



STABILIZING AND STRENGTHENING MEDICARE IN THE CONTEXT OF BROADER HEALTH REFORM

David Blumenthal, M.D., M.P.P.

President

The Commonwealth Fund

Invited testimony

United States Senate

Special Committee on Aging

Hearing on

“Strengthening Medicare for Today and Tomorrow—Controlling Costs and Improving Care”

February 27, 2013

I would like to thank Stuart Guterman, Kristof Stremikis, and Rachel Nuzum for their help in preparing this testimony. The Commonwealth Fund’s Commission on a High Performance Health System report on *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*, authored by Cathy Schoen, Stuart Guterman, Mark Zezza, and Melinda Abrams, was the source of much of the information presented here. Estimates for the report were developed by Jim Mays and his team at the Actuarial Research Corporation.

The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. This and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications as they become available, visit the Fund’s website and [register to receive email alerts](#).

STABILIZING AND STRENGTHENING MEDICARE IN THE CONTEXT OF BROADER HEALTH REFORM

Thank you, Chairman Nelson, Senator Collins, and Members of the Committee, for this invitation to testify on Strengthening Medicare for Today and Tomorrow. I am David Blumenthal, President of The Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mission by supporting independent research on health care issues and making grants to improve health care practice and policy.

Concerns about federal government spending and the budget deficit have focused discussion on so-called entitlement programs, particularly on Medicare. Although Medicare remains one of the most popular government programs in history, and costs in Medicare are rising more slowly than those in the private sector, it accounts for an increasing share of the federal budget and of our economic resources. With the number of beneficiaries projected to grow rapidly over the next two decades, the tenuous fiscal viability of the program and its effect on government spending have brought calls for changing how the program is structured.

This has brought policymakers to a figurative fork in the road. On one path, policies could be pursued that cut Medicare payments to providers, reduce the benefits available through the program, or restrict program eligibility. These policies could produce program savings, at least in the short run, but they would be both morally and politically difficult as they shift costs onto elderly Americans, renege on historic promises, and raise the prospect of second-class care for a group that is particularly vulnerable. Moreover, these policies generally do not address the underlying causes of the health spending problem, so the payment cuts, reduced benefits, and restricted eligibility would have to become increasingly severe over time.

An alternative—and far preferable—strategy would support comprehensive payment and delivery system changes that produce lower costs and better value not just in Medicare, but across the entire U.S. health system. This path builds on the Affordable Care Act and continues to lead away from our current fee-for-service reimbursement system with a set of initiatives that reward providers, consumers, and payers for choices that improve outcomes and use resources efficiently. We know this approach is viable, as many innovative changes of this type are already beginning to emerge on the health system landscape as the reform law is implemented and both public and private stakeholders act on the increasing awareness that reengineering health care is preferable to rationing it.

The federal government, largely through the efforts of the new Center for Medicare and Medicaid Innovation (CMMI), is undertaking innovative initiatives not only in Medicare, but also in Medicaid, as well as in partnerships between the two programs and between public and multiple

private payers. Last week, CMMI announced \$300 million in funding for 25 states working to reform their health care delivery systems and contain costs. Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont are at the leading edge of the movement to implement a health care innovation plan that utilizes multipayer payment reform and innovative service delivery models.

Many other state-level initiatives are under way and already beginning to return real savings to government programs and the patients they serve, including:

- The Missouri Health Home initiative, a program that integrates behavioral health and primary care and has resulted in a 16 percent reduction in per-Medicaid-beneficiary costs.
- The Illinois Medicaid Medical Home Program, which has reduced hospitalizations by 18 percent, lowered emergency room (ER) visits by 9 percent, and resulted in \$569 million in cost savings by using primary care case management.
- The Indiana “Right Choices” program, an initiative that focuses on improving care for frequent users of hospital emergency rooms and has reduced use by 72 percent.
- The care transition model, a program deployed in more than three dozen states, including the Visiting Nurse Service of New York, which has reduced hospital admissions by 54 percent, 30-day hospital readmissions by 24 percent, and ER visits by 27 percent.

Meanwhile, several private sector organizations are also at the forefront of reengineering care to lower costs and improve outcomes, including:

- Geisinger Health System in Pennsylvania, through its ProvenHealth Navigator medical home model, has realized an 18 percent reduction in hospital admissions, a 36 percent reduction in hospital readmissions, and significant improvement on several quality indicators related to chronic care management.
- Appleton Medical Center and Theda Clark Medical Center in northeastern Wisconsin have redesigned acute care processes using Lean methodologies and achieved cost-per-case reductions of 15 percent to 28 percent and lower length-of-stay and readmissions rates.
- Virginia Mason Medical Center in Seattle, a health care delivery organization, has partnered with health plans and employers to develop standardized approaches to common conditions, decreasing the use of advanced imaging by 23 percent, increasing the availability of same-day appointments, and achieving 91 percent patient satisfaction.
- Blue Cross Blue Shield of Massachusetts has implemented an Alternative Quality Contract in which physician practices are paid a fixed rate, with bonuses for improved quality, leading to 3 percent savings in the program’s first two years.

To build on these initiatives and encourage further progress down a transformative path to a health system that works for all Americans, The Commonwealth Fund's Commission on a High Performance Health System has released a report that recommends an approach to accelerating change across the health system. The three pillars of the Commission's framework involve: using provider payment reform to promote value and accelerate delivery system innovation; engaging consumers with information and positive incentives to choose high-value care and care systems; and undertaking systemwide action to improve how health care markets function.

Policies conforming to this approach could reduce federal government spending by more than \$1 trillion relative to current policy over the next 10 years, and the entire health system more than \$2 trillion—if these policies are enacted now, aggressively implemented, and effectively carried out, with all the system's stakeholders pulling in the same direction. Based on these projections, net Medicare spending could be \$761 billion lower. The material below elaborates on these points.

MEDICARE, HEALTH SPENDING, AND THE FEDERAL BUDGET

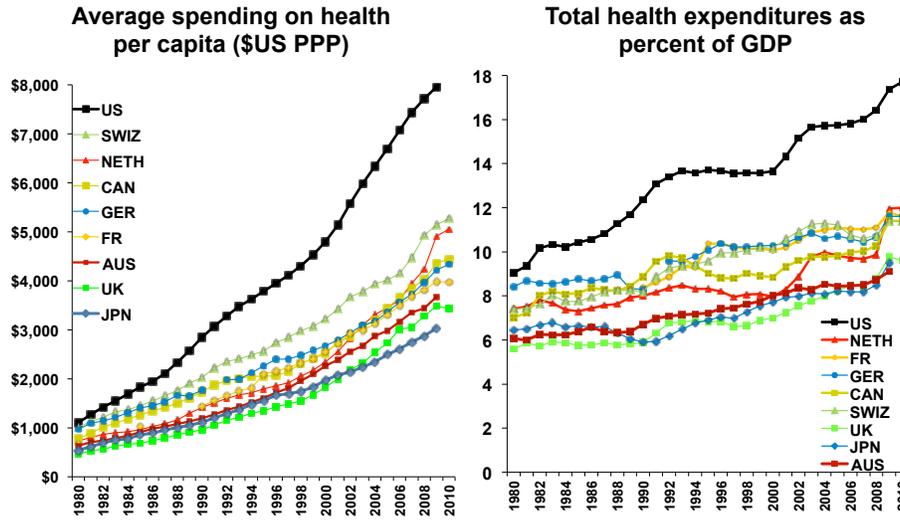
Federal health spending has been a subject of intense concern as Congress continues to search for ways to reduce the budget deficit. Earlier this month, the Congressional Budget Office (CBO) estimated that, although it is growing more slowly than previously projected, federal spending on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) will reach nearly \$900 billion in 2013, almost 25 percent of the federal budget and more than 5 percent of the nation's entire economic output (gross domestic product, or GDP).¹ Without fundamental change, federal health spending is projected to reach \$1.8 trillion and consume more than 30 percent of the federal budget by 2023.

