

HAGEL HEALTH CARE COMMISSION

CHARLES J. MARR, CHAIRMAN

FINAL REPORT
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BIOGRAPHIES

Charles J. Marr is the Founding CEO of Alegend Health in Omaha. Prior to his service at Alegend Health, he served as the President/CEO of both Immanuel Healthcare Systems of Omaha and Regional West Medical Center of Scottsbluff. Mr. Marr is currently active in many organizations, serving as Treasurer of the Omaha Community Playhouse Foundation, Nebraska State Coordinator for Sister Cities International, and Vice-Chair of Midland Lutheran College. In addition, Mr. Marr serves on the Nebraska Legislature's Behavioral Health Oversight Commission and is a Life Fellow of the American College of Healthcare Executives.

Jim Berarducci is President and Managing Director of the Health Care Division of Kurt Salmon Associates, a global health care and retail consulting firm based in Atlanta, GA. Mr. Berarducci has been involved in a wide variety of engagements in a broad range of health care settings with Kurt Salmon Associates for nearly 20 years. His clients include health care providers such as tertiary and community hospitals, academic medical centers, integrated systems, and physician group practices. Mr. Berarducci has directed a number of large, complex, and multi-functional planning engagements, including strategic planning, clinical program planning, consolidation and integration efforts, and capital planning through major building projects. Mr. Berarducci lives in Minneapolis and received his Master's of Health Care Administration from the University of Minnesota.

Dr. J. Chris Bradberry is Dean of the School of Pharmacy and Health Professions at Creighton University. Dr. Bradberry earned his Bachelor's degree in pharmacy and Master's degree in hospital pharmacy from the University of Louisiana at Monroe. He completed his doctor of pharmacy degree at the University of Tennessee Health Sciences Center, Memphis, and his residency in pharmacy at the University of Texas Medical Branch, Galveston. Dr. Bradberry served the Indian Health Service as the Chief Pharmacy Officer of the Chinle Health Center and has practiced in both community and institutional pharmacy. He has been on the faculties of the University of Nebraska, the University of Texas, the University of Oklahoma and the University of Tennessee. In August 2003, Dr. Bradberry was appointed to his current position at Creighton University.

Dr. William E. Bush completed his undergraduate education at Emory University and received his M.D. from the Medical College of Georgia. He received his postgraduate education in Anesthesiology at the University of Florida College of Medicine and practiced in Venice, Florida for 19 years. After retirement in 1995, Dr. Bush became interested in human psychology and Spiritual healing. Currently, Dr. Bush is pursuing the treatment of psychological and emotional dysfunction, including Post Traumatic Stress Disorder, through Electroencephalographic Biofeedback. Dr. Bush serves on the Council of Advisors of Tamassee School in South Carolina and the Environmental Leadership Center of Warren-Wilson College in Asheville, North Carolina. Dr. Bush resides in Salem, South Carolina.

Michael DeFreece is Chairman and Chief Administrative Officer of MarketSphere Consulting, LLC. Mr. DeFreece has considerable consulting experience, specializing in financial services to the healthcare industry. Prior to joining MarketSphere, Mr. DeFreece was a Managing Director of McCarthy & Co., an Omaha-based investment banking firm. He is also a retired Arthur Andersen Partner where he spent many years providing services to the health care industry. Mr. DeFreece is a Fellow in the Health Care Financial Management Association and was a member of the American Institute of Certified Public Accountants' National Health Care Committee for many years.

Dr. Mary Lee Fitzsimmons is the Nebraska Member Services Director of the Iowa/Nebraska Primary Care Association. Dr. Fitzsimmons assists the Association in providing development support services and programs to its member community and migrant health centers in Nebraska. Dr. Fitzsimmons served as the Executive Director of Omaha's OneWorld Community Health Center for nine years, providing comprehensive health care to some 6,500 minority patients annually. Dr. Fitzsimmons earned her bachelor's degree in nursing from Creighton University and her doctorate in Psychological and Cultural Studies from the University of Nebraska at Lincoln. Dr. Fitzsimmons was a winner of Omaha's YWCA Tribute to Women award.

Dr. Dennis Goeschel is Vice-Chairman of the Department of Family Medicine at the University of Nebraska Medical Center. Dr. Goeschel earned his medical degree at the University of Nebraska Medical Center and completed his residency in family practice at UNMC. Following his residency, Dr. Goeschel went into private practice in Scottsbluff County, Nebraska and served the Medical Committee of Regional West Medical Center in Scottsbluff for 12 years. Dr. Goeschel is a member of the National Board of Medical Examiners, the American Board of Family Practice and the American Academy of Family Physicians.

Dr. Charles D. Gregorius is a physician with Associated Anesthesiologists, P.C., in Lincoln, Nebraska. Dr. Gregorius earned his medical degree at the University of Nebraska College of Medicine and completed his residency in anesthesia at the University of Missouri Medical Center in Columbia. Dr. Gregorius is a member of the American Society of Anesthesiologists (ASA) and has served on the ASA Board of Directors for 15 years. He is currently Secretary of the ASA Political Action Committee. He has also served on a local hospital's Board of Trustees for nine years. Dr. Gregorius is a member of the Nebraska Society of Anesthesiologists, the Nebraska Medical Association, and the Lancaster County Medical Society.

Lisa Lechowicz is the Founder and Chief Executive Officer of HDM Corporation. Before establishing HDM, Ms. Lechowicz served as Senior Vice President of Health Care Business Operations for Mutual of Omaha. Ms. Lechowicz has an extensive background in systems development, project and process management, consulting, planning, and claims management within the health insurance industry.

