or saddled with significant additional costs and compliance burdens;
- Expanded coverage is accompanied by meaningful delivery system reform led by changes to Medicare; and
- As expected, purchasers in the private sector adopt these reforms.

The Status Quo Is a Prescription for Failure

As months of Congressional and now public debate have proved, discussion of coverage provisions and financing of health care reform is complex and controversial. The debate over health care reform is increasingly being framed as a choice between the current system and the uncertainty of what reform may bring. But the comparison should be between

About Hewitt

Hewitt Associates is a global human resources outsourcing and consulting company, providing services to major employers in more than 30 countries and employing 23,000 associates worldwide. This report draws heavily upon the experience of Hewitt’s consultants and actuaries who have extensive knowledge of—and direct experience with—the employer-sponsored health care system, the health insurance marketplace, and the emerging market trends and strategies aimed at broadening access, controlling cost, and improving the health and productivity of the U.S. workforce. Hewitt administers health plans for more than 200 large employers representing over 8.5 million participants. Hewitt created and maintains the Hewitt Health Value Initiative™ database, which contains detailed census, cost, and plan design information for 325 large U.S. employers representing 13.1 million participants and $50.5 billion in 2009 health care spending.

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the uncertainty of what reform may bring and the near certainty of what inaction will bring. Doing nothing is simply no longer an option. If current trends continue, the future looks dire for the U.S. health care system and for employer-sponsored coverage that is its foundation. Without change, Hewitt projects that employer-based health care costs will increase 166% by 2019, resulting in a cost burden of $28,530 per employee. This price tag approaches three times the 2009 per-employee cost of $10,743. America’s businesses cannot win in the marketplace when bidding against global companies shoulder- ing significantly lower health care cost burdens. In fact, runaway health care costs are threatening the employer-based system that provides coverage for the majority of Americans and their families today. Reform must bolster the employer-based system.

Expanding Coverage Is Part of the Solution

For previously uninsured individuals, access to health insurance coverage and expanded medical services will undoubtedly fill a significant gap in their economic security and well-being. While this is critically important, equally important is to understand how this expansion of coverage affects the overall system. Will supply simply expand to meet increasing demand? Or will the system become more rational as the indirect cost from uncompensated care is reduced and the delivery system is reformed to produce more coordinated care of chronic illness, improve quality and outcomes, and reduce future cost trends? The answers to these questions depend on how reforms are accomplished. Health reform must create the right incentives for continued innovation and efficiency improvements while safeguarding and strengthening the things that are working well.

There is compelling evidence that the economic benefits of expanding coverage could potentially result in a positive return on investment if done right. Potential benefits include improving markets, reducing cost shifting, improving health and productivity, enabling greater workforce mobility, improving personal financial health, narrowing disparities in care, reducing adverse selection, increasing efficiency, lowering administrative costs, and improving affordability.

The System Malfunctions, but It Can Be Fixed

Bottom line, the long-term viability of the U.S. health care system depends on meaningful delivery system and market reform. This paper suggests a number of areas that can make a real difference to both cost and quality. Promising reforms include strong insurance market reforms that create new markets and enable competition, bundled payments to medical providers, accountable care organizations, patient-centered medical homes, health risk assessments, value-based purchasing, transparency of cost and quality measures, and administrative simplification. The current system provides incentives that are often misaligned. It reimburses providers to treat illness without direct performance links to improved health outcomes. It insulates both providers and patients from the financial consequences of health care consumption. Without market pressure on cost and with little incentive to manage efficient utilization, traditional market forces that moderate costs don’t work in today’s health care system. Major structural changes are an imperative if the health care system is to operate efficiently.

The single best place to initiate these delivery system reforms is with the Medicare program. Because the Centers for Medicare & Medicaid Services (CMS) is the largest single purchaser of health care services in the United States, its actions can have a direct effect on the actions of private purchasers and on provider behavior more broadly; changes that diffuse into the broader health care system.

A Tipping Point

The time for health care reform is now, but how we get the job done has never been more important. The well-being of Americans and their families and the competitiveness of American companies are at stake.

Getting More Value for Our Money

Nearly two-and-a-half trillion dollars. That is how much the United States spent on health care in 2008.1 That’s about as much as we spent on food, clothing, and national defense combined. It dwarfs the $1.3 trillion of combined profitability generated from every corporation in America.2 If our health care system were its own country, it would rank as the seventh largest in the world—larger than the total domestic output of Italy, Russia, Spain, Brazil, or Canada.3

What value do we receive for this $2.4 trillion, which is one-sixth of our national economy and the most that any country spends on health care? By some accounts, we have the best health care system in the world. The fact that the United States has no budgeted spending limit for health care has allowed for significant investments in technology, innovation, and capacity. The result is some of the most advanced treatments available anywhere, with almost immediate access to the majority of Americans. Individuals who need lifesaving treatment can be reasonably confident that almost any hospital they enter in the United States will be adequately clean, will be equipped to handle all but the most specialized care, will be staffed by well-trained clinical personnel, and will contain the supplies and medicines needed for them to recover. The money we spend in medical research to treat and cure disease is unmatched anywhere in the world, and we make the results of this research available to our citizens quickly and broadly. For example, the United States supplies more MRI machines per capita than almost every other country in the world, based on the most recent comparative data from the Organization for Economic Coopera-
tion and Development (OECD).4

