

# Building a Better Health Care System

SPECIFICATIONS FOR REFORM



  
National  
Coalition on  
Health Care



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## SPECIFICATIONS FOR REFORM

A Report from the National Coalition on Health Care

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Ralph G. Neas



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1120 G Street, NW, Suite 810, Washington, DC 20005  
202-638-7151  
[www.nchc.org](http://www.nchc.org)

## Preface

The United States is in the midst of a major debate — a necessary debate — about the future of our health care system.

In 1993 and 1994, our nation had such a debate — in Congress, the press, and the polity — about a variety of proposals, from many quarters, for health care reform. Political leaders in both parties agreed that the problems confronting health care then — in particular, rising costs and increasing numbers of Americans without health insurance — constituted a genuine crisis and warranted an urgent policy response. That debate ended without legislative action. The health care system was not reformed, its problems remained unchecked, and the sense of urgency that had animated and permeated the debate dissipated.

The system-wide problems that triggered an intense national debate more than a decade ago are larger now than ever. The growth of these problems has overwhelmed incremental measures meant to alleviate them. If we needed comprehensive health care reform in 1993 and 1994 — and we did — we need it even more today.

The recommendations for comprehensive reform that you are about to read come not from a single organization or interest, not even from one sector of American society. They were developed, in a year of study and deliberations, by the National Coalition on Health Care, which brings together many interests and sectors. The Coalition is an organization of organizations — of roughly eighty of America's large and small businesses, unions, civil rights and advocacy groups, health care providers, associations of religious congregations, pension and health funds, insurers, and groups representing patients and consumers. Collectively, the Coalition is the nation's largest and broadest alliance working for the achievement of comprehensive health care reform. Our members represent — as employees, members, or congregants — at least 150 million Americans. They speak for a cross-section — and a majority — of our population.

The organizations that belong to the Coalition are united by their commitment to the pursuit of five principles or goals for a reformed health care system:

- Health Care Coverage for All
- Cost Management
- Improvement of Health Care Quality and Safety
- Equitable Financing
- Simplified Administration.

The Coalition is rigorously non-partisan. Its honorary co-chairmen are former Presidents George H.W. Bush, and Jimmy Carter. Its co-chairmen are former Iowa Governor Robert D. Ray, a Republican, and former Pennsylvania Congressman Robert W. Edgar, a Democrat. Our members believe that an effective response to the crisis in American health care is urgently needed and that it will require leadership from both political parties and a willingness to compromise across ideological, economic, and social divides.

It is in that spirit that we offer a series of interconnected specifications for reform. This brief document does not describe one plan, one potential course of action. Instead, it sets out objectives for reform, criteria by which alternative proposals can be assessed, and options for policymakers and the public to consider.

Our hope is that these specifications will help to further the national debate about how to build a better American health care system — and that they will help to embolden political leaders to act.

The specifications summarized here are tough, thorough, and ambitious. Our members have set aside their preconceptions and predispositions in order to forge a consensus document. Individual members may have different first preferences on some of the items addressed, but they recognize that for progress to be possible, a compelling national interest — in the assurance of excellent and affordable health care for all Americans, in the creation of a health care system that can serve us all well in the decades to come — has to be given precedence over narrow self-interest. They are unified in believing that these specifications represent a sound and sensible set of concepts and precepts for a public-private partnership to reform American health care.

That these recommendations were developed by such a diverse and large aggregation of powerful organizations — representing such a broad swath of our economy and society — should be heartening to those who had given up on the prospects for policy responses commensurate with the scope of the challenges we face. We should not be resigned to settling for small steps forward — not when the problems of the health care system are growing by leaps and bounds.

We need systemic, and rapid, reform.

# Our Ailing Health Care System

## THE URGENT NEED FOR COMPREHENSIVE REFORM

The American health care system is burdened by three huge and interrelated problems, any one of which would be reason enough for alarm: rapidly escalating costs; a huge and growing number of Americans without any health coverage; and an epidemic of sub-standard care.