Steven S. Martin is the President & CEO of Blue Cross/Blue Shield of Nebraska, the largest health insurance and health benefits administrator serving Nebraskans. Blue Cross/Blue Shield of Nebraska is a not-for-profit mutual insurance company and an independent licensee of the Blue Cross and Blue Shield Association. Mr. Martin serves on the board of directors for the Blue Cross and Blue Shield Association in Chicago. Mr. Martin also serves on the Policy Committee for the America's Health Insurance Plans (AHIP) organization in Washington, D.C. Mr. Martin is a Board Director for TriWest Healthcare Alliance in Phoenix, Arizona, and Prime Therapeutics, L.L.C. in Eagan, Minnesota. He serves as a Board Director for the United Way of the Midlands; Advisory Board member for the Salvation Army; Board Director for the Durham Western Heritage Museum; Trustee for the Cedars Foundation; Trustee for the Nebraska Council for Economic Education; Councilor for the Knights of AK-SAR-BEN; and Board Director for the Greater Omaha Chamber of Commerce.

Dr. Keith Mueller is a Professor and the Director of the Nebraska Center for Rural Health Research at the University of Nebraska Medical Center. Dr. Mueller is also the Director of the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis. He has served as President of the National Rural Health Association and as a member of the National Advisory Committee on Rural Health and Human Services. Dr. Mueller currently serves on the Advisory Panel on Medicare Education for the Centers for Medicare and Medicaid Services.

Dr. Todd Sorensen has served as President and Chief Executive Officer of Regional West Health Services and Regional West Medical Center since September 2000. Dr. Sorensen earned his medical degree from the University of Nebraska College of Medicine Omaha and a master's degree in administrative medicine from the University of Wisconsin at Madison. He completed an internal medicine residency at Denver's Presbyterian Medical Center and is a board-certified internal medicine physician. With two colleagues, Dr. Sorensen founded Scottsbluff Internal Medicine Group in 1976. In addition to his medical practice, Dr. Sorensen later served as medical director for Regional Care, Inc., where he helped develop a provider network and regional health plan.

Dr. Virginia Tilden is Dean and Professor at the University of Nebraska Medical Center College of Nursing. Prior to joining UNMC, Dr. Tilden held academic appointments at the University of California at San Francisco, the University of San Francisco and the Oregon Health & Science University (OHSU). At OHSU, Dr. Tilden served for 12 years as the Associate Director of the Center for Ethics in Health Care. In addition, Dr. Tilden is nationally recognized for her long-standing work in improving end-of-life care. She has been principal investigator or co-investigator of over 20 nationally-funded studies addressing the patient and family's experience at end-of-life in a full array of settings where Americans die. Dr. Tilden earned her Bachelor's degree in nursing from Georgetown University, and her Master's and doctoral degrees in nursing from the University of California San Francisco. She completed postdoctoral training in Clinical Bioethics at the University of Washington.

Jack Vetter is President of Vetter Health Services, a leading nursing home management company in the United States. Mr. Vetter began his career in long-term care as a nursing home administrator, founding Vetter Health Services with his wife after they acquired their third nursing home. Mr. Vetter owns and manages 32 long-term care facilities in Nebraska, Iowa, Missouri, Kansas, and Wyoming; many that have been acknowledged with company and state recognitions and state and national awards. In January of 2007, Vetter Health Services will celebrate its 32nd Anniversary. In addition to his work, Jack enjoys time with his family and traveling the world for pleasure, missions, and philanthropic work.

Dr. Daniel Wilson is Professor and Chairman of Psychiatry and Professor of Anthropology at Creighton University where he oversees a growing program of clinical care, teaching and research. Dr. Wilson has a unique range of training in medicine, psychiatry, anthropology and management at Yale, Iowa, Harvard, Cambridge and Case Western. His professional experience similarly spans a broad range from directing neuropsychiatry at Harvard Medical School, then later working at sharper edges of public health and forensic systems management in the Ohio Department of Mental Health and the University of Cincinnati. Dr. Wilson is a key proponent of Nebraska health reform, serving on both Gubernatorial and Legislative panels guiding system transformation.

MANDATE OF THE HAGEL HEALTH CARE COMMISSION

The Hagel Health Care Commission mandate was to review the current state of health care in the United States and present recommendations for developing an accessible and sustainable system for the 21st century. This report defines the challenges facing American health care and recommends federal initiatives for system-wide improvements. The Commission focused on several major questions including:

- How can we improve health care quality and delivery in America?
- How can we contain health care costs?
- What role will medical science and technology have in transforming future health care?
- Are there more effective financing vehicles for American health care than current public and private plans?
- How can we improve access to health care for all Americans?
- How do we address the demographic consequences of the baby boom generation and its impact on health care costs and services?

VISION STATEMENT

Health care for all Americans must be efficient, effective and affordable. The United States must create a new standard for health care by transforming its organization, financing and delivery. The Commission's vision for transformation includes:

- access to basic health care for all Americans
- delivery of safe, evidence-based, high quality care
- emphasis on care coordination, and prevention of disease and disability
- accountability by all participants

PREAMBLE

We, the Hagel Health Care Commission, propose urgently needed transformation of U.S. health care that would emphasize wellness and improve the access, quality, and financing of health care for all Americans. Rather than evaluating health care models from other countries or discussing importation of another country's system, the Commission chose to analyze the state of U.S. health care today and outline a course for a uniquely American solution.

The underlying assumptions of our transformation proposal are that all Americans must have access to basic health care; and the system must deliver efficient, effective health care. The new system must transparently balance supply and demand for health care, emphasize quality care, and require accountability by all participants.

Good health and good health care are essential to a productive society and a thriving economy. Successful and sustainable transformation must align with the principles and values of social responsibility—our shared duty to support a safety net for those who are unable to fund their own health care.