Yet for all its positives, the U.S. health care core system fails to achieve its full potential in a number of ways. Life expectancy, infant mortality rates, and deaths from heart attacks and cancer are not any better in the United States than in many indus-

1 Office of the Actuary, Centers for Medicare & Medicaid Services, National Health Expenditure Projections 2018–2018
3 The World Bank, World Development Indicators Database, 2009
4 Organization for Economic Cooperation and Development, OECD Health Data, 2009. (Note, however, that Japan exceeded the U.S. in the MRI category in 2005, and when the most updated report is eventually issued, Japan’s data may exceed the U.S. levels.)
The Status Quo Is a Prescription for Failure

As evidenced by the staggering cost of health care in the United States, health insurance has become synonymous with health care. Uninsured individuals do not have access to the same levels and quality of health care as their insured counterparts. Uninsured Americans consistently experience worse clinical outcomes than the insured and are at increased risk for dying prematurely. And because we have no system of universal coverage, an estimated 45.7 million Americans were without health insurance in 2007 and many suffered the consequences of inadequate care. This system, which allows voluntary sponsorship by private-sector employers and voluntary enrollment by the individual employees, now covers 177 million Americans, or 88% of all individuals with private insurance.

For several reasons, employers believe it is good business practice to provide health care benefits:

- People are an organization’s most important asset, and there is a direct link between employee wellness and workforce absenteeism and productivity.
- Employers believe it is their responsibility to protect employees from the risk of catastrophic loss arising from the expense of serious illness.
- Under current tax laws, providing coverage under an employer-sponsored program is the most efficient way to provide these benefits.
- Providing health care benefits allows employers to attract and retain key talent in a competitive marketplace.

However, the cumulative effect of years of explosive health care cost increases now threatens the employer-based system. Rising costs are hampering the ability of American companies to compete in a global economy. According to Business Roundtable’s Health Care Value Index, a relatively new, 100-point scale measure of the “value” (cost and performance) of the U.S. health care system relative to other countries’ systems, the United States faces a 23-point “value gap” relative to five leading economic competitors—Canada, Japan, Germany, the United Kingdom, and France (the “G-5”)—and a 46-point “value gap” relative to emerging competitors Brazil, India, and China (the “BIC group”). What does this “value gap” mean for our ability to compete in the international marketplace? As shown in exhibit 1, among countries tracked by the OECD, the health care cost that is borne by the private sector is the most striking difference between the United States and its trading partners.

If current trends continue, the future looks dire for the U.S. health care system and employer-sponsored coverage that is its foundation. If nothing changes, by 2019, total health care spending will reach $4.4 trillion and will consume over 20% of the U.S. gross domestic product. Employer spending and associated employee contributions will significantly outstrip increases in cash wages, causing a decline in consumer purchasing power that will hinder economic growth.

For decades and using a variety of techniques, employers have tried to control spiraling health care costs to rein in excessive utilization, obtain better prices, manage chronic disease, and promote health and wellness. These strategies have had varying levels of success, but in the face of unrelenting upward cost pressures, in the last eight years, total medical costs (employer and employee premiums, plus employee out-of-pocket payments) for large-employer plans have risen by 118%, from $4,918 per employee to $10,743 per employee.

Without fundamental changes to the system that continues to push costs upward, there is no reason to expect any different trend line over the next 10 years. If that happens, costs in 2019 will be 166% higher than they are in 2009. As summarized in exhibit 2, the average cost to American business will be over $28,000 per employee ($28,530).

Exhibit 1: Leading the Pack on Global Health Care Spend
Public and Private Per Capita Health Spending Among OECD Countries, 2007

<table>
<thead>
<tr>
<th>Country</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$3,310</td>
<td>$3,980</td>
</tr>
<tr>
<td>United Kingdom</td>
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</tr>
<tr>
<td>Switzerland</td>
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<tr>
<td>Spain</td>
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<td>$753</td>
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<tr>
<td>Poland</td>
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<td>Mexico</td>
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<td>Korea</td>
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</tr>
<tr>
<td>Canada</td>
<td>$2,726</td>
<td>$1,669</td>
</tr>
</tbody>
</table>

