



**STARTING ON THE PATH TO A HIGH PERFORMANCE
HEALTH SYSTEM: ANALYSIS OF THE PAYMENT AND SYSTEM
REFORM PROVISIONS IN THE PATIENT PROTECTION AND
AFFORDABLE CARE ACT OF 2010**

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ABSTRACT: This report, originally published in December 2009 and since updated to reflect the March 2010 passage of the Patient Protection and Affordable Care Act, analyzes the provisions in the new law that will affect providers' financial incentives, the organization and delivery of health care services, investment in prevention and population health, and the capacity to achieve the best health care and health outcomes for all. Major initiatives include establishment of health insurance exchanges and new market rules, creation of an Independent Payment Advisory Board and Center for Medicare and Medicaid Innovation, and introduction of payment policies designed to reward hospitals and physicians for value rather than volume. Recent analysis shows that these provisions have the potential to reduce administrative expenses and lead to significant modernization of the health care system, lowering the rate of cost growth and returning total national savings of \$590 billion or more in the coming decade.

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EXECUTIVE SUMMARY

To achieve a high performance health system, health reform must go beyond ensuring affordable coverage to addressing health system changes that will improve outcomes and the quality of care, increase efficiency, and slow the growth in total health system costs. This report analyzes how the new health reform law (The Patient Protection and Affordable Care Act of 2010, or ACA) will affect providers' financial incentives, the organization and delivery of health care services, investment in prevention and population health, and the capacity to achieve the best health care and outcomes for all.

The ACA will fundamentally change the health care system by increasing value for the money spent on health care. Most of the ideas that have been advanced by policymakers and health care opinion leaders to deal with rising health insurance premiums and health care costs are reflected in the law (Exhibit ES-1).

Exhibit ES-1. Projected Savings and Effectiveness of System Reform Provisions in Comprehensive Reform Law 2010–19 (in billions)

	CBO Estimate of Budget Savings, Affordable Care Act of 2010, 03/30/09	Percent Opinion Leaders Favor, or View as Effective	Projected Effectiveness in Containing Costs
Establish health insurance exchanges		92% ^b	++
Create new nonprofit plan choices			+
Review premiums and require minimum medical loss ratios			++
Incentivize primary care and prevention	\$6	61% ^c	+
Stimulate innovative provider payment reform	-\$8	97% ^c	+++
Create accountable care organizations	-\$5	54% ^f	++
Control spending growth; IPAB and productivity improvement	-\$176	75% ^e	++
Promote quality improvement and public reporting		53% ^a	+
Encourage Medicare private plan competition	-\$201	77% ^c	+
Tax high premium health insurance plans	-\$32	58% ^d	+

Authors' views of long-term effectiveness in controlling total health system spending: Very effective = +++, Effective = ++, Somewhat effective = +. Health Care Opinion Leaders Surveys: ^a Sept/Oct 2008; ^b Dec. 2008; ^c April 2009; ^d June 2009; ^e Oct. 2009; ^f July 2010. IPAB = the Independent Payment Advisory Board
Source: Commonwealth Fund estimates; Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Mar. 20, 2010.



KEY PROVISIONS TARGETING COSTS AND QUALITY

The new law will make several key changes to help ensure long-run cost containment and improve the quality of health care:

1. Establishing Health Insurance Exchanges and New Market Rules

The ACA will establish health insurance exchanges that give consumers the ability to compare and choose among health plans. It also sets rules on plans sold inside and outside the exchanges to shift insurers from competing for healthier enrollees to competing on value. While the Congressional Budget Office (CBO) does not credit savings that could be generated from increased competition among plans, it estimates that the insurance exchanges will lower administrative overhead by four to five percentage points. In the authors' view, the insurance exchanges will be effective over the long term in mitigating the rise in premiums and costs to employers and households. These positive effects will grow if the exchanges are gradually opened to larger firms (an option after 2017). A recent Commonwealth Fund report found that reform will lower administrative costs and encourage more efficient care delivery, reducing premiums by nearly \$2,000 per family by 2019. And according to a recent Commonwealth Fund survey of health care opinion leaders, support for establishment of health insurance exchanges is overwhelming (92%).

2. Creating New Nonprofit Plan Choices

The ACA authorizes the secretary of Health and Human Services (HHS) to provide loans and grants to member-governed nonprofit insurance issuers that offer qualified health plans within the new exchanges. Priority will be given to plans associated with integrated delivery systems. Nonprofit issuers will be allowed to enter into collective purchasing agreements with providers. Commonwealth Fund analysis has shown that nonprofit cooperatives with integrated delivery models have transformed health care delivery into mission-driven, patient-centered, and value-enhancing systems that are accountable to patients and consumers.

The federal Office of Personnel Management (OPM) also will contract with health insurers to offer at least two multistate health plans through the exchanges in each state. At least one of the plans must be nonprofit. OPM will negotiate contracts in a manner similar to its negotiations for the Federal Employees Health Benefits Program (FEHBP). The multistate plans must meet standards for medical loss ratios, profit margins, and premiums; cover essential health benefits; and meet the requirements for qualified health plans sold through the exchange.

3. Requiring Qualified Health Plans to Meet Minimum Medical Loss Ratios and Reviewing Insurance Premium Increases

Qualified health plans offered in the state exchanges will be required to spend 80 percent of premiums collected in the individual and small-group markets on medical care for enrollees. Eighty-five percent of premiums in large-group plans are to be spent on medical care. These provisions will encourage health insurance companies to eliminate wasteful administrative spending and increase the value consumers receive for their premium dollars. In addition, as a condition of receiving federal grants for reviewing insurance premium trends, states will make recommendations to the HHS secretary for [excluding carriers](#) from insurance exchanges on the grounds of unjustified rate hikes prior to reform implementation. The secretary, in conjunction with the states, will monitor premium increases inside and outside the exchanges beginning in 2014.

4. Incentivizing Primary Care and Prevention

The law includes a number of provisions to increase primary care payment rates under Medicare and Medicaid, cover effective preventive services without patient cost-sharing, and support community and employer prevention and wellness programs. The ACA also increases funding for community health centers and the National Health Service Corps, expanding access to basic health care services to some of the nation's most vulnerable and underserved communities. These provisions could begin to focus our health system on primary care, rather than specialty care; counter the impending shortage of primary care providers; and lay the groundwork for more fundamental payment reforms.

5. Stimulating Innovative Provider Payment Reform

The new law will establish a Center for Medicare and Medicaid Innovation with broad authority for the HHS secretary to test innovative payment methods for medical homes that provide patient-centered coordinated care and for bundled hospital acute and post-acute care. The ACA will reduce Medicare reimbursement rates by 1 percent for hospitals that have high rates of readmissions for certain conditions. The law also allows states to test and evaluate fully integrating Medicare- and Medicaid-covered health services provided to "dual eligibles," and to test and evaluate systems of all-payer payment reform. Nearly all health care opinion leaders (97%) support reforming provider payment to promote quality and efficiency.

6. Creating Accountable Care Organizations

The ACA creates a national, voluntary shared savings program for accountable care organizations (ACOs). ACOs are collections of health care providers that formally assume responsibility for the cost and quality of health care given to a defined group of patients. Research has shown that ACOs have the potential to reduce growth in health care costs and improve patient outcomes by introducing incentives for efficient use of resources and encouraging greater coordination of care. Fifty-four percent of health care opinion leaders believe that ACOs are an effective model for moving the U.S. health care system toward population-based, accountable care. CBO projects that the ACO shared savings program included in the ACA will save \$5 billion over 2010–19.

7. Controlling Spending Growth: Independent Payment Advisory Board

The ACA will establish an Independent Payment Advisory Board (IPAB) within the executive branch that has significant authority to identify areas of waste and opportunities for improving the quality of care for Medicare beneficiaries. The board’s recommendations will take effect in years when Medicare costs are projected to exceed predetermined rate-of-increase targets—unless Congress passes legislation to override those recommendations, in which case it would be responsible for achieving the same level of savings. The IPAB also will make recommendations for improving quality and slowing excess cost growth in the private sector. CBO estimates the board will generate \$16 billion in savings over 2010–19, mostly in the out-years. Three-fourths of health care opinion leaders (75%) support creation of an independent advisory council that has the authority to make decisions within parameters established by Congress and subject to review by the president and Congress.

The hospital industry agreed to slow increases in Medicare payment rates in recognition of the increased revenue hospitals will earn from covering more uninsured Americans and the potential for significant productivity improvements. Slowing Medicare payment rate increases for all health care providers (other than physicians, whose payments are considered separately) yields \$160 billion federal budget savings over 2010–19, according to CBO, and establishes the principle that rising expenditures cannot continue at projected rates.

8. Promoting Quality Improvement and Public Reporting

Under the ACA, the HHS secretary is tasked with developing a National Strategy to Improve Health Care Quality and establishing an interagency working group to coordinate and streamline federal quality activities. The law requires public reporting of physician quality and patient experience measures through a “Physician Compare”

Web site for Medicare beneficiaries. It also makes Medicare data available for pooling with data on provider performance from other payers—an important step toward creation of an all-payer provider performance database. (The law takes steps to ensure beneficiaries' privacy will be protected.) The American Recovery and Reinvestment Act (ARRA), signed into law by President Obama in February 2009, provides significant financial incentives for providers to adopt and demonstrate meaningful use of health information technology. These investments will facilitate the quality improvement and public reporting activities included in the ACA.

The law also includes a set of quality improvement reporting requirements for health insurance plans offered inside and outside the exchanges. Activities to be reported on include: improving health outcomes through care coordination and medical home models; preventing hospital readmissions through a comprehensive program for hospital discharge; and implementing activities to improve patient safety, reduce medical errors, and promote health and wellness. The secretary will make reports by health plans available to the public.

9. Encouraging Medicare Private Plan Competition

The ACA will level the playing field between Medicare private plans and the traditional Medicare public health insurance plan. This will yield \$201 billion in federal budget savings over 2010–19, according to CBO. Moreover, this policy change could provide more impetus for plans to compete on value, creating at least some downward pressure on health care costs. Three-fourths of health care opinion leaders (77%) support such a provision.

10. Encouraging Consumers to Be Cost-Conscious: Introducing a Tax on High-Premium Health Insurance Plans

The new law includes a 40 percent excise tax on health plans with premiums in excess of \$10,200 for individual policies and \$27,500 for families, to take effect in 2018. Thresholds will be higher for certain high-cost groups and will be adjusted in case of unexpected increases in medical costs prior to 2018. CBO estimates that the tax will yield \$32 billion over 2018–19.

ASSESSING THE LAW'S POTENTIAL IMPACT

Consistent with the president's belief that health reform should be financially sustainable and not add to the federal deficit, the new law offsets the cost of expanding and improving coverage with a mixture of system savings and new revenue sources.