COMMISSION PREMISES, VALUES, AND PRINCIPLES

Our transformation proposal for American health care rests upon a philosophical foundation of premises, values, and principles. *Premises* are fundamental underlying assumptions that serve to anchor transformation. *Values* are aspirations or ideals, whether as a means or an end. *Principles* are basic axioms with rules of action that, once established, should not be compromised.

Premises

- All Americans must have access to basic health care.
- Integrated care is essential to effective health care.
- Transformation of health care delivery and financing is an urgent national priority.
- The new U.S. health care system must solve the major problem of affordability, define the cost effectiveness of services, and create accountability by participating individuals and organizations.
- Transformation must reflect the pluralism of American society, the spirit of free enterprise, and the culture of self determination.
- Financing of health care must be based on a philosophy of non-discriminatory access, widely distributed risk pools, and portability of basic coverage.
- The nation's public health system must be comprehensive and fully integrated into the new health care system.

Values and Principles

Value: Social Responsibility

Principle: Americans have a shared responsibility to support a safety net for those who are unable to pay for their own health care needs.

Value: Quality

Principle: Health care policy must promote and enable appropriate access to quality care.

Value: Accountability

Principle: Transformation must achieve accountability for the cost, quality, and behavior of all participants.

Value: Choice

Principle: All Americans must have the information **and** the opportunity to make appropriate health care choices within a broad-based, flexible system.

COMMISSION ANALYSIS

Access to Care

The Commission identified several American values that serve as guiding principles in shaping the state of U.S. health care today. One of these key American values is choice. To Americans with health care insurance, choice is defined by convenient access to an array of services financed through governmental and commercial insurance. However, the number of people without health care insurance is growing, and for these Americans choice is not a reality.

Since the development of employer-based commercial health insurance in the 1940s and the Medicare Program in the 1960s, most Americans have become accustomed to an ever-expanding variety of health care services and a growing assortment of medical technologies and pharmaceuticals—most of which have greatly escalated health care costs for consumers and payers. Demographic trends and numerous research studies indicate that the current U.S. health care is *not* financially sustainable.

Health Care

American health care is complex and fragmented. Consumers often feel that health care is a series of complicated, unrelated services they must navigate alone. This fragmentation is partly the result of payment systems focused on reimbursement by procedure rather than a course of treatment.

American health care is a major economic force. U.S. hospitals, long-term care facilities, and home care services have expanded to meet the needs of a growing and diverse population. The health care industry directly generates more than 13.5 million jobs.

Population Changes

According to the U.S. Census Bureau, the U.S. population recently reached 300 million; 12% of which are age 65 or older. By 2050 the U.S. population will grow to 420 million with nearly 21% age 65 or older. Health care needs of the aging baby boom generation will have a dramatic impact on health care costs and resources. Sustaining quality of life for this generation will become an increasingly important goal that could overwhelm our current health care system.

Uninsured Population

Although most Americans find health care increasingly available, these services are not accessible to the more than 46 million people who are uninsured. Some individuals who could afford medical insurance consciously choose not to buy it. But an alarming number of people are uninsured because (1) their employers do not offer insurance coverage; (2) they cannot afford to purchase health coverage directly from insurers; (3) they do not qualify for government programs such as Medicare or Medicaid. Millions more people are *underinsured* because of high out-of-pocket expenses. The increasing costs of health care premiums will continue to create challenges for employers who want to provide health care coverage for their employees. Experts predict the number of non-elderly uninsured Americans will grow to 56 million by 2013.

COMMISSION ANALYSIS

Quality of Care, Safety and Protection, the Role of Technology

Quality of Care

Americans desire and expect the highest quality health care. Today, there is growing recognition that quality care is compromised by lack of adherence to evidence-based standards; lack of effective information technology; racial/ethnic, rural/urban, and rich/poor disparities; and a growing uninsured population. Quality care is compromised by a system-wide lack of emphasis on preventive care, under-management of chronic disease, unacceptable numbers of procedural errors, and a reimbursement system that pays for quantity of care rather than quality of care.

“Building on the innovative strategies from both the marketplace and government to improve the quality and efficiency of the health care system and enhance the ability of individuals to receive high quality care will help to control health care costs.”

-Health Care that Works for All Americans
Recommendations of the Citizens’ Health Care Working Group

The Institute of Medicine study, “Crossing the Quality Chasm,” identifies the essential components of high quality health care as safety, effectiveness, patient-centeredness, timeliness, and efficiency. Patient-focused care is characterized by compassion, empathy, and responsiveness to the needs, values, and preferences of individual patients. The foundation of quality health care is effective, strongly supported primary care that provides every American with accessible, continuous, coordinated care.

Patient Safety and Consumer Protection

The Institute of Medicine Patient Safety Project reported that patient safety has improved; but there is still a long way to go in improving safety, reducing errors, and establishing a national health information infrastructure that will improve overall patient safety.

- Leadership at the local, regional and national levels is essential to ensure that safety is imbedded in every aspect of health care.
- The Agency for Healthcare Research and Quality (AHRQ), the primary government agency for improving patient safety and quality, can help provide resources and accelerate improvements in quality.

Health care consumers deserve protection similar to consumers of banking, food, telecommunications, or credit services. While consumers have an important role in containing health care costs, they also have a right to understand who is billing them and why. Current industry-administered coding systems provide valuable information about the technical rationale for specific medical services, but the resulting information is complex and confusing to patients and consumers.

The Role of Technology

Technologies can save lives and increase life expectancies but can also drive up health care costs. The U.S. has a vast array of medical technology, although availability varies widely by region. Many urban areas have experienced an overabundance of technology which increases pressure for overuse. Costs will rise as new technologies and applications emerge in areas such as gene therapy, biomechanical devices, and nanotechnology. In other fields, the application of new technology usually contributes to making a product less expensive. In medicine, new technology generally multiplies costs because one technology fosters another and another. A new medical technology doesn't totally replace prior technology; it adds to overall cost.