### Rapidly Escalating Costs

The United States currently spends more on health care than any other nation.<sup>1</sup> According to the Centers for Medicare and Medicaid Services, national health expenditures in the United States will reach \$2.5 trillion by the end of 2009, accounting for 17.6 percent of the gross domestic product. By 2018, national health expenditures are expected to reach \$4.4 trillion – more than double the health care spending in 2007.<sup>2</sup> On a per capita basis, health care costs in the United States are more than twice the median level for the 30 industrialized nations in the Organization for Economic Cooperation and Development (OECD)<sup>3</sup> — even though 17 percent of the U.S. population under 65 has no health coverage at all<sup>4</sup> (and despite the fact that health outcomes associated with our higher spending are no better and, by several measures, worse than outcomes in nations that spend much less).<sup>5</sup>

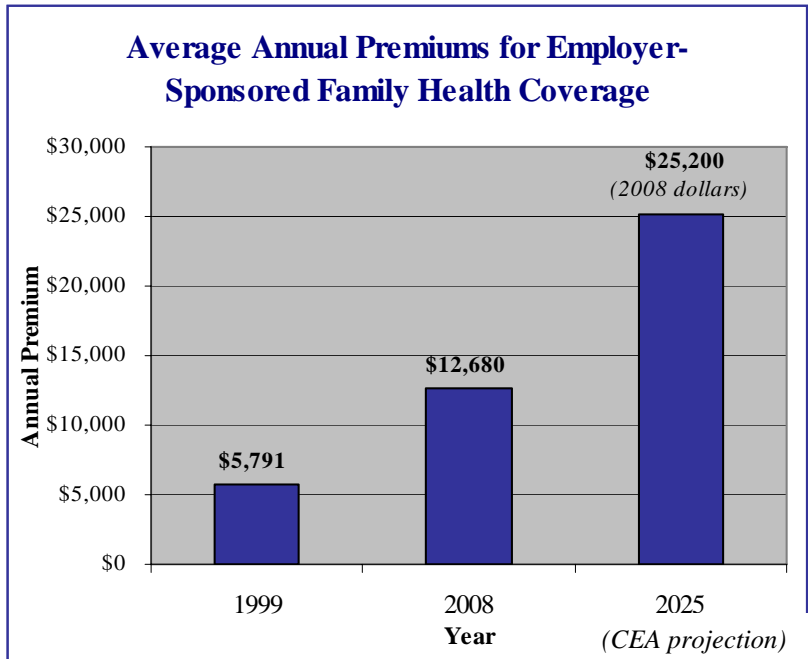
The leading source of health insurance in America is employer-sponsored coverage, yet rising costs are making it increasingly difficult for employers and employees to afford health insurance. Premiums for employer-sponsored health insurance have more than doubled over the last decade. The average cost of employer-sponsored premiums is now close to \$13,000 a year for a family of four and employees contribute roughly 27 percent of the bill. The recent increases in premiums are especially striking considering the U.S. has been in a period of low inflation. The average annual premium for employer-sponsored family health coverage has

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*Mark A. Goldberg, Executive Vice President, Joel E. Miller, Senior Vice President, and Julie Bromberg, Associate for Health Education and Public Awareness, contributed to the research and writing of this update of the report which was originally issued in 2004.*

risen to four times the rate of inflation and increases in wages over the last decade – average premiums have increased 119 percent, while inflation increased only 29 percent and wage earnings increased 34 percent.<sup>6</sup> The Council of Economic Advisers estimates that if real premium growth continues at 4 percent per year, employer-sponsored family coverage will surge to roughly \$25,200 per year by 2025 (measured in 2008 dollars)<sup>7</sup> – almost double the average premium of \$12,680 in 2008.<sup>8</sup> This projection is a conservative estimate given that the historical average of real premium growth is 5.5 percent.<sup>9</sup>

A study by the Urban Institute estimates that employer spending on premiums could reach \$847 billion by 2019 assuming moderate growth in incomes and health care costs – which would be a 97 percent increase in the cost of premiums in 2009. The cost burden from the rise in premiums will lead to lower wage earnings and corporate profits. Based on this intermediate economic model, individual and family spending will increase dramatically from \$326 billion in 2009 to \$521 billion in 2019.<sup>10</sup>



Source: Adapted from KFF and HRET, *Employee Health Benefits: 2008 Annual Survey*, September 2008; and CEA projections

These increases are making it more difficult for businesses to continue providing health coverage for their employees and retirees. In addition, individuals and families are feeling the strain to pay their rising share of the cost of employer-sponsored coverage or, for those who are not offered coverage by employers and are not eligible for public programs, to purchase private health insurance in the non-group market.

Americans are worried about rising health care costs as a problem that could affect them personally and profoundly. In a poll conducted in July of 2009 by the Kaiser Family Foundation, more than one third of respondents (34%) were “very worried” that they would not be able to afford necessary health care and 29% were “very worried” that they would lose their health insurance.<sup>11</sup> This sense of vulnerability to rising health care costs is widespread; it is also shared by those with health insurance and those without coverage, by middle-income and lower-income Americans, by Republicans and Democrats.