Annual Spending per Capita

7 U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States,” 2007
8 Ibid.
10 Organization for Economic Cooperation and Development, OECD Health Data, 2009
11 Hewitt Associates, Hewitt Health Value Initiative (database of 325 large-employer plans covering more than 13 million members). (Note: Projections assume trends from 2001 to 2009 are repeated from 2009 to 2019.)
Current health care reform proposals aim to increase access to health insurance coverage by expanding eligibility for Medicaid, by providing federal subsidies for low-income individuals and small businesses to purchase coverage, and by reforming the health insurance marketplace to eliminate medical underwriting and preexisting condition limitations. These actions may be combined with an individual mandate requiring every American to purchase health insurance coverage. Recognizing that 100% coverage is not achievable, many reformers’ goal is to reduce the number of uninsured individuals by approximately two-thirds. If achieved, this would translate to an additional 30 million Americans having some form of health insurance and lowering the percentage of uninsured Americans to below 10%—the lowest level since the Census Bureau first started tracking these numbers.14

For previously uninsured individuals, having access to health insurance coverage will undoubtedly fill a significant gap in their security and well-being. But what impact will this expansion of coverage have on the overall system? Will supply simply expand to meet increasing demand? Or will the system become more rational as the indirect cost from uncompensated care is reduced?

This paper examines the available research to determine the likely impact of expanding coverage as envisioned under the current health care reform proposals being considered by Congress. Where opportunity exists to generate greater market efficiencies through changes in low, regulation, infrastructure, and delivery system, specific suggestions are provided as a framework for further exploration. Those who seek to reform the health care system and those with a significant stake in the outcome share a common mission—a desire to drive toward a high-quality, highly efficient health care marketplace where the value of care delivered is commensurate with the large number of dollars spent.

Expanding Coverage Is Part of the Solution

Individuals who lack health insurance can still receive care under the current system, but they generally do not receive the same level of care as their insured counterparts. They may not receive the right care (such as appropriate preventive treatment), the most efficient care (such as when they substitute emergency room treatment for a timely visit to the physician’s office), or enough care (such as drugs to manage chronic conditions). In fact, individuals who are continuously uninsured for an entire year typically receive about a third of the health care services of those who are insured. In dollar terms, the difference is $1,686 per year versus $4,463.15

If more people were covered under the existing delivery system, overall spending would increase. The Kaiser Family Foundation estimates that total health care spending for full-year and partial-year uninsureds would add $122.6 billion to the annual cost of health care in the United States if this population became insured.16 Additional health care spending is quite likely to be a short-term result of expanded coverage as the medically underserved receive more and better care. However, there is additional evidence that the economic benefits of this increased spending in terms of improved health status, longevity, and productivity would result in a positive return on this investment. Perhaps the greatest challenge—and reward—will be to modify the underlying delivery system so that it is moved along a path of greater efficiency, quality, and lower cost trends in the future.

We believe there are many positive downstream implications to expanding coverage to more Americans.

Reducing Uncompensated Care Funding and Cost Shifting

Uninsured individuals currently consume approximately $86 billion in health care services annually and pay $30 billion of this amount through out-of-pocket payments.17 The remaining $56 billion is funded by a combination of direct government payments for uncompensated care and indirectly through cost shifting to private payers. Expanding

16 Ibid.
17 Ibid.
covemage to the uninsured, though it will have costs of its own, will generate some offsetting savings from reductions in the need for some of the existing government subsidies, as well as taking some of the pressure off providers to cost shift to other payers.

However, the type of coverage these newly insured individuals receive is critically important. If the primary vehicle for coverage is expanded Medicaid eligibility, not only may there be quality of care issues because there are fewer participating providers to select from, but the positive effects in reduced cost shifting will be diluted by insufficient reimbursements available to providers under the Medicaid system. Milliman estimates that Medicaid payments to physicians are approximately 53% of commercial plan rates, and only 67% of Medicare rates. Expanding the number of Medicaid recipients will likely exacerbate the cost shifting, not alleviate it. Similarly, if new coverage is provided under a public plan funded with Medicare-like reimbursements, we should expect little positive effect on private payers. In contrast, current proposals to pair an individual mandate with individual insurance market reforms and an exchange-enabled Medicaid system. Milliman estimates that Medicaid reimbursement, we should expect little positive effect on private payers. In contrast, current proposals to pair an individual mandate with individual insurance market reforms and an exchange-enabled Medicaid system, will generate some offsetting savings and in some cases expanded access through on-site clinics and pharmacies.

In contrast, public programs have truned on the innovation front. Legal restrictions and regulatory inflexibility make it difficult to evolve public models to improve quality of care and efficiency of delivery. In addition, risk-bearing entities have greater incentives to develop innovative approaches in treating patients more appropriately—particularly in the high-cost area of care coordination for chronic illnesses, which drive the lion’s share of health care costs. As will be discussed further, in connection with accountable care organizations, for example, such virtual adaptations of the original vision of coordinated care plans offer reimbursements tied to overall performance and outcomes rather than the amount and intensity of services. They rely on group/staff model provider organizations to bear the risk for the care they deliver. While much can and has been said about the failure of the managed care movement to rein in long-term health care costs, the payment and structure of the group/staff models have consistently proved to be an oasis of efficiency in a broader health care system where incentives are often misaligned.