Health information technology now includes advanced clinical information systems and localized electronic medical records systems that are specific to certain hospital and health systems. These systems vary greatly and were not developed according to standardized national guidelines.

Priorities for new health information technologies include:

- a universal electronic medical record and billing system developed for all organizations that interface with patients during care and which can help people participate in their own health care decisions
- electronic order entry systems for diagnostic and treatment services with cross-checks and warnings for information such as medication doses, interactions and allergies, as well as identified variances from clinical guidelines
- point-of-care systems with defined quality measures, benchmarks and identified variances

COMMISSION ANALYSIS

Financing and Expenditures

Beginning in the 1960s, U. S. health care costs began to escalate rapidly driven by two major forces: (1) the Medicare Program, which substantially increased access and demand by creating a third party to pay for hospital and physician services; and (2) the space program, which sparked technological innovations that were incorporated into modern medical practice. Experts now predict that total annual health care expenditures will reach 19% of America's GDP by 2014.

U.S. health care expenditures per person jumped from \$3,604 in 1994 to \$7,110 in 2006 or an average yearly increase of 6%. Today, the U.S. spends more on health care than any other country. Currently, public financed and subsidized programs make up nearly half of all health care spending.

Government Financing

Government-funded health insurance includes plans funded by federal, state and local governments. In 2004, approximately 79 million Americans were covered by government plans.

Medicare was signed into law in 1965; the following year, Medicare was implemented for 19 million individuals. Title XVIII of the Social Security Act created Medicare Part A, Hospital insurance and Medicare Part B, Supplementary medical insurance. Part C, Medicare+Choice, was added in 1997, and Part D, Prescription drug benefits, was added in 2003. During 2005, there were 42 million Medicare enrollees, representing approximately 14% of the population. To be eligible for Medicare, people must be 65 or older or disabled.

The Medicare Modernization Act of 2003 included a “Medicare Funding Warning.” This warning will be triggered if Medicare trustees predict (in two consecutive years) that general revenue funding of Medicare will exceed 45% of total Medicare outlays in the next seven years. When this prediction occurs, the President will be required to submit proposed legislation for remedial action. The Medicare payment Advisory Commission (MedPAC) indicates that this warning is likely to occur in 2008. If Medicare financing continues as it is currently structured, MedPAC also estimates that the program could grow from the current level of less than 3% of the GDP and to 8% by 2036.

Medicaid became law in 1965, as Title XIX of the Social Security Act. Medicaid is both a basic health insurance program and an insurance program for people with chronic or long-term care needs who meet income standards. Like Medicare, Medicaid costs are driven by demographic trends—primarily, growth in the number of low-income elderly Americans. Designed to provide support for low income people, Medicaid is operated by the states within federal guidelines, although there is a wide variation in eligibility and benefit standards among the states.

- The federal government matches state Medicaid spending using a calculation known as the federal medical assistance percentage. Medicaid now accounts for more than 40% of all federal funds flowing to states, and consumes 16% of state budgets on average.
- In 2005, approximately 16% of the U. S. population was covered by Medicaid. If Medicaid remains unchanged, the program funding requirement is predicted to jump 8% per year for the next several years.

Other programs affecting specific American populations include, the State Children’s Health Insurance Program, Military Health care including Tricare/Champus, Champva, the Veterans Administration, and the Indian Health Service.

Private Health Insurance

In 2004, approximately 199 million Americans (68% of the population) were covered by private health insurance. Of these, about 175 million received partial or total coverage through employers and nearly 27 million purchased insurance directly from insurance carriers, according to Census Bureau reports. Types of private health insurance include fee for service, managed care, self-insured plans, consumer choice plans, and health savings accounts, or a blend of these plans.

Costs not covered by Medicare and Medicaid and not paid by uninsured consumers are shifted to consumers, private payers, and providers as higher insurance premiums or unreimbursed costs. **Annual premium costs for family health insurance provided by private employers in 2005 included an extra \$922 in premiums due to cost of care for uninsured people, according to Families USA.**

“The problem of medical providers charging the insured more to cover costs of the uninsured will become even more prevalent. Public budgets will continue to feel the pressure of both the growing numbers of uninsured people and of the aging population, as long term care costs consume an even greater share of Medicaid funds. Additionally, uncompensated care, now estimated to be more than \$40 billion annually, will continue to rise, placing huge burdens on hospital providers and even forcing many safety net providers to close.” (p 31)

-Health Care that Works for All Americans
Recommendations of the Citizens’ Health Care Working Group

Legislation and Regulation

Tax code legislation passed in 1954 (Public Law 87-792) exempting premiums from employee payroll and income taxes continues to influence the development of new private insurance plans such as consumer choice plans and health savings accounts. All aspects of health care financing and delivery are regulated; Medicare regulations alone total 132,000 pages. Providers say the cost of complying with federal and state health care regulations is one of many reasons for the rapidly escalating cost of care.

Defensive Medicine

Defensive Medicine, characterized by over-use of tests in an effort to avoid litigation, is thought to contribute 6-10% to overall annual health care spending. Universal adoption and use of established clinical guidelines may be one solution to defensive medical practices and exposure to medical liability. These clinical guidelines should enable practitioners to more effectively support treatment regimens in view of third-party challenges. Federal legislation similar to state legislation requiring limits on non-economic damages awarded in medical liability cases is another approach that has been proposed to address this growing challenge. Because of defensive medical practices, millions of patients are exposed to unnecessary procedures and services. The culture of medical liability (determined mostly through tort cases) results in defensive medical practices which can be a barrier to patient safety and quality and can increase costs.