The escalation of health care costs is not only a health care issue; it is also a major national economic problem. As these costs continue to rise, they cut into corporate margins, reducing the capacity of firms across the economy to grow their businesses. This affects real business decisions to invest in research, new plant and equipment, and product development. Health care cost increases also slow the rate of job growth by affecting most firms’ ability to expand their employee base. They suppress wage increases for existing workers by driving up total compensation costs. The viability of pension funds and pension benefits for retirees are also compromised. Premium increases that outpace inflation — on top of what are already the highest per-worker health care costs in the world — put American firms at a steep and growing disadvantage in global markets, where they must compete against companies in countries with much lower health care costs.

A survey conducted in 16 states by the Small Business Majority – a nonpartisan group representing small firms – found that, on average, 86 percent of small businesses owners who do not offer health insurance to their employees say they cannot afford to provide coverage. For those firms providing coverage, nearly three-fourths of those surveyed (73 percent) say they are struggling to continue to provide coverage due to high insurance costs.<sup>12</sup> Large businesses

are also concerned about the rising costs of health care. A 2009 Hewitt Associates survey of 343 executives found that over half (52%) of employers believe the economic downturn will affect their health care programs in 2010. In addition, 19 percent of these employers are planning to move away from directly sponsoring health care benefits in the next three to five years, which is almost four times as many who reported this in 2008.<sup>13</sup>

Rising health care costs are also producing severe long-term federal budgetary problems. The Treasury Department, the Congressional Budget Office, and the General Accountability Office have warned that anticipated increases in Medicare and Medicaid obligations under current law will generate tens of trillions of dollars in unfunded liabilities in the coming decades. According to the Director of the Congressional Budget Office Douglas Elmendorf, these increases will be “unsustainable.”<sup>14</sup> He projects that by 2035, Medicare and Medicaid combined will consume 10 percent of the gross domestic product – more than double their current share (5 percent of the GDP in 2009).<sup>15</sup>

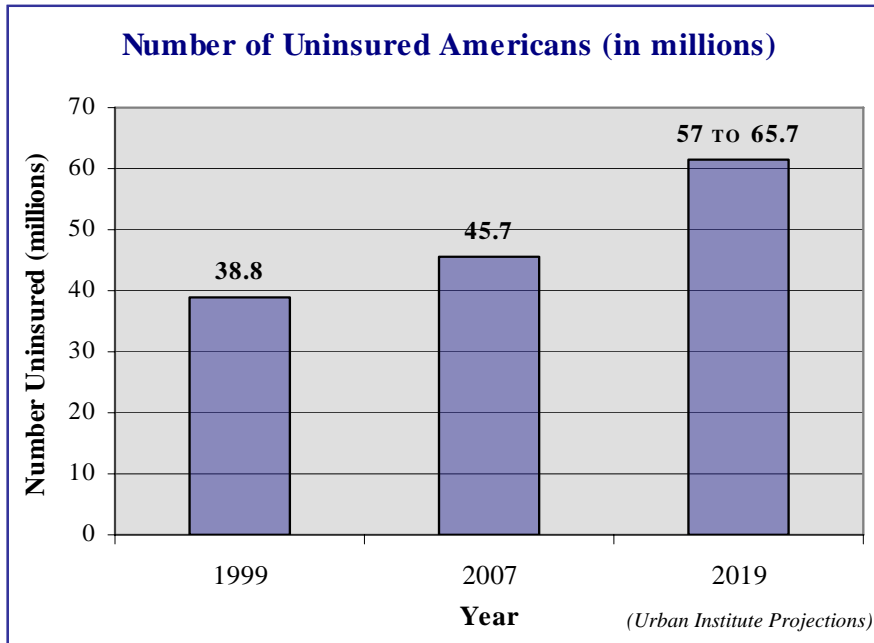
### **A Huge and Rapidly Growing Number of Americans Without Health Coverage**

According to the most recent official figures from the U.S. Census Bureau, the number of Americans without health insurance rose to 45.7 million in 2007.<sup>16</sup> Almost 7 million more Americans are without health insurance coverage since 1999,<sup>17</sup> yet these statistics are not recent enough to reflect the impact of the economic recession on jobs and health insurance coverage. According to University of California – San Diego researchers, nearly 7 million more Americans have lost and will lose their coverage between 2008 and 2010 primarily due to high and escalating health insurance premiums.<sup>18</sup> A recent report by the Urban Institute based on income, employment and health care cost trends projects that 62.2 million Americans will not have health insurance coverage by 2019 in the absence of policy changes.<sup>19</sup> This would amount to an addition of at least 16.5 million Americans to the ranks of the uninsured since 2007.

