



# Executive Summary

**IMPROVING QUALITY**  
*and VALUE in the U.S.*

# Health Care System

August 2009



BIPARTISAN POLICY CENTER



## Preamble

The Bipartisan Policy Center (BPC) is a public policy advocacy organization founded by former U.S. Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell. Its mission is to develop and promote solutions that can attract the public support and political momentum to achieve real progress. The BPC acts as an incubator for policy efforts that engage top political figures, advocates, academics, and business leaders in the art of principled compromise.

This report is part of a series commissioned by the BPC to advance the substantive work of the Leaders' Project on the State of American Health Care. It is intended to explore policy trade-offs and analyze the major decisions involved in improving health care delivery, and discuss them in the broader context of health reform. It does not necessarily reflect the views or opinions of Senators Baker, Daschle, and Dole or the BPC's Board of Directors.

The Leaders' Project was launched in March 2008. Co-Directed by Mark B. McClellan and Chris Jennings, its mission is (1) to create a bipartisan plan for health reform that can be used to transform the U.S. health care system, and (2) to demonstrate that health reform is an achievable political reality. Over the course of the project, Senators Baker, Daschle, and Dole hosted public policy forums across the country, and orchestrated a targeted outreach campaign to Members of Congress, the Administration, and key health care constituencies. In June 2009, they released the Project's final report entitled, *Crossing Our Lines: Working Together to Reform the U.S. Health System*, which includes a slate of comprehensive policy recommendations to address the delivery, cost, coverage, and financing challenges facing the nation's health system.

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*Improving Quality and Value in the U.S. Health Care System* was written by teams at the Engelberg Center for Health Reform at the Brookings Institution and by Avalere Health, LLC.

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# Executive Summary

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The U.S. health care system faces significant challenges that clearly indicate the urgent need for reform. Attention has rightly focused on the approximately 46 million Americans who are uninsured, and on the many insured Americans who face rapid increases in premiums and out-of-pocket costs. As Congress and the Obama Administration consider ways to invest new funds to reduce the number of Americans without insurance coverage, we must simultaneously address shortfalls in the quality and efficiency of care that lead to higher costs and to poor health outcomes. To do otherwise casts doubt on the feasibility and sustainability of coverage expansions and also ensures that our current health care system will continue to have large gaps — even for those with access to insurance coverage.

There is broad evidence that Americans often do not get the care they need even though the United States spends more money per person on health care than any other nation in the world. Preventive care is underutilized, resulting in higher spending on complex, advanced diseases. Patients with chronic diseases such as hypertension, heart disease, and diabetes all too often do not receive proven and effective treatments such as drug therapies or self-management services to help them more effectively manage their conditions. This is true for insured, uninsured, and under-insured Americans. These problems are exacerbated by a lack of coordination of care for patients with chronic diseases. The underlying fragmentation of the health care system is not surprising given that health care providers do not

have the payment support or other tools they need to communicate and work together effectively to improve patient care.

While many patients often do not receive medically necessary care, others receive care that may be unnecessary, or even harmful. Research has documented tremendous variation in hospital inpatient lengths of stay, visits to specialists, procedures and testing, and costs — not only by different geographic areas of the United States, but also from hospital to hospital in the same town. This variation has no apparent impact on the health of the populations being treated. These issues are particularly relevant to lower-income Americans and to members of diverse ethnic and demographic groups who often face great disparities in health and health care.

Reforming our health care delivery system to improve the quality and value of care is essential to address escalating costs, poor quality, and increasing numbers of Americans without health insurance coverage. Reforms should improve access to the right care at the right time in the right setting. They should keep people healthy and prevent common, avoidable complications of illnesses to the greatest extent possible. Thoughtfully constructed reforms would support greater access to health-improving care — in contrast to the current system, which encourages more tests, procedures, and treatments that are at best unnecessary and at worst harmful.

This report reviews the evidence on a range of payment and delivery system reforms designed to improve quality and value. It reaches several conclusions:

**1. While there is ongoing debate about the ability of various delivery system reforms to increase value, there are clear attributes of different approaches to reform that are more likely than others to improve health and slow cost growth.**

*Chronic Disease Management, Primary Care Coordination, and Health Information Technology (HIT)* — There is strong evidence that particular approaches or programs in these areas can improve quality and health outcomes. Some interventions also show evidence of lowering total cost growth. At the same time, these reforms, as implemented, have been very heterogeneous, and improvements in value and especially reductions in cost have not been automatic. While we find promising evidence that delivery system interventions can help slow the growth of health care costs, we argue that it should be possible to achieve larger and more certain savings by having meaningful risk-adjusted accountability incentives and requirements in place. These incentives and requirements should also be tied to particular quality improvement steps.

*Comparative Effectiveness Research (CER)* — Investment in CER holds promise for improving the value of health care over the longer term. Contrary to some common definitions of CER that focus narrowly on supporting and disseminating more head-to-head trials for particular treatments, CER could have a much larger impact if it is more broadly focused on (1) comparing the risks, benefits, and costs of different health care practice; (2) evaluating and revising policies that influence practices; and (3) developing strategies for targeting practices to specific groups of patients. This more broadly conceived approach to CER can support continuing

improvements in the delivery system and reduce disparities in health care based on race, geography, and other factors.

**2. Interventions that are targeted to specific patient populations and clinical areas typically have a greater impact on quality improvement and cost containment than broader approaches.**

Targeting treatments to the appropriate patients is increasingly important in medical science, and particularly important to promoting quality and value. Using predictors — such as high utilization, complexity of conditions, or other clinical and personal characteristics — may improve the returns from delivery system investments. Research has found that certain groups, including individuals with multiple chronic diseases, low-income and minority populations, and patients undergoing care transitions, are particularly vulnerable and are more likely to benefit from certain interventions. Further, chronic care management programs can have a substantial impact on frail patients and those with multiple chronic diseases via improved health outcomes, patient and family satisfaction, and reduced costs. Unfortunately, these sub-populations often have the least access to effective care management programs. Developing better evidence and analytic capabilities for targeting delivery system interventions appropriately will be particularly important for future reforms.

**3. Delivery system reforms are most effective when they are integrated and ensure real accountability from providers and patients to improve results.**

Evidence suggests that multiple approaches to delivery system reform may be necessary to bend the cost curve and improve care quality. For example, the effectiveness of a single disease management program may be limited for patients who have

multiple chronic conditions and who require coordinated care from many specialists. Moreover, efforts to coordinate care will be less effective without the use of electronic medical records and more comprehensive decision support for both patient and provider. Alone, sophisticated HIT systems will be ineffective if providers do not have payment and other incentives to promote systematic coordination of care. Finally, providers will not be as successful as they can be over the long term if they do not have access to practical evidence on which clinical practices work best in particular cases or which patients need timely interventions. Evaluations of past efforts to integrate delivery system reforms show promising results. Delivery system reforms must be implemented in concert with other reforms to provide the tools, resources, and incentives (for patients and providers) needed to assure better patient outcomes.

**4. Reforms are needed to transition provider reimbursement away from volume and intensity of services and toward quality and value.**

*Changing provider reimbursement* — Moving away from a focus on the volume and intensity of services provided and toward accountability for overall cost and quality is essential for supporting integrated delivery system reforms. Many valuable services that providers already deliver, such as effective preventive care or coordinated post-hospitalization care, are generally underprovided because doctors and hospitals do not have adequate financial or other support to provide them. The current system creates incentives for providing more care and more intensive treatments, with little regard to the effectiveness of these treatments in terms of improving health at the lowest possible cost. A reformed system should reward value before volume, quality before quantity, and organized delivery over disorganized care. Without payment reforms

that give providers the support they need to be increasingly accountable for delivering better care at lower overall cost, individual, incremental delivery reforms or interventions are unlikely to be adequate to address the major gaps in quality and value that currently exist in the U.S. health system.

*Changing benefit designs* — Assuring that cost is not a barrier to care is a critical component of designing health benefits. When faced with significant out-of-pocket expenses, patients are just as likely to forego necessary care as they are to forego unnecessary care. Cost-sharing requirements and coverage should be designed to encourage patients to utilize cost-effective primary care and preventive services that can delay or prevent the onset of costly chronic conditions.