Workforce Development

Of the 20 U.S. occupations projected to grow fastest in the next 15 years, 8 are in health care.

The net increase in total U.S. new jobs since 2000 occurred *entirely* in the health professions. American health care faces a severe shortage of physicians, nurses, allied health, and other health care professionals during the next 20 years. Along with other factors, the aging baby boom population will cause an explosion of demand for health care professionals which will exceed the ability of our current educational system to recruit and educate qualified health care professionals.

Currently, there is a complicated patchwork of programs that provide limited financial support for educating future physicians, dentists, nurses, and other health care professionals; but this support is rapidly eroding. According to the Council on Graduate Medical Education, U.S. health care lacks a coordinated planning function to address the shortage of health care professionals. To address this issue, the public and private sectors must work together to expand educational funding.

COMMISSION RECOMMENDATIONS

The Commission recommends that the United States Congress approve legislation that will transform American health care. The state of American health care today cannot be repaired with further incremental changes. A bold, new approach with private-public cooperation is essential to meet the public's expectation of a better system.

The new American health system will require all Americans to have a basic health plan benefit, provided by private insurers or through a new federally supported health plan. Financing this new system will rely upon employer, employee, individual and governmental premiums and revised, dedicated national taxes. Subsidies and tax credits will be available to individuals and employers who meet new qualification standards. The new national standards will motivate health system participants to respond with ingenuity and creativity as they develop a delivery system that achieves the national cost, quality, and access goals.

We recommend that an independent Health Care Transformation Commission (HCTC) be established to define and approve the new basic health plan for all Americans and to guide and structure the change process. The transformation should begin now and be completed by 2012. The Commission should be patterned after the unique regional-national structure of the Federal Reserve system. Other duties of the HCTC include establishing national standards for the universal exchange of health information, creating medical technology assessment standards, and developing a clearinghouse for national health care quality standards.

The American people deserve the best health care possible. Transforming U.S. health care assures a basic health plan for every American and establishes a foundation for future excellence.

"...establishing a core set of benefits and services, reflecting sound medical evidence, as a standard against which any coverage plan can be evaluated will go a long way toward creating health care that works for all Americans." (p 21)

-Health Care that Works for All Americans
Recommendations of the Citizens' Health Care Working Group

First Recommendation

All Americans must have a basic health plan that:

- emphasizes patient-centered care, delivered and coordinated by physicians and non-physician providers. Often called a “medical home,” this model focuses on prevention, health promotion services, and optimization of health—in short, accessible, coordinated care throughout the person’s lifetime. This model integrates all aspects of the health care continuum that apply to each consumer by focusing on care coordination and active disease management.
- provides proven, cost-effective diagnostic and therapeutic interventions (medications and technology) that are based on the clinical guidelines developed by agencies such as the Agency for Healthcare Research and Quality (AHRQ), U.S. Preventive Services Task Force, and Institute of Medicine.
- includes coverage for ambulatory and acute care, basic dental care, vision care, mental health care, palliative care, and long-term care.
- is portable across employers, geography, and health situations with no exclusions for pre-existing conditions.
- allows for the purchase of expanded health coverage. The consumer would be responsible for all such expanded premium costs.

Second Recommendation

The necessity to attract, develop, educate, and retain health care providers is a priority. National health policy must:

- assess the ability of our health system to respond to anticipated local and regional demand, and to adjust health profession training capabilities as needed.
- create funding mechanisms to support health workforce development, as well as recruitment, education, and retention of health care professionals.
- expand and implement innovative incentives for individual practitioners working in high need areas. This includes (but is not limited to) scholarships, loan forgiveness, National Health Service Corps expansion, service in community health centers, and differential reimbursement for practice in shortage areas.

Third Recommendation

Quality and safety must be improved. The new health care delivery system will:

- ensure all participants are accountable to quality and safety guidelines.
- emphasize evidence-based clinical guidelines for disease management with the expectation that providers will be reimbursed for using proven clinical guidelines and generating positive outcomes.
- create a secure, universal, individual standardized electronic medical record.
- feature health promotion that emphasizes provider and participant accountability.

Fourth Recommendation

Public health is vital to improving health, life expectancy, and quality of life. National health policy must:

- support national standards for public health services, as well as infrastructure, workforce, and safety net services such as transportation, interpreter services, and health education.
- support national activities to improve infectious disease control and emergency preparedness.
- expand programs related to disease prevention and health promotion, and expand the role of public health in encouraging healthful behaviors and consumer choices.

Fifth Recommendation

Reduce defensive medicine practices by establishing mandatory dispute resolution procedures that address malpractice claims under the basic health plan – similar to the process available under the Federal Tort Claims Act.

Sixth Recommendation

Give Americans choice in the selection of their health insurance plans. The new health care system must be structured so that:

- employers or individuals must purchase the basic health insurance plan from private health insurers or through a new federal insurance plan. However, current Medicare beneficiaries may stay with traditional Medicare plans, purchase the new federal plan, or purchase a basic benefit plan from a private health insurer.
- Medicare (following its phase-out) and Medicaid will be replaced by the new federal insurance plan.
- private health insurers may offer the basic health plan, expanded or supplemental coverage plans.

Seventh Recommendation

A public-private partnership is essential to American health care. Financing the new health system requires that:

- private sector health premiums will be paid by employers, employees and individuals who purchase the basic benefit plan.
- all employers will contribute toward the basic health plan premiums. Employees will share the cost on a predetermined basis, according to income.
- subsidies and tax credits will be used to assist employers, employees and individual purchasers.
- public sector funding will come from savings created by eliminating inefficiencies and duplication in the current system; a redesigned Medicare FICA tax; state contributions that are now directed toward the Medicaid program; continued federal funds presently committed to Medicare, Medicaid, and other national health plans; and a national tax on alcohol and tobacco consumption.
- Americans without proof of health insurance will incur penalties.
- all public funds intended to provide subsidies for premium payments must be segregated into a trust fund.
- a new payment methodology be developed that rewards providers for efforts to improve patients' overall health and makes providers responsible for the quality of services they provide.

