

# A Century Foundation Report



## Better Care for Less

### How the Affordable Care Act Pays for Itself and Cuts the Deficit



BY

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## INTRODUCTION

The Patient Protection and Affordable Care Act signed into law by President Barack Obama in the spring of 2010 will extend health insurance to millions of uncovered Americans while launching reforms aimed at making our highly inefficient medical system less wasteful. The legislation (which often is referred to as the Affordable Care Act, or ACA), would also reduce federal budget deficits through a combination of tax increases and spending reductions. The Congressional Budget Office (CBO) has concluded that the ACA will more than pay for itself, provide coverage for 32 million uninsured Americans, and trim federal budget deficits by some \$210 billion over the ten years ending in 2021.<sup>1</sup>

In addition, Medicare's Trustees report that the legislation "substantially improved the financial outlook for the Medicare program" without shifting costs to seniors, reducing medical benefits, or making across-the-board cuts to physicians' pay.<sup>2</sup>

The ACA also strengthens Medicare benefits: copayments and deductibles for preventive care disappear, and more than a million seniors who, in the past, have fallen into the Medicare Part D coverage gap (or "donut hole") will pay less for

prescription drugs. At the same time, the law hikes Medicare and Medicaid reimbursements to physicians and nurse practitioners who provide primary and preventive care, while raising fees for general surgeons who work in under-served areas. Fees for doctors who offer primary care to Medicaid patients will be raised to Medicare levels. Finally, if patients enjoy better outcomes at a lower cost, doctors, hospitals, and others that collaborate in accountable care organizations (ACOs) to improve care will share in the savings.

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The assessments coming from CBO and Medicare's Trustees may seem hard to believe. How can Washington guarantee insurance for an additional 32 million people, improve Medicare's coverage, and simultaneously save money without rationing care, charging seniors more, or slashing physicians' fees?

Although the news media has provided overviews of the law's provisions, most Americans remain confused. They are not convinced that reform can make the American health care system more cost efficient, while simultaneously improving both coverage and the quality of care. The truth lays in the details. As Medicare's Trustees observed in their 2011 Annual Report, the ACA "contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse, and initiating a major program of research and development for alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and/or reduce its costs to Medicare."<sup>3</sup>

Little wonder that no one can sum up the effect of those 165 changes in a page or two. The goal of this report is to synthesize the relevant numbers and offer in-depth analysis of exactly how the ACA will both strengthen health insurance protections and save money.

## OVERVIEW OF THE NUMBERS

On the cost side of the ledger, the CBO puts the “gross cost of coverage provisions” from 2010 through 2019 at \$940 broken down as follows:

- \$434 billion to expand Medicaid and Children’s Health Insurance Plan enrollment,
- \$466 billion to provide subsidies so that individuals and families earning less than 400 percent of the federal poverty level can buy insurance, and
- \$40 billion to provide tax credits for small employers.<sup>4</sup>

On the other side of the ledger, CBO projects that over the same ten years, the legislation will generate at least \$950 billion. CBO estimates fall into three categories:

### 1. \$750 BILLION IN RELIABLE REVENUES AND SAVINGS

- \$210 billion generated by lifting Medicare taxes for high-income individuals with adjusted gross income above \$200,000 and married couples earning over \$250,000;<sup>5</sup>
- \$145 billion saved, over a period of ten years, by phasing out overpayments to those private sector Medicare Advantage insurance companies that are not delivering value for health care dollars;<sup>6</sup>
- \$107 billion in new fees that insurers, drug makers, and medical device companies have agreed to pay;<sup>7</sup>
- \$69 billion in penalties paid by employers and individuals who choose not to purchase insurance;<sup>8</sup>
- \$36 billion saved by cutting government subsidies to hospitals that will no longer be forced to absorb the cost of treating 32 million uninsured Americans (these subsidies, paid to hospitals that serve a “disproportionate share” of low-income patients, will be cut for a total projected savings of \$57 billion between 2012 and 2021, according to CBO);<sup>9</sup>
- \$32 billion raised by taxing very expensive (“Cadillac”) health insurance policies that cost more than \$27,500 for family coverage, or \$10,200 for an individual;<sup>10</sup>
- \$23.6 billion paid by producers of black liquor (the wood pulp byproduct that paper companies use to power their mills), which will no longer be eligible for the cellulosic bio-fuel producer tax credit;<sup>11</sup>

- \$20.7 billion saved by eliminating the Medicare Improvement Fund (the ACA creates a new Innovation Center within the Centers for Medicare and Medicaid Services, making the Medicare Improvement Fund redundant);<sup>12</sup>
- \$19.4 billion saved by limiting the use of medical savings accounts (MSAs), health savings accounts (HSAs), flexible savings arrangements (FSAs), and health reimbursement arrangements (HRAs) as tax havens for dollars that may never be used to pay for medical expenses (for details, see Appendix A);<sup>13</sup>
- \$19 billion saved by reforming the student loan program, expanding Pell Grants, while eliminating the federal program which provides guarantees for student loans made by banks, replacing them with loans made directly by the government;<sup>14</sup>
- \$15.2 billion generated by lifting the threshold for the itemized medical expense deduction from 7.5 percent of adjusted gross income to 10 percent;<sup>15</sup>
- \$10.7 billion saved by reducing the Medicare Part D premium subsidy for seniors with incomes over \$85,000 and couples earning more than \$170,000;<sup>16</sup>
- \$4.5 billion saved by eliminating the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments;<sup>17</sup>
- \$2.7 billion raised by collecting 10 percent excise tax on indoor tanning services;<sup>18</sup>
- \$2.6 billion collected from private insurance plans that will pay a fee equal to \$2 for each individual covered to finance the Patient-Centered Outcomes Research Trust Fund;<sup>19</sup>
- \$75.1 billion in savings that the right-leaning Tax Foundation describes as flowing from “Interactions between Medicare programs” (\$29.1 billion) and “Associated effects of coverage provisions on revenues” (\$46 billion).<sup>20</sup>

The numbers on this list do not represent “hoped-for” savings that depend on someone responding in a positive way to financial incentives. These are firm estimates that CBO was able to “score” with some confidence, based on known facts and solid historical data. For instance, companies in the health care industry already have agreed to pay a certain amount in new fees, and CBO can project how much changes in tax law will bring in by consulting IRS records.

## 2. \$196 BILLION IN LESS-CERTAIN SAVINGS

The CBO estimates that \$196 billion will be saved as Medicare trims annual increases (or “updates”) in payments to hospitals, skilled nursing facilities, ambulatory surgical centers and other “non-physician

providers” by 1 percent a year for ten years.<sup>21</sup> If, in a given year, hospitals normally would receive an adjustment from the Centers for Medicare and Medicaid Services (CMS) that raised reimbursements by 3 percent, under the new law their reimbursements would rise by just 2 percent. The legislation explicitly exempts doctors, calling for reductions “in payment updates for most Medical goods and services other than physicians’ services.”