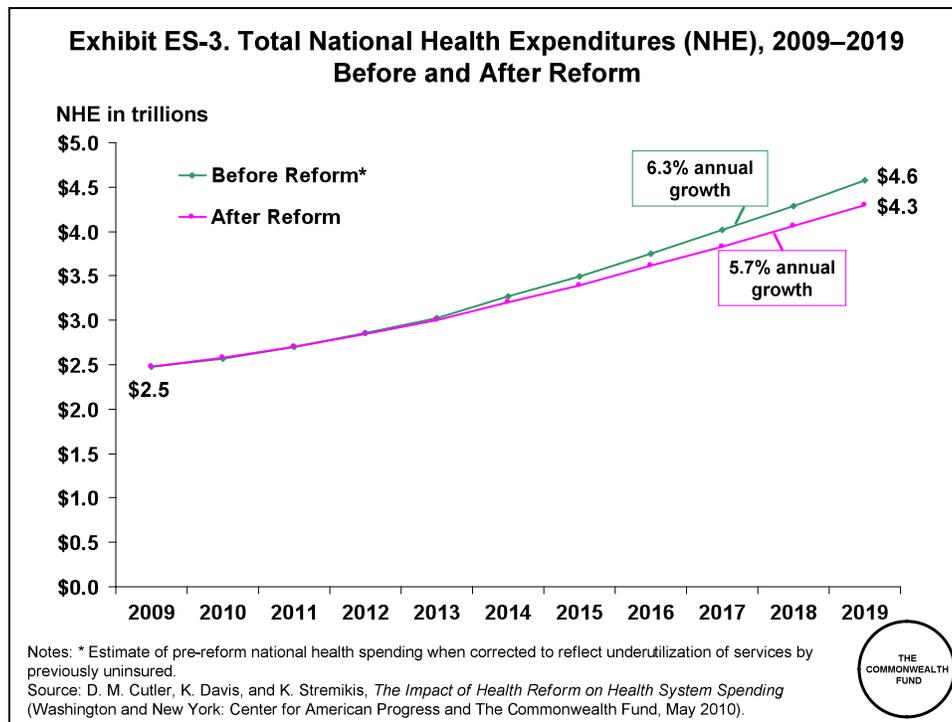
According to CBO, the total net impact of the ACA on the federal budget deficit is a reduction of \$143 billion over the 10-year period 2010–19 (Exhibit ES-2). This figure reflects the net federal costs of expanding coverage (\$820 billion), offset by reductions in federal health (\$511 billion) and education (\$19 billion) spending as well as new revenues (\$432 billion).

Exhibit ES-2. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019	
Dollars in billions	
	CBO estimate of Affordable Care Act of 2010
Total Net Impact on Federal Deficit, 2010–2019	–\$143
Total Federal Cost of Coverage Expansion and Improvement	\$820
<i>Gross Cost of Coverage Provisions</i>	<i>\$938</i>
• Medicaid/CHIP outlays	434
• Exchange subsidies	464
• Small employer subsidies	40
<i>Offsetting Revenues and Wage Effects</i>	<i>–\$117</i>
• Payments by uninsured individuals	–17
• Play-or-pay payments by employers	–52
• Associated effects on taxes and outlays	–48
Total Savings from Payment and System Reforms	–\$511
• Productivity updates/provider payment changes	–160
• Medicare Advantage reform	–204
• Other improvements and savings	–147
Education System Savings	–\$19
Total Revenues	–\$432
• Excise tax on high premium insurance plans	–32
• Surtax on investment income for high income earners	–123
• Other revenues	–277

Note: Totals do not reflect net impact on deficit due to rounding.
Source: Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Mar. 20, 2010.

The new reform law has the potential to produce substantial total health system savings for the nation—well beyond what is reflected in the estimated federal budget impact. The combined effect of these provisions on trends in national health expenditures, however, is difficult to estimate, and CBO has indicated that it does not have the modeling capacity to do so. Estimates released by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) indicate that the law could produce modest increases in national health expenditures, but this estimate gives little credit for savings to measures that will reform provider payment, increase competition among plans in an insurance exchange, encourage public reporting, or apply the results of comparative effectiveness research. Yet these measures are a crucial platform for developing and implementing further policies to contain health care cost growth. As such, they have broad support from health care opinion leaders and business leaders as effective ways to control costs.

For example, an analysis by the Business Roundtable, prepared by Hewitt, found that such legislative reforms could potentially reduce the trend line in employment-based health care spending by \$3,000 per employee by 2019. An analysis by The Commonwealth Fund and the Center for American Progress put health system spending savings at \$590 billion over the 2010–19 period, slowing the annual growth in health expenditures from 6.3 percent to 5.7 percent (Exhibit ES-3).



CBO’s estimates of federal budget impacts are fraught with uncertainty, given the multitude of changes and their potentially synergistic effects. On the last three occasions when CBO has estimated the savings or costs of major health reforms (the 1982–83 Medicare changes in hospital payment, the 1997 Balanced Budget Act, and the 2003 Medicare Modernization Act that established Medicare prescription drug coverage), the estimates were off the mark—with savings more than double those estimated in the first two cases and costs overstated by 40 percent in the third. Estimates of cost and savings under the ACA could similarly be seriously underestimated or overestimated; if so, policy conclusions based on current estimates may have to be reevaluated.

The measures incorporated in the law will stimulate significant changes in the organization and delivery of health services and create powerful incentives to improve efficiency and productivity. Given the uncertainties as to their ultimate impact,

however, it will be especially important to establish a system for monitoring progress on agreed-upon health reform goals and provide a mechanism for mid-course corrections and further changes as needed to move the United States toward a high performance health system by 2020. Stronger measures may be required over time to move toward value-based methods of payment.

Even under current estimates, 23 million people will remain uninsured, and many others will still face financial barriers to obtaining needed care or hardship in paying premiums or medical bills. Additional steps may be required to ensure affordability for families as well as stable financing.

Finally, the one major omission from the new reform law is the absence of more significant incentives or levers for private insurers to control health care costs. Private insurers, in opposing a public plan, essentially have argued that they do not have the ability to slow premium growth or achieve economies because of demands for higher prices from a powerful and increasingly consolidated health care provider sector. It is important that the HHS secretary use new discretionary authority to test multipayer provider payment reforms and be responsive to requests from states or local groups to test innovative multipayer approaches. Over time, as experience is gained with new provider payment methods, strategies for harmonizing public and private provider payment and leveraging their joint purchasing power will be needed to avoid having public and private provider incentives working at cross-purposes.

The ACA will usher in a new era in American health care—one in which every American will have access to affordable health insurance coverage and no one is turned away simply because they have a preexisting condition. The new insurance market protections set to take effect in this and subsequent years are designed to work in concert with important payment and system reforms that will improve access and quality, and reduce cost growth for everyone. Reform is a historic victory for all Americans, who deserve the finest health system in the world. It will require the efforts of all stakeholders to make the promise a reality.

**STARTING ON THE PATH TO A HIGH PERFORMANCE HEALTH SYSTEM:
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The test of health reform should be whether it puts the United States on a path to a high performance health system with better access to care, improved quality, and greater efficiency. Extending coverage to all—as essential as it is to ensuring access, quality, and efficiency—is not sufficient to achieve value for health spending and slow the growth in health care costs. Becoming a high performance health system requires fundamental reforms in the organization, delivery, and financing of health care, as well as investment in capacity and infrastructure to reach attainable goals on health outcomes, quality, access, equity, and efficiency.

This report analyzes those elements of the new health reform law (The Patient Protection and Affordable Care Act of 2010, or ACA) that will affect health care providers' financial incentives, the organization and delivery of health services, investment in prevention and population health, and the capacity to achieve the best care and outcomes for all. A companion to this report will analyze the extent to which the new law will cover the uninsured and ensure affordability of coverage and care for all.¹ The Commonwealth Fund's Health Reform Resource Center outlines and enables searches of the delivery system, insurance coverage, and revenue provisions of the new law.²

STRATEGIES FOR ACHIEVING THE GOALS OF HEALTH REFORM

President Obama has stressed three major goals of health reform: ensuring stability and security of health insurance coverage for those who have it, providing insurance for those who do not, and slowing the rise in health care costs for employers, families, and government. He has taken a pragmatic approach, aimed at building on what works and fixing what does not, while signaling his openness to the best ideas from all sources. Congress has passed comprehensive reform that achieves these goals and moves the health system down the path to high performance.

The new law embraces the five essential strategies for comprehensive health system reform set forth by The Commonwealth Fund Commission on a High Performance Health System in its February 2009 report, [*The Path to a High Performance U.S. Health System*](#).³ These include:

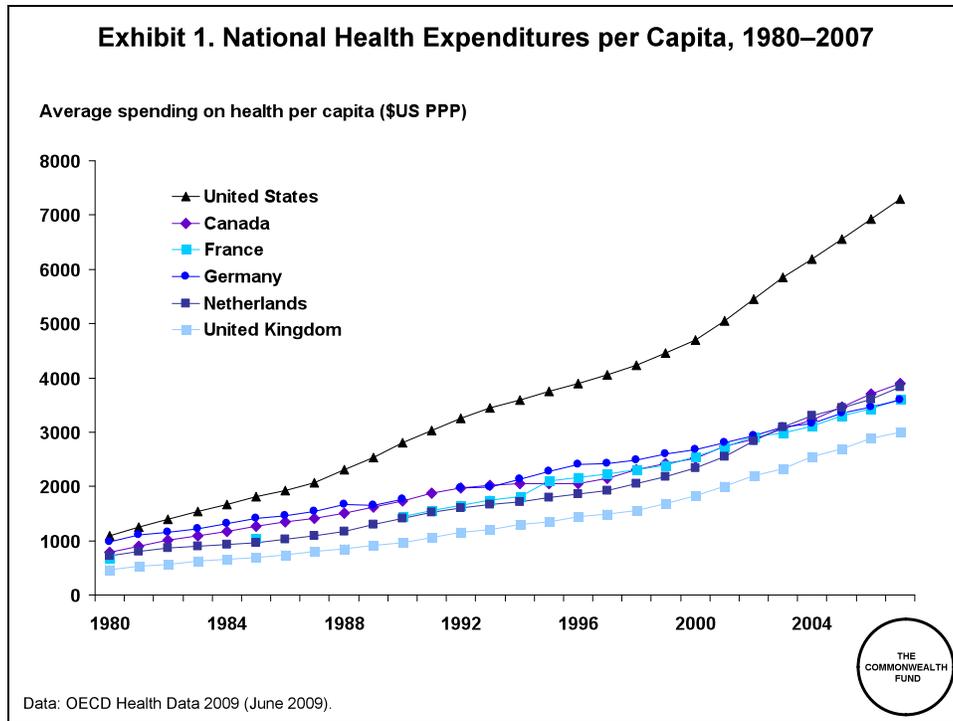
- extending affordable coverage for all;
- aligning incentives to enhance value and achieve savings;
- organizing care delivery systems to ensure accountable, accessible, patient-centered, coordinated care;
- meeting and raising benchmarks for better health outcomes, higher quality, and greater efficiency; and
- ensuring accountable leadership and public–private collaboration to set and achieve national goals.

These strategies are critical in achieving the goals of health reform.

THE NEED FOR HEALTH REFORM

The need for health reform is compelling. The recent [*State Scorecard on Health System Performance*](#) issued by the Commonwealth Fund Commission has documented twofold to threefold variation within the U.S. on indicators of access, quality, equity, cost, and health outcomes.⁴ It concluded that national reform is needed to raise performance in all areas of the U.S. to the best achievable levels.

Addressing the rising cost of health care and wide variation in quality throughout the U.S. requires that reforms go beyond expanding coverage to transforming the health system through information, rewards, and assistance with meeting benchmark levels of performance. Slowing the growth in health care costs is particularly urgent in the context of the current economic crisis. The cost of health care in the U.S.—higher than anywhere else in the world and rising faster than our gross domestic product—is taking its toll on families, employers, and government. U.S. health care spending per person is more than twice that of any other country, with costs projected to continue to rise rapidly over the next decade (Exhibit 1). Health care already consumes 17 percent of the nation’s economy, and will reach 21 percent by 2020 if current trends continue.⁵



With increases regularly exceeding economic growth, ever-higher health spending has directly contributed to stagnating or declining incomes for middle-class families and workers.⁶ Family health insurance premiums under employer plans have risen from 11 percent of family income in 1999 to 18 percent today, undermining wage increases and family financial security.⁷ If we continue on our current course, premiums will reach 24 percent of family income by 2020.