Eighth Recommendation

Create an independent Health Care Transformation Commission (HCTC) to guide implementation of the previous recommendations, ongoing modifications, updates, and evaluation of further health policy changes.

The core functions of the Health Transformation Commission are to:

- develop and modify clear national standards for a basic health plan within the parameters of the legislated mandate.
- develop and modify clear national standards and protocol for the universal exchange of health information.
- develop and modify clear national quality standards, including clinical guidelines for best practices and for collection of information for quality assessment and research.
- develop and modify approval standards that distinguish new medical technology that has demonstrated evidence of effectiveness.
- disseminate information about quality and effectiveness.
- foster regional discussion and implementation of national standards and work force development

The new national Health Care Transformation Commission:

- will be modeled after the Federal Reserve, an idea currently supported by industry, academia, and the nonprofit sector (Wilensky 2006).
- will not have financing responsibilities.
- will make binding recommendations.
- will work closely with sources of quality health research and information, and may also require that, if needed, appropriate bodies conduct additional research.
- will reflect a geographically diverse membership of delivery, consumer, and financing interests. The President will make bipartisan appointments, and the Senate will confirm these appointments. Commissioners will serve staggered terms.

EXECUTIVE SUMMARY

The Hagel Health Care Commission was established to review the current state of health care in the United States and propose recommendations for developing an accessible, sustainable health care system for the 21st century. Our recommendations are based on the premise that all Americans must have access to basic health care; and the system must deliver efficient, effective health care. We concluded that the new system must transparently balance supply and demand for health care, emphasize quality care, and require accountability by all participants.

Rather than evaluating health care models from other countries, the Commission analyzed the state of health care in the U.S. and outlined a uniquely American solution. We acknowledge that good health and good health care are essential to a productive society and a thriving economy. The Commission believes that the actions taken to transform American health care must be aligned with the principles and values of social responsibility—our shared duty to provide a safety net for those who are unable to fund their own health care.

Recommendations

After wide-ranging discussion and analysis of the many complex issues related to American health care, the Hagel Commission carefully formulated the recommendations summarized below:

- Mandate a basic health care plan for all Americans that emphasizes patient-centered care focused on prevention, health promotion, and coordinated care across the life-span. Often called a “medical home,” this model integrates all aspects of the care continuum and focuses on care coordination and active disease management.
- Address the problem of attracting, developing, educating, and retaining health care providers by designing a funding mechanism to support workforce development and by creating innovative incentives to attract practitioners to high-need areas.
- Focus on quality and safety as key components in American health care. Ensure that all participants are accountable for using evidence-based guidelines and are rewarded for positive outcomes. Create a secure, universal, individual standardized electronic medical record to facilitate this transformation.
- Emphasize the vital role of public health in improving health, life expectancy, and quality of life. Expand public health infrastructure and services.
- Decrease the practice of defensive medicine by establishing mandatory dispute resolution procedures that address malpractice claims under the basic health care package.
- Give all Americans free choice in the purchase of insurance plans, and give consumers clear information on billing and coding for health services.
- To finance the new system, establish a public-private partnership that includes employers, employees, and government support. The new system will be funded by eliminating inefficiencies and duplication in American health care today; a redesigned Medicare FICA tax; state contributions that are now directed toward the Medicaid program; continued federal funds presently committed to Medicare, Medicaid, and other national health plans; and a national tax on alcohol and tobacco consumption.

To carry out these recommendations, the Hagel Commission proposes creating an independent Health Care Transformation Commission patterned after the Federal Reserve Board, as outlined in this report. This body also will make binding resolutions, carry out ongoing modifications and updates, and evaluate changes to national health care policies. The President and the Senate will make bipartisan appointments, and commissioners will serve staggered terms.

Conclusion

To redesign health care, policy makers must develop integrated systems to improve the continuity of care for every American. The Hagel Health Care Commission believes this challenge can best be addressed through patient-centered primary and specialty care. Payment and delivery systems must also be reformed through an active partnership of consumers, providers, insurers, suppliers, and government. To complement the transformation, the national public health system should receive additional emphasis and national coordination. Improving our capacity to recruit, educate, and retain health professionals is essential to the new system.

The Health Care Transformation Commission (HCTC), an independent federal agency modeled after the Federal Reserve Board, will be the vehicle for managing the health care transformation process. This non-political Commission will develop the basic health plan; establish national standards and protocols for health information technology; assess new medical technology; and will set national standards for best practices, data collection, quality assessment, and research.

We believe that rising health care costs result, in part, from a lack of clear national policies regarding health care delivery and financing. Clarity and consistency in federal health care policy are essential first steps in addressing health care cost containment. The Hagel Commission concludes that the best way to finance the transformed health care system will be through the private and public sectors. Private sector premiums will be paid by all employers and employees on a predetermined basis. The public sector will provide premium subsidies to help employees and individuals based on federal poverty guidelines. Public sector funding will come from the sources noted in our recommendations. We recognize the problems caused by defensive medicine and believe that a mandatory dispute resolution procedure should be adopted nationally.

The Hagel Commission believes we can retain individual choice of plan and providers; at the same time, the delivery system can become more accessible and understandable. Consumers will be able to expect and receive coordinated quality care in the most appropriate setting, and ever-increasing health care costs will be restrained.