Encouraging Health Care Innovation

Over the years, employers have been the drivers behind many innovations in health care solutions. Recent innovations include value-based design, price transparency, consumer-oriented incentives, and robust coaching models. There are promising outcomes emerging from extensive wellness and disease management programs that encourage participants to engage in healthy activities, identify their health risks, and manage their illnesses. By investing in the health of their workforces, employers help make employees and their families healthier, while also gaining better control over health care costs and employee absences. The employer-based system has also preserved broad access to primary care, specialists and hospitals, and in some cases expanded access through on-site clinics and pharmacies.

Improving Health and Productivity

Almost 21 million uninsured individuals—45% of the total—have a full-time job. They are uninsured because their employers don’t provide coverage, the coverage is too expensive, or they choose not to cover themselves and their families. Increased coverage options will likely lead to improved pre-ventive screening, early detection of disease, and better management of chronic conditions. This will result in reduced absenteeism and higher levels of productivity. A more productive labor force translates into higher tax revenues on additional years of earnings and income, and lower rates of disability under federal and employer-provided income replacement programs.

Providing Greater Workforce Mobility

Certainly the financial turmoil of the last year is forcing many Americans to stay in the workforce longer than they originally planned. This reality just exacerbates the issue of “job lock.” The scenario is that individuals with a preexisting health condition are afraid to leave their current job for fear that they won’t qualify for coverage at a new job. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addressed this problem by placing limits on preexisting condition clauses. Today, most large employers have dropped all restrictions for preexisting conditions, going well beyond the minimum standards established under federal law, allowing for easy transfer of coverage as individuals move from employer to employer. Restrictions, however, still may exist in the individual and small group markets. A 2008 EBRI survey found that one in four adults responded that they had passed up another job opportunity, stayed at a job they would have quit, or declined to retire early in order to retain employer-provided health insurance. Additionally, a complex statistical analysis done by the U.S. Census Bureau found that if an employee’s chance of obtaining employer-based health insurance in their job increased from 60% to 73%, the employee was 6% more likely to stay at his or her current job.

A reformed health insurance marketplace that eliminates preexisting condition exclusions and ensures guaranteed access to coverage would reduce or eliminate individuals’ fears that health conditions would block them from obtaining health coverage based on where they work. This would ultimately result in a more level playing field for talent between small employers and large employers. One out of every four employed Americans works for a company with fewer than 20 employees, and 82% of Americans are employed by companies with fewer than 500 employees. Businesses with fewer than 500 employees account for over 50% of private non-form GDP and play a large role in supplying inputs and innovation to the American economy. Barriers to affordable health insurance hinder the growth of small, entrepreneurial business; we need to remove these barriers to stimulate small business development.

Improving Personal Financial Health

Large numbers of both uninsured and underinsured Americans have filed for personal bankruptcy. One recent study reported more than one-quarter of all personal bankruptcy filings in 2001 were caused by a specific illness or injury. Others estimate this number to be around 30%. Increasing the
The disparity in health care outcomes between insured and uninsured individuals is well documented. Similarly, health care outcome disparities exist across racial, ethnic, and socioeconomic boundaries. It is likely that these two factors are connected. After studying the prevalence of hypertension, diabetes, and coronary heart disease, researchers at the Harvard Medical School found that disparities narrowed dramatically once individuals became insured (in this study, eligible for Medicare). For systolic blood pressure, racial disparities decreased by 60%. For diabetes risk factors, racial and ethnic disparities fell by 78%. And for total cholesterol levels, educational disparities disappeared altogether. While efforts at reducing health disparities even among the insured population remain an important objective of health care reform, expanding health insurance coverage offers the potential to overcome long-standing differences in health risk and outcomes across different demographic and socioeconomic groups.

Opt-out rates (the percentage of employees who do not purchase coverage when it is offered to them) increase as employer subsidies decrease, and can range from under 5% in heavily subsidized plans to more than 50% in plans with very low subsidies. Overall, 18% of employees offered health insurance by their employers choose not to purchase it. Many of these individuals presumably obtain coverage through their spouses or other sources, but selective enrollment by individuals creates a pool of insured Americans that is tilted toward the least healthy. Either by establishing a legal requirement that individuals obtain health insurance and/or by requiring automatic enrollment of individuals in private health plans, expanding coverage to more Americans means increasing the number of healthier (i.e., lower-risk) individuals in the pool. With more insurance dollars flowing through employer and insurer pools, the overall cost of coverage should decrease for currently insured individuals.

The public health effects of expanding coverage—more targeted, cost-effective preventive care, early detection and treatment, and better management of chronic illnesses—will have downstream implications for the efficiency of the delivery system, especially if paired with a strengthening of the primary care system. The Agency for Health Care Research and Quality found that, while the uninsured represent approximately 15% of the U.S. population, they account for nearly 20% of all emergency room visits. Using the emergency room for conditions that could be treated in a less acute environment is not only inefficient for the patient, but also strains the capacity and financial resources of hospitals—particularly in communities with high proportions of uninsured populations. Reducing the number of uninsured will likely increase the number of Americans who have primary care physician relationships and lead to more efficient use of emergency department resources. Associated hospitalizations for acute episodes of pediatric asthma, diabetic shock, and heart conditions should also decrease with greater availability and compliance with more affordable maintenance medications. As mentioned previously, more insurance translates into more care—but if corresponding efficiencies can be gained in the process, this additional cost can be offset, either in whole or in part. Getting the right care at the right time in the right place by the right provider is a goal that can be furthered by more efficient use of health care resources.