Medicare’s goal is to motivate hospitals to create better “systems” that will, in turn, provide better support for hospital workers, making them more productive. Research done by the Medicare Payment Advisory Commission (MedPAC) reveals that, when hospitals enjoy market power and payments from private insurers are generous, hospitals spend more.<sup>22</sup> By contrast, when hospitals are under some financial pressure, they shave their costs and even manage to turn a profit on Medicare patients.

These savings are less certain because no one can know how institutional providers will respond to reduced updates, and how successful they will be in implementing systems that will make them more efficient. Skeptics suggest that Medicare will not be able to trim updates for the full ten years without pushing hospitals into the red.<sup>23</sup> But empirical evidence demonstrates that hospitals committed to reducing errors and waste can save billions.

For example, in the first two years of a safety improvement collaborative convened by Premier Inc., the 157 participating hospitals saved an estimated 22,164 lives while collectively reducing health care spending by \$2.13 billion. During a period when national inpatient costs rose 14 percent, those of the collaborating hospitals increased only 2 percent.<sup>24</sup>

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If all hospitals could achieve these results, hospitals alone could save \$22.6 billion annually.<sup>25</sup> Consider the additional savings that skilled nursing facilities, ambulatory surgical centers, and other non-physician providers could realize, on an annual basis, by becoming more efficient, and it becomes clear that, if providers are committed to reducing waste and errors, they could adjust to reduced updates that would save Medicare \$196 billion over ten years.

Add that \$196 billion to the \$750 billion itemized under “Reliable Revenues and Savings,” and the ACA generates nearly \$1 trillion—enough to pay for the legislation, cover 32 million uninsured, and reduce the deficit.

### 3. SAVINGS FROM STRUCTURAL REFORMS THAT CBO DID NOT TRY TO SCORE

In their 2011 Annual Report, Medicare’s Trustees point out that the ACA proposes deep structural reforms that could “transform” U.S. health care “in both the way it is delivered and in the manner in which it is financed.” The legislation “takes important steps in this direction” the Trustees observe, “by initiating



programs of research into innovative payment and service delivery models as ‘accountable care organizations,’ ‘patient-centered medical homes,’ “payment bundling’ and ‘pay-for-performance.’”<sup>26</sup>

These reforms are unprecedented. Because they have never have been tried on a national scale, CBO did not attempt to estimate just how much waste these changes will squeeze out of the system.

Nevertheless, this is the third and perhaps most important way that reform legislation sets out to “break the curve” of health care inflation. The goal is to replace the perverse incentives of fee-for-service payments—which reward providers for “volume”—by moving to payment systems that instead reward “value,” more-effective care at a lower cost. While CBO could not put a number to potential savings, over the long term what cannot be counted may count most. Note that money saved here will be above and beyond the roughly \$950 billion in revenue and savings that the CBO was able to score.

Overall, CBO analysts calculate that the savings and revenues associated with the ACA should generate approximately \$950 billion or more to cover reforms that will cost roughly \$940 billion over ten years (2010–2019).

Not everyone agrees with the CBO forecasts. Opponents to health care reform continue to charge that the legislation is filled with “budgetary gimmicks” and that CBO’s estimates are simply wrong. (Paul Van de Water of the Center on Budget and Policy Priorities has rebutted the charges leveled by both House Republicans and former CBO director Douglas Holtz-Eakin. See Appendix B for his point-by-point response.)

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While much of the confusion about savings associated with the ACA comes from the misinformation sown by partisan politicians, some of it arises from uncertainty as to how providers others will respond to incentives. As noted, it has proven very difficult to estimate just how much structural reforms in how we pay for care and how care is delivered will trim from Medicare’s annual bill. These changes will not be embraced everywhere; much depends on the local medical culture. Putting a number on total savings would require reading the minds of hospital and nursing home executives, not to mention millions of patients and doctors, and predicting how they will react over the next ten years. Nevertheless, empirical evidence shows that, when fee-for-service is replaced with other payment systems, health care bills fall, without undermining the quality of care.<sup>27</sup>