While this new system will require greater accountability on the part of all, it will be built on the uniquely American strengths of private and public cooperation and will provide efficient, patient-focused care for all. In the overall transformation of U.S. health care, the Hagel Commission urges policy makers to combine the American values of social responsibility, choice, and individual accountability with a passionate commitment to quality. Revitalizing a sense of community and interest in the common good can transform our health care system for the 21st century.

CITATIONS

Medical Technology and Research

Bleich S. Medical Errors: Five Years After the IOM Report. Issue Brief; July 2005; 1-10. Commonwealth Fund Publication No. 830, The Commonwealth Fund www.cmf.org.

Blendon RJ, et al. View of Practicing Physicians and the Public on Medical Errors. *New England Journal of Medicine*, 2002; 347(24):1933-40.

Callahan, D. Conservatives, Liberals and Medical Progress. *The New Atlantis*, No.10, 2005 pp. 3-16

Center for Drug Evaluation and Research. CDER Report to the Nation 2002 and 2004, available at www.fda.gov/cder.

Food and Drug Administration Plan Focuses on Patient Safety and Reducing Medication Errors - Secretary Tommy Thompson Unveils New Proposal at National Patient Safety Foundation's 2003 Patient Safety Congress March 13, 2003 <http://www.npsf.org/html/pressrel/2003-03-13.html>

<http://www.ahrq.gov>

<http://www.leapfroggroup.org>

<http://www.npsf.org>

<http://www.patientsafety.org>

<http://www.patientsafetyinstitute.ca.html>

<http://www.who.int/patientsafety>

Institute of Medicine, *Patient Safety: Achieving a New Standard of Care*, November 2003, National Academies Press, 500 Fifth St. NW, Washington, DC 20001.

Kaiser Family Foundation, *Prescription Drug Trends*, November 2005, accessed at <http://www.kff.org/insurance/upload/3057-04.pdf>.

Kohn LT, Corrigan JM, Donaldson M, Eds. *To Err Is Human: Building a Safer Health System*, Washington, DC, National Academy of Sciences, 1999.

Louis Harris & Associates, *Public Opinion of Patient Safety Issues – Research Findings*, prepared for the National Patient Safety Foundation at the AMA, September 1997.

McCarthy, D. and D. Blumenthal. *Committed to Safety: Ten Case Studies on Reducing Harm to Patients*. The Commonwealth Fund. April 2006.

National Academy of Sciences, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academy Press, 2001 at www.nap.edu/books/0309072808/html.

National Institutes of Health, *New Efforts for FY 2007 Fact Sheet*, available at <http://www.nih.gov/about/researchresultsforthepublic/neweffortsforfy2007.df>.

National Institutes of Health, *NIH Roadmap for Medical Research*, available at <http://nihroadmap.nih.gov/>.

National Institutes of Health, *Summary of the FY 2007 President's Budget*, February 6, 2006. Accessed at <http://officeofbudget.od.nih.gov/pdf/Press%20info%20final.pdf>.

National Survey on Consumer's Experiences with Patient Safety and Quality Information: News Release. November 2004. Kaiser Family Foundation, Agency for Healthcare Quality and Research, and the Harvard School of Public Health.

Pharmacists Letter. New Molecular Entities/Significant Biologicals. Available at: [http://www.pharmacistsletter.com/\(ylzc1q55upa2mr45yfue00q5\)/pl/NewDrugs.aspx?s=PL&cs=&st=0&li=0](http://www.pharmacistsletter.com/(ylzc1q55upa2mr45yfue00q5)/pl/NewDrugs.aspx?s=PL&cs=&st=0&li=0).

Pharmaceutical Research and Manufacturers of America, *Pharmaceutical Industry Profile 2006* (Washington, DC: PhRMA, March 2006), accessed at <http://www.phrma.org/files/2006%20Industry%20Profile.pdf>.

Research Agenda: Medical Errors and Patient Safety. National Summit on Medical Errors and Patient Safety Research. Oct 2000.

The Cost of Medical Technologies: Maximizing the Value of Innovation, Booz, Allen, Hamilton. Accessed at <http://www.boozallen.com/media/file/137991.pdf>

The Medical Technology Industry at a Glance, AdvaMed, 2004. Accessed at www.advamed.org/newsroom/chartbook.pdf

Youngberg, BJ and MJ Hatlie. *The Patient Safety Handbook*, Jones and Bartlett Publishers, 2004, pp: 753-764.

Workforce, Education and Demographics

Anderson, G. "Chronic Care and the Private Sector." November, 2001. Presentation to the Health Sector Assembly. Sundance, Utah.

Gilmer, T. and R. Kronick. (2005) "It's the Premiums, Stupid: Projections of the Uninsured Through 2013." *Health Affairs Web Exclusive* W5. April 5, 2005.

Joyce, G.F., E.B. Keeler, B. Sang and D.P. Goldman (2005). "The lifetime burden of chronic disease among the elderly." *Health Affairs Web Exclusive*. W5-R 18. September 26, 2005.

Schoen, C., M.M. Doty, S.R. Collins and A.L. Holmgren. (2005) "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs Web Exclusive* W5. June 14, 2005.

Swartz, K. *Reinsuring Health*. New York: Russell Sage Foundation. 2006.

U.S. Census Bureau. "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin." www.census.gov/pc/usinterimproj/

U.S. Department of Labor, Bureau of Labor Statistics. "Tomorrow's Jobs." www.bls.gov/oco/oco2003.htm/.

U.S. Census Bureau. "Health Insurance Coverage: 2004." www.census.gov/hhes/www/hlthins/hlthin04/hlth04.asc.html/

U.S. Census Bureau. "Current Population Survey, March, 2005." Data runs conducted by Nebraska Center for Rural Health Research, University of Nebraska Medical Center. February, 2006.

Government, Legal, and Regulatory

Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending*, April 2006.