**Lowering Administrative Costs**

Increasing the volume of insured individuals, reducing adverse selection (particularly in the small group and individual markets), and lowering insurance marketing and underwriting costs for policies purchased through proposed health insurance exchanges will translate into lower administrative costs that are built into overall insurance premiums. Eliminating medical underwriting provisions will greatly reduce insurer underwriting expense. Focusing on delivery of individual and small business coverage through regional or national health insurance exchanges will reduce distribution and marketing expenses, and certain reform proposals anticipate that, eventually, large employers may be able to purchase health insurance coverage through the exchanges as well.

Federal guidelines around plan design should reduce the extreme variation between insurance plans and streamline claims adjudication. As shown in exhibit 3, the Lewin Group estimates that overall administrative costs in an exchange-enabled mar-

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**Exhibit 3: Health Exchanges Promise Big Savings in Administrative Costs for Individual and Small Group Coverage**

Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Current</th>
<th>Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>12.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Individuals</td>
<td>9.6%</td>
<td>40.9%</td>
</tr>
<tr>
<td>2 to 4</td>
<td>13.3%</td>
<td>47.4%</td>
</tr>
<tr>
<td>5 to 9</td>
<td>11.3%</td>
<td>30.3%</td>
</tr>
<tr>
<td>10 to 19</td>
<td>10.2%</td>
<td>28.5%</td>
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<td>20 to 49</td>
<td>10.5%</td>
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<td>50 to 99</td>
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<td>100 to 499</td>
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<td>500 to 2,499</td>
<td>10.4%</td>
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<tr>
<td>2,500 to 9,999</td>
<td>6.7%</td>
<td>26.5%</td>
</tr>
<tr>
<td>10,000+</td>
<td>4.5%</td>
<td>47.4%</td>
</tr>
</tbody>
</table>

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28. Hewitt Associates estimates


Current reform efforts to expand health insurance coverage to more Americans and dramatically reduce the ranks of the uninsured will result in more health care services delivered to a population that is largely underserved. Previous estimates of the cost of this expansion fail to take into account the positive downstream impacts that will occur with respect to cost shifting, uncompensated care funding, labor force productivity and mobility, health disparities, and market efficiency. The net cost impact may still be positive, but the value to American society and commerce of providing more than 90% of its citizens with access to comprehensive health insurance will no doubt outweigh the cost.

For the health care system to operate at optimal efficiency, major structural changes are imperative. Health care providers need the right incentives to practice according to the best clinical guidelines. Consumers need the right incentives to engage in healthy behaviors, manage their illnesses, and access the health care system at the right time and in the right way. Federal and state regulations should enable market efficiency and innovation, not create additional complexity and compliance burdens. Employers should have incentives to provide health care benefits to employees and reward healthy behaviors. And finally, insurance companies should have strong incentives to manage risk, not avoid it.

We have established that there is a business and societal advantage to giving more people access to health insurance coverage even in a health care system plagued by obvious flaws. The positive impact can be magnified if expansion of coverage is accompanied by fundamental reform of the health care market and delivery system that underlie the insurance benefit. The following are suggestions to improve market and delivery system efficiencies to both enable and promote a strongly functioning health care market.

**Health Information Technology (HIT)**

Incentives and investment to improve health information technology were partially funded by the American Recovery and Reinvestment Act. The impact of HIT is also outlined in the Congressional Budget Office’s December 2008 Budget Options documents. While it may be difficult to measure the immediate financial impact of a digitized health care system, its potential impact on the efficiency of health care delivery is immense, if nothing else, as an enabler of other strategies for coordinating care more effectively and efficiently. Some of the positive outcomes will include:

- More efficient transcription and documentation processes for doctors, nurses, and other clinical staff;
- Reduction in redundant laboratory testing and imaging services from multiple providers treating the same patient;
- Improved communication of patient history for better clinical treatment, especially in emergency departments;
- Reduced medical errors and adverse events in prescriptions and medication instructions;
- Reduced administration costs through electronic claims adjudication;
- Reduced costs to the health care provider from incomplete and unclear patient information;
- Immediate financial impact of a digitized health care system.

The following are suggestions to improve market and delivery system efficiencies to both enable and promote a strongly functioning health care market.

**The System Malfunctions, but It Can Be Fixed**

The success of health care reform efforts ultimately rests on our ability to reform the current health care market and our delivery systems to reverse the runaway cost of care. Today’s U.S. health care system is the victim of three structural weaknesses:

- A “usual and customary” limit on fees that results in an ever-increasing ceiling of payments; and
- A third-party payment system that effectively insulates both the provider and the patient from the financial consequences of health care consumption.