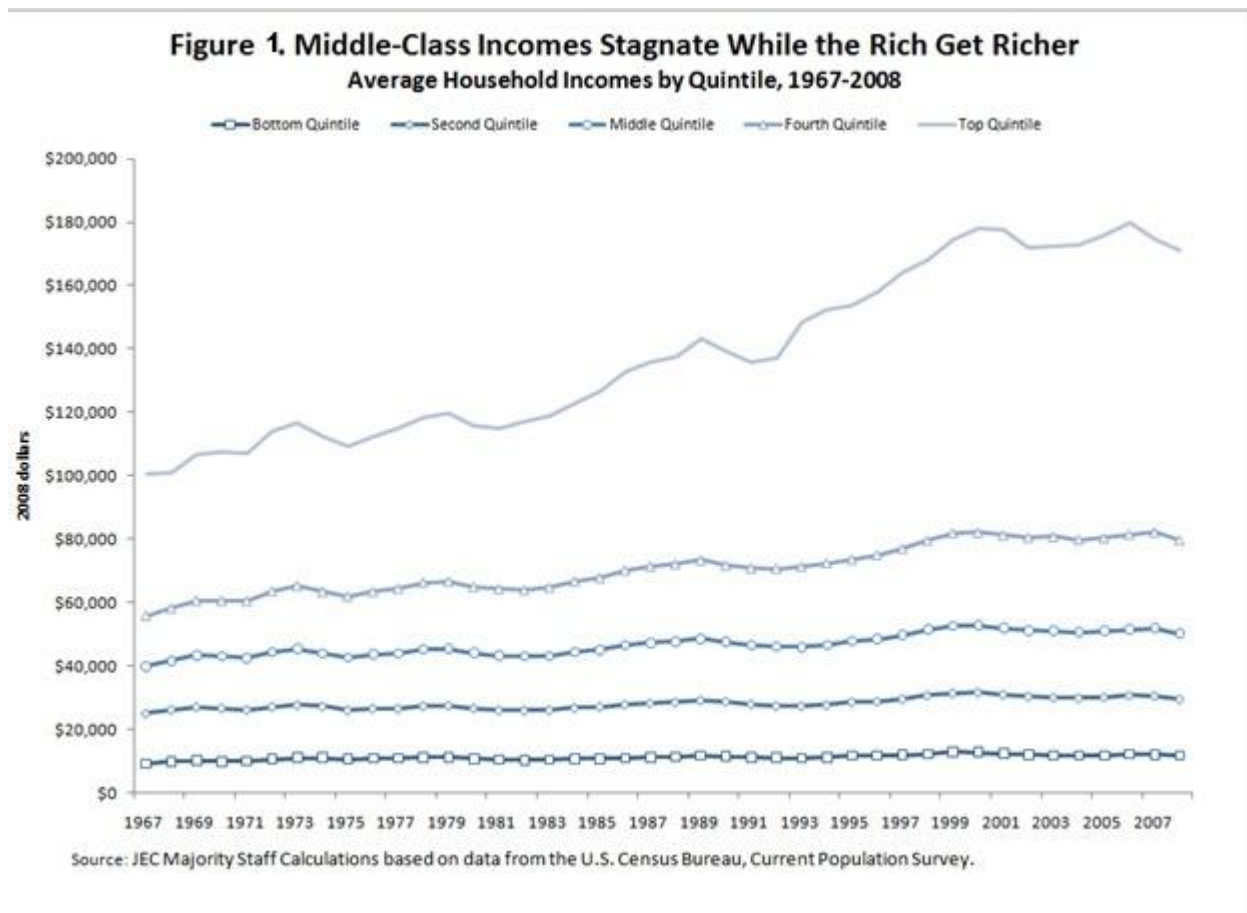
## THE DEBATE ON NEW SAVINGS AND REVENUES UNDER THE ACA

What follows is a more detailed analysis of the revenues and savings projected to arise from the health care legislation that takes the skeptics’ objections into account. The discussion considers criticisms of how the ACA raises the money as well as doubts about the CBO estimates.

## A CLOSER LOOK AT THE \$750 BILLION IN RELIABLE REVENUES AND SAVINGS

**New Taxes on the Wealthy.** The biggest item on the list of assured revenues is the \$210 billion that wealthy taxpayers will be contributing. Those with an adjusted gross income over \$200,000 (\$250,000 for couples) will pay an additional 0.9 percent on wages and self-employment income over \$200,000 and 3.8 percent on investment income over that amount.<sup>28</sup>

To some, it may seem unfair to force those in the top 2 percent to shoulder such a large share of the cost of reform. Critics argue that the tax should be repealed. But consider this: in recent decades, the wealthiest 10 percent of households saw their share of the nation's total income climb from 34.6 percent in 1980 to 48.2 percent in 2008. Over the same span, the richest 1 percent (earning over \$368,000 in 2008) watched their slice of the income pie more than double, rising from 10 percent in 1980 to 21 percent in 2008.<sup>29</sup> Meanwhile, as the middle line in Figure 1 illustrates, middle-class incomes remained relatively flat.



Over the past thirty years, not only were the very wealthy earning more, they began paying out a smaller share of their income in the form of taxes. (See Appendix C.) During this period, the average marginal income tax rates for those perched on the highest step of the income ladder plunged—from an average of 48.2 percent during the eight years of the Reagan administration in the early 1980s, to 39 percent during



President H. W. Bush’s administration in the early 1990s.<sup>30</sup> Today, the top marginal rate stands at 35 percent—the lowest in eighty years.<sup>31</sup>

To put tax rates for high-income households in a larger historical context, keep in mind that, during the Eisenhower and Kennedy administrations of the 1950s and early 1960s, the top marginal rate was 91 percent.<sup>32</sup> Taxes on capital gains and dividends also stand at historic lows.

***Trimming the 13 Percent Premium Paid to Medicare Advantage Insurers.*** Cuts in what many call unwarranted subsidies for private sector Medicare Advantage insurers represent the second-largest source of funding in the Affordable Care Act. When Congress passed the Medicare Modernization Act in 2003, it agreed to pay private sector Medicare Advantage insurers an average of 13 percent more than it would cost Medicare to cover the same patients. The argument was based on the assumption that private sector insurers would be more efficient than any government program, and that by making the program sufficiently lucrative for insurers, those companies would be able to offer seniors “extras” such as free eyeglass frames, gym memberships, and lower copayments.

In February of 2008, the Government Accounting Office (GAO) reported that only 11 percent of the premiums that the government would be paying Medicare Advantage insurers over the next four year would go to extra benefits. Most of the rest would be used to reduce out-of-pocket spending and copays. At first glance, this might seem to be good news—until analysts realized that the 35.3 million Medicare beneficiaries still enrolled in traditional Medicare would be paying higher premiums in order to fund lower copays for seniors who had signed up for Medicare Advantage. Thus, as Marsha Gold, a senior fellow at Mathematic Policy Research, pointed out in *Health Affairs*, while “individual enrollees may gain, beneficiaries as a whole may be harmed if higher payments add to the fiscal stress on Medicare, making the program less viable in the long run.” The dynamics of Medicare Advantage “essentially allow[s] firms to ‘piggyback’ on Medicare’s existing investment and policies,” Gold pointed out, while doing “relatively little to improve care management.”<sup>33</sup>

*Once Medicare Advantage plans had signed up customers, some hiked copays on expensive cancer drugs to as much as 20 percent (or \$20,000 for a drug that costs \$100,000 for a course of treatment). Others refused to cover certain procedures.*

Meanwhile, once Medicare Advantage plans had signed up customers, some hiked copays on expensive cancer drugs to as much as 20 percent (or \$20,000 for a drug that costs \$100,000 for a course of treatment). Others refused to cover certain procedures. A 2007 American Medical Association survey revealed that 50 percent of physicians polled reported that they had seen Advantage plans deny services typically covered by traditional Medicare.<sup>34</sup> This might help explain why, despite heavy advertising, only one quarter of Medicare beneficiaries have enrolled in Advantage plans, while the remaining 75 percent of seniors have stayed with the original Medicare program. As for the “extras” that Advantage insurers did continue to offer, even Advantage customers acknowledge that freebies are not worth that much to them.

A 2009 study published in the *International Journal of Health Care Finance and Economics* reveals that, when Advantage beneficiaries were asked how much they would pay, out of their own pocket, for the benefits provided by their insurer, they estimated the value of those benefits at just 14 cents for every extra dollar that Medicare was paying insurers.<sup>35</sup> Economist Austin Frakt, a coauthor of the report, concludes: “This relatively poor return of value on taxpayer dollars is why I support reductions in Advantage payments.”

When ACA passed, some observers worried that, if the government whittled down the subsidies for Medicare Advantage insurance companies, many insurers would drop out of the program—or hike premiums. But as of March 2011, that does not seem to be the case—even though Medicare has frozen payments to Medicare Advantage insurers this year, and has announced that it plans to raise them by only 1.6 percent (less than health care inflation) in 2012.<sup>36</sup>

While the legislation phases out high premiums to Advantage insurers, it provides bonuses to Advantage plans receiving four or more stars, based on the current five-star quality rating system that Medicare uses. This will reward the best plans, ensuring that they stay in business, while encouraging others to pay more attention to the quality of care their customers receive. “Over time, the best Medicare Advantage plans will survive and the least efficient will close,” observes the *New York Times*.<sup>37</sup>

Almost all seniors still will have access to an Advantage plan if they are already on one. And with the new authority that the ACA grants to the secretary of the Department of Health and Human Services (HHS), Secretary Kathleen Sebelius protected Medicare beneficiaries from excessive increases in cost-sharing and premiums in 2011. This year the premium on the average Advantage plan fell by 1 percent. Under the ACA, seniors on traditional Medicare also will receive lower copays and better benefits.