At the same time, patients should be encouraged to choose high-quality care at a lower overall cost, and should have access to information to help them make well-informed decisions. Often, patients cannot get reliable information on the important outcomes and overall costs of their treatment options. With better information on value — outcomes, satisfaction, and costs — patients could make more confident decisions about getting the care they need while spending no more than necessary. This is important because, in many insurance plans today, patients with chronic diseases incur substantial out-of-pocket costs. And in the frequent cases where they have reached the out-of-pocket spending limit in their plan, they do not stand to share in any of the savings that could be achieved if they get less costly care that meets their needs. Enabling such patients to pay less when they get better care that lowers overall costs would provide better support for effective integrated care.

These findings also suggest that efforts to support integrated delivery reforms through provider payment and benefit reforms should be combined

with expanded health care coverage to improve the performance of the overall system in a feasible and sustainable way.

**5. *To be most effective, changes in the delivery system and coverage expansions should be implemented together.***

Reforming health care payment and delivery and expanding coverage are not only complementary; each is critical to achieving the other. Coverage expansion is critical to fully address the underuse of effective care, a problem that is particularly severe among the uninsured. At the same time, successful payment and delivery reform is needed to increase the value of health care, with better quality care and slower cost growth. These improvements will likely induce more Americans to purchase health insurance coverage as it becomes more affordable and valuable. Modeling results presented in this paper predict that if delivery system reforms can help achieve reasonable increases in value, millions of additional Americans could obtain health insurance coverage by 2019, even absent expansions in coverage. Of course, delivery system reforms alone will not ensure universal coverage; major steps must be taken to explicitly ensure coverage for every American. Yet substantial progress toward effective delivery system reform is critical to achieving goals with respect to expanded coverage.

These findings have several implications for policy actions by Congress and the Administration:

- Develop and promote the consistent, meaningful use of valid and widely available information on the quality and cost of health care, with a particular emphasis on measuring health outcomes and overall costs at the level of episodes of care and at the level of individual patients. This includes using HIT systems to simplify data collection and reporting, and building better evidence on which delivery approaches best work.
- Promote an integrated approach to delivery reform by giving providers a feasible pathway for organizing local delivery systems around the principle of accountability. Simultaneously work to (1) implement and continually improve HIT and quality measurement infrastructure, (2) provide better systems for the coordination of primary care and the delivery of preventive care, and (3) introduce new payment systems to support reductions in cost growth and improvements in quality.
- Encourage efforts at the state and regional levels to enable public and private payers, including Medicaid and Medicare, to participate in private-public initiatives aimed at using better, outcome-focused performance measures to support payment and benefit reforms that promote accountability for greater value.
- Lead with Medicare by implementing a clear vision for transitioning payments to promote greater accountability for improving the value of health care. Efforts to promote delivery reform that do not include Medicare cannot have a major impact on the environment of medical practice.



## **Crossing Our Lines: Working Together to Reform the U.S. Health System**

*Crossing Our Lines* is a bipartisan agreement for comprehensive health reform reached by Senators Howard Baker, Tom Daschle, and Bob Dole. It is the culmination of an inclusive year-and-a-half effort that included strategic outreach to key health care stakeholders, a series of state-based public policy forums, and months of personal deliberations by

the Senators. Taken together, the recommendations ensure that all Americans have quality, affordable health coverage, while improving health care quality and reining in skyrocketing costs. Organized around four "pillars" of health reform, the policies are inextricably intertwined, and consequently work together to achieve more significant improvements in the health care system than could be achieved if they were considered in an isolated manner.

- I. Promoting High-Quality, High-Value Care**
- II. Making Health Insurance Available, Meaningful and Affordable**
- III. Emphasizing and Supporting Personal Responsibility and Healthy Choices**
- IV. Developing a Workable and Sustainable Approach to Health Care Financing**

To download a copy of the key recommendations or the full report, please visit [www.bipartisanpolicy.org](http://www.bipartisanpolicy.org).

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