Without market pressure on unit cost and with little incentive to control utilization, the traditional supply and demand equation doesn’t work in health care. Add to this a medical liability system that exposes medical providers to potentially large lawsuits, raises provider costs through higher-than-needed medical malpractice insurance premiums, and creates incentives for the practice of defensive medicine, and it is understandable that health care costs have escalated for decades.

Employers and health care providers need the right incentives to control utilization, manage their illnesses, and access the health care system at the right time and in the right way.
• More robust quality of reporting via electronic medical records;
• Enablement of remote decision making through portable, comprehensive personal health records;
• Security and privacy protocols not possible in a paper-based system.

The RAND Corporation estimates potential annual savings from HIT over the next 15 years to be $80.9 billion, compared to annual costs (one-time and ongoing) of $7.6 billion. This is a convincing return on this investment from a system view.23 Business Roundtable previously put this opportunity into an even more compelling context, noting that the potential savings from HIT investments could:

• More than double the level of annual U.S. public spending on all types of medical research;
• Pay for the direct medical treatment costs for all types of cancer in a year;
• Save an average of $670 per household in out-of-pocket outlays for health care (about 25% of total spending); and
• With the benefits of improved health outcomes included, the total savings could be as much as $165 billion a year—enough to insure roughly three-quarters of all uninsured Americans.24

Medical Liability Reform
Reforming medical liability laws is widely discussed as a necessary component of overall health reform, particularly among health care providers. By some estimates, high malpractice insurance premiums and the defensive medicine associated with seemingly unlimited malpractice awards are responsible for 7% to 9% of health care spending. The Congressional Budget Office, in its December 2008 Budget Options documents, however, estimates medical liability reform and limits on malpractice awards as having less than 1% impact on health care spending. Certainly medical liability law reform alone cannot curb excessive utilization in a system with so many misaligned incentives. Perhaps the appropriate direction would be a combination of steps including greater dissemination of evidence-based guidelines and a “safe harbor” from lawsuits for physicians who follow quality standards and practice according to these guidelines. This would avoid the politically charged controversy over imposing caps on damages, yet provide strong financial incentives for physicians to seek out and adopt evidence-based practice patterns. Malpractice premiums would no doubt fall for providers exhibiting these behaviors, and excess utilization from defensive medicine would moderate.

As part of health care reform, Congress should consider authorizing and adequately funding pilot projects to evaluate alternative ways to resolve medical liability claims, including medical courts, alternative dispute resolution, and other efforts. Based on the results of such pilots, Congress should enact those changes in laws that enhance the fair compensation of individuals who are harmed because of negligence by a provider of health care services. However, these initiatives should also produce a reduction in “defensive” medical costs by supporting the use of appropriate medical practice guidelines as developed by national professional organizations or other similarly qualified organizations. If the guidelines are followed by a physician, they should act as a rebuttable presumption that no medical malpractice has occurred.

Medical liability reforms have been proposed in various pieces of proposed federal legislation and, in a report by the Engelberg Center for Health Care Reform at Brookings,25 have recently been suggested among a variety of steps for gradually bending the cost curve. And, according to a survey conducted by the Texas Hospital Association five years after the implementation of significant medical liability reforms, “Texas hospitals continue to experience major reductions in their liability costs and to reinvest their savings in programs that benefit patients and their communities.” According to the survey, 58% of hospitals used reduced liability coverage costs to expand patient safety programs, and 51% used the savings to provide coverage and services for uninsured/underinsured patients.26

Bundled Payments and Accountable Care Organizations
These virtual adaptations share the vision of the original coordinated-care plans. They offer reimbursements tied to overall performance and outcomes rather than the amount and intensity of services by relying on group/staff model provider organizations to bear the risk for the care they deliver. While much can be and has been said about the failure of the managed care movement to rev in long-term health care costs, the payment and structure of the group/staff models have consistently proved to be an oasis of efficiency in a broader health care system where incentives are often misaligned.

In 2007 and 2008, Hewitt Associates conducted two proprietary studies of the financial efficiency of HMOs compared with other plans, based on data from the Hewitt Health Value Initiative27 database of 325 large employer plans over a 10-year period. These studies showed that, in general, HMOs are slightly (1% to 5%) more efficient than PPOs, primarily because of greater provider discounts available in closed-panel models.

However, the study also showed that specific HMOs—California HMOs in general and group/staff models in particular (Kaiser Permanente and Group Health of Puget Sound, for example)—were as much as 10% to 15% more efficient than PPOs.28 These organizations shared several key characteristics that drove this additional efficiency:

• The presence of coordinated core teams;
• Investments in health IT infrastructure to transfer information quickly and accurately across care teams;
• Financial arrangements with providers involving capitation payments per patient or straight salary; and
• Dissemination and adherence to evidence-based practice guidelines, including step therapy for branded medications.