These numbers do not capture the real scope of the health care uninsured problem in America. Nearly 87 million Americans — 33 percent of the non-elderly population — spent at least a portion of 2007 or 2008 without coverage. Of these, nearly half — about 42 million — lived in households with annual incomes above 200 percent of the federal poverty line (more than \$42,400 for a family of four in 2008); 18.3 million were in families with annual incomes above 400 percent of the federal poverty line (more than \$84,800 for a family of four in 2008).<sup>20</sup> And as polls have indicated, the sense of vulnerability to the potential loss of insurance is shared by tens of millions of other Americans who have managed to retain coverage in recent years.

The impacts of the uninsurance on the uninsured are clear and severe. First, the uninsured generally receive less health care than those with coverage. In a 2007 survey by the Commonwealth Fund, more than 70 percent of non-elderly adults without health insurance said that they postponed seeking care in the past twelve months due to cost, compared to 35 percent of adults with insurance.<sup>21</sup> Second, uninsured individuals who did not receive care when they needed it typically had poor outcomes. This is most telling when looking at the statistics on the uninsured population compared to insured individuals. The uninsured are less likely to get cancer screening, are more likely to be diagnosed with advanced stages of disease, and are less likely to survive the diagnosis compared to those who are privately insured.<sup>22</sup> Controlling for age, race, sex, and income, uninsured cancer patients are 1.6 times more likely than insured patients to die within five years of diagnosis.<sup>23</sup> Third, the uninsured must live each day in financial as well as physical jeopardy, knowing that if they are injured or contract a serious disease, they either will not be able to obtain care — or will be forced to liquidate their savings or possessions to pay for it.<sup>24</sup>

As a practical matter, because those without insurance receive less care — and receive it in the later stages of diagnosis — than those with coverage, they are on average less healthy and unable to function as effectively in their daily lives. And, sadly, their risk of mortality is 25 percent higher than if they had health insurance.<sup>25</sup>



Source: Data adapted from U.S. Census Bureau, CPS Annual Social and Economic Supplements; and Urban Institute projections, *Health Reform: The Cost of Failure*, 2009

A study conducted by Harvard University medical researchers found that, compared to previously insured adults, previously uninsured adults reported significantly improved long-term medical outcomes after gaining Medicare coverage at age 65, particularly for patients with cardiovascular disease and diabetes. The researchers highlighted that acquisition of Medicare coverage increased patients' use of effective treatments and produced considerable health benefits.<sup>26</sup>

The impacts of uninsurance are not confined to the uninsured. First, family members, neighbors, and colleagues at work are adversely affected by the incapacities that befall the uninsured. Second, as the number of uninsured Americans increases, so does the cost-shifting for uncompensated care built into the insurance premiums of those who purchase coverage. Third, the high incidence of uninsurance generates losses throughout the economy, primarily due to the lower productivity of uninsured (and, on average, less healthy and functional) workers. The Center for American Progress projects that the cost of reduced productivity attributable to uninsurance will be between \$124 billion and \$248 billion in 2009.<sup>27</sup>

## **An Epidemic of Sub-Standard Care**

The American health care system provides excellent care to many of its patients much of the time, but, on the evidence, not to enough of its patients enough of the time. As a series of landmark reports from the Institute of Medicine documented, there is in our health care system what the Institute terms a “quality chasm” — a wide gulf between the care that patients should receive and the care that is actually delivered.<sup>28</sup>

Although nearly \$2.5 trillion will be spent this year on medical care,<sup>29</sup> many people are not receiving adequate care. A major study conducted by RAND highlights the vast gaps in quality. Researchers examined the medical records of random samples of thousands of patients across twelve metropolitan areas and evaluated the care that these patients received over a two-year period. Using 439 indicators of quality developed by multispecialty expert panels, the analysts found that participants in the study received only 54.9 percent of recommended care — a proportion that varied little across the categories of preventive, acute, and chronic care.<sup>30</sup>

Mismatches of this magnitude between ideal and actual practices would not be tolerated in most industries. Why are they permitted to persist in health care, where they cost lives and produce pain and suffering?