Medicare historically has been the dominant component of federal health spending. CBO estimates that the federal government will spend nearly \$600 billion—or about two-thirds of its current health care outlays—on the more than 50 million Medicare beneficiaries in 2013. With the post-World War II baby boom generation beginning to become eligible for Medicare, the number of beneficiaries is projected to grow to nearly 70 million by 2023, putting increasing pressure on the program's finances and the federal budget.

These concerns about the growth in Medicare spending must, however, be put in the context of three important facts. First, Medicare spending growth is part of a larger trend occurring across the health sector. Health spending nationwide in the United States is the highest in the world, and has been increasing faster than in other developed countries for the past three decades (Exhibit 1). The factors that drive health spending in the public and private sectors, and in different parts of the country, may differ somewhat, but it is clear that it is not just a Medicare problem, or a federal problem, or even a public sector problem.

Second, our health system is financed about equally by funds from the public (federal, state, and local governments) and private (employers and households) sectors, and spending in both those

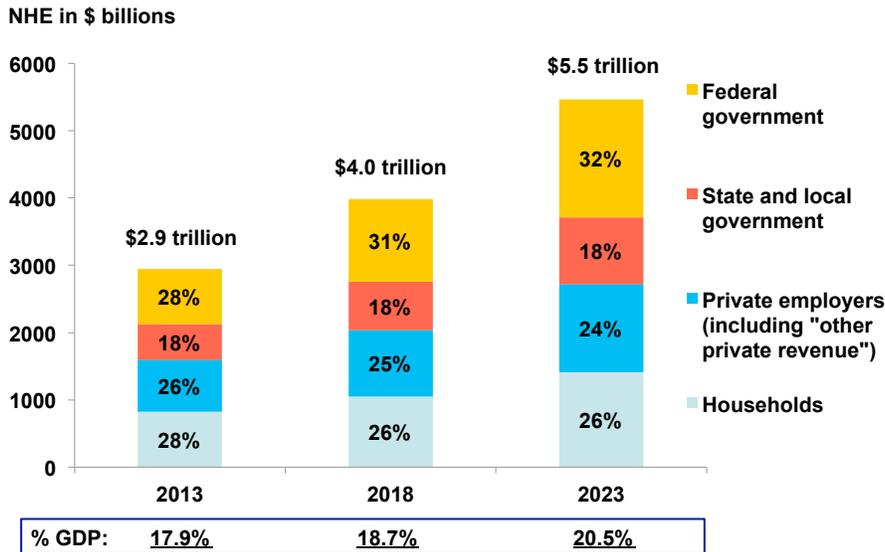
Exhibit 1. International Comparison of Spending on Health, 1980–2010



Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

sectors is projected to grow rapidly over the next 10 years (Exhibit 2). Consequently, solutions to the larger health spending problem are not likely to be effective if pursued only in one part of the health care system rather than systemwide. For example, drastically cutting reimbursement rates in public programs could shift costs onto private payers and do little to solve the underlying problem.

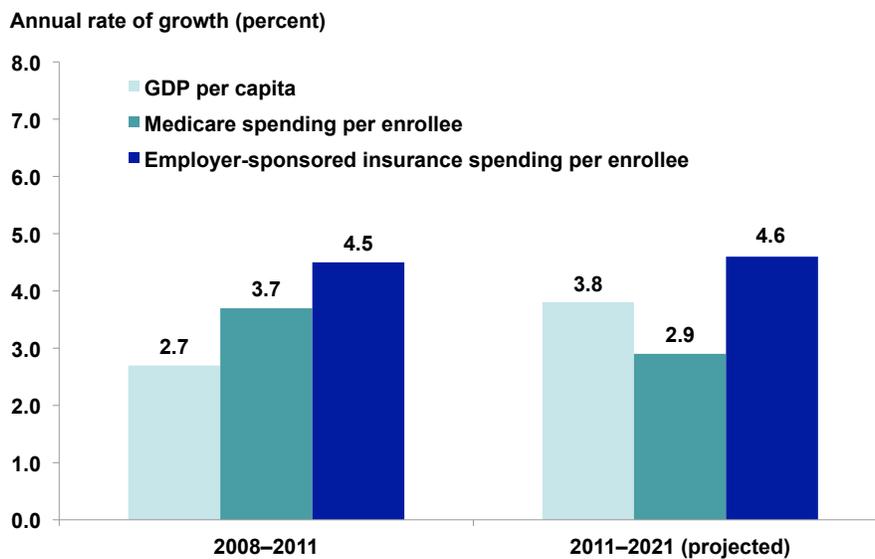
Exhibit 2. Projected U.S. National Health Expenditures (NHE) by Source, 2013–2023



Note: GDP = gross domestic product.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

Third, although the number of Medicare beneficiaries is projected to increase sharply, spending per beneficiary recently has grown more slowly than spending per enrollee in private employer-sponsored plans, and it also is projected to grow more slowly than GDP to the end of this decade (Exhibit 3). Focusing on cuts in Medicare payments, reductions in Medicare benefits, or restrictions in Medicare eligibility without considering systemwide solutions would be ineffective in dealing with the underlying factors that are responsible for health spending growth and also would threaten the program’s continued ability to fulfill its objective: ensuring access to needed care for elderly and disabled Americans.

Exhibit 3. Medicare Spending per Enrollee Projected to Increase More Slowly Than Private Insurance Spending per Enrollee and GDP per Capita

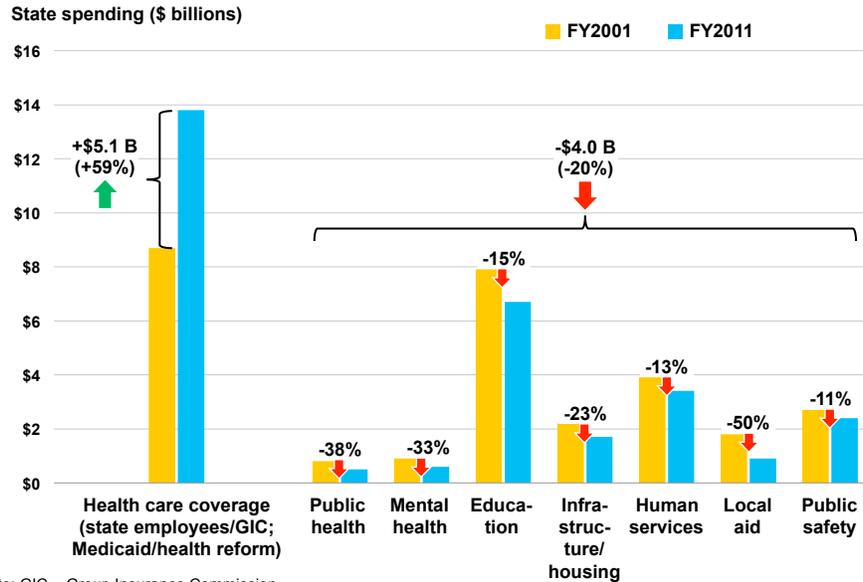


Note: GDP = gross domestic product.
Source: CMS Office of the Actuary, National Health Expenditure Projections, 2011-2021, updated June 2012.

These considerations should not detract from our concern about the health spending problem and its impact on the government budgets. For decades, growth in health care spending has outpaced economic growth, consuming resources that might otherwise have been spent on education, infrastructure, and investments necessary to compete in a global economy. Recent analysis of spending in my home state of Massachusetts shows that, since 2001, state spending on health care coverage has increased by \$5.1 billion, or 59 percent, crowding out spending on all other priorities, including education, infrastructure, and public safety (Exhibit 4). As a result, the state’s budget for everything other than health care coverage has fallen by \$4 billion, or 20 percent, over the past decade.

We must remember, though, that the pressure of health spending growth is not limited to the federal or state and local governments. Businesses and families have faced rapid increases in health insurance costs, with average premiums rising almost four times as fast as general infla-

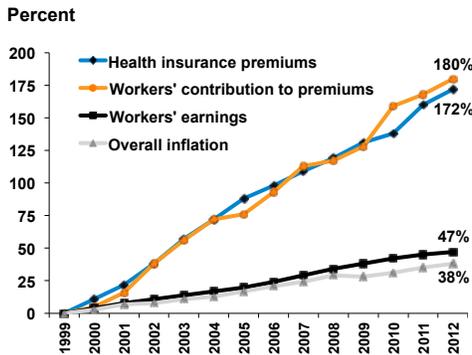
Exhibit 4. Rising Health Spending Crowds Out Other Priorities Massachusetts State Budget, FY 2001 vs. FY 2011



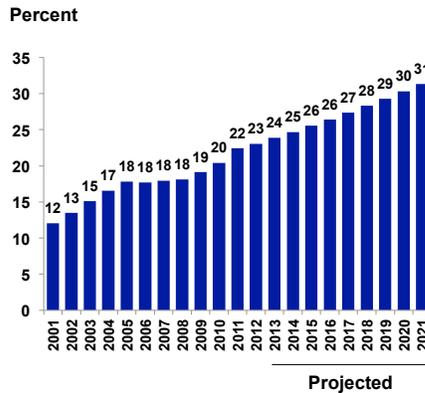
Note: GIC = Group Insurance Commission.
Source: Massachusetts Budget and Policy Center Budget Browser.

Exhibit 5. Premiums Rising Faster Than Inflation and Wages

Cumulative changes in insurance premiums and workers' earnings, 1999–2012



Projected average family premium as a percentage of median family income, 2013–2021



Sources: (left) Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys*, 1999–2012; (right) author's estimates based on CPS ASEC 2001–12, Kaiser/HRET 2001–12, CMS OACT 2012–21.

tion and wages since 1999 (Exhibit 5). The full annual cost of health insurance premiums already amounts, on average, to 23 percent of median family income for working-age Americans. If projected trends hold, the average premium for a family plan would exceed \$24,000 by 2021—the equivalent of 31 percent of median family income, intensifying pressure on family budgets.

Moreover, across the health system, we are not getting value for our substantial spending. The Institute of Medicine has estimated that thousands of patients die in hospitals each year as a result of medical errors that could have been prevented.² The Medicare Payment Advisory Commission (MedPAC) has calculated that 13.3 percent of hospital readmissions within 30 days of discharge are avoidable.³ Researchers at the RAND Corporation found that patients receive only 55 percent of recommended care for their health conditions.⁴ The Institute of Medicine has estimated that about 30 percent of nationwide health spending in 2009 went for unnecessary services, excessive administrative costs, and other costs that did not produce better patient outcomes.⁵ We can and must do better. And, as the largest payer for health care, Medicare can play a lead role in these efforts.

The primary challenge before us is to build on the foundation established by initiatives in both the public and private sectors and pursue new policies that stabilize the growth not only of federal health spending, but total national health expenditures. These policies must involve all stakeholders, rather than simply shifting costs from one group to another. Most important, success will require initiatives that cut across our entire health system, bringing both public and private payers together to accelerate adoption of innovative approaches to organizing, delivering, and paying for health care. This is a significant undertaking, but one both possible and urgently needed.

A FORK IN THE ROAD: RATIONING HEALTH CARE OR REENGINEERING THE HEALTH SYSTEM?

We find ourselves at a fork in the road, and we must choose our path carefully. One path, which may be seen as expedient, given the pressing demands for immediate and dramatic reductions in federal health spending, would pursue policies that result in instant savings from budgetary scorekeepers. Strategies of this type center on cuts in provider payments, reductions in benefits, and restrictions on eligibility for public programs.

While provider payment cuts would indeed produce needed budgetary savings in 2013, this strategy is problematic given that Medicare payments already are lower than private insurance, and further cuts could undermine providers' willingness to participate in the program. Moreover, as already mentioned, Medicare spending per beneficiary is growing more slowly than both private insurance spending per enrollee and GDP. Targeted reductions in Medicare payments may be warranted, given the prices the government pays for some procedures, devices, and drugs, as has been recommended by MedPAC.⁶ But continued, sharp across-the-board reductions in Medicare payment rates will likely hinder access to needed care for Medicare beneficiaries and will not address the underlying factors that drive health spending growth.

Policymakers can also produce immediate budgetary savings by reducing benefits and cutting eligibility for public programs. Examples of this type of strategy include increasing cost-sharing and raising the age of eligibility. But increasing cost-sharing across the board does not address the underlying cost of health care—it merely shifts more of those costs to beneficiaries, increas-

ing the burden on a vulnerable population at a time when they need protection most. Raising the age of Medicare eligibility has been found to have a relatively small net affect on federal costs, shifting costs from Medicare to Medicaid and, beginning in 2014, the federal subsidies available through the new health insurance marketplaces, having a potential adverse impact on access to care for older adults who do not have access to other affordable coverage.⁷ Targeted policies that include value-based insurance designs with differential cost-sharing for essential versus discretionary care and policies that both provide and encourage better choices by patients can be constructive, but broad reductions in benefits or eligibility would not address the causes of spending growth and would hinder access to needed health care for a vulnerable population.

The preferable—and more effective—strategy for addressing the growth of federal health spending involves addressing costs across the entire health system, primarily by aligning incentives for providers, consumers, and payers to reward choices that lead to better patient outcomes and use resources wisely. This path leads away from the current fee-for-service reimbursement system that encourages volume rather than value, and instead puts in place policies to reduce unnecessary utilization, increase care coordination, and improve outcomes.

To address federal and broader national concerns about affordability and health care costs, it is imperative to act, but do so in ways that are consistent with the goals of a high-performance health system. Incentivizing quality and value, rather than relying on indiscriminate across-the-board payment or eligibility cuts, is key to simultaneously lowering costs, maintaining access, and improving outcomes. This strategy requires that key public and private stakeholders work together, pulling in the same direction to achieve common goals. An effective approach that produces significant savings not just for the federal government, but also for state governments, businesses, and families, must include clear, consistent goals and coordinated incentives for all the key actors in our health system.

THREE PILLARS FOR ACCELERATING SYSTEM IMPROVEMENT: PAYMENT REFORM, ENGAGING CONSUMERS, AND MAKING MARKETS WORK BETTER

With these considerations in mind, The Commonwealth Fund’s Commission on a High Performance Health System has proposed a comprehensive, synergistic set of policies that could generate needed budgetary savings for the federal and state and local governments, provide relief to millions of American businesses and families, and improve value for spending on health care.⁸ The Commission set a goal of holding the growth of nationwide health spending per person to no greater than per capita economic growth, and would accomplish that goal by changing the way health care is paid for, used, and organized.

The three-pronged approach recommended by the Commission would:

- use provider payment reform to promote value and accelerate delivery system innovation;
- engage consumers with information and positive incentives to choose high-value care and care systems; and

- undertake systemwide action to improve how health care markets function.

Under this approach, policies would be enacted that harness both provider and consumer incentives and improve market interactions to produce better care and care experiences at lower cost. These policies would allow flexibility for local innovation and provide better, more transparent information to enable consumers and health system leaders to choose and act wisely.

Using Provider Payment Reform to Promote Value and Accelerate Delivery System Innovation

Payment reform could be used to accelerate the pace of delivery system innovation and care coordination, while increasing accountability for improving outcomes and reducing cost growth over time. To maximize their impact and ensure consistent signals, the policies should be coordinated across public and private programs. The aim of these policies would be to accelerate the move from our current fee-for-service system that ties payment to the provision of individual services to one that rewards efficient care and better patient outcomes. These policies also would strengthen primary care by providing incentives and expanded resources for practices committed to providing coordinated care and helping patients navigate the health care system.

- **Improving provider payment.** This policy would repeal and replace the sustainable growth rate (SGR) formula and the reduction it calls for with a Medicare physician payment policy that provides incentives to improve health outcomes and participate in care system innovation. The Medicare fee schedule would be restructured to reduce payment rates for services meeting specified criteria as overpriced, and institute a system for future increases tied to performance.⁹ To move more quickly to models of coordinated care with accountability for outcomes, the policy would provide future increases in fees only for providers participating in innovative payment or delivery systems such as patient-centered medical homes, bundled payment, and accountable care organizations (ACOs). Fees would otherwise remain at 2013 levels. To use the market to drive down costs, Medicare could institute competitive bidding for medical commodities (e.g., drugs, equipment, and supplies).¹⁰ Payment rates for several other types of providers (from among those recommended by MedPAC) would be recalibrated to improve alignment with cost and value.
- **Strengthening patient-centered primary care and supporting care teams for high-cost, complex patients.** Strengthening the primary care foundation of the nation's health system is critical to providing timely access to care, preventive care, and better outcomes for those with chronic disease. Rich evidence from within the United States and abroad attests to the potential of redesigned primary care and care teams to improve care and patient experiences—and to lower costs over time by preventing complications and reducing avoidable use of hospitals and more specialized care.¹¹ By enhancing primary care payment for patient-centered medical homes that use teams for managing chronic conditions across sites of care, payment reform would strengthen primary care and care overall. This policy would augment fee-for-service

payments with additional payment for care coordination, 24/7 access, and the use of teams for care delivery. It would include incentives for providers to improve patient outcomes.

In addition to providing core support for medical homes, this policy would invest in the development and more intensive use of teams to manage care and improve care coordination by providing enhanced payment to providers that have the team-based capacity to care for high-cost patients with multiple chronic diseases or disability. Such teams would include nurses and other clinicians working with primary care physicians and would provide and coordinate after-hours or at-home care. Care teams responsible for high-risk, high-cost patients would work interactively with hospitals and specialists to ensure patients make smooth transitions across care settings and receive follow-up care after hospitalizations. Such teams would be held accountable for patients receiving timely, safe, and effective care.

- **Bundling hospital payment to focus on total costs and patient outcomes.** Medicare, Medicaid, and private-insurer payments for hospital care typically do not include physician services and do not hold hospitals accountable for readmissions or follow-up care. More inclusive bundled payments in which a single payment is made for all care provided during an episode of care involving a hospital stay—including physician services—would provide incentives for teamwork and accountability for the total costs of care and outcomes associated with hospital episodes of care. Medicare has begun a pilot to test alternative approaches to bundled payment. One model being tested bundles physicians' services and postacute transition care for selected procedures. Several bundled payment initiatives have been implemented in the private sector as well.¹² Accelerating bundled payment for hospital and postacute care would support movement toward high performance and provide incentives for hospitals, physicians, and postacute care providers to make transitions and follow-up care a priority. Greater use of bundled payment for hospital care and postacute care also would make it easier for patients as well as payers to compare and assess the total costs of care and quality for certain procedures and conditions such as hip replacement surgery, appendectomy, or heart bypass surgery.
- **Adopting payment reforms throughout markets, with public and private payers working in concert.** With federal and state health care programs insuring over 40 percent of the population, the acceleration of payment policy innovations among federal and state public programs would stimulate change across the country, supporting local care system innovation to achieve the triple aim of better care, better health, and lower costs. This effect would be amplified if consistent payment methods and reporting requirements were adopted by private as well as public payers in local markets. This would also reduce complexity for physicians and strengthen incentives to transform their practices in ways that improve the value of care. More consistent payment approaches among payers could also help counteract the concentration of provider market power, lowering private insurance premium costs for businesses and families.

Examples of promising payment reform initiatives in practice. Many states, private insurers, and health systems have already begun to implement innovative payment arrangements. Missouri and Illinois are just two examples of states that are actively promoting the patient-centered medical home model of payment and delivery system transformation. Early results are promising in both states, with a 16 percent reduction in per-Medicaid-beneficiary costs in the Missouri Health Home initiative and 18 percent fewer hospitalizations in the Illinois Medicaid Medical Home Program. In the private sector, Geisinger Health System, an integrated care system in rural Pennsylvania, Empire Blue Cross Blue Shield of New York, and Group Health Cooperative of Puget Sound are just a few of the payers and health systems already realizing significant savings and better outcomes with the medical home model.¹³

Geisinger’s advanced medical home program has been particularly successful at improving quality and increasing value for chronically ill patients in Pennsylvania. Marketed as the “ProvenHealth Navigator,” the medical home program features an embedded nurse case manager in practice sites and the use of real-time data to monitor the utilization of services by patients with complex care needs. The reimbursement structure and financial incentives embedded in ProvenHealth include a hybrid of fee-for-service payments, pay-for-performance bonuses, and infrastructure transformation stipends. Quality targets are set through a collaborative process with providers and health plan teams, and efficiency goals are based on per-member-per-month experiences with each primary care practice. The results are promising—the program experienced an 18 percent reduction in hospital admissions and a 36 percent reduction in readmissions after two years.¹⁴

Blue Cross Blue Shield of Massachusetts continues to realize savings under its innovative Alternative Quality Contract (AQC) program, in which health care providers receive fixed payments for patient care delivered within a defined period.¹⁵ Providers in the AQC are then eligible for bonuses of up to 10 percent if certain quality-related process, outcome, and patient experience measures are met. Early evaluations of the program have been positive—data suggest that the AQC is slowing spending growth by encouraging physicians to refer patients to physicians and hospitals that charge lower prices. Researchers have concluded that such changes in referral patterns could pressure more-expensive facilities to lower their fees, injecting renewed price competition into the provider markets and leading to additional savings across the state.

