



Perspective

Health Care Reform and Cost Control

Peter R. Orszag, Ph.D., and Ezekiel J. Emanuel, M.D., Ph.D.

After nearly a century of failed attempts, comprehensive health care reform was enacted on March 23, 2010, when President Barack Obama signed the Affordable Care Act (ACA). In attempting

to modernize and improve a large part of the health care system, it may be one of the most ambitious and consequential pieces of legislation in U.S. history.

Although the bill has now been signed into law, the debate over its design and intended effects has not abated. As concerns appropriately mount about the nation's medium- and long-term fiscal situation, critics of the ACA have resurrected doubts about its cost-containment measures and overall fiscal impact. Many commentators have claimed that the bill focuses mostly on coverage and contains little in the way of cost control.

Yet we would argue that even from a purely "green eyeshade" viewpoint, the bill will significantly reduce costs. Projections

suggest that with reform, total health care expenditures as a percentage of the gross domestic product will be 0.5% lower in 2030 than they would otherwise have been. In addition, although the Congressional Budget Office (CBO) expressed concern that health care costs will remain high even after reform, it also determined that the ACA will reduce the federal budget deficit by more than \$100 billion over the first decade and by more than \$1 trillion between 2020 and 2030. And the Commonwealth Fund recently projected that expenditures for the whole health care system will be reduced by nearly \$600 billion in the first decade.¹

But these savings will be illusory if we do not reform health

care delivery to bring down the long-term growth in costs, and the ACA puts us on the path to doing just that. In fact, it institutes myriad elements that experts have long advocated as the foundation for effective cost control. More important is how the legislation approaches this goal. The ACA does not establish a rigid bureaucratic structure to be changed only episodically through arduous legislative action. Rather, it establishes dynamic and flexible structures that can develop and institute policies that respond in real time to changes in the system in order to improve quality and restrain unnecessary cost growth.

So what are the cost-control elements of the ACA? First, some reforms aim to eliminate unnecessary costs to the system; these include measures against fraud and abuse in the Medicare and Medicaid programs, which the Department of Health and Human Services predicts will return

approximately \$17 in reduced spending for every dollar invested² (\$7 billion over 10 years, according to the CBO).³ Administrative simplification under the ACA will reduce unnecessary paperwork and create uniform electronic standards and operating rules to be used by all private insurers, Medicare, and Medicaid — saving the federal government an estimated \$20 billion over 10 years² and saving insurers, physicians, hospitals, and other providers tens of billions of dollars a year (according to the U.S. Healthcare Efficiency Index). And the ACA ensures a pathway for approval of generic biologic agents that is expected to save the government more than \$7 billion, and citizens and insurers additional billions, over 10 years. An estimated \$1.1 billion will be saved in Medicare by calculating payment for complex imaging studies under the assumption that the machines will operate not just 50%, but 75%, of the time. And about \$135 billion will be saved in the first decade by eliminating unjustified subsidies to Medicare Advantage plans.

These savings are oriented toward reducing the level of health care costs rather than the growth rate of such costs. If that were all the legislation did, it would technically pay for health care reform but would miss an opportunity to put downward pressure on the growth of health care costs — an essential step in reducing our long-term fiscal imbalances.

One prominent component of the ACA that will help to bend the long-term cost curve is an excise tax on “Cadillac” insurance plans — plans that, in 2018, will charge more than \$27,500 for

families and \$10,200 for individuals, excluding vision and dental benefits. Beginning in 2018, the ACA will impose a 40% tax on the portion of health insurance that is over these amounts. After 2020, the premium threshold for the tax will increase at the rate of overall inflation in the economy, the Consumer Price Index. Thus, the tax will create incentives for employers and health insurers to devise more cost-effective health plans with lower premiums, and because the premium threshold will increase with overall inflation rather than growth of health care costs, it will help to bend the cost curve. The majority of tax revenue will come not from the direct taxation of high-cost plans but from increased workers’ wages, as companies shift compensation out of benefits and toward take-home pay.

Yet “bending the curve” of health care inflation also requires a more direct change in the way health care is delivered. Health care costs are unevenly distributed: 10% of patients account for 64% of costs. Many of these are patients with chronic conditions, such as congestive heart failure, diabetes, and hypertension. Sustained cost control will occur only with more coordinated care that prevents avoidable complications for patients with chronic illness. As Stanford’s Victor Fuchs has noted, coordinated care requires three “I”s: information, infrastructure, and incentives.