Economists differentiate between those factors that cause the level of health care costs to vary across the U.S. or across countries and those factors that drive the overall rate of cost increase.⁸ Both of these sets of factors are important in reducing cost growth. Addressing geographic variation in the current level of costs can yield savings now, shifting the cost curve downward but continuing at the same rate of increase. These one-time savings also lead to permanently lower costs over time, by decreasing the current cost base. Addressing the factors that determine the underlying rate of increase in costs over a period of time is desirable because it can yield long-term savings, permanently bending the cost curve downward. Even small improvements can have a large effect over time if they are sustained. For example, annual productivity improvements of 1 percent a year or similar reductions in waste can have a marked impact—slowing the projected growth in national health care spending by one percentage point per year would produce almost \$2 trillion in savings over the next 10 years. It is important to understand the

sources of each type of savings and fashion policies that will reduce cost growth both immediately and over time.

One-time savings are likely to derive from approaches that address factors contributing to current high levels of U.S. expenditures, inefficiency, and waste. These factors include:

- overuse, inappropriate use, or ineffective care;
- payment incentives that reward the delivery of more services and more intensive services, without considering clinical value or benefit;
- market power of insurers, providers, and the health industry—including pharmaceutical companies, device manufacturers, and other suppliers—that enables them to set prices above competitive levels;
- a low ratio of primary to specialty care physicians and services;
- access barriers to preventive and primary care that contribute to avoidable hospital admissions, emergency department use, and complications of chronic and acute disease;
- a lack of coordination across providers and settings that leads to unsafe, duplicative, or conflicting care;
- inadequate information systems and information exchange; and
- high administrative costs, including the high proportion of insurance premiums devoted to overhead costs, the complexity of insurance benefit design and duplicative and uncoordinated requirements, and the resulting administrative costs for providers.

The principal factors that contribute to long-term trends in rising expenditures that might be amenable to policy change include:

- introduction of new technologies and innovations without comparative information on clinical outcomes or cost-effectiveness to guide decisions on adoption and use;
- lack of consumer information, incentives, and choice of providers and services;
- growing market power and consolidation of insurers, providers, and the health industry—including pharmaceutical companies, device manufacturers, and other suppliers—contributing to less choice and higher prices; and

- the increasing prevalence of chronic diseases.

Some of the factors contributing to higher health spending are desirable, such as medical research that discovers new cures and new technologies that extend and improve the quality of life. Other factors, such as the rise in chronic disease, are difficult to address. But policies are needed that seek to improve public health and encourage the provision of services that offer high value, and that enable providers, patients, and payers to identify those services.

The keys to long-run cost containment that can be most effectively addressed in health reform include:

- **Changing the insurance market**
 - Establish a health insurance exchange with choice, rules, and transparency.
- **Offering new nonprofit plans**
 - Transform the competitiveness of insurance markets with new nonprofit, community-oriented insurance plan options.
- **Setting requirements on insurance premiums**
 - Set standards for minimum medical loss ratios that mandate what proportion of premiums must be dedicated to medical care.
 - Review premium increases for reasonableness as a condition of participation in insurance exchanges.
- **Incentivizing primary care and prevention**
 - Strengthen prevention and primary care through changes in payment rates.
 - Develop models that emphasize population health needs and coordinated care.
- **Instituting provider payment reform**
 - Institute payment innovation to reward physicians and hospitals for value and safety, not volume.
 - Leverage purchasing power to obtain fair and reasonable rates of provider payment.
- **Creating accountable care organizations**
 - Share savings with accountable care organizations that agree to be accountable for the total care of patients, patient outcomes, and resource use.

- **Controlling spending growth**
 - Establish an independent commission to identify and correct overpriced services and wasteful practices and harmonize public and private payer policies to enhance value.
 - Require ongoing provider productivity improvements by limiting payment updates.
 - Leverage purchasing power to obtain fair and reasonable prices; employ reference pricing based on lowest-price alternative.
- **Promoting quality improvement and public reporting**
 - Publicly report total price, quality, and outcomes for treatment of conditions, services, procedures, devices, and pharmaceutical products.
- **Encouraging Medicare private plan competition**
 - Require private plans to compete with traditional Medicare public coverage on quality and responsiveness to beneficiary needs.
- **Encouraging consumers to be cost-conscious**
 - Institute value-based benefit design and consumer incentives linked to comparative effectiveness research as well as information on the costs and quality of care.

Most of these strategies are included in the new reform law. If effectively implemented, they will work together to achieve savings to offset the federal budget cost of covering the uninsured and making coverage affordable for low- and moderate-income families. In addition, they will slow the growth of national health expenditures.

Major cost-containment strategies not incorporated in the law include a public health insurance plan option and negotiation of pharmaceutical drug prices. Another strategy not included is harmonizing public and private provider payment and thus gaining leverage from the combined purchasing power of private and public plans. Such a strategy is an effective way to align payment incentives with the goals of systemwide reform. Nor does the law include value-based designs or incentives that would encourage consumers to be conscious of the costs of care.

MAJOR HEALTH SYSTEM REFORM PROVISIONS IN THE AFFORDABLE CARE ACT

The following sections assess the extent to which provisions in the health reform law embody these strategies and recommendations, and are likely to be effective in achieving a high performance health system. They include key provisions on transforming the health insurance market; reforming provider payment and changing the health care delivery system; creating an independent advisory board to seek consensus and speed legislative action on measures to achieve savings and improve quality and safety; and fostering greater competition on value between private Medicare plans and Medicare public coverage. A summary of key provisions is contained in Exhibit 2. The Commonwealth Fund's Health Reform Resource Center details and enables searches of the delivery system, insurance coverage, and revenue provisions of the new law.⁹

Exhibit 2. System Improvement Provisions of Affordable Care Act of 2010	
Affordable Care Act of 2010, 03/30/09	
Insurance Standards, Plans, and Premium Review	State or regional exchanges; private and co-op plans offered; essential health benefits 60%–90% actuarial value, four tiers plus young adults policy; insurers must meet medical loss ratio of 80 percent for individual and small groups, 85 percent for large groups; review of premium reasonableness
Primary Care, Prevention, and Wellness	Primary care 10% bonus for 5 years; Medicaid payment rates to primary care physicians no less than 100% of Medicare rates in 2013 and 2014; annual wellness visit and/or health risk assessment for Medicare beneficiaries; preventive services without cost-sharing; local and employer wellness programs
Innovative Provider Payment Reform	CMS Innovation Center; Medicaid medical home designation; test bundled payment for acute and post-acute care; value-based purchasing
Accountable Care Organizations	ACOs to share savings in Medicare
Controlling Health Spending	Independent Payment Advisory Board recommendations to meet Medicare expenditure target; total system spending non-binding recommendations; productivity improvement update factor
Quality Improvement and Public Reporting	Direct HHS to develop national quality strategy, public reporting
Medicare Private Plan Competition	Level the playing field between Medicare Advantage and traditional Medicare FFS plans
Cost-Conscious Consumers	Introduce a 40% excise tax on high premium health insurance plans beginning in 2018

Note: ACO = accountable care organization; PCP = primary care physician; AHRQ = Agency for Healthcare Research and Quality. HHS = Department of Health and Human Services
Source: Commonwealth Fund analysis.



Establishing Health Insurance Exchanges

The reform law will enhance value, lower administrative costs, and foster competition in the insurance market by creating health insurance exchanges to facilitate choice and promote competition among health plans. The insurance exchanges initially will be open to individuals and small businesses and will gradually be opened to larger firms.

Starting in 2014, small businesses with up to 100 employees will be able to purchase plans for their employees through the exchanges. (Until 2016, states will have

the option to limit enrollment in the exchanges to businesses with up to 50 employees.) States may allow businesses with more than 100 employees to purchase coverage through the exchange beginning in 2017.

All plans, whether offered through the exchanges or independently, must meet certain standards, including offering open enrollment to all, regardless of health status, and setting community-rated premiums that do not vary with health status. Premiums can vary with age, but the spread is limited (to 3:1 between older and younger adults).

In the insurance exchanges, plans will offer standardized benefits within each of four tiers, making it easy to compare premiums for plans with comparable benefits.

These provisions will increase the number of choices available to individuals and employees of small businesses. It also will make coverage more stable for employees, who will be able to keep their health plan if they move from one firm to another firm participating in the exchange. Pooling risks across larger groups should also lower premiums. The law allows states to establish separate pools for individuals and small businesses, though they have the option of establishing one exchange serving both groups, as long as separate resources were available to assist them.

Creating New Nonprofit Plan Choices

The ACA authorizes the HHS secretary to provide loans and grants to member-governed nonprofit insurance issuers that offer qualified health plans within the new health insurance exchanges. Nonprofit issuers will be allowed to enter into collective purchasing agreements with providers. Commonwealth Fund analysis has shown that nonprofit cooperatives with integrated delivery models have transformed health care delivery into mission-driven, patient-centered, and value-enhancing systems that are accountable to patients and consumers.¹⁰

The Office of Personnel Management (OPM) also will contract with health insurers to offer at least two multistate health plans through the exchanges in each state. At least one of the plans must be nonprofit. OPM will negotiate contracts in a manner similar to its negotiations for the Federal Employees Health Benefits Program (FEHBP). The multistate plans must meet standards for medical loss ratios, profit margins, and premiums; cover essential health benefits; and meet all requirements of a qualified health plan sold through the exchange.

Reviewing Premiums and Requiring Minimum Medical Loss Ratios

The law establishes minimum medical loss ratios of 80 percent for insurance plans offered in the individual and small-group markets and 85 percent for plans in the large-group market. The new requirements will improve the value consumers receive for their health insurance payments and place downward pressure on premiums over time. Commonwealth Fund analysis has found that, for some small employers, as much as 30 percent of premiums are spent on administration, and some individuals see 40 percent of their payments spent on administration.¹¹ High marketing expenses, underwriting, churning, benefit complexity, sales commissions, and brokers' fees account for most of the administrative costs. Our country now leads all other industrialized nations in the share of health care expenditures devoted to administration.¹²

The HHS secretary has been tasked with defining medical costs in order to calculate medical loss ratios. America's Health Insurance Plans, a major health insurance industry trade group, has argued for an expansive definition of medical costs that includes quality improvement, public health, and fraud prevention and detection efforts.¹³ The National Association of Insurance Commissioners has unanimously recommended a narrower definition that encourages spending on activities that relate directly to medical care.¹⁴ A final determination by the secretary has not been made.

Regardless of the final definition, several coverage and system reform provisions in the new law will help insurers reduce wasteful spending and meet the targets. The creation of state and regional health insurance exchanges and essential standard benefits packages will more efficiently pool risk, reduce benefit complexity, and lower advertising expenses. Requiring individuals to carry coverage and restricting carriers from varying premiums on the basis of health, age, and gender will significantly reduce insurers' underwriting costs. And improving the portability of coverage will reduce churning and increase efficiency across individual and small-group markets.

In addition to the new minimum medical loss requirements, states will require insurance carriers seeking certification as qualified health plans to submit a justification for any premium increase prior to its implementation. The exchanges will then be required to take the information into consideration when determining whether to allow the sale of the plan through the exchanges. Beginning with insurance plan years starting in 2010, the HHS secretary and states will establish a process for annual review of unreasonable premium increases. Health insurers will be required to submit to the secretary and the relevant state a justification for such an increase prior to its implementation. This information must be posted on insurers' Web sites. The bill

appropriates \$250 million to the secretary for grants (\$1 million to \$5 million) to states over the five-year period, 2010 to 2014, to review and approve premium increases. As a condition of receiving a grant, state insurance commissioners will be required to provide the secretary with information on state trends in premium increases and make recommendations to the state insurance exchanges on whether particular carriers should be excluded from participation based on a pattern or practice of excessive or unjustified premium increases.

Incentivizing Primary Care and Prevention

Easy access to basic medical care is key to both better patient outcomes and lower costs.¹⁵ Yet the U.S. health care system disproportionately rewards specialty care, which in recent years has contributed to a sharp decrease in the number of newly trained physicians electing primary care practice.¹⁶ Rectifying the imbalance between primary and specialty care compensation is essential to reversing this trend.