Despite heightened attention and effort devoted to improving the quality of care in recent years, the Institute of Healthcare Improvement found that roughly 15 million instances of medical harm occur each year in the United States—a rate of more than 40,000 per day.<sup>31</sup> The Institute of Medicine’s 1999 landmark study estimated that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals.<sup>32</sup> This range of projections does not include the 99,000 deaths that, according to the Centers for Disease Control and Prevention, occur because of infections contracted during hospitalization, nor does it include deaths due to preventable medical errors in settings other than hospitals.<sup>33</sup>

Despite spending more money on medical care than any other industrialized country, the United States fares worse on many measures of health care quality compared to other nations.<sup>34</sup> A 2008 Commonwealth Fund study found that out of 19 industrialized countries,

the U.S. ranked last on deaths that could have been prevented with timely and effective care. As many as 101,000 premature deaths a year would be averted if the U.S. was able to achieve the same mortality rate as other leading countries.<sup>35</sup>

A 2008 HealthGrades study on the quality of care in U.S. hospitals found that between 2005 and 2007, there were 238,000 potentially preventable deaths from the Medicare population alone. Nearly 50 percent of these preventable deaths were associated with four diagnoses – heart failure, community-acquired pneumonia, sepsis and respiratory failure.<sup>36</sup>

The Coalition believes that the United States needs to mount an all-out effort to combat this hidden epidemic – now, before millions of more Americans die needlessly from the ministrations of a health care system that they turn to for help, not harm.

Health care quality is also an enormous cost issue. Research from the Dartmouth Institute for Health Policy and Clinical Practice found that higher health care spending does not result in better quality of care, whether it is measured by technical quality issues, reliability of hospital or outpatient care or survival following serious conditions such as a heart attack or hip fracture. Medicare beneficiaries in higher-spending regions did not receive more effective or more patient-preferred care than beneficiaries in lower-spending regions. Patients from higher-spending areas merely spent more time in health care settings—for example, they were more likely to be hospitalized and spend more time in the ICU than similar patients in lower-spending regions.<sup>37</sup> The 2008 Commonwealth Fund National Scorecard study estimated that reducing readmissions and hospitalizations for preventable conditions alone could save the Medicare program at least \$12 billion per year.<sup>38</sup>

According to John Wennberg and Elliot Fisher of the Dartmouth Institute for Health Policy and Clinical Practice:

*“In addition to improving the quality of care, transforming the delivery system would also save money ... if all providers were to adopt the practices of organized practices ... Using the Mayo Clinic as a benchmark, the nation could reduce health care spending by as much as 30 percent for acute and chronic ill-*

*nesses; a benchmark based on Intermountain  
Healthcare predicts a reduction of 40 percent.”* <sup>39</sup>

This prospect of cost saving alone should provide more than enough incentive — if the potential to save lives were not already a sufficiently compelling reason — for Americans to demand improvements in the quality of their care.

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# What Must Be Done

## SPECIFICATIONS FOR REFORM

As noted above, the Coalition's specifications for reform reflect a consensus among our member organizations. Before turning to the specifications themselves, we would make three points:

### **Health care reform must be a national priority.**

Comprehensive health care reform is long overdue. Every year that reform is delayed, tens of millions of Americans live in peril, without health insurance; millions are harmed, and hundreds of thousands die needlessly, because of sub-standard care; and health care costs continue to spiral ever upwards.

The Coalition's specifications are meant not just to encourage and help to frame a national debate about health care reform, but to create momentum for the passage of legislation. These specifications are an expression of operational intent: Our member organizations are determined to work with other organizations and with policy-makers in both parties to secure the reforms described here. Yes, we need a vigorous debate about health care policy — but what we really need is action, and soon.

### **Health care reform must be systemic.**

The Coalition's specifications were developed not as a shopping list of potential stand-alone initiatives, but as a linked series of targets, criteria, and options — meant to be adopted concurrently and to work together.

The vast American health care sector is exquisitely and elaborately interconnected. Partial or piecemeal reforms, even those conceived and implemented with the best of intentions, can produce unanticipated adverse consequences far from the focus or locus of those targeted reforms.

For example, a dramatic expansion of access, implemented without accompanying measures to improve quality and manage costs, could produce an overloaded health care system that delivers worse care (albeit to more people) at higher costs. Similarly, constraints on costs (and reimbursements for care), pursued in isolation, could compromise both access and quality.

A system is a set of institutions and processes that function together to achieve defined objectives. The Coalition's specifications were designed to serve multiple goals simultaneously. We began our development of recommendations by agreeing on five core principles for reform (which appear below as section headings for our specifications). Then, as our deliberations proceeded, we continuously revisited and recalibrated our recommendations to make sure that the individual components fused together into a sensible systemic strategy.

We believe that a systemic approach can increase not only the substantive coherence of reform, but also its political feasibility. Thus, if constraints on health care cost increases were proposed in isolation, providers might understandably anticipate that their revenues going forward would be diminished. By contrast, if those same constraints were conjoined in a systemic strategy with an assurance of coverage for all Americans and financing for their care, providers would receive payment for care that they now provide, with little or no compensation, to uninsured patients.

### **Health care reform must be system-wide.**

The Coalition is calling for system-wide reforms, not for changes that would apply to only some payers, patients, or providers. Unless reform is system-wide, gains in some sectors or for some groups are likely to be offset by losses elsewhere.

There is, in addition to this practical consideration, another compelling argument for making certain that reform is system-wide. America is already a nation of health care haves and have-nots. Reform should aim to assure that all Americans receive excellent health care and are able to enjoy the quality of life and peace of mind for which such care is essential. Piecemeal reform that helps some cate-

gories of people to the detriment of others would not take us closer to an optimal health care system and could actually make it harder to attain.

We should move forward together. Let us begin by specifying where we want to go:

## **PRINCIPLE 1**

### *Health Care Coverage for All*

Every American\* should have health care coverage, as defined below, and access to the services covered. Health care reform must provide health care access for all children in America regardless of their parent's status. Coverage should include the children of immigrants who themselves are often American citizens. Coverage should also address the needs of Americans between the ages of 55 and 64 (the "bridge years") who face unique challenges in retaining or securing adequate, affordable health insurance coverage.

Participation should be mandatory. The goal of health care coverage for all Americans should be achieved within two to three years after the passage of enabling legislation. We recognize that this is an ambitious timetable, but lives, and the quality of lives, are at stake.

Coverage should encompass medically necessary, comprehensive care, including emergency care, acute care, prescription drugs, early detection and screening, preventive care, oral health, comprehensive smoking cessation services, care for chronic conditions, and end-of-life care. Pre-existing conditions should not be excluded from coverage. The details of the core benefit package, within each of the categories noted, should be consistent with best medical practices and should be adjusted over time, as science and technology advance and as the understanding of best practices evolves. Enrollees should be guaranteed the right to timely appeal of denials of

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\* We recognize that a more precise delineation of the application of this principle would require the consideration of issues — regarding immigration policy and its enforcement — beyond the ambit of our deliberations about health care reform. In light of the importance of health care and, therefore, health care coverage as predicates and safeguards for physical and financial well-being, we hope that policymakers will be more, rather than less, inclusive.

coverage for particular services — first through internal review processes and then through independent external review processes.

Individuals or their employers should be able to purchase supplemental coverage — that is, coverage beyond the core benefit package.

The Coalition has identified a range of viable options for insuring all Americans:

- employer mandates (supplemented with individual mandates as necessary).
- expansion (and perhaps consolidation) of existing public programs that cover subsets of the uninsured (such as the State Children’s Health Insurance Program).
- creation of new programs targeted at subsets of the uninsured.
- establishment of a universal publicly financed program.

Legislation incorporating any, or a combination, of these mechanisms

- should include adequate subsidies for those who are less affluent.
- should assure continuity of coverage for those who move from one form or context of coverage to another.
- should facilitate enrollment by all those eligible for coverage.
- should require individuals to establish — for example, by appending documentation to their annual tax returns — that they have coverage.

Group purchasing is more efficient and more equitable than disaggregated purchasing. Therefore, the Coalition recommends against relying on individual mandates and individuated purchasing as the sole or central mechanisms in a national strategy to achieve coverage for all Americans.

The Coalition also recommends against reliance on a sub-national strategy in which individual states would be responsible for devising and passing legislation to attain coverage for their own citizens. We recognize, however, that progress can and should be made in individual states pending the passage of national legislation to cover all Americans.

## PRINCIPLE 2

### *Cost Management*

Average annual percentage increases in the health care costs and insurance premiums associated with the core benefit package should be brought into approximate equivalence with annual percentage increases in per-capita gross domestic product. Cost management measures should be designed to achieve that goal within five years after the enactment of legislation. (The Coalition recognizes that unusual discontinuities, such as epidemics or the emergence of revolutionary new medical technologies with benefits that clearly outweigh costs, may warrant short-term cost or premium increases that exceed the rate of growth of per-capita gross domestic product.) In addition, cost management should serve the longer-term goal of increasing the value generated by health care expenditures — that is, the health benefits that accrue to patients from any given level of spending.

Cost management must be a multi-faceted undertaking. It must incorporate a mix of more and better information and incentives for patients, providers, and purchasers; a commitment to improving the quality and outcomes of care, as described below; an increased emphasis on prevention and early detection of disease; the accelerated development of an integrated national information technology infrastructure for health care; and steps to modernize and simplify the administration, and dramatically reduce the administrative costs, of the health care system.