At its core, payment reform is the most effective way to drive and reward delivery system innovation. Correctly aligning incentives in the U.S. health system would allow providers and care systems to be rewarded for successfully reengineering care to lower costs and improve outcomes. There are numerous examples of these transformations in practice, such as Appleton Medical Center and Theda Clark Medical Center in northeastern Wisconsin. These systems have redesigned acute care processes using Lean methodologies and achieved cost-per-case reductions of 15 percent to 28 percent and lower length-of-stay and readmissions rates.¹⁶ Further, Virginia Mason Medical Center, a health care delivery organization in Seattle, has partnered with health plans and employers to develop standardized approaches to common conditions, decreasing the

use of advanced imaging by 23 percent, increasing the availability of same-day appointments, and achieving 91 percent patient satisfaction.¹⁷

Estimated budget impact of payment reforms. The Commonwealth Fund contracted with the Actuarial Research Corporation (ARC) to estimate the potential cumulative effects if all recommended payment policies were in place starting in 2013, with first-year impacts in 2014.¹⁸ ARC estimated the incremental and cumulative spending impact over the 10-year period 2014 through 2023, compared with baseline projections under current policies.¹⁹ To estimate the potential of the combined policies, ARC adjusted estimates for each policy to reflect potential overlap.

The payment reform policies described above could produce an estimated \$788 billion in federal savings over the next 10 years, with state and local governments realizing \$163 billion in savings, private employers \$91 billion, and households \$291 billion.²⁰ Based on these projections, net Medicare spending would be an estimated \$587 billion lower than under current policy—more than enough to offset the cost of eliminating the SGR cuts in physician fees. These estimates are contingent also on the synergistic effects of these and other policies, described below, that would improve system performance nationwide.

Engaging Consumers with Information and Positive Incentives to Choose High-Value Care and Care Systems

Currently, patients and consumers have very little information to guide their care decisions or to help them choose care or care systems wisely.²¹ The lack of information about different treatment choices, clinical outcomes, prices, total costs, and quality of care has discouraged efforts to develop insurance benefit designs that provide positive incentives to seek care from high-value care teams or networks. Engaging consumers effectively requires providing better information on alternative care choices, as well as incentives to choose care systems that provide better patient outcomes and more patient-centered care. A consumer-friendly, patient-centered approach to providing information and positive incentives to choose wisely would complement payment policies that give providers incentives to improve their performance. Positive consumer incentives include reducing cost-sharing or eliminating cost-sharing altogether for essential, highly effective care, and providing patients with comparative cost information for equivalent care choices. To enable such informed choice, there is also a critical need to expand scientific information about the comparative risks and benefits of alternative treatment choices, with assessment of outcomes for existing as well as new medical technologies and practice. These illustrative policies would promote consumer engagement in making informed, high-value choices about providers and treatments.

- **A new Medicare Essential plan with more comprehensive benefits and better protection against catastrophic costs, with provider and enrollee incentives to achieve better care, better health, and lower costs.** This proposal would offer Medicare beneficiaries a competitive Medicare Essential plan with integrated benefits and a limit on out-of-pocket costs while providing positive incentives to seek care from high-value care networks and teams. This ap-

proach would engage Medicare beneficiaries in making better health choices while protecting access and affordability. These positive incentives would work in tandem with the provider payment policies described above to encourage physician participation in high-performing health care organizations and innovative payment arrangements. Medicare Essential could be designed as self-financing, with beneficiaries paying a premium directly to Medicare. In estimating the potential premium cost for such a plan, we find it would generally be lower than the amount seniors typically pay for current Medicare supplements (i.e., Medigap policies), in part because of lower administrative costs.²² This confirms earlier analyses that similarly found that the resulting premium could be less than the current premiums paid by beneficiaries with private Medigap policies that provide supplemental coverage.²³

- **Modifying the payment policy for private Medicare Advantage plans to encourage beneficiaries to enroll in high-performing plans.** The benefit package of a Medicare Essential plan would more closely correspond to that provided by private plans in Medicare Advantage and those available through public and private employers. This would provide beneficiaries with real choices among comparable health plan options. Recalibrating payments to Medicare Advantage plans based on the costs of the new Medicare option, with shared savings for lower-cost, high-quality plans and their enrollees, would encourage plans to operate more efficiently and encourage beneficiaries to select the best plan for them. High-quality plans would be those that perform well according to the rating system used by Medicare (i.e., four or more stars out of the maximum of five).²⁴
- **Providing positive incentives for Medicare and Medicaid beneficiaries to seek care from high-value, patient-centered medical homes, care teams, ACOs, and integrated delivery systems.** To complement provider incentives to strengthen primary care and participate in accountable care networks, both Medicare and Medicaid would offer beneficiaries positive incentives to select care from practices and networks with proven track records of better outcomes. In Medicare, the deductible would be waived for primary care for beneficiaries who register with a practice that is a medical home or for care teams with the capacity to care for high-cost, high-risk patients. Cost-sharing also could be reduced for those patients who agree to receive care from networks that participate in the Medicare Shared Savings Program or the Pioneer ACO initiative. To spread this approach in Medicaid, high-cost and chronically ill patients who elect to receive care provided by teams would be provided with access to enhanced services. Private plans participating in Medicare Advantage, Medicaid, and the health insurance marketplaces would be encouraged to follow a similar approach and to align incentives throughout entire markets to support high-value care teams and care systems. Efforts to align information and provide incentives for all payers within a market would be particularly important to encourage and support networks participating as ACOs with multiple payers.
- **Enhancing clinical information on outcomes of care and patient experiences to inform choice of care and care systems.** Providing better information on the benefits, safety, and cost of alternative high-cost medical treatments or technologies would inform decisions by

patients and providers. As use of electronic medical records spreads, with enhanced capacity to exchange information across providers, the nation has the potential to reap benefits from its investment in smarter information systems and clinical support. Meaningful use of such systems, however, will require a concerted effort across care systems to pool information on outcomes to track and assess patient experience. The potential to learn from experience would be further enhanced with registries that track experience with medical devices or other high-tech procedures, such as the registry for total joint replacement maintained by Kaiser Permanente.²⁵ Developing a national approach, rather than relying on private systems, would provide more complete and accurate information about the safety of devices and other technologies as well as their comparative benefits for patients and doctors. Having all-payer information on prices, quality, patient experiences, and outcomes of care, at both the state and community levels, would inform consumer choice and efforts by providers to improve care. This information also would enable payers—both public and private—to develop more value-based insurance benefit designs.