The new reform law seeks to strengthen primary care by providing 10 percent bonus payments to primary care providers (and general surgeons) under Medicare for five years. Medicaid payment for primary care services also will be raised to Medicare levels in 2013 and 2014. In addition, the law strengthens chronic care management by providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition.¹⁷

These increases in payments for primary care and chronic care management are an important step toward addressing the imbalance in payment incentives that reward specialized procedures over primary care. A substantial majority (61%) of health care opinion leaders feel that increasing the supply of primary care providers through payment reform would be an effective strategy for reducing the growth in health care costs.¹⁸ Favored policies include raising payments for primary care services, providing additional payments for providers who serve as a patient-centered medical home accountable for quality and efficiency, rewarding providers for high-quality and coordinated care, and offering incentives that encourage patients to enroll in medical homes.

The ACA will cover proven preventive services under Medicare and Medicaid and eliminate any cost-sharing for preventive services in Medicare. The law also requires private insurance plans to cover effective preventive services without cost-sharing (except for existing grandfathered plans and those that use a value-based insurance design). The law also expands the number of covered preventive services, including an annual wellness visit under Medicare and, for pregnant women under Medicaid, a

comprehensive health risk assessment, personalized prevention plan, and tobacco-cessation programs.

The law calls for development of a national prevention and health-promotion strategy that sets specific goals through a variety of mechanisms, including a prevention and public health investment fund, competitive grants to state and local governments and community-based organizations, and creation of task forces on clinical and community preventive services that foster greater attention on prevention. It also provides support for employer wellness programs, with technical assistance to small businesses.

Stimulating Innovative Provider Payment Reform

Changing the way providers are paid to reward the delivery of higher-quality, more-effective care and the appropriate stewardship of resources will be key to improving health care quality and achieving greater efficiency. This will require moving away from the current fee-for-service payment system toward one that emphasizes the value rather than the volume of services provided and fosters the growth of organizations that are accountable for offering accessible, well-coordinated, and patient-centered care that is responsive to patients' needs and efficiently provided. While the new reform law does not immediately implement fundamental payment reform, it lays the groundwork for it through an intensive period of testing new payment and delivery system innovations. These payment innovations are supported by almost all health care opinion leaders (97%).¹⁹

Primary Care and Medical Homes

The law creates an Innovation Center within CMS to test payment and service delivery models for reducing expenditures while preserving or enhancing the quality of care provided to Medicare and Medicaid beneficiaries. Preference is to be given to models that aim to improve the coordination, quality, and efficiency of health services. Models mentioned in the law include: broad payment and practice reforms in primary care, including patient-centered medical homes for high-need individuals; medical homes that address women's unique health needs; and initiatives focused on transitioning primary care practices away from fee-for-service and toward comprehensive payment or salary-based payment.

The law also will allow states to test and evaluate fully integrating Medicare- and Medicaid-covered health services provided to "dual eligibles," and to test and evaluate systems of all-payer payment reform. In addition, it gives states the option of allowing Medicaid beneficiaries with chronic conditions to designate a provider as a medical

home, with qualified providers required to report applicable quality data. Finally, the law will provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model.

These provisions will move the U.S. toward a delivery system in which everyone has a personal source of care that is accessible, coordinates care, and is accountable for obtaining the best health results. Savings from this model—for example from reduced numbers of avoidable hospitalizations and emergency department visits—should be distributed to medical homes on the basis of provider performance.

CBO does not attribute savings to the medical home payment pilots.²⁰ RAND researchers, however, have found that while medical homes are unlikely in the current environment to produce substantial savings, they could have a synergistic effect when combined with the use of health information technology and other reforms.²¹

Bundled Payment for Acute-Care Episodes

Hospital readmission rates and post-acute care expenses vary widely from hospital to hospital.²² Avoidable hospital readmissions are both undesirable for patients and costly for the system. As much as \$12 billion a year could be saved by reducing the number of avoidable hospital readmissions.²³

New payment methods applied to acute-care episodes (including the hospital stay plus 30 days after discharge) will encourage hospitals and other providers to collaborate in improving care transitions and reducing the number of avoidable hospitalizations. Bundling payment for the initial hospitalization and follow-up care will reward providers that achieve fewer complications, better transitional care, and lower total expenditures for hospitalization of patients with acute episodes. Under the current fee-for-service payment system, such providers stand to lose revenues as they reduce readmissions.

The health reform law calls for development of a voluntary pilot program to encourage hospitals, doctors, and post-acute providers to achieve savings for Medicare through better collaboration and coordination, allowing providers to share in the savings. The law requires hospitals to report preventable readmission rates for certain conditions. It will reduce Medicare payments by 1 percent for hospitals with high readmission rates among patients with three conditions for which there are risk-adjusted readmission measures endorsed by the National Quality Forum. The secretary will have the authority to expand the policy to additional conditions in future years. The law also creates a Community Care Transitions Program to fund eligible hospitals and community-based

organizations that provide patient-centered, evidence-based transitional care services to Medicare beneficiaries at highest risk of preventable rehospitalization.

Bringing providers under the same payment umbrella will encourage communication and collaboration among physicians and hospitals. Having a pilot-testing period will give providers time to prepare for the new system and Medicare time to develop rates that reflect the cost of efficient provision of various bundles of care.

RAND estimates that one bundled payment approach (the Prometheus model), if used for six chronic and four acute conditions, has the potential to reduce national health expenditures by 5.4 percent between 2010 and 2019.²⁴

Value-Based Purchasing

The new law will begin to establish a value-based purchasing program to pay hospitals and physicians based on their performance on quality measures. By 2012, a hospital value-based purchasing program will provide incentives for enhanced quality outcomes for acute care hospitals. The secretary also will submit a plan to Congress on how to move home health and nursing home providers into a value-based purchasing system. Hospitals with high rates of patients with hospital-acquired conditions will have their Medicare reimbursement cut by 1 percent beginning in 2015. As described above, hospitals also will be subject to payment reductions if they have high rates of avoidable hospital readmissions.

The ACA also improves on the current Physician Quality Reporting Initiative (PQRI) and establishes a physician value-based purchasing program. Incentives to physicians who report quality data under the PQRI will be extended until 2014, at which time providers who do not report measures will have their Medicare payments reduced. The secretary will create and phase in a budget-neutral value-based payment modifier under the physician fee schedule beginning in 2015. Medicare physician payments will reflect the quality and cost of care that is delivered. Measurements will be risk-adjusted and geographically standardized.

Geographic Disparities

There are wide variations across the U.S. in the cost and quality of care, yet there is no systematic relationship between the two.²⁵ Providers in some geographic areas provide high-quality care at lower cost, while providers in other areas have Medicare expenditures per beneficiary that are twice as high as similar geographic areas—without better quality or patient outcomes.²⁶ The ACA modifies the adjustments to the Medicare

physician fee schedule that are intended to reflect geographic differences in the cost of resources needed to produce physician services: physician work, practice expenses, and medical malpractice insurance. Medicare payment also will be linked to quality of care under the new law (see below).

In addition, the HHS secretary has asked the Institute of Medicine to examine the factors used to adjust hospital and physician payment for geographic differences in the cost of providing care and to examine the causes of geographic variation in health spending and their relation to the quality of care.

Physician Fee Update

The ACA does not address the 21 percent reduction in Medicare physician fees that was, according to a mechanism put in place by the Balanced Budget Act of 1997 (BBA), scheduled to take effect in January 2010; instead, a companion law (PL 111-157, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010) replaced the scheduled cut with a temporary 2.2 percent increase in fees through November 30, 2010.²⁷ To preserve Medicare beneficiaries' access to physician care, further action will be needed to address the steep cuts scheduled over the next few years,

Creating Accountable Care Organizations

Coordinating care across the continuum of health care services is most easily accomplished within a larger organization that directly provides those services and/or has contractual relationships with providers to deliver some subset of services. For example, a multispecialty physician group practice that includes primary and specialty care can coordinate care through a common electronic information system that shares medical records among providers, a scheduling system that facilitates prompt and easy referral to specialists, and timely and effective communication among physicians caring for a patient with complex health conditions. An integrated delivery system, including one or more hospitals and a multispecialty physician group practice, can ensure effective transitions between inpatient and outpatient care.

The ACA includes specific incentives for providers to move toward more integrated models of care, including creation of a new provider category beginning in 2011: accountable care organizations (ACOs). To be eligible, an ACO must have a mechanism for shared governance, and may include professionals in group practice arrangements, networks of individual practices of ACO professionals, hospitals employing ACO professionals, or partnerships or joint venture arrangements between hospitals and ACO professionals. The ACO must be willing to be accountable for the

quality, cost, and overall care of Medicare fee-for-service beneficiaries assigned to it for at least a three-year period, and have a formal legal structure to distribute shared savings. It must have sufficient primary care professionals to care for its patients; have a leadership and management structure that includes clinical and administrative systems; report information on participating professionals, quality of care, and other information required for the determination of savings; and define processes to promote evidence-based medicine and patient engagement and meet various patient-centered criteria specified by the HHS secretary.

Medical homes and ACOs are complementary models of care delivery.²⁸ The medical home emphasizes primary care that is patient-centered, delivered in practice settings with 21st-century infrastructure, and based on evidence-based processes. The ACO is a larger provider organization that is willing to deliver or manage the full continuum of care and be accountable for the overall costs and outcomes of care for its defined population. ACOs provide an organizational structure that enables providers to contract with payers to align financial incentives with the goal of improving clinical performance, slowing the growth in spending, and achieving better outcomes and greater efficiency. High-performing primary care is critical to the success of an ACO. These complementary and mutually reinforcing models can work together to meet the goals of health reform—achieving better quality and slowing the rate of health care spending.

Under the new law, ACOs can initially participate in a shared savings program, under which they receive a share of savings on Medicare Part A and B expenditures for their patients relative to a spending target. The shared savings model in the ACA is a refined version of the approach used in the Medicare physician group practice demonstration, which provides “upside” rewards for productivity and efficiency gains, without the “downside” financial risk of a fixed premium, which could lead to losses if expenses exceed premium revenues. The law also permits the HHS secretary to employ other payment methods in lieu of the shared savings model, including partial capitation or any other payment model that the secretary determines will improve the quality and efficiency of care delivered through ACOs.

The Innovation Center is tasked with developing and testing alternative payment models for future use in paying ACOs, including partial capitation or full capitation for highly integrated systems of care capable of bearing risk and other approaches that the secretary determines will result in improved quality and efficiency of care. Flexibility to test a variety of shared-risk and shared-savings models will provide much-needed evidence and experience and would form the basis for future payment reforms.

In addition, ACOs that have or develop insurance products, or partner with insurance plans to offer a choice of enrollment in their systems of care through the insurance exchange, stand to gain market share if they are able to provide high-quality care more efficiently than their competitors. Under the proposal advanced by the Commonwealth Fund Commission on a High Performance Health System, such insurance products would be available on a regional basis through the national health insurance exchange, thus expanding their markets substantially.²⁹

CBO estimates that providing ACOs with shared savings will save \$4.9 billion over the 10-year, 2010–19 period.³⁰

Controlling Spending Growth: Independent Payment Advisory Board

In a September 2009 address to Congress, President Obama called for creation of an independent commission to identify and spread best practices that achieve savings and eliminate waste.³¹ The ACA establishes an Independent Payment Advisory Board with a mandate to make payment recommendations within parameters established by Congress and subject to review by the president and Congress. Congress is to consider its recommendations under an expedited procedure that limits debate. If the board fails to make a recommendation in a given year, the HHS secretary is required to issue recommendations for Medicare spending reductions.