Financial efficiency was not due to age, sex, geography, plan design, or health risk of the population. These plans performed better—because in a controlled environment they were able to realign the incentives for superior performance. The Congressional Budget Office has scored the Accountable Care Organization pilot program as saving $2 billion over seven years. The Hewitt data shows the savings potential to be much greater, especially as prevalence of these models increases to cover more geographies and employee populations.

25 Engelberg Center for Health Care Reform at Brookings, “Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth,” August 2009
26 Texas Hospitals Reinvesting Savings from Medical Liability Reform, THA survey shows patients, providers, and system benefit from more specialists, expanded services, http://www.texashospitalsonline.org/PressRoom/TexasHospitalsReinvest09.asp, September 10, 2008
The concept of medical homes is a promising recent development aimed at strengthening the primary care system. In this model, each patient has an ongoing relationship with a personal physician charged with the responsibility of providing continuous and comprehensive care. This physician, and the team that supports him/her, is responsible for either delivering the care or ensuring that appropriate care is delivered by others. Prevention, nutrition counseling, and chronic disease management are some examples of services that medical homes would provide that may not be found in a traditional primary care relationship.

Medical home pilots typically require more primary care doctors to serve a given population due to the increased time each physician needs to spend with a patient. As such, recent medical home pilots have required a combination of faith in the model and up-front investment. Despite Congressional Budget Office estimates that medical home pilots will increase costs initially, early results are nonetheless promising on a number of dimensions. A recent pilot conducted by Blue Cross Blue Shield of North Dakota, Community Care of North Carolina, Geisinger Health System in Pennsylvania, and Horizon Blue Cross Blue Shield of New Jersey.

Health Risk Assessments

Health risk assessments have been in use by the private sector for many years. They are the cornerstone of the health improvement strategy for many employers. Private and secure health risk assessments collect information about an individual’s biometric statistics, behaviors, family history, and self-reported health status. When fed into a predictive model, this information can trigger appropriate follow-up and clinical coaching based on risk factors—the precursor to disease. Employers often provide significant financial incentives for employees to complete health risk appraisals, because identifying and preventing future illness is a powerful strategy to control health care costs, reduce absenteeism, and improve productivity. Allowing employers the flexibility to design incentives for employees and their spouses to complete a confidential health risk assessment is central to promoting health and wellness and should be included in final health reform legislation.

Value-Based Pricing

Value-based pricing would be a natural evolution from Centers for Medicare & Medicaid Services’ (CMS) current “pay for reporting” initiatives toward the more desirable “pay for performance” model. The best example of how this can improve performance and quality is the Integrated Health Care Association’s (IHCA’s) Pay for Performance (P4P) initiative launched in 2002. Common performance measures were developed across employer, provider, and insurer stakeholders with economic incentives for high performance in areas covering patient satisfaction, clinical outcomes, and utilization of information technology. The IHCA P4P program is now the largest physician incentive program in the United States, encompassing 35,000 physicians serving 11.5 million individuals. Since the program’s inception, aggregate results have improved year over year in each category. Health plans have distributed approximately $264 million in incentive payments to primary care physicians from 2004 through 2008. Yet despite strong interest in more performance-based payments to health care providers, on an enrollment-weighted basis, only 36% of commercial health insurers used payment methods that rewarded higher-value hospitals and physicians in 2008. The incentive payments, though large in the aggregate, only represent 2% of physician revenue. The private sector needs additional incentives to change Medicare to expand its ability to stimulate wider adoption of P4P.

Transparency of Cost and Quality

While both health plans and employers are committed to improving transparency of cost and quality to create better-informed health care consumers, this goal has proved to be elusive. Progress has been made with certain health plans in areas such as prescription drugs, high-tech imaging services, hospital services, and primary care. Hospital quality and performance data has been available for several years through state-level databases and the MEDPAR data set, and a review of available literature suggests that publicly releasing hospital performance data actually stimulates quality improvement activity.

However, most employers and health plans lack sufficient data to achieve the necessary statistical validity to make a quality designation, even when working collaboratively; they cannot document enough episodes of care for individual physicians. We advocate for the release of CMS data in a way that protects patient data, similar to the MEDPAR data set, so that a comprehensive set of statistically valid data on claims, pricing, and quality is available. This would equip every American with the necessary information on relative cost and quality of their health care providers to make their own value judgments when they need treatment.

Administrative Simplification

Leveraging available technology being used in other sectors of the economy will help simplify the administrative process, as well continue investments in HIT. However, a reformed marketplace that increases the compliance burden on individuals, health care providers, and employers will dilute the effectiveness of well-intentioned structural changes. As efforts to reform the insurance markets and broader delivery system move forward, careful attention should be paid to the reporting and compliance requirements being placed on the participants in this system.

Medicare as a Change Agent

The place to start these delivery system reforms should be the Medicare program. Total Medicare expenditures are expected to be $500 billion in 2009, making the federal government the largest single purchaser (by far) of health care services in the United States. This kind of buying power gives the federal government the ability to set prices—which is part of the problem—but more important, to set policy—which can be part of the solution. Actions taken by CMS in the Medicare program have a direct impact on provider behavior. These actions also tend to disseminate quickly to private plans. The speed of which many private health plans adopted the Medicare DRG hospital payment approach, or some variation of it, is well known. Three other recent examples highlight this phenomenon:

The term “never events” has been used to describe serious, costly, and preventable medical errors—situations that should have a zero tolerance level in any properly functioning health care system. Examples include surgery on the wrong body part, a foreign body left in a patient after surgery, or a mismatched blood transfusion. Researchers from the Agency for Health Care Research and Quality concluded that medical errors may account for annual systemic costs of 2.4 million extra hospital days, $9.3 billion in excess charges (for all payers in 2000 dollars), and 12,600 deaths.26 In April 2008, CMS announced changes to its payment policies limiting reimbursement for a list of “never events” as of October 1, 2008. Within weeks, all major health plans had followed CMS’ lead, adopting the same criteria and payment standards coincident with the October 1 effective date. Faced with near-universal payer policy, hospitals had no choice but to agree not to charge for the CMS-approved list of “never events.”

CMS then the Health Care Financing Agency) was a pioneer in recognizing the need for having a practical methodology to adjust payments to insurers based on the underlying health risk of their respective populations. These studies began in the early 1980s and culminated in the use of risk adjustment in 2000 in the managed care program (then Medicare+Choice, today Medicare Advantage). The model was gradually implemented into the payment process and has been fully utilized since 2007. As a result of this early research, private-sector initiatives have used similar models to adjust rates paid to HMOs, most notably Minnesota’s Buyers Health Care Action Group and California’s Health Insurance Purchasing Co-op.

A Tipping Point

The problems and the successes in the U.S. health care system developed over decades, and it would be naive and unrealistic to expect that a $2.4 trillion health care system can be radically overhauled very quickly. It will take time. The challenge to key stakeholders in this debate is to positively influence a solution that will first address the current inequities in the system. However, as we reap the positive benefits, it is even more important to put structures and incentives in place which, over time, will produce significant and sustainable reductions in the future cost of health care. We are at a tipping point where continued escalation of health care costs will break not only the Medicare and Medicaid systems that protect our elderly and indigent, but also the companies that the majority of Americans rely on to provide valuable health insurance protection for themselves and their families. Reform in coverage must be accompanied by changes in the underlying markets and delivery system to generate higher-quality and more efficient health care for every American.

As the largest single purchaser of health care services, CMS and the Medicare program can serve as a positive catalyst for change to the rest of the market. Movement away from fee-for-service payments to a more bundled approach for episodes of care, providing greater transparency of cost and quality, and strengthening of the primary care system are necessary to drive the systemwide reforms that are critical to keeping health care costs under control. History has demonstrated the private sector’s willingness and ability to follow Medicare’s lead.

Creation of the health insurance exchanges, common to all the current proposals, offers much promise, especially when paired with an individual responsibility for Americans to purchase coverage if they can afford it and federal subsidies for those who cannot. The acceptance of all risk, the large-scale pooling of this risk, and the availability of multiple coverage options will solve many of the current deficiencies in the individual insurance market and will introduce major improvements in the small group marketplace.

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In this process of improving coverage while managing cost growth, it is critically important that existing sources of employer-based coverage not be disrupted, destabilized, displaced, or saddled with significant additional costs or compliance burdens. We hope that bipartisan discussions on health care reform will yield an outcome that suggests that such a goal can indeed be realized.

The status quo is not a viable option; our health care system must change in order to keep the United States competitive in a global marketplace. We believe health care reform, done right, can generate positive benefits as outlined in this paper. We have offered suggestions to further build upon a solid foundation of access to affordable, high-quality health care for all Americans.

At the outset, we noted that, for previously uninsured individuals, having access to health insurance coverage will undoubtedly fill a significant gap in their security and well-being and in the health treatments that they receive. But we also asked, What impact will this expansion of coverage have on the overall system? Will supply simply expand to meet increasing demand? Or will the system become more rational and efficient as the indirect cost from uncompensated care is reduced, administrative costs come down, and adverse selection is mitigated?

The large potential benefits of health care reform can be realized if four essential conditions are met:

- Health insurance coverage is expanded to as close to universal levels as we can reasonably get;
- Existing sources of employer-based coverage are not disrupted or displaced or saddled with significant additional costs and compliance burdens;
- Expanded coverage is accompanied by meaningful delivery system reform led by changes to Medicare; and
- As expected, purchasers in the private sector adopt these reforms.

Achieving the necessary efficiency improvements requires progressive changes in the Medicare program. Only then will we improve quality, deliver better overall value, and reduce future increases that are inevitable in the absence of meaningful delivery system reform. We need “game changing” strategies and we can’t wait much longer. Not only does the future financial solvency of the Medicare program depend on them, but they will be the key to systemwide performance enhancements and efficiency.