Examples of promising consumer engagement initiatives in practice. There are many examples of efforts to improve the availability of information. The most advanced involve all-payer claims databases to allow for a more meaningful understanding of costs, quality, and patterns of care across Medicaid, Medicare, and private payers.²⁶ Maine, Massachusetts, New Hampshire, Tennessee, and Utah are early leaders in the all-payer claims database effort. Oregon and New York also are implementing all-payer claims databases.

Value-based insurance design is one consumer engagement strategy that links evidence-based information and patient incentives in an effort to lower costs and improve outcomes. Pitney Bowes, a multinational U.S. corporation that provides customer communications technologies, introduced a value-based insurance program in January 2007. The initiative eliminated copayments for cholesterol-lowering drugs known as statins for all employees with diabetes or vascular disease and lowered copayments for all employees prescribed the clot-inhibiting drug clopidogrel. A Commonwealth Fund–supported evaluation of the program found an increase in patient adherence to both care regimens, suggesting that when coupled with evidence-based research and guidelines, value-based insurance design could lead to better care outcomes and slow the growth in health care spending.²⁷ Several of our international peers are already successfully utilizing such strategies on a broad scale.²⁸

Estimated budget impact of consumer engagement policies. The 10-year impact of the consumer engagement policies described above—if enacted now and implemented quickly, aggressively, and effectively—on federal spending overall was estimated at \$71 billion relative to the current policy baseline over 10 years. State and local governments would realize an estimated \$16 billion in savings, private employers \$51 billion, and households \$51 billion.²⁹ The potential impact on net Medicare spending is an estimated \$70 billion. Although these estimates are small relative to the payment reform policies described above, providing and encouraging improved

consumer choices is crucial to the achievement of the savings attributed to those payment reforms and to the attainment of a high-performance health system.

Undertaking Systemwide Action to Improve How Health Care Markets Function

Currently, health care markets do not function well. Fragmented payment policies and reporting requirements have given rise to an incoherent and inconsistent pricing and added layers of administrative costs for providers and health plans. At the same time, current malpractice liability laws provide incentives to do more testing while failing to address safety concerns.

Within local markets, consolidation of providers that may result in higher-quality and more-integrated care also has the potential to increase prices, irrespective of value, if a relative imbalance of market power results from the consolidation. In recent years, increasing concentration has been an important factor in driving up costs for care systems and for health insurance. Indeed, increases in prices paid for care by private insurers for “must-have” providers or dominant systems have accounted for much of the rise in private insurance premiums as insurers pass on those higher costs, taking the path of least resistance.³⁰ This dynamic creates a growing discrepancy between private and public payment rates and impedes efforts to slow cost growth.

As described above, transparency about health care prices, quality, and outcomes would inform consumer choice as well as providers’ efforts to improve. However, transparency alone will do little to address rising prices. Indeed, there is the potential for lower-cost providers to aim for the high end of the range once this is made public. And in communities where markets are concentrated, with few alternative sources of care, consolidated market power could overwhelm and undermine any incentives for consumers to compare costs.

Given the reality of the current health insurance and delivery system market dynamics, systemwide efforts will be needed to complement payment reforms and changed incentives for consumers. This includes efforts to lower the administrative costs that result from having multiple payers and failure to coordinate or standardize insurers’ policies. To support payment reforms and incentives for consumers to choose wisely, the following policies would seek to further improve the functioning of health care markets by reducing excessive administrative costs, reforming malpractice to promote safety and fair compensation, and enabling multipayer approaches.

- **Simplifying administrative policies and procedures across public and private plans to reduce administrative costs and complexity.** Policies that simplify and require more uniform administrative policies and procedures across public and private plans would reduce an expensive layer of paperwork and make it easier for providers to focus on furnishing more effective, coordinated, and efficient care. Integrating administrative records systems, electronic submission of claims, shared provider enrollment and credentialing systems, and common quality reporting would reduce redundancy and complexity that add time and staffing costs for practices and hospitals. The reduced administrative cost burden would largely accrue to physicians and hospitals. Streamlined enrollment processes for Medicaid and new insur-

ance marketplaces would also reduce health plan and insurance system administrative costs and promote more continuous enrollment.³¹ Such efforts would build on beginning steps for administrative simplification embedded in the Affordable Care Act.³²

- **Reforming medical malpractice policy.** Malpractice reforms should be linked to payment reforms and should provide fair compensation for injury while promoting patient safety and adoption of best practices. Like administrative burdens, high premiums for professional liability insurance add to practice costs, especially for some specialties. Yet, despite its expense, the current malpractice system fails to create effective incentives to provide safe or evidence-based care, or to encourage admission of errors to inform corrective action. Reforming the malpractice system to include provisions for fair compensation for injury and medical costs, policies to encourage disclosure of errors, and protection for those adopting evidence-based practice could curb incentives to provide excessive or inappropriate care. Creating an environment that encourages the medical profession to police itself—such as sharing information about physician records across state borders for licensure—would further protect patients. Such an approach would also promote patient safety and evidence-based practice, and coupling such malpractice reform with Medicare payment reform would further focus incentives on value, and avoid liability incentives that could lead to or be cited as the reason for excessive care.
- **Establishing spending targets.** Establishing a spending target and adjusting policies as needed if the target is exceeded would focus attention on identifying the sources of excessive cost increases. For example, certain geographic regions, more consolidated markets, or specific service areas may be at the heart of the problem. Data would be collected to enable state or local communities to establish baselines, set targets, and adjust policies as needed. A spending target also would guide any multipayer negotiations with providers of payment methods and rates. A policy that includes provisions for adjustment of policies over time and allows for focusing on specific geographic areas or services if trends exceed the target would provide impetus to act and collaborate. A well-designed policy could enable targeted action at the geographic or service area or within local markets, with flexibility to refocus over time as needed.

Examples of promising initiatives that improve how health care markets function. The creation of state-based health insurance marketplaces, as required under the Affordable Care Act, provides a key mechanism through which policymakers can simplify administrative policies and procedures across public and private plans. States like Utah and Massachusetts already had functional exchanges in place before the enactment of the new law and can continue to be leaders in developing new initiatives that reduce redundancy and complexity in claims and credentialing.

Massachusetts also has enacted a statewide spending target that is intended to provide an impetus to control health spending growth in the state.³³ The target is tied to growth in the state's economy, and includes provisions to improve transparency and accountability for health care

providers with regard to quality and cost, and to improve clarity for consumers about the out-of-pocket costs they face. The act creates a Health Policy Commission to implement the new law and a Center for Health Information and Analysis to collect and analyze data on health care costs and quality.

Texas began medical malpractice reform in 2003, placing an upper boundary on noneconomic damages for plaintiffs in cases against individual physicians. This policy has led to a reduction in medical malpractice premiums for providers, but additional steps could be taken to promote patient safety and adoption of best practices by granting a degree of protection for providers who can demonstrate that they used evidence-based practices. Coupling such malpractice reform with Medicare payment reform would further focus incentives on value, and avoid liability incentives that could lead to or be cited as the reason for excessive care.

Estimated budget impact of policies to improve how markets function. The 10-year impact of these policies to improve market functioning on overall federal spending is an estimated saving of \$177 billion, with state and local governments realizing \$62 billion in savings, private employers \$48 billion, and households \$194 billion.³⁴ Based on these estimates, net Medicare spending would be reduced by \$104 billion relative to projections under current policy. In addition to producing direct system savings, administrative simplification and other suggested policies would reinforce the effect of improved financial incentives, enable better choices that would improve care, enhance the efficient use of health care resources, and reduce costs for providers as well as patients and insurers.

OVERALL IMPACT AND IMPLICATIONS OF A COMPREHENSIVE APPROACH TO HEALTH REFORM

The combined policies proposed by the Commission on a High Performance Health System have the potential to reduce projected national health spending by a cumulative \$2.0 trillion from 2014 through 2023. This assumes that all these initiatives are enacted together as part of a unified, synergistic strategy (Exhibit 6). Of that amount, federal savings would total \$1.0 trillion over 10 years. Net Medicare spending would be \$761 billion lower than projected under current policy.

Looking at potential savings by major payer category, there would be substantial potential savings for both public and private payers compared with baseline projections as policies spread across markets (Exhibit 7). In addition to federal government savings, households would save an estimated \$537 billion as a result of lower premium and out-of-pocket costs for medical care. State and local governments would save \$242 billion, primarily as a result of slower growth in their share of Medicaid costs, but also because of slower growth in public employee health care costs. And private employers would save an estimated \$189 billion as a result of lower costs per person for their employees and retirees.

These estimates suggest that it is within our capability to hold the growth of national health expenditures to no more than GDP growth per capita for most of the decade. Specifically, the

Exhibit 6. Cumulative Impact of Comprehensive Strategy on Health Spending, 2013–2023: Medicare, Federal, and NHE

Net impact in \$ billions

	Medicare	Federal	NHE
Provider payment reforms	–\$587	\$788	–\$1,333
Provide and support high-value choices by consumers	–\$70	–\$71	–\$189
Make markets work better	–\$104	–\$177	–\$481
Cumulative impact	–\$761	–\$1,036	–\$2,004

Note: NHE = national health expenditures. Components may not add to total because of rounding.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

Exhibit 7. Cumulative Impact of Comprehensive Strategy on Health Spending, 2013–2023, by Payer

Net impact in billions

	Total NHE	Federal government	State and local government	Private employers	Households
2013–2023	–\$2,004	–\$1,036	–\$242	–\$189	–\$537

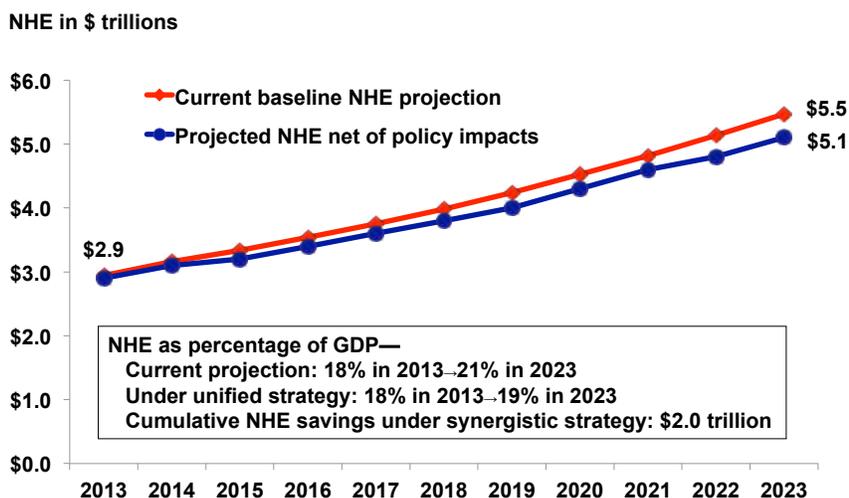
Note: NHE = national health expenditures. Components may not add to total because of rounding.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

Commission’s recommendation would hold health spending to an estimated 19 percent of GDP by 2023, compared with the current projection of 21 percent (Exhibit 8).

Notably, although private spending per insured enrollee would slow, it would continue to exceed GDP annual growth and Medicare per beneficiary growth throughout the decade as it has in recent years. The analysis described here does not examine what could happen to private payer trends if dominant private payers were better able to leverage their purchasing power by paying for value or through multipayer initiatives.

It is important to note that despite the substantial savings produced by these policies over 10 years, the health sector would still grow—with adequate resources to adopt innovations in care

**Exhibit 8. Projected National Health Expenditures (NHE), 2013–2023:
Potential Impact of Synergistic Strategy**



Note: GDP = gross domestic product.
 Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

delivery, introduce new medical breakthroughs, and ensure care for an aging population. Even under these policies, health spending is projected to increase from \$2.9 trillion in 2013 to \$5.1 trillion in 2023—an increase of more than 75 percent over the decade. Spending on both hospitals’ and physicians’ services would continue to grow, with the potential for net revenue growth as administrative costs decline.

This substantial—but somewhat slower, more stable, and better targeted—growth in health spending would continue to allow for expansion of services to those who are now uninsured and underinsured, the ongoing adoption of information technology, the introduction of new prescription drugs and medical breakthroughs, and an increase in compassionate care for the most vulnerable, including low-income individuals, the elderly, and the disabled. It also provides for jobs in the health sector, stable incomes for health care professionals, and fiscal viability for efficient hospitals providing essential services.

CONCLUSIONS

In summary, it should be possible to stabilize health care spending growth for both public and private payers while also improving the performance of the health system overall and both quality and efficiency of care. Through a combination of reforming provider payment, engaging consumers to make high-value choices, and improving the way health care markets function, with all stakeholders involved and pulling together, we can achieve this goal.

In combination, these policies would lead to wiser and more efficient expenditures of health care dollars, while also enhancing the benefits of health care. These policies not only would strength-

en Medicare for today and tomorrow but also make our health care system as a whole more viable. The resulting savings could be redirected to other essential uses, both in the public and private sectors. In the end, reduced health spending by federal, state, and local governments and private employers would accrue to households, which ultimately bear the burden of rising health spending through higher taxes, reduced wages, or direct out-of-pocket costs.

Moving from concept to action, however, will require that national policy leaders reach consensus that health care cost growth is a vital national concern, not just a federal budget concern. The need for action applies not only to the federal government, but also to state and local governments, businesses, and households, all of which are under increasing financial pressure as a result of the growth in health spending. Ideally, all of these stakeholders would work together toward the same goals: simplifying the health system, reducing administrative waste, changing the way we pay for care to hold care systems accountable for population health while providing flexibility to innovate, and leveraging the impact of policy changes across payers. By pulling together to stabilize health spending, we have the opportunity to reduce the federal deficit, free up resources for state and local governments, and make care and high-value health insurance more affordable for families and employers.

NOTES

¹ Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023* (Washington, D.C.: Congressional Budget Office, Feb. 2013).

² L. T. Kohn, J. M. Corrigan, and M. S. Donaldson (eds.), *To Err is Human* (Washington, D.C.: Institute of Medicine, 2000).

³ Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, D.C.: MedPAC, June 2007).

⁴ E. A. McGlynn, S. M. Asch, J. Adams et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, June 26, 2003 348(26):2635–45.

⁵ M. Smith, R. Saunders, L. Stuckhardt et al. (eds.), *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Washington, D.C.: Institute of Medicine, 2012).

⁶ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2012).

⁷ T. Neuman, J. Cubanski, D. Waldo et al., *Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform* (Washington, D.C.: Kaiser Family Foundation, July 2011).

⁸ Commission on a High Performance Health System, *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System* (New York: The Commonwealth Fund, Jan. 2013).

⁹ Specific criteria to identify overpriced services could include: services with unusually large increases in volume, services that are ordered and provided by the same practitioner, and services provided together routinely in the course of the same treatment.

¹⁰ E. Emanuel, N. Tanden, S. Altman et al., “A Systemic Approach to Containing Health Care Spending,” *New England Journal of Medicine*, Sept. 6, 2012 367(10):949–54.

¹¹ For examples, see D. D. Maeng, J. Graham, T. R. Graf et al., “Reducing Long-Term Cost by Transforming Primary Care: Evidence from Geisinger’s Medical Home Model,” *American Journal of Managed Care*, 2012 18(3):149–55; and R. Reid, K. Coleman, E. Johnson et al., “The Group Health Medical Home at Year 2: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers,” *Health Affairs*, May 2010 29(5):835–43. For references and summary of other studies see: J. Holahan, C. Schoen, and S. McMorro, *The Potential Savings from Enhanced Chronic Care Management Policies* (Washington, D.C.: Urban Institute, Nov. 2011).

¹² See M. A. Zezza, S. Guterman, and J. Smith, “The Bundled Payment for Care Improvement Initiative: Achieving High-Value Care with a Single Payment,” *The Commonwealth Fund Blog*, January 7, 2012; R. A. Paulus, K. Davis, and G. D. Steele, “Continuous Innovation in Health Care: Implications of the Geisinger Experience,” *Health Affairs*, Sept./Oct. 2008 27(5):1235–45; and L. N. Newcomer, “Changing Physician Incentives for Cancer Care to Reward Better Patient Outcomes Instead of Use of More Costly Drugs,” *Health Affairs*, April 2012 31(4):780–85.

¹³ R. Reid, P. Fishman, O. Yu et al., “A Patient-Centered Medical Home Demonstration: A Prospective, Quasiexperimental, Before and After Evaluation,” *American Journal of Managed Care* 2009 15(9):e71–e87; Reid, Coleman, Johnson et al., “The Group Health Medical Home,” 2010; A. Devries, C. Winnie, G. Sridhar et al., “Impact of Medical Homes on Quality, Healthcare Utilizations and Cost,” *American Journal of Managed Care*, Sept. 2012 18(9):534–44.

- ¹⁴ R. Gilfillan, J. Tomcavage, M. Rosenthal et al., “Value and the Medical Home: Effects of Transformed Primary Care,” *American Journal of Managed Care*, Aug. 2010 16(8):607–14
- ¹⁵ Z. Song, D. G. Safran, B. E. Landon et al., “The ‘Alternative Quality Contract,’ Based on a Global Budget, Lowered Medical Spending and Improved Quality,” *Health Affairs* Web First, July 11, 2012.
- ¹⁶ C. Bielaszka-DuVernay, “Redesigning Acute Care Processes in Wisconsin,” *Health Affairs*, March 2011 30(3):422–25.
- ¹⁷ C. Blackmore, R. Mecklenburg, and G. Kaplan, “At Virginia Mason, Collaboration Among Providers, Employers, and Health Plans to Transform Care, Cut Costs, and Improve Quality,” *Health Affairs*, Sept. 2011 30(9):1680–87.
- ¹⁸ See J. Mays, D. Waldo, R. Socarras, and M. Brenner, *Technical Report: Modeling the Impact of Health Care Payment, Financing, and System Reforms* (prepared for The Commonwealth Fund by Actuarial Research Corporation, Jan. 2013).
- ¹⁹ The “current policy” baseline used to develop these estimates assumed that Congress would continue to defer the Medicare physician fee reductions under the SGR formula, instead increasing fees by 1 percent in 2013 and then holding them constant from 2014 through 2023.
- ²⁰ These estimates also include the impact of the malpractice reform policy described below, which adds only about \$30 billion over 10 years to the estimate of nationwide savings.
- ²¹ Choosing Wisely, an initiative of the ABIM Foundation, promotes discussion between physicians and patients to help determine the most effective care for each individual patient. See <http://www.ChoosingWisely.org>.
- ²² K. Davis, C. Schoen, and S. Guterman, “Medicare Essential: Enhancing Value in Medicare by Providing Better Protection and Encouraging Better Choices,” draft submitted for journal review, Oct. 2012.
- ²³ K. Davis, M. Moon, B. S. Cooper, and C. Schoen, “Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries,” *Health Affairs* Web Exclusive, Oct. 4, 2005, w5-442–w5-454.
- ²⁴ Currently, the benchmarks used to set Medicare Advantage plan payments are set well above projected costs under traditional Medicare, and plans alone receive an extra payment if their costs are below that benchmark level.
- ²⁵ E. W. Paxton, M. Inacio, T. Slipchenko et al., “The Kaiser Permanente National Total Joint Replacement Registry,” *The Permanente Journal*, Summer 2008 12(3):12–16.
- ²⁶ D. Love, W. Custer, and P. Miller, *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency* (New York: The Commonwealth Fund, Sept. 2010).
- ²⁷ N. K. Choudhry, M. A. Fischer, J. Avorn et al., “At Pitney Bowes, Value-Based Insurance Design Cut Copayments and Increased Drug Adherence,” *Health Affairs*, Nov. 2010 29(11):1995–2001.
- ²⁸ C. Schoen, R. Osborn, D. Squires, M. M. Doty, R. Pierson, and S. Applebaum, “How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries,” *Health Affairs* Web First, Nov. 18, 2010.

²⁹ These estimates also include the impact of a policy that would raise the required medical loss ratio in the individual and small-group markets, which adds only about \$15 billion over 10 years to the estimate of nationwide savings.

³⁰ Health Care Cost Institute, *Health Care Cost, 2012*; and Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Care, 2011*.

³¹ E. Wikler, P. Basch, and D. Cutler, *Paper Cuts: Reducing Health Care Administrative Costs* (Washington, D.C.: Center for American Progress, June 2012).

³² These include: electronic submission standards and streamlined rules for consistent format and data content to comply with HIPAA. Examples include eligibility verification and electronic funds transfers. The adoption of standards are expected to save providers billions over the next 10 years. Since most of the benefits accrue to providers rather than plans, however, these may be difficult to enforce without further action. The Affordable Care Act also limits the administrative overhead for health insurance plans with provisions for thresholds for medical loss ratios, requiring plans to rebate excess overhead charges. The thresholds have provided strong incentives for plans to reduce overhead costs to ensure profit margins.

³³ See R. Steinbrook, “Controlling Health Care Costs in Massachusetts with a Global Spending Target,” *Journal of the American Medical Association*, Sept. 26, 2012 308(12):1215–16.

³⁴ The potential impact of a spending target was not included in these estimates.