Board (or, as a default, secretarial) proposals must contain recommendations to achieve specific Medicare spending reductions, including recommendations that extend Medicare solvency, improve the health care delivery system and health outcomes, and protect and improve beneficiaries' access to necessary and evidence-based services. In 2018 and beyond, the target growth rate is the projected five-year average percentage increase in the nominal per capita gross domestic product plus one percentage point. However, the levers available to the Independent Payment Advisory Board are sharply circumscribed: recommendations cannot pertain to benefits, cost-sharing, Medicare premiums, or eligibility and, at least in the beginning, they must exclude the major providers, such as hospitals.

Although the board is authorized to make recommendations to control Medicaid and private sector costs as well, these recommendations are not binding. In the event of continued unsustainable health spending increases, that authority might appropriately be broadened to enable the board to harmonize public and private payer payment policies and leverage purchasing power across the health system to reduce national health expenditures. Currently, private insurer pricing is often chaotic; for health care markets to

work properly, payment incentives need to be aligned across payers, with consistent goals for health care quality and efficiency.³² Seventy-five percent of health care opinion leaders in the Commonwealth Fund survey favor the creation of an independent Medicare advisory council that has the authority to make payment and benefit design decisions within parameters established by Congress and subject to review by the president and Congress.³³ Nearly nine of 10 (89%) leaders favor granting such a council the authority to collaborate in multipayer initiatives that include Medicare, private payers, and Medicaid, and 79 percent support allowing an independent council to develop policies that could be applied by Congress not only to Medicare, but also to Medicaid and other payers to align incentives across the health care system.

The ACA also adjusts hospital payments to reflect anticipated improvements in productivity. The major hospital associations entered into an agreement with the Obama administration to save \$155 billion in Medicare outlays over the period 2010–19.³⁴ This is to be achieved by lowering the projected Medicare increases in hospital payment by one percentage point a year and phasing out a portion of disproportionate share payments—established in 1986 to defray the costs of treating uninsured patients—as many of the uninsured obtain coverage. This agreement reflects an understanding that the hospital sector can improve productivity and that it will be the beneficiary of increased payments for the uninsured and reduced bad debt. The Commonwealth Fund Commission’s *Path* report also included an adjustment to payments for annual hospital productivity improvements of 1 percent, with the view that new methods of payment and delivery would provide an opportunity to reduce complications, shorten lengths of stay, and reduce hospital readmissions.³⁵

The law incorporates the productivity improvement allowance of one percentage point across all Medicare services (other than physician services, which are considered separately). These productivity improvement requirements and other payment update changes yield a 10-year budget savings of \$160 billion from 2010–19, according to CBO (Exhibit 3).³⁶ Changes to Medicare and Medicaid disproportionate share payments will yield \$36 billion of those savings.

Exhibit 3. Payment and System Reform Savings, 2010–2019

Dollars in billions

	CBO estimate of Affordable Care Act of 2010
Total Savings from Payment and System Reforms	-\$511
• Productivity improvement/provider payment updates	-160
• Medicare Advantage reform	-204
• Primary care, geographic adjustment	6
• Payment innovations	-8
• Hospital readmissions	-7
• Disproportionate share hospital adjustment	-36
• Prescription drugs	29
• Home health	-40
• Independent Payment Advisory Board	-16
• Other improvements and interactions	-75

Source: Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Mar. 20, 2010.



Promoting Quality Improvement and Public Reporting

The Commonwealth Fund Commission has documented wide variation in quality of care across the U.S. By setting targets and implementing policies that meet and raise benchmarks of top performance, the U.S. could save lives, improve Americans’ quality of life and care experiences, lower safety risks to patients, and prevent the onset of disease and complications. For example, the *Path* report notes that up to 100,000 lives could be saved annually if the U.S. reduced rates of mortality amenable to medical care to those achieved in the best three countries. It also finds that the proportion of adults receiving recommended preventive care could be increased from 50 percent to 80 percent if the U.S. reached attainable benchmark rates of preventive care.³⁷

The health reform law calls for public reporting on the quality and efficiency of care. This effort will build on current Medicare databases on the quality of hospital, nursing home, and home health care and will be expanded to include health outcomes and cost comparisons. National, regional, and state databases also will include standardized reporting of insurance revenues and claims to enable comparisons of administrative, marketing, and other overhead costs, as well as medical loss ratios and insurers’ margins. Publicly reported data will help inform improvement efforts by providing benchmarks based on top performance. Spread of health information technology will enable an ever-richer information resource that could be used to identify and learn from efforts to reach

and raise benchmarks of top performance in health outcomes and patient care experiences.

The law requires public reporting of physician quality and patient experience measures through a “Physician Compare” Web site for Medicare beneficiaries. Physicians reporting quality data will be eligible for bonus payments and, after 2015, subject to penalties for failure to report. Effective 2012, the HHS secretary will generate confidential reports for individual physicians based on claims data to compare their patterns of resource use with those of other physicians. It also makes Medicare data available for pooling with provider performance data from other payers—an important step toward creation of an all-payer database. Steps will be taken to ensure beneficiaries’ privacy is protected. Beginning in 2015, a value-based payment modifier under the physician fee schedule will reward physicians based on the quality of the care delivered, compared with its cost. Starting with specific groups of physicians, the payment modifier will be applicable to all physicians and physician groups by 2017. These reporting and incentive initiatives will make extensive information on physician quality performance available to patients.

The new law lays out a comprehensive strategy for quality improvement. It requires HHS to develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health and publish an annual national health care quality report card. It calls for development of quality measures that will enable assessments of health outcomes, continuity, and coordination of care; safety, effectiveness, and timeliness of care; health disparities; and appropriate use of health care resources. It also requires public reporting on quality measures through a user-friendly Web site, and requires hospitals to report preventable readmission rates. It creates an interagency working group to coordinate and streamline federal quality activities.

Encouraging Medicare Private Plan Competition

Medicare beneficiaries have a choice of enrolling in a private Medicare Advantage (MA) plan or being covered under the Medicare fee-for-service program. Initially, private managed care plans were paid at 95 percent of projected Medicare per capita fee-for-service costs in each county, to allow the government to share in anticipated savings from this model of care and to account for any favorable selection—the tendency for healthier (and less costly) beneficiaries to enroll in managed care plans—that might occur.

Medicare beneficiary enrollment in private plans grew rapidly through the mid-1990s, but then declined markedly when the BBA, which tightened fee-for-service payment rates for providers in the traditional Medicare program, resulted in slower

growth in private plan payment rates as well.³⁸ The Medicare Modernization Act (MMA), enacted in 2003, established a new payment system for managed care and other types of private plans in Medicare. This system led to payments that in 2009 averaged about 113 percent of projected Medicare fee-for-service costs. Such overpayments send a price signal that discourages efficiency and value.³⁹

Under the previous system (prior to the changes enacted in the ACA), MA plans submitted bids that represented the payment rate they required to be able to provide their enrollees with the same benefits offered by traditional Medicare. The payment received by the plan for each enrollee was based on the relationship of its bid to a benchmark rate established for each county and updated annually. If the plan's bid was below the benchmark, it received the amount of the bid plus a "rebate" equal to 75 percent of the difference between the bid and the benchmark. These additional payments were offset by premium reductions or coverage of additional services. If a plan's bid was at or above the benchmark, it received the benchmark amount.

Payments to MA plans have been so high because the benchmark rates were set very high: in 2009, the benchmark rates averaged 117 percent of projected fee-for-service costs. The ACA restructures payments to MA plans using new benchmarks that are much closer to fee-for-service costs, although that relationship varies by county: counties are stratified into quartiles by projected per capita Medicare spending, with the benchmarks in the most costly counties set at 95 percent of fee-for-service costs and the benchmarks in the less costly groups of counties set at 100 percent, 107.5 percent, and 115 percent of fee-for-service costs, respectively.⁴⁰ As before, plans with bids below the benchmark will receive the amount of their bid plus a rebate, but the rebate percentage will be reduced from 75 percent to 50 percent of the difference between the bid and the benchmark.

The law cushions the impact of these changes for beneficiaries in counties in which MA payment rates would be reduced most sharply by requiring the HHS secretary to provide additional transitional benefits to beneficiaries who experience a reduction in benefits. Also, for the first time, MA plan payments will depend on their performance according to quality and patient experience measures: plans with performance ratings of 3.5 to 5 stars according to system used by CMS will be eligible for increases in both the benchmarks and the rebate percentages used to determine their payment rates. CBO estimates 10-year federal budget savings of \$204 billion resulting from the MA payment changes.

These provisions will eliminate, in the aggregate, excess payment to MA plans. Doing so will address the inequity of providing federal funds to purchase extra benefits for certain Medicare beneficiaries (i.e., those in private plans) and ensure that the federal government does not reward higher-cost coverage. Moreover, the addition of direct rewards for high performance will place greater emphasis on quality and responsiveness to enrollee needs. More than three-fourths of health care opinion leaders (77%) support bringing payment of Medicare managed care plans in line with the traditional fee-for-service Medicare program.⁴¹

Encouraging Consumers to Be Cost-Conscious

The new law includes a 40 percent excise tax on health plans with premiums in excess of \$10,200 for individual policies and \$27,500 for families, to take effect in 2018. Thresholds will be higher for certain high-cost groups and will be adjusted in case of unexpected increases in medical costs prior to 2018. Indexing this cap to the overall rate of inflation in the economy plus one percentage point will encourage insurers to continue to seek out value and efficiency, thus placing downward pressure on premiums over time. CBO estimates that the tax will yield \$32 billion over 2018–19.

The theory is that such a tax would reduce the use of “Cadillac” plans that offer excessive benefits and, as a result, employers would offer more basic plans and use the reduction in premium expenses to raise employee wages, which would generate income and payroll tax revenue. By this reasoning, the reduced coverage of excessive benefits also would control the growth in utilization of services. However, Fund-sponsored work has shown that benefit design accounts for only a fraction of the variation in employer-sponsored premiums, suggesting that any tax on high-cost plans must be carefully targeted and account for factors such as industry sector and geography.⁴² A majority of health care opinion leaders (58%) support ending the federal income tax exemption for employer-financed premiums above a certain level as an approach to financing coverage expansion. Other approaches, such as value-based benefit design, reference pricing, or exclusion of benefits deemed nonessential, may be more effective alternatives that deserve further research and consideration.

SYSTEM REFORM PROVISIONS AND THE FEDERAL BUDGET

To achieve a high performance health system, reform proposals must go beyond ensuring affordable coverage to addressing health system changes that will improve outcomes and the quality of care, increase efficiency, and slow the growth in total health system costs. The health reform law includes key provisions that will affect the way we pay for care by giving providers an incentive to deliver high-value care, as well as slow the rate of

increase in health care costs over time by requiring ongoing productivity improvements. In combination with provisions of the ARRA, they will enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term.

The federal budget impact of the health care payment and delivery system reform provisions of the new law is detailed in Exhibit 4. Health reform will produce an estimated \$511 billion in payment and system reform savings. New savings come primarily from the productivity improvement requirement and other changes in provider payment updates (\$160 billion) and from correcting Medicare Advantage payment rates (\$204 billion). Some provisions add to Medicare outlays, at least over the 10-year budget horizon, while improving health system performance and laying a foundation for future changes and eventual savings.