Care Model

Ettner, et al., Multidisciplinary Physician/Nurse Practitioner Teams Can Reduce the Costs of Hospital Care While Maintaining Care Quality, *Medical Decision Making*, 26, 2006

Fahey, et al., Care Assisted by Nurses or Pharmacists Provides Better Blood Pressure Control, *American College of Physicians Journal Club*, 144 (3), 2006.

Falk et al. 2001. Ambulatory care sensitive hospitalizations and emergency care visits: Experiences of Medicaid patients using federally qualified health centers. *Medical Care*, 39, 551-58.

Falk et al. 2006. Comparative effectiveness of health centers as a regular source of care. *J Ambul Care Mgmt* 29, 24-35

Flexnor, Abraham. *Medical Education in the United States and Canada*. New York: Carnegie Foundation for the Advancement of Teaching, 1910.

Gabow, et al. Denver health: a model for the integration of a public hospital and community health centers. *Ann Int Med* 138:2 143-150.

Grumbach, K and Bodenheimer, T. 2002. A primary care home for Americans. *JAMA* 288:7 889-893

Health Insurance in the United States; Melissa Thomasson, Miami University. Retrieved from EH.net Encyclopedia, <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>

Institute of Medicine 2001. *Crossing the Quality Chasm*.

“Kaiser Commission on Medicaid and the Uninsured: Key Facts,” Washington, D.C., January, 2004
<http://tricareu.tricare.osd.mil/publiccourse/toc.html>

Pickens, et al. 2002. Community oriented primary care in action: a Dallas story. *AJPH* 92:11 1728-1732.

Rosenberg, Charles E. *The Care of Strangers*. New York: Basic Books, Inc., 1987.

Ryan, J. “The Basics: Medicaid Financing,” National Health Policy Forum, September 14, 2004.

Sisk et al., Effects of Nurse Management on the Quality of Heart Failure Care in Minority Communities: A Randomized Trial. *Annals of Internal Medicine*, 145 (4), 2006.

Starfield, Shi, and Macinko, Contribution of primary care to health systems and health. 2005 *Milbank Quarterly* 83:3, 457-502.

Testimony of the American Hospital Association before the Task Force on Health of the Budget Committee of the United States House of Representatives on Complexity and Burden of Medicare Regulations on Providers, 5/18/2000.

U.S. Census Bureau: Health Insurance Coverage: 2004; accessed 8/19/2006.

<http://www.census.gov/hhes/www/hlthins/hlthin04/hlth04asc.html>

There are many estimates of the number of people covered by government-funded and private insurance. These estimates are fraught with difficulty, however, and the reader should consider the numbers quoted in this paper to be imprecise. See "Health Care Delivery Covered Lives – Summary of Findings," Center for Business and Government, John F. Kennedy School of Government, Harvard University, 2005, for an excellent discussion of the challenges presented in making such estimates.

1954 Internal Revenue Code US Census Bureau: <http://www.census.gov/hhes/www/hlthins/historic/hihist1.html>,

Health Insurance Association of America's Guide to Health Insurance,

http://www.pueblo.gsa.gov/cic_text/health/guidehealth/guidehealth.htm

<http://www.dol.gov/dol/topic/health-plans/erisa.htm>

<http://www.treasury.gov/offices/public-affairs/hsa/about.shtml>,

<http://www.census.gov/hhes/www/hlthins/hlthinatypes.html>,

<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?>

<http://www.military.com/benefits/veterans-health-care/champva-overview>

William Scanlon presentation to Alliance for Health Reform, 5/16/2005.

http://findarticles.com/p/articles/mi_m0795/is_2_27/ai_n16108607/print,

Financing

American Health Care Association, Long Term Care Finance Reform, 2004.

Center for American Progress, *The Problem with our Health Care System*, February 9, 2006

Gingrich, N. *Saving Lives & Saving Money*, Alexis de Tocqueville Institutions, 2003.

Healthcare Financial Management Association, Consumerism in Health Care, An Initiative of the Patient Friendly Billing Project, Summer 2006

Interim Recommendations of the Citizens' Health Care Working Group. Accessed at:

<http://www.citizenshealthcare.gov>

Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2005.

Accessed at http://medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf

Modern Healthcare's Daily Dose, June 28, 2006

National Health Policy Forum, George Washington University, *Medicaid in 2006: A Trip Down the Yellow Brick Road*, March 29, 2006.

National Health Statistics, Centers for Medicaid and Medicare Services

U.S. Department of Health and Human Services, Agency for Research and Quality, 2005 *National Disparities Report*

The Institute of Medicine, *The Chasm in Quality: Select Indicators from Recent Reports*, 2003.

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MEETINGS OF THE COMMISSION

April 28, 2006	<i>at Creighton University</i>
May 22, 2006	<i>at Boys Town Research Hospital</i>
June 30, 2006	<i>at University of Nebraska – Omaha</i>
July 28, 2006	<i>at University of Nebraska Medical Center</i>
September 29-30, 2006	<i>at Blue Cross Blue Shield Nebraska – Lincoln</i>
October 27, 2006	<i>at University of Nebraska Medical Center</i>
December 1, 2006	<i>at MarketSphere Consulting, LLC</i>
December 19, 2006	<i>at MarketSphere Consulting, LLC</i>
January 9, 2007	<i>at MarketSphere Consulting, LLC</i>

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Director of Health Policy, Center for American Progress

Elizabeth Scanlon-Hall

Director, Office of Legislative Affairs, Centers for Medicare and Medicaid Services

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Public Policy and Advocacy Coordinator, Alegant Health Systems

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Dr. James Bowden

Senior Vice President and Medical Director, Mutual of Omaha Insurance Company

Dr. Richard O'Brien

Mr. Brad Stephan

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