***New Fees that the Health Care Industry Has Agreed to Pay.*** Under the ACA, the health care industry itself becomes the third largest source of funding. While reformers were hammering out the plan, insurers, drug makers, and device makers agreed to contribute \$107 billion to help cover the cost of reform. This was a pragmatic decision. These companies knew that if reform passed, their revenues would climb as millions of uninsured and under-insured new customers came to them, government subsidies in hand, able to pay for their products and services.

***Penalties Associated with the Insurance Mandate.*** Next on the list of new revenues, the CBO projects that individuals and employers who choose not to buy health care insurance will pay penalties of roughly \$69 billion.

Employers with more than fifty full-time employees (defined as employees working thirty or more hours a week) will be subject to penalties, but only if one of their full-time employees is receiving a subsidy from the government to help buy insurance. In most cases, if the employer offers coverage, employees will not be eligible for this government aid. These “premium credits” will be available only if: (1) the employer’s

insurance requires that the employee contribute more than 9.5 percent of his income for individual coverage, or (2) the plan pays for less than 60 percent, on average, of covered health care costs.<sup>38</sup>

Individuals who ignore the mandate to buy insurance also would be subject to penalties. The individual mandate has generated much controversy. Why should Americans be forced to pay a fine if they decide not to buy insurance? Some suggest that the mandate will be repealed, and the fines eliminated.

But those same critics favor the provision in the ACA that requires private insurers to cover anyone who signs up—without regard to “pre-existing conditions.” They also support the provision that prevents companies from charging a subscriber more because he is sick. Under reform, insurance companies will not be able to refuse to cover a sick patient, drop a customer if he becomes ill, or cap how much they will pay, in a given year, or over the course of a lifetime, for an individual patient. Parents of chronically ill children or adults suffering from cancer will no longer struggle to find affordable coverage.

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If there were no mandate, many people would wait until they became sick before signing up for insurance, secure in the knowledge that insurers would have to cover them, and could not charge them more. This would mean that the majority in the insurance pool would be ill, and insurance would quickly become unaffordable.

Some of reform’s critics have suggested that, instead of mandating that everyone buy insurance, we should pass legislation that stipulates that individuals and families can only sign up for insurance once a year. If they become sick in the meantime, they would have to pay for their care out of pocket. But the truth is that the bulk of our health care dollars are spent when we are very ill, suffering from chronic diseases such as cancer, or recovering from a catastrophic accident. The vast majority of Americans do not have the savings to cover these costs, even for eight months.

More importantly, everyone knows that, in this country, we would not abandon uninsured citizens, letting their cancer spread for those eight months, or leaving accident victims to bleed to death on the street. When push came to shove, the uninsured would receive care. Citizens who had responded to the mandate, purchased insurance and paid premiums for years would wind up covering the “free riders.” Those who say they do not want or need insurance count on this, even if they do not admit it to themselves.

Libertarians and others who object to the individual mandate (and the penalties) also should note that households who ignore the mandate are expected to contribute less than one-third of the \$60 billion that the insurance industry will be shelling out. In return, those individuals will enjoy the security of knowing that, if, at some point in the future, they or their families become sick and decide to purchase coverage,

insurers cannot turn them away, or gouge them by charging them more than healthier customers. This is why those who reject the mandate are asked to help fund reform. They, too, will benefit.

### **A CLOSER LOOK AT THE \$196 BILLION IN LESS-CERTAIN SAVINGS**

***Encouraging Efficiency by Hospitals, Skilled Nursing Facilities, and Others.*** The legislation trims Medicare’s annual increases in payments to hospitals, skilled nursing facilities, ambulatory surgical centers, home health care agencies, and hospices by 1 percent a year, for ten years, in hopes of motivating them to become more productive. This means that if, in a given year, hospitals normally would receive an adjustment from CMS that raised reimbursements by 3 percent, under the new law their reimbursements would rise by just 2 percent. (Note that this provision does not apply to doctors, only Medicare Part A providers.)<sup>39</sup> CBO projects that, over a decade, this could save \$196 billion.

Skeptics are not convinced. Medicare actuary Richard Foster has suggested that CBO’s estimates in this area are “unrealistic.”<sup>40</sup> In his “Statement of Actuarial Opinion” at the end of the Medicare Trustees’ 2011 Annual Report, Foster declares that the ten-year plan is just not “viable” because “most health care providers cannot improve their productivity to this degree.”<sup>41</sup>

He points out that the legislation uses economy-wide nonfarm productivity gains as a model, and Foster doubts that hospitals and other medical institutions “will be able to improve their own productivity to the degree achieved by the economy at large.” After all, he notes, health care is labor intensive, and unlike companies in other sectors of the economy, hospitals cannot downsize. For-profit hospitals have shown us that, when they try to trim their nursing staffs, patients die.

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But the ACA is not calling for downsizing. Rather, it suggests reforms that would improve hospital systems and rules, providing better support for health care workers so that the same number can be more productive. When reformers talk about increasing “productivity,” they are not talking about asking hospital employees to work harder; they are thinking about creating systems that help them work more efficiently.

Foster ignores the amount of waste in the system: Health care experts estimate that up to one-third of our health care dollars are squandered on ineffective, sometimes unwanted and often unproven treatments.<sup>42</sup>

***Provide Incentives to Increase Patient Safety in Hospitals.*** Avoidable medical errors added \$19.5 billion to the nation’s health care bill in 2008, according to a claims-based study conducted by Milliman, Inc. on behalf of the Society of Actuaries (SOA).<sup>43</sup> Most of that amount, \$17 billion, was the cost of providing inpatient, outpatient, and prescription drug services to individuals affected by medical errors, says Jim Toole, chairman of SOA. Milliman consultant Jonathan Shreve, a coauthor of the report, described the

estimates as conservative. “This number includes only the errors that we could identify through claims data, so the total economic impact of medical errors is in fact greater than what we have reported.”

The report listed the ten most expensive types of errors in 2008, the number of errors, the cost per error, and the total cost. At the top of the list:

- pressure ulcers (bedsores)—374,964 errors, \$10,288 per error, and \$3.858 billion total;
- postoperative infections—252,695 errors, \$14,548 per error, \$3.676 billion total.

Not all errors are avoidable, but many, including bedsores, usually can be prevented. Nurses and their assistants need to identify patients at risk, check their skin daily, and move them often. This is labor intensive, but less expensive than letting these sores fester at a total cost of nearly \$4 billion a year.