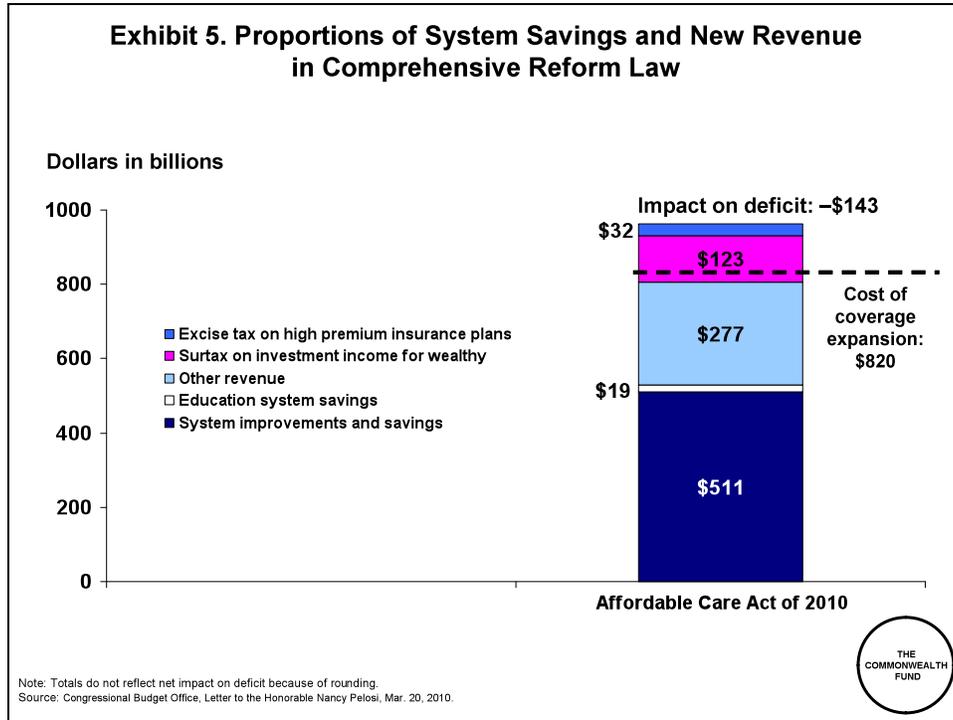
CBO estimates that, from 2010 to 2019, the insurance coverage expansions and improvements will cost the federal budget \$820 billion. These costs will be more than offset by system savings and new revenues. Over the same time period, provisions in the law will reduce the deficit by \$143 billion. CBO further estimates that health reform will reduce the federal deficit in the following decade by over \$1 trillion.⁴³

Exhibit 4. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019	
Dollars in billions	
	CBO estimate of Affordable Care Act of 2010
Total Net Impact on Federal Deficit, 2010–2019	–\$143
Total Federal Cost of Coverage Expansion and Improvement	\$820
<i>Gross Cost of Coverage Provisions</i>	\$938
• Medicaid/CHIP outlays	434
• Exchange subsidies	464
• Small employer subsidies	40
<i>Offsetting Revenues and Wage Effects</i>	–\$117
• Payments by uninsured individuals	–17
• Play-or-pay payments by employers	–52
• Associated effects on taxes and outlays	–48
Total Savings from Payment and System Reforms	–\$511
• Productivity updates/provider payment changes	–160
• Medicare Advantage reform	–204
• Other improvements and savings	–147
Education System Savings	–\$19
Total Revenues	–\$432
• Excise tax on high premium insurance plans	–32
• Surtax on investment income for high income earners	–123
• Other revenues	–277

Note: Totals do not reflect net impact on deficit due to rounding.
Source: Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Mar. 20, 2010.

New Revenue Sources

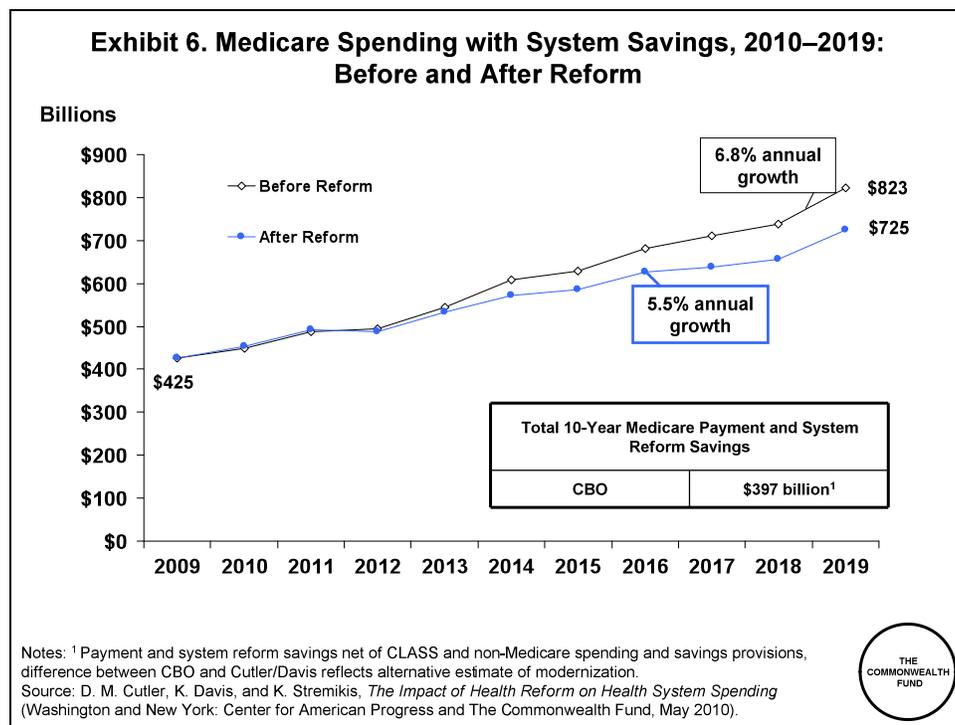
Savings from delivery system reforms and improvements will offset nearly two-thirds of the net cost of coverage expansion. New revenues will more than offset the remainder of the costs (Exhibit 5). The law looks to the health industry as a source of financing and includes new taxes or fees on medical device manufacturers, manufacturers and importers of branded drugs, and health insurance providers.



The largest source of new revenues, accounting for one-quarter of them, will be a tax on unearned income for wealthy individuals and families. As described above, the law also will impose a 40 percent excise tax on health insurance premiums over a given threshold (\$10,200 for individual policies and \$27,500 for family policies) beginning in 2018. The premium threshold will be indexed to the consumer price index plus one percentage point in subsequent years; this increase will be slower than the projected rate of health care cost growth, resulting in an annual increase in the number of people with plans that exceed the threshold unless health care cost growth slows substantially. The Joint Committee on Taxation estimates this will yield revenues of \$32 billion over 2018–19.

ASSESSING THE LAW'S POTENTIAL IMPACT

Prior to enactment of the ACA, Medicare expenditures were projected to grow 6.8 percent annually through 2019 (Exhibit 6). Applying the net Medicare savings in the new reform law reduces that projected annual growth rate to 5.5 percent, according to CBO. Although additional federal outlays are required to cover the uninsured and improve benefits for the underinsured, those are one-time shifts in spending. The Medicare provisions in the reform law set in motion genuine reform that enhances value and slows the underlying rate of spending growth, with important long-term implications. Total 10-year Medicare savings resulting from the health reform law are estimated at \$397 billion by CBO.



Projecting the savings and costs of policy changes is, in many ways, an art rather than a science. Certainly, CBO tries to produce reasonable estimates, as do agencies and organizations such as the Office of Management and Budget (OMB) and the HHS Office of the Actuary. Yet estimates can vary significantly as a result of differences in the way policies are designed and assumptions built into the estimating models. Exhibit 7 illustrates differences among the estimated savings of health reform options outlined in [The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way](#), a Commonwealth Fund report; estimates of various legislative proposals by CBO; and proposals from the president as estimated by OMB.⁴⁴ As shown, the estimates vary widely across these sources. Although some portion of these differences may be related to alternative specifications of the proposed policies, CBO is particularly

conservative in estimating savings based on changed incentives for providers, since it maintains that more evidence is required as a firm basis for such projections.

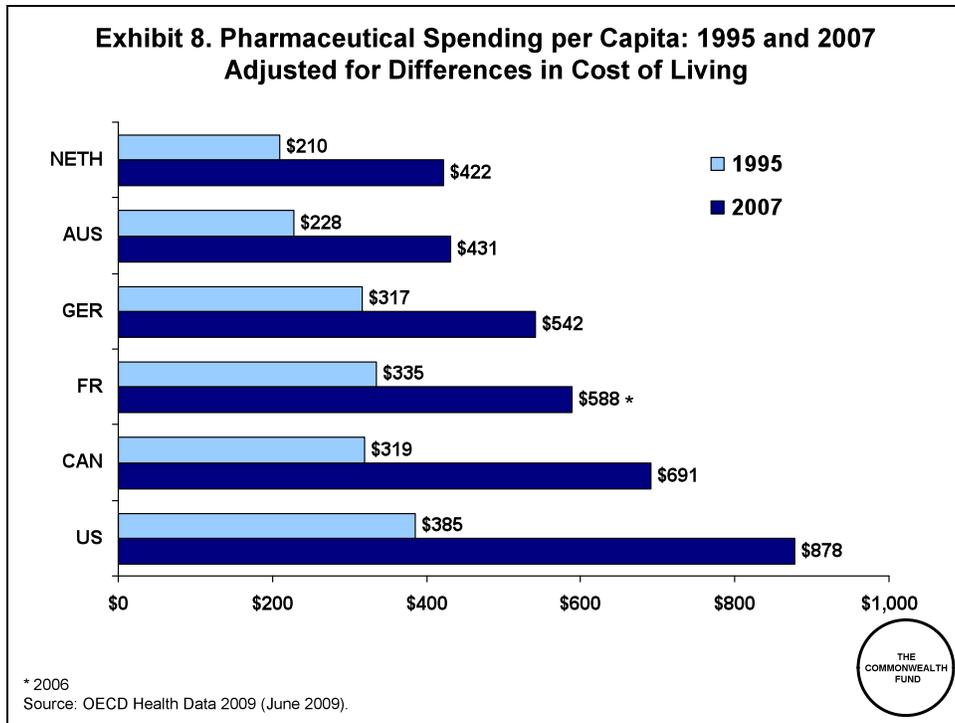
**Exhibit 7. Bending the Curve:
Options that Achieve Savings
Cumulative 10-Year Federal Budget Savings**

	Path Estimate	CBO Estimate	OMB Estimate
Aligning Incentives with Quality and Efficiency			
• Hospital pay-for-performance	–\$ 43 billion	–\$ 3 billion	–\$ 12 billion
• Bundled payment with productivity updates	–\$123 billion	–\$201 billion	–\$110 billion
• Strengthening primary care and care coordination	–\$ 83 billion	+\$ 6 billion	—
• Modify the home health update factor	—	–\$ 50 billion	–\$ 37 billion
Correcting Price Signals in the Health Care Market			
• Reset Medicare Advantage benchmark rates	–\$135 billion	–\$158 billion	–\$175 billion
• Reduce prescription drug prices	–\$ 93 billion	–\$110 billion	–\$ 75 billion
• Limit payment updates in high-cost areas	–\$100 billion	–\$ 51 billion	—
• Manage physician imaging	–\$ 23 billion	–\$ 3 billion	—
Producing and Using Better Information			
• Promoting health information technology	–\$ 70 billion	–\$ 61 billion	–\$ 13 billion
• Comparative effectiveness	–\$174 billion	+\$ 1 billion	—
Promoting Health and Disease Prevention			
• Public health: reducing tobacco use	–\$ 79 billion	–\$ 95 billion	—
• Public health: reducing obesity	–\$121 billion	–\$ 51 billion	—
• Public health: alcohol excise tax	–\$ 47 billion	–\$ 60 billion	—

Source: R. Nuzum, S. Mika, C. Schoen, and K. Davis, *Finding Resources for Health Reform and Bending the Health Care Cost Curve* (New York: The Commonwealth Fund, July 2009).