Information will come from the spread of electronic health records, a process that will be jump-started by the Recovery Act’s \$26 billion investment in health information technology. Electronic health records will supply pro-

viders with more accurate and real-time data on their patients, as well as provide checks on drug interactions and decision support to improve the quality of care. In addition, the Patient-Centered Outcomes Research Institute (PCORI) that was created by the ACA will empower physicians and patients with new information regarding the effectiveness of various medical technologies and interventions. The integration of the PCORI’s research findings with decision supports, guidelines, and other aspects of electronic health records should greatly enhance the information that physicians and patients can use in choosing the right tests and treatments for a particular situation.

Infrastructure reform is evident in the law’s provisions supporting enhanced horizontal coordination among providers and more constant monitoring of patients. For physicians, health care reform encourages greater integration in many ways — for instance, through the redesign of delivery systems such as medical homes and accountable health care organizations. In addition, the law includes a new hospital readmission policy to address the fact that nearly 20% of Medicare patients are readmitted within 30 days after a hospital discharge⁴ and that lack of coordination in “handoffs” such as hospital discharges has been identified as a particular problem in the health care system overall. More than half of these readmitted patients have not seen their physician between discharge and readmission, and a recent study suggests that better coordination of care can reduce readmission rates for major chronic illness.⁵ The policy provides \$500 million over 5 years

to manage care for 30 days after hospital discharge and also imposes payment penalties on hospitals with high risk-adjusted readmission rates for certain conditions.

These changes in information and infrastructure will not spontaneously affect how doctors deliver care; incentives within the system also need to be recalibrated, since the dominant fee-for-service payment system creates disincentives to making the changes necessary for coordinated care. In addition to the hospital readmission policy, the ACA will create incentives for hospitals to adopt proven practices that substantially reduce their rates of hospital-acquired infections and other avoidable conditions; hospitals that still have rates in the top 25% will face reductions in Medicare payments. Similarly, the ACA's pilot programs involving bundled payments will provide physicians and hospitals with incentives to coordinate care for patients with chronic illnesses: keeping these patients healthy and preventing hospitalizations will be financially advantageous. (These efforts will also enhance physicians' autonomy by allowing them to devise the best practices for keeping patients healthy.)

Perhaps most fundamentally, the ACA recognizes that reform, particularly changing the delivery system, is not a one-time event. It is an ongoing, evolutionary process requiring continuous adjustment. The ACA therefore establishes a number of institutions that can respond in a flexible and dynamic way to changes in the health care system. The PCORI will assess new medical tests, drugs, and other treatments as they are developed, thereby pro-

viding continuously updated information for physicians and patients. Similarly, over the next decade, the Innovation Center in the Centers for Medicare and Medicaid Services will be developing, testing, and evaluating new policies and programs that enhance the quality of care for Medicare beneficiaries, reduce the cost of their care, or both. And the secretary of health and human services (HHS) is empowered to expand successful pilot programs without the need for additional legislation.

The most important institutional change in the ACA, however, is likely to be the establishment of the Independent Payment Advisory Board (IPAB), an independent panel of medical experts tasked with devising changes to Medicare's payment system. Beginning in January 2014, each year that Medicare's per capita costs exceed a certain threshold, the IPAB will develop and propose policies for reducing this inflation. The secretary of HHS must institute the policies unless Congress enacts alternative policies leading to equivalent savings. The threshold is a bit complex; initially, it is a combination of general and medical inflation, but in 2018 and thereafter, the cap is set at general inflation plus 1%.

The combination of these three bodies — the IPAB, the Innovation Center, and the PCORI — holds the potential for providing up-to-date information and developing policies that can improve the quality of care and the value provided by the health care system on an ongoing basis. Ensuring that these new bodies live up to their potential and earn reputations for rigor and integrity will be one of the most important

challenges as the implementation of the ACA continues.

The ACA not only will extend health care coverage to millions of Americans but also will enact many policies specifically aimed at reducing the amount we are spending on health care and, by changing the delivery system, reducing the rate of growth in health care costs over time. Indeed, one of the essential aspects of the legislation is that unlike previous efforts, it does not rely on just one policy for effective cost control. Instead, it puts into place virtually every cost-control reform proposed by physicians, economists, and health policy experts and includes the means for these reforms to be assessed quickly and scaled up if they're successful. By enacting a broad portfolio of changes, the ACA provides the best assurance that effective change will occur. Moreover, by taking a multifaceted approach that includes hard savings plus the mechanisms for creating a dynamic health care system, it enables physicians, hospitals, and other providers to consistently improve outcomes, boost quality, and reduce costs as health care evolves.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

Dr. Orszag is the director of, and Dr. Emanuel a special advisor on health policy to, the White House Office of Management and Budget, Washington, DC; Dr. Emanuel is also chair of the Department of Bioethics at the National Institutes of Health, Bethesda, MD.

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