The urgent need for relief from rapidly rising costs also requires the establishment of constraints as soon as practicable after the passage of legislation. These constraints should take two forms: rates for reimbursing providers for episodes of care encompassed by the core benefit package and, only after those rates take effect, limitations on increases in insurance premiums for the coverage defined by that package.

Aligned with the Coalition's belief that Americans should be able to afford specialized medicines for complex diseases, the Coalition supports the creation of a generic pathway for high quality biologics as part of comprehensive reform. Biologics are among the most expensive and important drugs available to patients today. The inclu-

sion of an effective and timely approval process for more affordable generic versions of biologic medicines will lead us in the right path towards addressing the rising cost of medicine for Americans.

An independent board, chartered and overseen by Congress, should be responsible for establishing and administering these measures and for calibrating rates and limitations that keep increases in costs and premiums in alignment with defined annual targets. (This board, which would also be responsible for coordinating efforts to improve the quality of care, is described in more detail below in the specifications regarding Principle 3.) The board could also develop capitated rates for particular categories of care (for example, care for patients with specified chronic diseases) to encourage coordinated, integrated, and efficient provision of care in those categories.

A national strategy for cost management should also incorporate the following elements: First, it should make health insurance premiums more readily comparable by requiring insurers to establish explicitly separate premiums for the core benefit package and for any supplemental coverage they offer. Second, it should include a rational mechanism for increasing the cost-effectiveness of capital spending. Third, it should incorporate cost-sharing and other tools to provide incentives for patients to make appropriate choices about health maintenance and health care and for reducing both overuse and underuse of care. To assure that the use of such tools does not block access to needed care, subsidies or exemptions should be provided for those who are less affluent.

### **PRINCIPLE 3**

#### *Improvement of Health Care Quality and Safety*

A comprehensive and concerted national effort should be launched and sustained, with dramatically more public funding than has been previously available for this purpose, to improve the quality and safety of American health care.

Some progress has been made, in both the public and private sectors,

on initiatives to help reduce medical errors and improve quality, but we need to do much more, much faster, across the entire health care system. A system-wide effort to improve quality should increase investment in the generation of information — about effectiveness and cost-effectiveness — to improve recommendations and choices among options for care. It should develop and make widely available measurements — of process and outcomes quality — to facilitate choices among plans and providers by payers and consumers. It should be designed to reduce variability, across regions and providers, in patterns of practice — and, more generally, to improve the consistency of such patterns with best practices. It should seek to link payments for care to the measured quality of care.

A national quality-improvement effort should accelerate the development of an integrated national information technology infrastructure for the health care system. This infrastructure should include protocols for electronic patient records, prescription ordering, and billing; standards to protect privacy; a process for updating protocols and standards to reflect experience and technological advances; and mechanisms to incentivize and provide capital for the upfront investments necessary to build, and build out, the infrastructure.

These mechanisms to encourage investments in automated clinical information systems — and in further integration and coordination of the delivery of care — could include supplemental payments, changes in tax policy, programs to provide long-term low-interest loans to qualifying providers and provider organizations, and targeted grant programs.

This concerted national effort to improve the quality of health care in America should be coordinated by the new independent national board — with members drawn equally from the public and private sectors to reflect and reinforce a public-private partnership for improved quality. This board would be chartered and overseen by Congress.

The new board should be responsible for coordinating the development and refinement of national practice guidelines. The guidelines should be based on reviews, by panels of leading health care professionals, of research that has been conducted on the impacts of alternative technologies and procedures. These panels should collaborate with and leverage the work of professional societies, pro-

vider organizations, health plans, universities, companies and industry associations, patient groups, payers, and other organizations. For technologies and procedures about which additional data are needed for the development of guidelines, new studies and assessments should be funded by the board. The board should assure that guidelines are continually updated as new data — on current and new technologies and procedures — become available.

The board should also be responsible for disseminating national practice guidelines and measures of process and outcomes quality to those who deliver, pay for, or receive care. It is vital not only that more and better information be developed, but that it be encapsulated and communicated broadly so that it can be acted on.

The practice guidelines issued by the board could be adduced in malpractice cases as evidence of what is considered best medical practice. Conformance to these guidelines should help to protect medical professionals from frivolous or marginal lawsuits. Use of the guidelines, the development of an information technology infrastructure that includes computerized prescription ordering and electronic patient records, and the ready availability of measures throughout the system of process and outcomes quality should over time work to reduce the incidence of medical errors and malpractice and to protect the safety of patients.

As noted above, the core benefit package should not be static. The board should periodically review the components of that package and adjust them as needed to reflect changes in national practice guidelines.