For an example of how perspectives on the potential effects of policies may differ, consider CBO’s estimates of savings from negotiating pharmaceutical prices. CBO estimates no savings from negotiation of pharmaceutical prices by the HHS secretary over those currently obtained by pharmaceutical benefit managers. Yet other countries achieve substantially lower drug prices than the U.S. through systems of price negotiation on behalf of their entire population. The U.S. pays far more per capita for pharmaceutical products than do other countries, with the differences growing wider over the last 15 years (Exhibit 8). Countries such as Germany and Denmark have had great success with “reference pricing”—paying the price of the lowest-cost effective drug in a given category, with patients paying the difference if they want to buy a higher-cost drug that has not been shown to be more effective. Patients have an incentive to select the lowest-cost, equally effective alternative. In the U.S., such concepts are included in value-based benefit design.⁴⁵



Such differences have led CBO to substantially underestimate the savings from and overestimate the costs of the proposals included in the last three major health reforms (Exhibit 9). A recent analysis of CBO estimates of health reforms in the past three decades by Jon Gabel of the National Opinion Research Center illustrates the magnitude of this tendency.⁴⁶ Gabel's study indicates that actual savings from the Medicare hospital prospective payment system introduced in 1983 were double those estimated by CBO, while the BBA enacted in 1997 saved 113 percent more in 1999 than CBO had projected and actual spending under the MMA enacted in 2003 was 40 percent lower than projected.

**Exhibit 9. CBO Estimates of Major Health Legislation
Compared with Actual Impact on Federal Outlays**

Health Provision	CBO Projection	Actual Impact
Medicare hospital PPS, 1982–1983	\$10 billion savings, 1983–1986	\$21 billion savings, 1983–1986
BBA 1997: skilled nursing facilities; home health; and fraud, waste, and abuse reduction	\$112 billion savings total, 1998–2002	Actual savings 50% greater in 1998 and 113% greater in 1999 than CBO projections
MMA 2003: Medicare Part D	\$206 billion additional spending	Actual spending 40% lower than projection

Source: J. Gabel, "Congress's Health Care Numbers Don't Add Up," *New York Times*, Aug. 25, 2009.



Gabel notes that CBO has particular difficulty estimating savings when it considers more than one change at a time. He notes CBO’s reluctance to project savings from initiatives that represent significant changes from current policy—for example, its projected estimate of zero savings from the pilots on innovative payment methods. Commonwealth Fund studies of ways to invest in primary care, create medical homes, bundle hospital acute-care episode payments with post-hospital care, and make productivity improvements find that such policies have the potential to yield considerable savings.⁴⁷

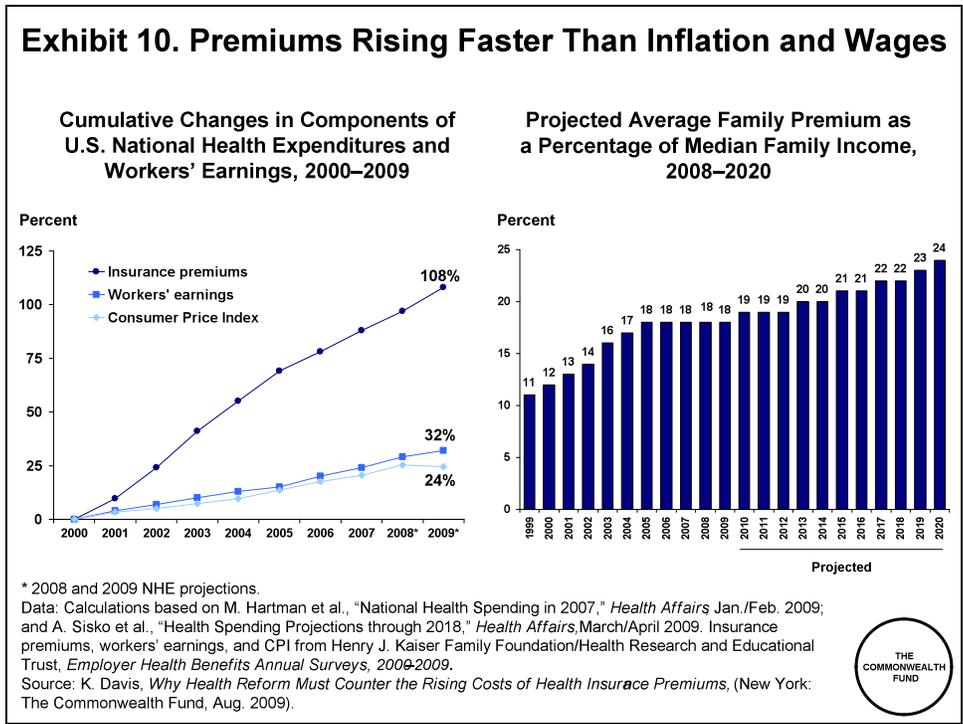
Given the inevitable uncertainties as new policy terrain is embarked upon, Congress may want to establish a system for monitoring actual spending and savings, as well as access to care and quality, over time. Modifications or mid-course corrections to health reform could be conditioned on actual experience, rather than hinging on information that is inherently difficult to project with any precision.

NATIONAL HEALTH SPENDING AND OTHER IMPACTS

By mandate, CBO focuses on federal budget cost. It does not provide estimates to Congress of the effect of policies on cost-containment across the health system. By contrast, the Commonwealth Fund *Bending the Curve* report focuses on total health spending, including spending by employers and households.⁴⁸ If a certain policy saves money for employers or households because, for example, premiums are reduced or rise at a slower rate, those would be desirable and much-needed savings. Such savings are just

as beneficial to American families and businesses as a tax cut and deserving of much greater attention than they receive.

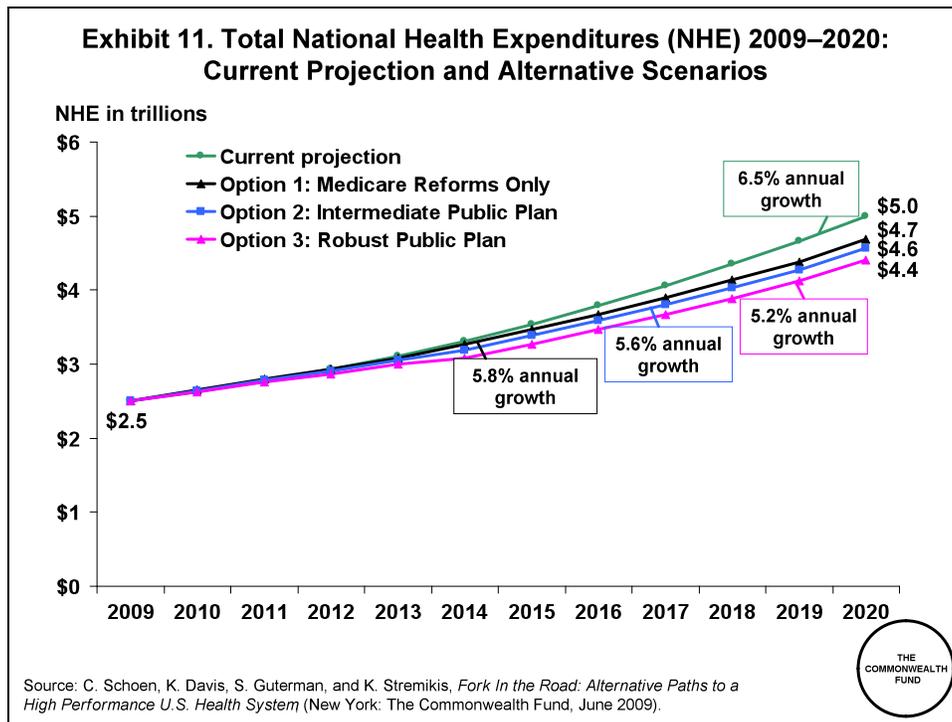
In fact, over the last decade health insurance premiums have taken a toll on the real incomes of working families. Premiums have more than doubled, rising by 108 percent, while workers' earnings have increased by 32 percent and the consumer price index has increased by 24 percent (Exhibit 10). Family premiums as a percentage of family incomes have increased from 11 percent at the beginning of this decade to 18 percent in 2009. With increases in employer health insurance premiums regularly exceeding economic growth, ever-higher health spending has directly contributed to stagnating or declining incomes for middle-class families and workers.⁴⁹



High and rapidly rising premiums reflect the lack of competition in the health insurance market, high administrative costs, and the absence of effective private sector cost containment tools. A public plan, proposed but not included in the final health reform law, is an important element of an overall strategy to transform the insurance market and slow the growth in total system costs in the long term. CBO estimated that a robust public health insurance plan, with the authority to use Medicare payment rates and implement innovative payment methods (along the lines of the bill that was passed by the Ways and Means Committee), would yield a premium 10 percent lower than private plans within the exchange and would enroll about 10 million people.⁵⁰ Even more

important, a public plan could slow the rate of increase in premiums over time by incorporating requirements for productivity improvement.

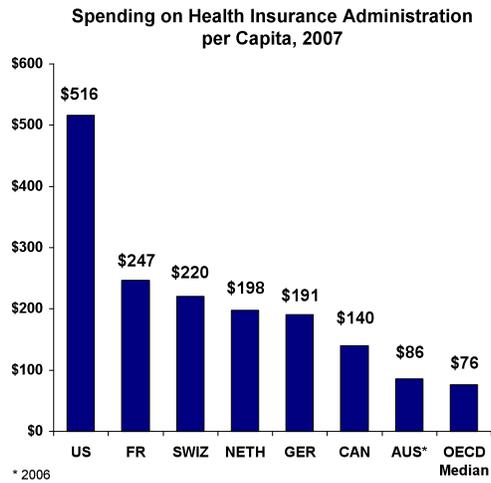
A Commonwealth Fund analysis of trends in national health expenditures found that inclusion of a robust public plan along with other health reforms similar to those included in the ACA could achieve system savings of \$3 trillion from 2010 through 2020, slowing the growth rate in national health expenditures from 6.5 percent to 5.2 percent (Exhibit 11).⁵¹ A strong public health insurance plan could achieve significant system savings, providing much-needed relief to individuals and small-business workers. Three-fourths of health care opinion leaders support including a public health insurance option in the exchange.⁵²



A public plan could put significant pressure on private insurers to slow growth in premiums for employers and workers over time. Currently, the U.S. health system has the highest administrative costs of any country, with \$516 per capita spent on administration in 2007, compared with an OECD median of \$76 (Exhibit 12). A McKinsey report estimates that high administrative costs add an unnecessary \$90 billion a year to health spending—costs borne by employers as well as workers.⁵³

Exhibit 12. High U.S. Insurance Overhead: Insurance Related Administrative Costs

- **Fragmented payers + complexity = high transaction costs and overhead costs**
 - McKinsey estimates adds \$90 billion per year*
- **Insurance and providers**
 - Variation in benefits; lack of coherence in payment
 - Time and people expense for doctors/hospitals



* McKinsey Global Institute, *Accounting for the Costs of U.S. Health Care: A New Look at Why Americans Spend More* (New York: McKinsey, Nov. 2008).



Employer-based coverage will remain the mainstay of the American insurance market, with 159 million Americans, or 56 percent of those under age 65, holding employer-sponsored plans. However, the health insurance market improvements in the new health reform law will affect trends in total health system spending. Important provisions include the creation of the insurance exchange and insurance market rules, including, for example, minimum medical loss ratios for plans. Administrative overhead in individual plans now averaging 40 percent, and 15 to 35 percent in small-business plans, will fall to 12 to 14 percent in plans offered through the insurance exchanges.⁵⁴ On average, 13 to 18 percent of private premiums now go toward administration (e.g., marketing, claims, and underwriting) and profit margins for the dominant commercial for-profit plans.⁵⁵

We should expect these costs to decline if we simplify administration and intensify competition.⁵⁶ CBO assumes premium reductions of between 1 and 4 percent for small groups in the exchanges and no savings for large groups, for an average of about 0.4 percent.⁵⁷ These savings come primarily from eliminating underwriting and reducing reliance on insurance brokers to select plans. The ability to compare plans should increase competition and lead to lower premiums, although no savings are attributed by CBO to this dynamic. Cutler and colleagues assume additional savings above those estimated by CBO, totaling \$184 billion over 2010–19.⁵⁸ When combined with greater estimated savings from health system modernization and reform of payment

methods, these savings become quite significant over time. Without reform, family premiums are expected to increase from \$13,305 in 2010 to \$21,458 in 2019. Relative to this increase, premiums under reform increase only three-quarters as much. By 2019, family premiums would be nearly \$2,000 lower.

