Cost Containment

The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* will rein in unsustainable increases in health care costs to ensure future sustainability of the system, and will reduce federal deficits by $143 billion over the next ten years. [Congressional Budget Office (CBO), 3/20/10] The bill will also bend the cost curve over the long-term, as it will continue to reduce federal deficits in the decades following 2019.

Twenty-three prominent economists, including Nobel laureates and members of both Democratic and Republican administrations, identified four key measures that will lower costs and reduce long-term deficits. [Letter to the President, 11/17/2009] The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* include all four measures: deficit neutrality, an excise tax on high-cost plans, an Independent Payment Advisory Board, and delivery system reforms.

A Business Roundtable report confirms that many delivery system reform policies will help reduce costs. As the report explains, "[a] number of the proposed reforms offer real promise, not only to save federal dollars, but also to reduce the rate of increase in private sector spending if adopted and implemented appropriately." [Business Roundtable, 11/2009]

Streamlines the Health Insurance Market

Specific provisions fundamentally change the way insurance companies do business, so they spend less time and money determining how to avoid covering patients, and focus more of their efforts providing efficient, lower-cost care.

- ✓ **Ensures Efficiency By Limiting Insurance Company Administrative Costs and Profits**
  - Precludes health insurance companies from spending unlimited amounts of premium revenues on administrative costs, such as marketing and profits, by requiring them to spend more on medical services and delivery system innovations, and to provide consumers a rebate if non-medical costs exceed certain thresholds.
  - Prevents insurers from arbitrarily increasing premiums by requiring insurers to publicly disclose the amount of premium increases prior to any increase taking effect, and to provide a justification for the increase. This will limit the industry's ability to hike up insurance rates to push less healthy individuals and small businesses off their rolls.
- ✓ **Reduces Insurance Bureaucracy**
  - Directs the Secretary of Health and Human Services (HHS) to establish standards simplifying and standardizing paperwork, including enabling electronic transactions. CBO estimates that the Federal savings alone would be $20 billion over ten years. Physicians on average spend 140 hours and $68,000 a year dealing with health insurance paperwork. [*Health Affairs*, Casalino, et al, 2009]
- ✓ **Steers Behavior Away from High-Cost Plans**
  - Imposes an excise tax on insurers for high-cost employer-sponsored health coverage. The Joint Committee on Taxation projects that the excise tax will raise $32 billion and contribute to deficit reduction [JCT, 3/20/10]. Most of the revenue from the excise tax stems

from savings due to the incentives to keep premiums below the threshold when the assessment kicks in.
  - Congressional Budget Office (CBO) Director Douglas Elmendorf stated that changing the tax treatment of high-cost health insurance is one of "two powerful policy levers" the federal government can use to encourage changes in medical practice and slow increases in health care costs. [CBO, 6/16/2009]

✓ **Empowers Consumers Through Information**
  - Ensures that information on the value of health insurance benefits is on each employee's annual Form W-2 beginning in 2010. This will enable workers to see how much money goes toward their health benefits, In addition, standardized information on benefits and a new website will offer consumers information about their options, improve decision-making and lower health care costs.
  - Most employees do not always know the amount of the contributions that their employers make for their health insurance. Similarly, there are few trusted sources of information on insurance choices, benefits, and premium.

✓ **Creates Administrative Savings Through the Health Insurance Exchange**
  - The health insurance Exchange will lower premiums in three ways. First, precluding insurers from discriminating against individuals who have been sick in the past will eliminate medical underwriting, a substantial part of health insurance costs today. Second, the Exchange will streamline the process of standardizing plan information, consumer education, and customer assistance and require the use of one, simple enrollment form for every insurance plan. Third, competition and choices in the Exchange will drive down premiums and cost growth.
  - Premiums in the Exchange will be lower than those offered in the individual market – if for no other reason than they will not have 23 percent overhead that CBO attributes to plans selling insurance in the individual market today. [CBO, 9/22/2009] CBO found that average premiums will be 14-20 percent lower in 2016 compared to the same coverage purchased today. [CBO, 11/30/09]

Reforms Provider Payment Systems to Create Accountability and Efficiency

Our health care system wastes too much and takes too long to adopt innovations. For years, experts have recognized actions needed to reduce waste and to ensure that patients receive cutting-edge and cost effective care. Many of these critical reforms will become law, improving outcomes and bringing down health care costs.

✓ **Establishes a Centers for Medicaid and Medicaid Services (CMS) Innovation Center**
  - Establishes a CMS Innovation Center to develop and expand new patient-centered payment models to encourage evidence-based, coordinated care for Medicare, Medicaid, and CHIP.
  - CBO estimates that the Center will decrease Medicare spending by $1.3 billion dollars over the next 10 years.