In addition, quality of care can be improved through the use of the patient-centered medical homes to provide comprehensive primary care for children, youth and adults. Under this approach medical care is coordinated and integrated across all components of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

## **PRINCIPLE 4**

### *Equitable Financing*

Reform should seek to reduce or eliminate cost-shifting across categories of insurance programs and payers, both public and private, and to make the distribution of financial burdens more equitable.

The Coalition has identified a range of mechanisms or sources that could be used, individually or in combination, to fund the program costs of the initiatives described here, including the costs of assuring coverage for all Americans:

- general revenues.
- earmarked taxes and/or fees.
- contributions required from employers.
- contributions required from individuals and families (including co-payments, deductibles, and contributions toward premiums).

Financial obligations should be gradated, or subsidies provided, based on relative ability to pay for less affluent individuals, families, and employers.

## **PRINCIPLE 5**

### *Simplified Administration*

The United States spends more than any other nation to administer its health care system. Compared to three other industrialized countries where private health insurance companies have a substantial role, the administrative costs as a share of national health expenditures are 30 to 70 percent higher in the United States. And as the complexity of our system continues to increase, so too does the associated administrative outlay. According to the 2008 Commonwealth Fund's National Scorecard, per capita administrative expenses rose 68 percent between 2000 and 2006, from \$289 to \$485 per person covered, while national health expenditures only rose 47 percent during this period.<sup>1</sup>

The complexity of the American health care system confuses and frustrates patients, payers, and providers. In addition, because it reduces the transparency of transactions and the comparability of performance and cost data, it also undermines accountability and the capacity of health care markets to function efficiently.

The mechanisms and initiatives recommended in these specifications would produce a streamlined, rationalized health care system — one that would be more efficient (and less costly), less cumbersome and perplexing, and safer. We can, and we should, reduce unproductive inconsistencies across the system. We can, and we should, more fully leverage in health care the capacities of available information and communications technologies — capacities that have improved productivity and performance in so many other sectors of the American economy.

For example, the assurance of coverage for all Americans and the establishment of a core benefit package would create a consistent set of ground rules and understandings for patients, payers, and providers — reducing the variations that now draw time and resources away from the protection and advancement of health. The creation, at long last, of an integrated national information technology infrastructure for health care — including electronic patient records, prescription ordering, and billing — would not only decrease administrative complexity and costs, but help to reduce medical errors, protect the safety of patients, and improve outcomes. (At present, only 17 percent of health care providers use computerized medical records.) Similarly, the development and application of national practice guidelines would simultaneously reduce complexity and variability and improve the quality of care for millions of patients.

The expensive administrative complications of our current health care system are not productive uses of our scarce resources. We would be better off saving some of the money we now spend just to administer our system — or investing that money in new technologies or organizational innovations that would improve the health of the American people.

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<sup>1</sup> The Commonwealth Fund Commission on a High Performance Health System. “Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.” The Commonwealth Fund. July 2008.

## Conclusion

The members of the National Coalition on Health Care are determined to work for comprehensive reform of the American health care system. We offer these specifications for reform as an agenda — an urgent agenda — for action. We close with two observations.

First, we would emphasize again our conviction that reform must be systemic and system-wide. The problems of our health care system — and the principles that guided our development of specifications for reform — are so closely interrelated that they must all be addressed at the same time. One-dimensional reform will not work.

Consider: Unless we improve the quality of care, we will not be able to manage costs or afford universal coverage. Unless we manage costs effectively, we will not be able to achieve equitable financing or cover all Americans. And unless we assure coverage for everybody, we will be unable to make the system less complex, establish a level playing field without cost-shifting, or create a truly competitive health care marketplace. (In fact, many of those who first advanced the market-based reform hypothesis called managed competition warned that a market for health care cannot function efficiently or effectively in the absence of mandatory universal coverage and government oversight.)

Second, the status quo — clearly, undeniably — is not working. It leaves tens of millions of Americans with no health insurance at all. It allows costs to skyrocket year after year, putting coverage out of reach for millions of Americans and compromising the vitality of our economy and its capacity to create and sustain jobs. And it jeopardizes the safety of patients because of widespread sub-standard care.

The status quo is not acceptable. It is time — it is past time — to change it. The readers of this report can have a tremendous impact on the prospects for reform and the shape of reform. We hope that you will work with us in this important effort.



*National Coalition on Health Care*

*1120 G Street, NW  
Suite 810  
Washington, DC 20005  
202-638-7151  
[www.nchc.org](http://www.nchc.org)*