The insurance market has grown increasingly concentrated in the last decade.⁵⁹ The top two insurance plans account for over 50 percent of enrollment in all but three states.⁶⁰ Without significant competition, plans can increase profit margins and simply pass along higher prices demanded by providers to employers and households, with administrative costs going up at the same rate in a form of “cost-plus” pricing.

The new law will give the exchanges authority to reject plans with unjustified premium increases prior to implementation. Commonwealth Fund studies estimate that slowing premium growth by one percentage point annually would save \$2,571 in family premiums in 2020; slowing by 1.5 percentage points annually, as pledged by an industry coalition, would save \$3,759 for the average family in 2020.⁶¹ Slowing growth in national health expenditures from 6.5 percent annually to 5.2 percent would save the average family \$2,200 in 2020.⁶²

In short, health reform has the potential to produce substantial total health system savings for the nation—well beyond what is reflected in the estimated federal budget impact. The combined effect of these provisions on trends in national health expenditures, however, is difficult to estimate, and CBO has indicated that it does not have the modeling capacity to do so. Estimates released by the CMS Office of the Actuary indicate that the legislation could produce modest increases in national health expenditures, but this estimate gives little credit for savings to measures that will reform provider payment, increase competition among plans in an insurance exchange, encourage public reporting, or apply the results of comparative effectiveness research.⁶³ Yet these measures are a crucial platform for developing and implementing further policies to contain health care cost growth. As such, they have broad support from health care opinion leaders and business leaders as effective ways to control costs.

AREAS FOR FURTHER ATTENTION

The health reforms now signed into law will fundamentally change our current course of rising costs and increasing numbers of uninsured and underinsured people. The law reflects a pragmatic approach to closing the gaps in insurance coverage, building on a mix of employer coverage and private plans in health insurance exchanges, retention of Medicare, and expansion of Medicaid. Most of the ideas that have been advanced by policymakers and health care opinion leaders to deal with rising costs are reflected in the bills.

Yet the U.S. health system is unlikely to reach its potential without more far-reaching measures in the coming years. Even given the additional outlays for coverage of the uninsured and improved coverage of the underinsured, an estimated 23 million people will remain uninsured and the costs of coverage and care will create financial burdens for many others. The reforms in the ACA should lead to a substantial slowing of the growth in health spending, but further reforms may be needed to hold rates of increase in national health expenditures to a course that is sustainable and affordable to employers, households, and government.

It will be especially important to establish a system for monitoring progress on agreed-upon health reform goals, with a mechanism for making mid-course corrections and further changes as needed to move the U.S. health system toward a high performance health system by 2020. Estimates of cost and savings could be seriously underestimated or overestimated; if so, corrective actions may be required. Additional steps may be required to ensure affordability for families as well as stable financing. In addition, as experience is gained with new provider payment methods, strategies for harmonizing public and private provider payment will be needed to avoid having public and private incentives for providers working at cross-purposes.

Health Goals, Monitoring, and Reporting

A system should be instituted for monitoring progress toward health reform goals. They should include achievable goals by 2020 for: health outcomes; the share of population receiving care from patient-centered medical homes and accountable care organizations; performance on quality, safety, and disparities in care; the share of population covered by health insurance meeting an affordability standard; and progress in bending the health care cost curve. Exhibit 13 presents illustrative health system performance goals for 2020 and examples of possible shorter-range target indicators.

Exhibit 13. Illustrative Health Reform Goals and Tracking Performance

1. **Secure and Stable Coverage for All**
 - Percent of population insured
 - Percent of population with premiums and out-of-pocket expenses within affordability standard
2. **Slowing Growth of Total Health Spending and Federal Health Outlays**
 - Annual growth rate in total health system expenditures
 - Annual growth rate in Medicare expenditures
 - Impact on federal budget: new spending, net savings, new revenues
3. **Health Outcomes and Quality**
 - Percent of population receiving key preventive services or screenings
 - Percent of population with chronic conditions controlled
 - Percent reduction in gap between benchmark and actual levels of quality and safety
4. **Payment and Delivery System Reform**
 - Percent of population enrolled in medical homes
 - Percent of physicians practicing in accountable care organizations
 - Percent of provider revenues based on value



Coordinating national leadership for all of these components of the health system would enable the federal government to: 1) assign clear responsibility and authority for the key aspects of the health system; and 2) provide the necessary capacity to enable agencies and organizations to act to secure access for all, better health outcomes, and slow the rate of cost growth. The new leadership roles needed to provide a coordinated and systemic approach to improving population health and wresting better value from health spending should be addressed as part of health reform legislation.

Harmonization of Public and Private Provider Payment

While the reform law makes a major start on rapid-cycle testing of payment innovation in Medicare, it does not specifically address private sector payment. Broadening the mandate of the Center for Medicare and Medicaid Innovation to include both public and private sector payment would:

- amplify the power of effective incentive approaches by sending the same signals about what is valued across different payers;
- simplify administrative complexity and reduce burdens associated with existing payment methods, as well as minimize administrative burden for providers who must respond to these new methods; and
- reduce the likelihood of payment distortions across payers or regions.⁶⁴

The health reform does encourage the secretary of HHS and the CMS Innovation Center to reach out to private insurers and other public payers to develop multi-payer payment strategies.⁶⁵ CMS could foster Medicare and Medicaid participation in local payment pilots designed by other payers and providers that are responsive to state and regional needs, as well as support pilots designed and developed by federal officials that involve the private sector and state payers—thus participating in both bottom-up and top-down efforts.

Congress also should make clear that it wants rapid-cycle testing and learning, coordination across pilots so that providers desiring to participate in both medical home and accountable care organizations can do so, and rapid spread of successful innovations. It should provide the funding and tools that CMS needs to carry out this function and make the HHS secretary accountable for doing so.

Perhaps most important, Medicare, Medicaid, and private plans participating in the health insurance exchanges should incorporate proven payment methods as they emerge from rapid-cycle testing. The Independent Payment Advisory Board can also play an important role in promoting harmonization of provider payment rates under private plans, Medicare, and Medicaid in its health system recommendations. Productivity improvement requirements on increases in provider payment for plans covering those under age 65 should be similar to those required for Medicare payment increases.

A NEW ERA IN AMERICAN HEALTH CARE

The new reform law contains several provisions that will go a long way toward changing the financial incentives and support required to transform the organization and delivery of health care (Exhibit 14).

Exhibit 14. Projected Savings and Effectiveness of System Reform Provisions in Comprehensive Reform Law 2010–19 (in billions)			
	CBO Estimate of Budget Savings, Affordable Care Act of 2010, 03/30/09	Percent Opinion Leaders Favor, or View as Effective	Projected Effectiveness in Containing Costs
Establish health insurance exchanges		92% ^b	++
Create new nonprofit plan choices			+
Review premiums and require minimum medical loss ratios			++
Incentivize primary care and prevention	\$6	61% ^c	+
Stimulate innovative provider payment reform	–\$8	97% ^c	+++
Create accountable care organizations	–\$5	54% ^f	++
Control spending growth; IPAB and productivity improvement	–\$176	75% ^e	++
Promote quality improvement and public reporting		53% ^a	+
Encourage Medicare private plan competition	–\$201	77% ^c	+
Tax high premium health insurance plans	–\$32	58% ^d	+

Authors' views of long-term effectiveness in controlling total health system spending: Very effective = +++, Effective = ++, Somewhat effective = +. Health Care Opinion Leaders Surveys: ^a Sept/Oct 2008; ^b Dec. 2008; ^c April 2009; ^d June 2009; ^e Oct. 2009; ^f July 2010. IPAB = the Independent Payment Advisory Board
 Source: Commonwealth Fund estimates; Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Mar. 20, 2010.



As described above, the combined effect of these provisions on trends in national health expenditures is difficult to estimate, and CBO has indicated that it does not have the modeling capacity to do so. The CMS actuary estimates modest increases in trends in national health expenditures from these provisions, but similarly gives little credit for savings to measures that will reform provider payment, increase competition among plans in the insurance exchanges, encourage public reporting, or apply the results of comparative effectiveness research.⁶⁶ Yet these measures are a crucial platform for developing and implementing policies to contain health care cost growth. As such, they have broad support from health care opinion leaders and business leaders as effective ways to control costs.

American businesses and families stand to gain substantially from reform. For example, an analysis by the Business Roundtable, prepared by Hewitt, found that such legislative reforms could potentially reduce the trend line in employment-based health care spending by \$3,000 per employee by 2019.⁶⁷ A recent report by The Commonwealth Fund and the Center for American Progress found that reform will lower administrative

costs and encourage more efficient care delivery, reducing premiums by nearly \$2,000 per family by 2019.⁶⁸

CBO assumes that these provisions will bring significant savings to Medicare, of \$397 billion over 2010–19. Medicare outlays were projected to grow 6.8 percent annually from 2010–19 before reform. This growth will be slowed to 5.5 percent annually under reform. In 2019, Medicare spending as a percent of gross domestic product will be 3.8 percent without reform; it will fall to 3.3 percent with reform, according to CBO estimates.

CBO's estimates of federal budget impact, however, are fraught with uncertainty, given the multitude of changes and their potentially synergistic effect. As detailed above, on the last three occasions when CBO has estimated the savings or costs of health reforms (the 1982–83 Medicare changes in hospital payment, the 1997 Balanced Budget Act, and the 2003 Medicare Modernization Act covering prescription drugs), it was off the mark—with savings more than double those estimated and cost overstated by 40 percent.

There is good reason to be optimistic that the measures incorporated in the law will stimulate significant changes in the organization and delivery of health services, and create powerful incentives to improve efficiency and productivity. Analysis by The Commonwealth Fund and the Center for American Progress has shown that the synergistic effect of the multiple payment and delivery system reform provisions included in the ACA will lead to significant modernization of the U.S. health care system, saving \$590 billion in total national health expenditures over the 10-year, 2010–19 period. The annual growth in health care expenditures is predicted to slow from 6.3 percent to 5.7 percent.⁶⁹

Congressional oversight will be critical as health reform implementation proceeds. Congress should insist that the administration establish a system for tracking performance on major health reform goals, with annual reports issued by the president and recommendations for additional policy actions. If necessary, Congress should act in future years to modify reform, including phasing in various provisions more slowly or quickly, or adding additional safeguards or savings.

Even under current estimates, 23 million people will remain uninsured and many others will still face financial barriers to obtaining needed care. Additional steps may be required to ensure affordability for families as well as stable financing.

Finally, the one major disappointment in the new law is the absence of significant incentives or levers for private insurers to control health care costs. Private insurers, in opposing a public plan, have basically argued that they do not have the ability to slow premium growth or achieve economies because of demands for higher prices from a powerful health care provider sector. Over time, as experience is gained with new provider payment methods, strategies for harmonizing public and private provider payment will be needed to avoid having public and private provider incentives working at cross-purposes and to leverage the combined purchasing power of public and private payers.

The Affordable Care Act will usher in a new era in American health care—one in which every American has access to affordable health insurance coverage and no one is turned away because he or she has a preexisting condition. The new insurance market protections set to take effect in this and subsequent years are designed to work in concert with important payment and system reforms that will improve access and quality, and reduce cost growth for everyone. Reform is a historic victory for all Americans, who deserve the finest health system in the world. It will require the efforts of all stakeholders to make the promise a reality.

NOTES

¹ Additional background on the new law and its provisions, specifically related to how health insurance coverage and affordability will change, will be included in the forthcoming Commonwealth Fund report, *The Affordable Care Act: Implications for Coverage, Affordability, and Costs*.

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