✓ **Develops Bundled Payments**
  - Establishes pilot programs on bundled payments in Medicare and Medicaid, to improve care coordination, efficiency, and to generate cost savings.
  - Bundling provider payments as a lump sum fee, instead of paying a fee for each service, encourages care coordination and streamlining and removes the incentive to generate additional services for added reimbursement.

- Bundled payments, such as those used at Geisinger Medical Center for coronary artery bypass graft (CABG) surgery, have produced successful quality improvement and cost containment. [Annals of Surgery, Casale, et al, 10/2007]

✓ **Reduces Preventable Hospital Readmissions**

- Reduces unnecessary hospital readmissions by reducing payments to hospitals with high preventable readmission rates for select conditions and investing in transitional care to avoid preventable readmissions.
- Preventable hospital readmissions diminish quality and efficiency in the health care system. Nearly 20 percent of Medicare patients who are discharged from the hospital are readmitted with 30 days. [*New England Journal of Medicine*, Jencks, et al, 2009] The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spent $12 billion on potentially preventable hospital readmissions in 2005, which would be more than $15 billion today. [MedPAC, 6/2007, inflated to 2009 dollars using CMS National Health Expenditure Accounts]
- CBO estimates that reducing avoidable hospital readmissions in Medicare will reduce health care spending by $7.1 billion over 10 years. As these programs expand to other payers, savings will multiply.

✓ **Creates Accountable Care Organizations (ACOs)**

- Establishes voluntary ACO shared-savings programs in Medicare and Medicaid allowing high-quality providers to coordinate care across health care settings and share savings. CBO estimates that the encouragement of Accountable Care Organizations would save $5 billion over the next 10 years.
- Patients receive the best care when doctors coordinate care. The current fee-for-service structure penalizes effective care coordination. When providers in different settings work together – such as doctors' offices, hospitals, nursing homes and rehabilitation facilities – patients receive better care, and costs decrease as complications decrease.

✓ **Creates Medical Homes**

- Provides additional payments for patient-centered medical homes through pilot programs in Medicaid and will create community health teams to support the patient-centered medical home. The Innovation Center will also enable such policies to be adopted in Medicare.
- Medical homes encourage providers to coordinate a patient's care more effectively. These models encourage providers to coordinate specialists, track prescriptions, avoid duplication of treatments or tests, and follow a patient's health progress.
- Patient-centered medical homes have demonstrated success in improving care and reducing costs. The Johns Hopkins Guided Care PCMH Model experienced a 24 percent reduction in total hospital inpatient days, 15 percent fewer ER visits, and a 37 percent decrease in skilled nursing facility days. Each Guided Care nurse produced annual net Medicare savings of $75,000, or $1,364 per patient.[1]

✓ **Develops Value-Based Purchasing**

- Creates a Medicare program where a share of hospital payments will be tied to hospital performance on quality measures for conditions such as heart attack and pneumonia care. Hospital value based purchasing demonstration projects will also be established in 2012 for critical access hospitals and hospitals excluded from the broader program as a result of data limitations. Providing such incentives will improve care and lower costs.
- Adjusts payments for hospitals with high rates of hospital acquired conditions. Health care associated infections are among the top ten leading causes of death in the United

States and drive up the cost of health care by $28 to $33 billion per year. [CDC, 3/2009] One project to reduce HAIs produced a 66 percent reduction in targeted hospital associated infections, saving $200 for every dollar invested. [Testimony by Peter J. Pronovost, 4/1/2009] This policy would take effect in 2015 and CBO estimates it would save $1.4 billion over 10 years.

- Modifies the Medicare fee-for-service physician payment formula to pay physicians for quality and cost effective care. Physicians will report quality measures and receive feedback reports, beginning in 2012. Payment modifications will begin in 2015 and by 2017, all physicians will be rewarded based on performance.
- Value-based purchasing (VBP) encourages providers to deliver high-quality, efficient and patient-centered care. Unlike fee-for-service, VBP does not reward over-treatment or inefficient service delivery programs.

✓ **Establishes an Independent Payment Advisory Board**

- Establishes an Independent Payment Advisory Board, beginning January 1, 2014, to present Congress with proposals to strengthen the Medicare program. In years when Medicare costs are projected to be unsustainable, Board proposals will take effect unless an alternative is adopted by Congress. The Board would not make proposals that ration care, raise taxes, or change Medicare benefit or eligibility standards.
- CBO estimates that the Board will save $15.5 billion between 2015, the implementation year of the Board's first set of recommendations, and 2019.

Translates Savings to the Private Sector

A recent report by the Business Roundtable found that if many of the delivery system reforms were adopted by the private sector (including value-based purchasing, accountable care organizations, and reducing preventable hospital readmissions), large businesses could save $3,000 per employee by 2019. [Business Roundtable, 11/2009]

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[1] Grumbach K, Bodenheimer T and Grundy P. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies.