

are two broad and closely linked strategies for accomplishing these aims: fostering the growth of more organized systems of care and implementing fundamental payment reform. Consensus is emerging that integrated delivery systems that provide strong support to clinicians and team-based care management for patients offer great promise for improving quality and lowering costs. Most physicians already practice within local referral networks around one or more hospitals, which could form local integrated delivery systems with little disruption of practice.⁴ Policymakers would need to remove legal barriers to collaboration and offer incentives — such as larger payment updates or subsidies for implementing electronic health records — to providers who were willing to establish real or virtual accountable care systems.⁵ Our volume-based payment systems could then be changed to incorporate partial capitation, bundled payments, or shared savings, thereby fostering accountability for overall costs and quality of care. Although much remains to be learned about aligning reforms

in delivery systems with payment reforms, early results from demonstration projects have been promising and could provide the foundation for national reform.

The good news is that small changes in annual per capita growth rates have enormous implications for the long-term solvency of Medicare and the sustainability of expanded insurance coverage. Using data from the 2008 Medicare trustees' report on projected revenues and total Part A and B spending, we estimate that Medicare will be \$660 billion in the hole by 2023. Reducing annual growth in per capita spending from 3.5% (the national average) to 2.4% (the rate in San Francisco) would leave Medicare with a healthy estimated balance of \$758 billion, a cumulative savings of \$1.42 trillion.

Such a change would not solve the country's long-term fiscal challenges. But it suggests that if we focus reform efforts on current areas of overspending — overuse of hospitals and unnecessary visits, consultations, tests, and minor procedures — we may be able to bend the cost curve while continu-

ing to enjoy the benefits of technological advances.

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1. Skinner JS, Staiger DO, Fisher ES. Is technological change in medicine always worth it? The case of acute myocardial infarction. *Health Aff (Millwood)* 2006;25:w34-w47.
2. Chernew ME, Hirth RA, Sonnad SS, Ermann R, Fendrick AM. Managed care, medical technology, and health care cost growth: a review of the evidence. *Med Care Res Rev* 1998;55:259-88.
3. Sirovich B, Gallagher PM, Wennberg DE, Fisher ES. Discretionary decision making by primary care physicians and the cost of U.S. health care. *Health Aff (Millwood)* 2008;27:813-23.
4. Bynum JP, Bernal-Delgado E, Gottlieb D, Fisher E. Assigning ambulatory patients and their physicians to hospitals: a method for obtaining population-based provider performance measurements. *Health Serv Res* 2007;42:45-62.
5. Shortell SM, Casalino LP. Health care reform requires accountable care systems. *JAMA* 2008;300:95-7.

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HEALTH CARE 2009

Investing in Health Care Reform

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Indicating that health care reform is integral to his policy agenda, President Barack Obama has moved swiftly to incorporate elements of reform into his economic recovery bill and signed reauthorization of the State Children's Health Insurance Program (SCHIP). Enactment of comprehensive reform, however, is likely to hinge on the development of a plan that is affordable to fam-

ilies, employers, and taxpayers. It will need to combine expanded health insurance coverage with investments designed to improve care and slow spending growth if it is to be sound and sustainable in the long term.

The Commonwealth Fund Commission on a High Performance Health System, in its new report, *The Path to a High Performance U.S. Health System* (Path proposal),¹ has

endorsed a set of health care policies that would produce savings for the system: the creation of a national health insurance exchange with a choice of private plans and a new public-plan option; investment in systemic changes, such as accelerated adoption of health information technology and health insurance benefits that are based on evidence of the comparative effectiveness of treatment options;

realignment of incentives for health care providers under Medicare and the public plan to encourage accountability for patient outcomes and prudent use of resources; and public health measures, including increasing taxes on harmful products as a way of combating smoking and obesity. All these policies would require substantial changes in the financing and delivery of health care, and all would be politically difficult to accomplish. Estimates of the effect of this proposal on the trajectory of health care spending and coverage were prepared with the use of a health-benefits-simulation model and assumptions derived from the literature.²

Inclusion in the national insurance exchange of a public-plan option that would be open to businesses and individuals is key to achieving savings. Medicare has lower administrative costs and

provider-payment rates than fee-for-service commercial insurers; if private plans did not bring down rates, a new public-plan option could offer premiums that would be 20 to 30% lower than commercial rates for similar benefits.¹ To be competitive, private insurers would need to become more efficient and work with providers to integrate, coordinate, and redesign care to treat chronic conditions more effectively and avert preventable hospitalizations, complications, and readmissions.

Up-front investments that are key to long-term savings and improved performance include those designed to accelerate adoption of health information technology and evidence-based care. Under the Path proposal, an assessment on private insurers of 1% of premiums, plus an equal proportion of projected Medicare spending, would provide about \$13 billion

per year to assist safety-net, rural, and small medical practices in adopting information technology and establish a national electronic network to facilitate the exchange of patient health information. Similarly, an assessment on private insurers of 0.05% of premiums, along with the same proportion of projected Medicare and Medicaid spending, would generate about \$14 billion through 2020 for research, undertaken by a newly established center for comparative effectiveness, to evaluate devices, drugs, procedures, and other treatments in order to encourage the use of cost-effective therapies.

Achieving substantial savings in care delivery will require payment reforms in both the public and private sectors. The Path proposal would increase payment for primary care services by 5% through revision of the Medicare

Table 1. Sources of Savings under the Path Proposal and the Projected Net Effect on the Federal Budget and National Health Expenditures (2010–2020).*

Variable	Federal Budget	Total National Health Expenditures
	<i>billions of dollars</i>	
Affordable coverage for all		
Covering net costs of insurance expansion and redistribution of coverage sources	+1,924	-432
Payment reform (aligning incentives to enhance value)		
Enhancing payment for primary care	-30	-71
Encouraging adoption of the "medical home" model	-101	-175
Bundling payment for acute care episodes	-211	-301
Adjusting prices to reflect value	-407	-464
Improving quality and health outcomes		
Accelerating the spread and use of health information technology	-101	-261
Creating a center for comparative effectiveness	-232	-634
Public health policies and taxes on harmful products		
Reducing tobacco use	-95	-255
Reducing obesity	-154	-406
Total net effect	+593	-2,998

* Data are from the Commonwealth Fund Commission on a High Performance Health System.¹

fee schedule; encourage adoption of the “medical home” model to promote coordinated care; implement a global case rate for episodes of acute hospital care, including follow-up care; and correct overpayments for prescription drugs and other services to align payments with value.

Substantial savings could be achieved by eliminating excess payments to Medicare Advantage plans relative to the costs of traditional Medicare.³ Prices that are paid for prescription drugs in the United States continue to be well in excess of those paid in other countries.⁴ In addition, other countries are more advanced in assessing the cost-effectiveness of treatments and basing prices on the lowest-cost treatment with equivalent effectiveness.⁵

The Path proposal also calls for strategies to improve public health, including increasing the federal excise tax on cigarettes by \$2 a pack, instituting a new federal tax on sugar-sweetened soft drinks of 1 cent per 12 oz, and increasing the federal excise tax on beer by 5 cents per 12-oz can and on other alcohol products by proportional amounts. A portion of these tax revenues would be used to fund state and local public health initiatives.

Our analysis of these proposals indicates that reform that simultaneously improves coverage,

quality, and efficiency can lead to better health and economic security for American families. The inclusion of an individual mandate to obtain coverage, along with income-related assistance in paying premiums and expanded coverage under Medicaid and SCHIP, would lead to near-universal coverage, with only 4 million people, or 1% of the U.S. population, uninsured in 2020, instead of a projected increase to 61 million under current policies.¹

Equally important, the projected growth in annual national health expenditures through 2020 would slow from 6.7% to 5.5% — resulting in cumulative savings of \$3 trillion over 11 years. These savings, while representing approximately 7% of the \$42 trillion in health care spending that is currently projected through 2020, would reduce expenditures in that year from 21% of the gross domestic product to 18%.

The cumulative cost to the federal budget of expanding coverage alone is \$1.9 trillion over the same 11-year period (see Table 1). Though difficult to achieve, the above-mentioned reforms — in the context of a coverage expansion that broadened the potential effect by increasing the number of patients to whom the reforms apply and eliminating the need for cross-subsidies and a patchwork of public policies now used to off-

set the costs of care for the uninsured — could offset more than two thirds of the incremental costs in the federal budget.

At the same time, employers, state and local governments, and households would realize net savings totaling \$3.6 trillion. In light of these savings, the balance of \$600 billion in federal-budget costs could be offset in a number of ways. For example, design features, such as the level of the public-plan premium or premium assistance, could be calibrated to achieve greater federal-budget savings while leaving substantial savings for employers and households. The return on federal investment in reforms would accrue to all payers (see Table 2), and ongoing financing could then be shared more broadly by all organizations that realize gains. Although payers would benefit from the reduction in spending growth (as well as from greater access and more effective care), providers would continue to benefit from a growing health care system: even under the Path policies, national health care spending in 2020 is projected to be \$4.6 trillion — 80% higher than in 2009.

The simultaneous achievement of universal coverage, better health outcomes, and slowed spending growth requires changing the way public policy is shaped, as well as rapid experimentation and learn-

Table 2. Net Cumulative Effect of the Path Proposal on National Health Expenditures for Major Payer Groups (2010–2020).*

Period	Total National Health Expenditures	Net Federal Government	Net State or Local Government	Private Employers	Households
<i>billions of dollars</i>					
2010–2015	-677	+448	-344	+111	-891
2016–2020	-2,321	+145	-690	-342	-1,434
2010–2020	-2,998	+593	-1,034	-231	-2,325

* Data are from the Commonwealth Fund Commission on a High Performance Health System.¹

ing. Currently, the secretary of health and human services does not have sufficient flexibility to test and fine-tune savings strategies on a statewide or regional basis. I believe that the secretary should be given far greater authority, with accountability to the President and Congress — perhaps with the advice of a council of independent experts — to act as a prudent purchaser, test new payment and system reforms, and rapidly spread and implement promising reforms. It is time to

change “business as usual” and to invest in the health care reforms that will benefit the public and patients and put our nation on a sounder economic footing.

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1. The Commonwealth Fund Commission on a High Performance Health System. The path to a high performance U.S. health system: a 2020 vision and the policies to pave the way. New York: Commonwealth Fund,

February 2009. (Accessed February 4, 2009, at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=815367.)

2. Path to a high performance health system: technical documentation, Washington, DC: Lewin Group, February 2009.

3. Budget options. Vol. 1. Health care. Washington, DC: Congressional Budget Office, December 2008.

4. Accounting for the cost of U.S. health care: a new look at why Americans spend more. Washington, DC: McKinsey Global Institute, November 2008. (Accessed February 4, 2009, at http://www.mckinsey.com/mgi/publications/US_healthcare/.)

5. Davis K. Slowing the growth of health care costs — learning from international experience. *N Engl J Med* 2008;359:1751-5.

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HEALTH CARE 2009

Expanding Coverage for Children — The Democrats’ Power and SCHIP Reauthorization

John K. Iglehart

In the first demonstration of Democratic dominance on health care issues since Barack Obama captured the White House, the new Congress quickly reauthorized the State Children’s Health Insurance Program (SCHIP), enabling the president to sign the measure into law within days after taking office. Though falling short of President Obama’s goal of ensuring that “every child in America has access to affordable health care,” the measure should sustain SCHIP’s current enrollment of about 7 million and expand coverage to an additional 4.1 million children by 2013.

The rapid action underscored Democrats’ intention to reverse or amend many health policies put in place during the Bush administration. Twice in 2007, Democrats failed to override vetoes of similar SCHIP bills by former President George W. Bush, who objected to their financing of the program

through increased federal tobacco taxes and to their going “too far in federalizing health care.” But the newly authorized SCHIP expansion still faces a formidable hurdle. With federal and state governments seeing substantial losses in tax revenue as the recession deepens,¹ many states will find it challenging to stabilize, much less expand, their current SCHIP and Medicaid enrollments, even as more people lose their jobs and their employer-sponsored health insurance.² A large economic stimulus package moving through Congress contains substantial relief for states, including monies to bolster SCHIP and Medicaid programs.

On January 14, eight days after the 111th Congress convened, the House approved a 4.5-year extension of SCHIP by a vote of 289 to 139. The bill attracted 40 Republican votes, reflecting some bipartisan support for expansion of public coverage for the most po-

litically popular uninsured group, children who live in low-income families, most of which have an employed family member. On January 29, the Senate voted 66 to 32 in favor of a similar bill. Only nine Republican senators voted for the measure. Legislators quickly resolved the only issue that separated the House and Senate measures. They eliminated from the final bill a House-approved provision that would essentially have banned the future development of specialty hospitals owned or invested in by physicians who refer patients to these facilities. President Obama signed the bill into law on February 4.

SCHIP was established by the Balanced Budget Act of 1997 as a federal–state program serving children living in families with incomes at or below 200% of the federal poverty level (\$35,200 for a family of three in 2008). SCHIP expanded on coverage provided by Medicaid, a far larger federal–state