Most medical mistakes involve more than one worker. Usually, the problem is not that one individual is careless, but rather, that the collective procedures, policies, and system of the organization are flawed. This is why improving patient safety means redesigning processes, or *how* things are done, and making rules about hand-washing, use of checklists, both in surgery and when inserting catheters, while insisting that everyone, including star physicians, stick with them. As part of the “team” approach to medicine, nurses and others are encouraged to speak up when they see a mistake in the making: “Doctor, I think you forgot. . . .” By using health information technology, hospitals also can avoid medication mix-ups.

*“Preventable readmissions” cost the health care system about \$25 billion every year, according to consulting firm PricewaterhouseCoopers.*

But for safety initiatives to work, a hospital’s administration must be committed. To get management’s attention, the ACA stipulates that, beginning in 2015, Medicare will reduce its payments by 1 percent to hospitals with the highest rate of medical errors and infections. That 1 percent reduction may not sound like a huge penalty, but for a hospital that enjoys a 2 percent or 3 percent profit margin on its Medicare patients (which many do), a 1 percent reduction will spur hospital management to pay more attention to medical mistakes and infections.

Too often, patients who pick up infections in hospitals are discharged prematurely and wind up being readmitted within thirty days. These “preventable readmissions” cost the health care system about \$25 billion every year, according to consulting firm PricewaterhouseCoopers.<sup>44</sup> Under reform legislation, in 2012, Medicare will stop paying hospitals for preventable readmissions tied to health conditions such as heart failure or pneumonia. In 2014, HHS will expand that policy to cover four additional health conditions.

Finally, in 2015, HHS will start reporting each hospital’s record for medical errors and infections pertaining to Medicare patients. This could have a significant effect on a hospital’s reputation, and is likely to lead



CEOs to invest more in patient safety. Extensive research done by the Institute for Healthcare Improvement (IHI) shows that hospitals are able to improve productivity by becoming more efficient. Mark Graban, a senior fellow at the Lean Enterprise Institute and the author of the book *Lean Hospitals: Improving Quality, Patient Safety, and Employee Satisfaction*,<sup>45</sup> offers an example of what he learned at a 2009 IHI forum: “One of the breakout sessions that had an impact on me was from Kaiser Permanente and Ascension Health about freeing up time for nurses to spend with patients. They cited a 2006 study that showed nurses spent only about 30% of their time in patient rooms due to waste of all varieties.”<sup>46</sup> In looking at the factors that impacted nurse productivity, the studies showed that personal work style was important and also that without good support processes nurses will struggle to provide the right patient care. For example, according to Graban,

The recommendations for improving productivity and patient care included having supplies and equipment available on demand at the point of use and the time of need.

That sounds so basic and fundamental, doesn’t it? Shocking to those of you from outside of healthcare? One health system did a study of their ‘smart pumps’ and discovered that, due to a lack of organization . . . and lack of standard process, they had over-purchased this one item to the tune of \$20 million since the pumps they had often couldn’t be found, so additional ones got purchased. What an easily preventable form of waste and overspending.

Nurses often hoard and hide equipment as a workaround to make sure they can provide care to their patients. It might seem selfish, but it’s well-intended in the short-term, yet does nothing to fix the real system. One presenter said the ‘strangest’ place they found a piece of hoarded/hidden equipment was a pulse oximeter found in the ceiling above the tile in a patient room. Nurses and hospital staff shouldn’t have to go to such lengths to ensure they have the tools to do their jobs.<sup>47</sup>

*A study by the American Society of Consultant Pharmacists indicates that the annual cost of medication-related mix-ups in nursing homes led to additional care that cost nearly \$4 billion. Other estimates suggest that hospital errors alone add \$20 billion to the nation’s annual health care bill.*

In this case, increasing productivity means enforcing one simple rule: equipment that nurses need should be kept behind the desk at each nurse’s station to be signed out when they take it. If the equipment a nurse needs is not available at her station because someone is using it, she can borrow it from a different station. The sign-out sheet will ensure that the equipment is returned.

Hospitals are not alone. A study by the American Society of Consultant Pharmacists indicates that the annual cost of medication-related mix-ups in nursing homes led to additional care that cost nearly \$4 billion. Other estimates suggest that hospital errors alone add \$20 billion to the nation’s annual health care bill. And the same errors occur, week after week, in hospitals across the country. “We don’t study routine failures . . .



[but] when we look closely, we recognize the same balls being dropped over and over, even by those of great ability and determination,” writes Dr. Atul Gawande in *The Checklist Manifesto*. “We know the patterns. We see the costs. It’s time to try something else.”<sup>48</sup>

Accidents hike costs. In November 2011, Consumer Reports Health.org called attention to a study done by the Office of the Inspector General of the Department of Health and Human Services that found that one in seven Medicare patients who are hospitalized each month suffer at least one “adverse event.” That comes to 134,000 people a month, or 1.6 million a year. Of those, 15,000 die (180,000 a year)—either as a direct result of the error or because the error contributed to their death.<sup>49</sup>

The high rate of medical mistakes is not a sign that care workers are indifferent or sloppy. Rather, they are working in an industry that has not developed the systems needed to create a safe, efficient workplace. Just one easy example: in the airline industry, pilots and co-pilots use checklists before taking off. In U.S. hospitals, most surgical teams do not. Yet, we have staggering evidence that lives and dollars could be saved by adopting this one, humble quality-control tool.<sup>50</sup>

*A Consumer Reports investigation found that a checklist can prevent nearly all of the central line infections that are responsible for at least 30 percent of the 99,000 annual hospital-infection-related deaths.*

Nevertheless, few U.S. hospitals insist that surgical teams use checklists. After all, many star surgeons are “rainmakers” who bring well-insured patients to the medical center, and it is not unusual for them to refuse to use checklists.

“It somehow feels beneath us to use a checklist, an embarrassment,” Gawande, who is himself a surgeon, explains. “It runs counter to deeply held beliefs about how the truly great among us—or those we aspire to be—handle situations of high stakes and complexity. The truly great are daring. They improvise. They do not have protocols and checklists. Maybe our idea of heroism needs updating.”

Hospital workers know, better than anyone, how dangerous our hospitals can be. This is why, when asked, “Would you want the checklist to be used if you were having an operation?” fully 93 percent said “yes,”—even though “20 percent of hospital staff resist using a checklist.” In his book, Gawande confides that he himself began using checklists in his operating room—and was chagrined to discover that he, too, needed the safety net.

Not all errors can be prevented. But the HHS study labeled 44 percent of the adverse “events” it identified as “clearly or likely preventable.” Hospitals themselves have demonstrated how many medical errors can be prevented when they make a concerted effort to reduce medical mistakes. For example, a Consumer Reports investigation found that a checklist can prevent nearly all of the central line infections that are responsible for at least 30 percent of the 99,000 annual hospital-infection-related deaths.<sup>51</sup>

Of course, the majority of patients do not die of these infections; they just spend more time in the hospital recovering. This is why adverse events add to the price of health care—and to hospital costs. Hospitals often cannot recoup the expense of these longer stays. Going forward, it will be even harder: both Medicare and private insurers will be refusing to pay for the added expense of preventable errors and readmissions.

One might expect that any reforms that reduced procedures would mean lower revenues for the hospitals. But as Ken Terry, author of *Rx for Health Care Reform*, has explained, the Premiere Safety Project showed that, as productivity increased and supply costs dropped, the hospitals involved in the project were able to deliver diagnosis-related-group (DRG) services and hospital days at a lower cost, which meant higher profits because these payments are fixed in advance.<sup>52</sup> Premiere also points out that the hospitals' labor costs dropped because they paid less overtime and made better use of temporary workers.

Admittedly, not all hospital CEOs are committed to reform. What would it take to motivate these top executives to make safer, better coordinated care a top priority? Empirical evidence suggests that a drop in revenues could force them to become more efficient. This is precisely what Medicare is trying to do by reducing annual updates.

*Patients do not benefit from waste.*

In its June 2010 report, the Medicare Payment Advisory Commission (MedPAC) pointed out that, when revenues are low—either because the hospital has fewer patients, or has a larger share of Medicaid patients, or because private insurers are paying less—many do become more productive. In fact, they become so efficient that they manage to turn a profit on their Medicare patients.<sup>53</sup>

This should come as no surprise. Like most other organizations, hospitals tend to spend lavishly when feeling flush, investing in hotel-like amenities, new wings (which often are not needed), higher salaries for executives, and pricey if not fully tested cutting-edge equipment.<sup>54</sup> On the other hand, when money is tight, the same institutions are more likely to concentrate on avoiding waste. And in most cases, when hospitals make that effort, the quality of care also improves. Patients do not benefit from waste.<sup>55</sup>

According to the conventional wisdom, Medicare underpays hospitals. But the same MedPAC report reveals that one-third of U.S. hospitals make a profit on Medicare patients. The problem is not so much that Medicare pays hospitals too little, but that private insurers over-pay brand-name hospitals that use their market clout to demand especially high payments for the simplest services. Insurers then pass the cost along as they lift premiums.<sup>56</sup>

It is true that “safety-net hospitals” and other medical centers that treat a large number of uninsured patients have a very hard time staying in the black. Under the ACA, however, they will no longer be absorbing the cost of caring for so many uninsured, and even though 32 million uninsured Americans now will be covered, these hospitals will continue to receive 25 percent of the subsidies that they receive today. They still will be caring for those who will not be covered by reform, and they will be treating Medicaid

patients—accepting reimbursements that are much lower than the fees Medicare pays for seniors. Over time, as it becomes clear how much help safety-net hospitals need, CMS will adjust its subsidies.

The bottom line: under reform legislation, the vast majority of hospitals should be financially stable, even though Medicare reduces their annual updates—as long as they concentrate on reducing waste.

It may be the case that some extremely inefficient hospitals, skilled nursing facilities, and home health agencies will be forced to close their doors. But most parts of the country have more hospital beds than needed, and skilled nursing facilities that do little more than warehouse patients and provide sub-par care while defrauding taxpayers should be shuttered. Under reform, many nursing homes will be replaced by community homes. Vermont has demonstrated how this can be done with a program called SASH (Support and Services at Home), which keeps Medicaid patients out of nursing homes and hospitals by combining affordable housing with integrated care.<sup>57</sup> Jobs lost when subpar institutions are closed can be replaced by new jobs at community homes for seniors and community health clinics (CHCs).

The ACA offers generous funding for CHCs, expanding their capacity by 50 percent. When hospitals that cannot or will not create a safer, more productive workplace are closed, CHCs can pick up the slack—and do a better job of providing continuous care for many patients who now receive their primary care in a hospital’s emergency room.

### **A CLOSER LOOK AT THE BILLIONS THAT CAN BE SAVED, LONG-TERM, FROM UNPRECEDENTED STRUCTURAL REFORMS**

The Affordable Care Act “has the potential to fundamentally transform our health system into one that delivers better care at lower cost,” former Office of Management and Budget director Peter Orszag declared in June of 2010. “This potential isn’t fully captured in CBO’s numbers,” he added, “and that’s appropriate. CBO produces its estimates based on what has happened in the past and we have never enacted such a fundamental transformation.”<sup>58</sup>

Orszag is referring to deep structural changes in how we reimburse for care and how care is delivered. The goal is to replace fee-for-service payments—which encourage providers to “do more” with payments that reward hospitals and doctors for better outcomes at a lower price. Many refer to these reforms as “Medicare Modernization.” Medicare will lead the way, but private insurers have indicated that if Medicare reform works to save dollars, they will follow. They just want Medicare to provide political cover. Keep in mind that if costs in the private sector slow, this will put a lid on the subsidies that middle-income families need, lowering the cost of reform.

CBO did not try to include savings from these fundamental reforms in its projections because it is not yet known which pilot projects will succeed, where they will succeed—and just how much they will save. Different strategies will work in different parts of the country.

But it is known that these changes can reap significant savings. Research published in peer-reviewed medical journals and on-the-ground experience both demonstrate that moving away from fee-for-service payment, rewarding hospitals and doctors for collaborating rather than competing, comparing the effectiveness of treatments, providing patients with the information they need to share in decision-making, and giving seriously ill patients an opportunity to choose palliative or hospice care, not only cuts waste but reduces needless suffering while protecting patients against exposure to unnecessary risks.<sup>59</sup>

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The goal of the Affordable Care Act is not just to rein in health care inflation, but to transform a profit-driven system into a patient-centered system that supports the many doctors, nurses, and other practitioners who are eager to work in a more efficient workplace where they can provide better patient care. Here are some of ways that the Affordable Care Act would “modernize” Medicare in the complete sense of the word—both through process and savings.

***Let Accountable Care Organizations Share in Savings.*** As research published in Health Affairs earlier this year reveals, large multi-specialty organizations such as Geisinger, Intermountain, and the Mayo Clinic tend to provide better care at a lower cost by emphasizing a team-based approach to collaborative, evidence-based medicine.<sup>60</sup>

The study shows that, in most markets, after adjusting for demographic factors such as age, sex, race, and income, as well as co-morbidities, these integrated groups provide higher-quality care at a 3.6 percent lower annual cost. The authors note: “For Medicare, although a 3.6 percent cost savings is relatively small, if all physicians could perform at this level, about \$15 billion a year in savings to the Medicare program would be generated. This would amount to \$150 billion over ten years—enough to make a substantial contribution to the \$940 billion estimated cost of the health care legislation.”

These integrated systems serve as the model for what reform legislation calls “accountable care organizations” that are designed to integrate hospitals, doctors, and other caregivers into a seamless entity that can deliver cost-effective care. Doctors and hospitals that volunteer to be accountable for the quality and cost of treatment that they deliver to Medicare patients will have the opportunity to share in savings if they manage to deliver high-quality care for less than benchmark projections.

The Affordable Care Act authorizes many pilot and demonstration programs that will test a range of accountable care concepts.<sup>61</sup> One model would have Medicare pay everyone involved in an episode of care a single “bundled payment” for all services—acute inpatient hospital, physician, outpatient, and post-acute care—for an episode of care that begins three days prior to a hospitalization and spans thirty days following

discharge. An “episode of care” might describe a surgery, such as a knee replacement or a coronary artery bypass grafting.

A bundled payment encourages caregivers to work together as a team, and to make changes in their systems in order to reduce waste in the form of errors and redundancy by ensuring that primary care physicians, specialists, surgeons, hospitalists, skilled nursing facilities, and home health care agencies are communicating with each other. In our fragmented health care system, this is not easy. But we have evidence that bundling can work.

In the 1990s, a Medicare demonstration project that “bundled” hospital and physician payments for coronary artery bypass grafting (CABG surgery) saved 10 percent of the cost for these procedures over a five-year study period. Three of the four original hospital participants made major changes in physician practice patterns and hospital operations to generate savings. On a risk-adjusted basis, participating hospitals had a significantly lower rate of inpatient deaths compared with Medicare’s national averages.<sup>62</sup>

*In the 1990s, a Medicare demonstration project that “bundled” hospital and physician payments for coronary artery bypass grafting (CABG surgery) saved 10 percent of the cost for these procedures over a five-year study period.*

Using its research databases, Thomson Reuters calculated the average cost per CABG for both Medicare and commercial patients and then applied the savings rate from the demonstration project to these figures, concluding that bundled payments could reduce the national cost of CABG procedures by over \$1.4 billion a year.<sup>63</sup>

**Reward Patient-Centered Medical Homes.** The ACA sets out to reinvigorate primary care by providing bonuses for patient-centered “medical homes” formed by integrated health systems, community health clinics, primary care physicians, nurse-practitioners, gerontologists, or others willing to provide the support needed to keep chronically ill patients out of emergency rooms and hospitals. These medical homes offer an ongoing relationship with a primary care provider or team, and use health information technology (IT) to help coordinate care. Medical homes also must offer prompt access to care through open scheduling as well as expanded and after-hours access to personal physicians and practice staff by telephone and through secure e-mail.<sup>64</sup>

Typically, these medical homes will be paid a lump sum to keep a patient or group of patients “well” for a year. Like accountable care organizations, they will be taking on some of the risk and responsibility for providing patient-centered efficient care.

**Make Comparative Effectiveness Research Widely Available.** The ACA includes comparative effectiveness research (CER) funding that should reach an estimated \$500 million in 2014. Will health care providers pay attention to the research?



A June 2010 white paper by Thomson Reuters on waste in our health care system reports that, when it comes to practicing evidence-based medicine, many caregivers just do not follow agreed upon standards for best practice: “Even where accepted standards exist, there is a significant lack of consistent awareness, understanding, and application.”<sup>65</sup> They offer an example: “In a recent article on CER, Milton Weinstein, et al reported that a study of colon cancer treatment demonstrated that the authors found significant variability in the use of inappropriate chemotherapy. They conclude that ‘we can save money without compromising outcomes—if we can induce providers to cut back on cost-ineffective services and replace them with more cost-effective, but underutilized services.’”

*A June 2010 white paper by Thomson Reuters on waste in our health care system reports that, when it comes to practicing evidence-based medicine, many caregivers just do not follow agreed upon standards for best practice.*

Under reform, physicians and hospitals will not be forced to follow evidence-based guidelines. But if they are not able to improve quality and reduce costs, they will not be eligible for bonuses. Research shows that, when caregivers use comparative effectiveness research, they are likely to achieve better outcomes for less.

***Let an Independent Payment Advisory Board Monitor Medicare Inflation.*** Reform legislation establishes a new Independent Payment Advisory Board (IPAB) with authority to recommend proposals to limit Medicare spending growth. If projected per capita Medicare spending exceeds target growth rates, the Board is required to recommend proposals to reduce Medicare spending by specified amounts, with the first set of recommendations due in 2014 for implementation in 2015. (Prior to 2018, the target growth rate is the projected five-year average rate of change in the Consumer Price Index for All Urban Consumers [CPI-U] and the CPI for Medical Care [CPI-M] averaged together. In 2018 and beyond, the target growth rate is the projected five-year average percentage increase in the nominal per capita gross domestic product [GDP] plus 1.0 percentage point.)

The IPAB is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, or increase beneficiary premiums and cost-sharing requirements. This suggests that the IPAB will focus on eliminating waste, in the form of medical errors as well as ineffective and unnecessary care. One way to do that is by continuing to move away from fee-for-service which encourage providers to “do more,” while also lowering fees for particularly lucrative services if volume is rising with no clear medical benefit. In this way, the IPAB might be able to correct misplaced incentives that reward overuse of some services.

The legislation makes it very difficult for Congress (or lobbyists) to meddle. Congress can veto the recommendations only if it adopts alternative proposals resulting in an equivalent level of savings. Most likely, legislators will be reluctant to put their name on alternative cost-saving recommendations because any such recommendations will cut into someone’s income stream. This is why legislators are likely to step back, and let the IPAB take the responsibility (and the heat) for achieving savings.



If Congress does not vote on the IPAB's recommendations, they still go into effect. If Congress approves the recommendations and the president signs them, they go into effect. If Congress votes against the recommendations but the president vetoes and Congress cannot find the two-thirds necessary to overturn the veto, the recommendations go into effect. It is only when Congress votes the recommendations down and the president agrees that they die.

White House budget director Peter Orszag underlined the ground-breaking importance of the IPAB in an interview with the Washington Post's Ezra Klein, saying, "I believe this commission is the largest yielding of sovereignty from the Congress since the creation of the Federal Reserve."<sup>66</sup>

*In the past decade, growth in Medicare spending has outpaced the CPI, while outstripping GDP growth by 2 percent to 3 percent a year.*

In the past decade, growth in Medicare spending has outpaced the CPI, while outstripping GDP growth by 2 percent to 3 percent a year. This provision alone could make Medicare affordable far into the future.

***Encourage Shared Decision-Making.*** Reform legislation calls for pilot projects exploring shared decision-making (SDM)—a formal process that lets patients participate in making “informed choices” about elective procedures. Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire, has led the way by opening a Center for Shared Decision Making where doctors and decision-making coaches learn to use various “decision-making aids” to help patients weigh their options on interventions and testing.<sup>67</sup> Many other hospitals and breast cancer centers now follow the center's protocol.

These aids, which are developed and updated by physicians and medical researchers at the Foundation for Informed Medical Decision Making, include pamphlets that spell out the risks and benefits of various elective tests and procedures, as well as videos featuring patients who describe how they went about making the decision—and whether they are happy with the outcome.

After the patient has had an opportunity to absorb the information, a shared decision-making coach asks him about his own preferences, fears, and priorities. Are there certain side effects that he fears more than others? Is he a risk-taker? How does he feel about uncertainty? Is the breast cancer patient's first priority to try to preserve her breast, or would she prefer to “get it over with” by having a mastectomy? Is a patient diagnosed with early-stage prostate cancer willing to risk the possible side-effects of treatment, or is he willing to consider “watchful waiting”? The treatment that might be “right” for one patient will not be right for another.

The ACA calls for grants to health care providers who participate in training at Shared Decision-Making Resource Centers to develop and implement these techniques. Research shows that SDM can reduce overuse of surgical treatments by as much as 25 percent.<sup>68</sup>

According to a Thomson Reuters report, if those states with “higher than average use” of what the National Priorities Partners calls “unwarranted procedures” used informed decision-making “to reduce their use to the average, total savings would be \$3.3 billion per year for employer sponsored healthcare plans alone.”<sup>69</sup>

***Elevate the Public Profile of Palliative and Hospice Care.*** Twenty-five percent of Medicare dollars are spent during the final year of a patient’s life, and we know that, in some cases, patients are subjected to tests and treatments that they do not want—or would not want if they knew how low the odds were that the treatment would help them. This is the cruelest form of overtreatment. But too often, patients and their families do not have the information they need to share in decision-making.

While fear-mongering about “death panels” killed a provision in the ACA that would compensate physicians for talking to patients about options for end-of-life care, a little noticed provision in the legislation does direct the secretary of HHS to “establish a program to award grants or contracts—to develop, update, and produce patient decision aids concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options.”

Too often, patients and their families are not aware that a hospital offers palliative care. (Some specialists are reluctant to let a patient talk to a palliative care team. These physicians would prefer to “do everything” that they possibly can before letting palliative care specialists explain the risks and benefits of various treatments to patients.) If hospitals make decision aids available to all patients, many more would become aware of what “palliative care” offers. It does not mean that treatment must stop. And it does not mean that the patient is dying.<sup>70</sup> It does mean that pain is controlled, and the patient is given an opportunity to share in decision-making.

*A recent study of cancer patients revealed that those who had access to palliative care enjoyed a better quality of life, lower rates of depression, and survived longer.*

A recent study of cancer patients revealed that those who had access to palliative care enjoyed a better quality of life, lower rates of depression, and survived longer.<sup>71</sup> Another study of 4,493 patients suffering from heart failure, lung cancer, pancreatic cancer, or bowel cancer revealed that those who were admitted to a hospice lived longer than those who did not receive hospice care.<sup>72</sup> If failing to offer good palliative care may hasten death in some patients, concern about “death panels” seems misplaced.

Dying in a hospice or at home with palliative care is also much less expensive than dying in an intensive care unit. A study published in the *Annals of Internal Medicine* reveals that bills for patients who received palliative care and survived were \$1,696 lower, while among patients who died, adjusted cost savings equaled \$4,906 per patient.<sup>73</sup>

This new evidence supporting the benefits of palliative or hospice care should open the door to raising payments for these services. The Affordable Care Act gives the secretary of Health and Human Services the authority to review the Medicare payment schedule and adjust “misvalued” physicians’ services to prevent over or under-use. Under this provision, the secretary might well increase payments for palliative care teams. Today, Medicare reimburses these teams so poorly that some hospital CEOs are reluctant to hire them, arguing that palliative care just is not a “revenue center.”

## **EXPEDITING CHANGE BY REDUCING THE POWER OF LOBBYISTS**

If we know what we need to do to rein in health care inflation, why has it taken so long to reform Medicare? Why should we think that Medicare will be improved by this reform?

For many years, two obstacles blocked Medicare reforms that tried to squeeze waste out of the system:

- Congress, acting as Medicare’s “board of directors,” and
- a payment system that discouraged innovation: when health care providers became more efficient, offering better value, they would lose revenue.

The Affordable Care Act addresses both problems. First, the legislation establishes the Center for Medicare and Medicaid Innovation (CMI) to test pilot projects, and most importantly, stipulates that “the Secretary of Health and Human Services has the authority to expand the duration and scope of a demonstration, even nationwide,” assuming she determines that the expansion would reduce spending without cutting the quality of care.

In other words, the secretary of HHS does not have to go through Congress: if a pilot project is successful, she can roll it out nationwide. This represents a radical change in the law.

In their 2011 annual report, Medicare’s Trustees recognize the importance of this provision. When discussing the “possibility that health care in the U.S. can be transformed, in both the way that it is delivered and the manner in which it is financed,” they note that “if the new approaches” proposed under the ACA “can be demonstrated to improve the quality of health care and/or reduce costs, then they can be adopted for Medicare without further legislation. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower Medicare cost growth rates to levels compatible with the lower price updates payable under current law.”<sup>74</sup>

In the past, Medicare needed congressional approval before expanding a pilot project, and too often lobbyists persuaded legislators to delay or derail successful initiatives. For example, Congress refused to expand the Medicare demonstration project discussed above that showed that “bundling” payments for coronary artery bypass grafting could save 10 percent of the cost of these procedures while also reducing

mortalities.<sup>75</sup> Despite the project's success, only the original seven hospitals ever tried this new approach to payment for CABG.<sup>76</sup>

Lobbyists often pressure legislators to kill cost-saving reforms; after all, one man's waste is another man's income stream. In another case, a demonstration project that tested competitive bidding for durable medical equipment between 1999 and 2002 discovered that the program reduced Medicare expenditures by 19 percent. Although Congress authorized the CMS to expand the program, it postponed implementation until 2010. Presumably companies that manufactured the equipment were not enthusiastic about bidding that would trim their revenues.<sup>77</sup>

It is worth noting that, when voting to give the secretary of HHS this latitude on expanding demonstration projects, Congress chose to tie to its own hands. This suggests that, in their heart of hearts, many Congressmen recognize that they themselves represent the major obstacle to true health care reform. Like Odysseus lashing himself to the mast, legislators have chosen to defend themselves against the siren song of lobbyists.

*A demonstration project that tested competitive bidding for durable medical equipment between 1999 and 2002 discovered that the program reduced Medicare expenditures by 19 percent.*

The second problem that has blocked past efforts to get better value for our Medicare dollars is this: when providers become more efficient, their revenues suffer. As Dr. Brent James, the chief quality officer at Intermountain Healthcare, a network of hospitals and clinics in Utah and Idaho, points out: "We discovered that . . . when you achieve cost savings, the money all went back to purchasers as windfall savings. I mean, your costs drop, but your revenues drop as far or further. Don Berwick [the new director of the Centers for Medicare and Medicaid] hates it when I say this, but clinical quality improvement is a fast way to the poor house if you haven't figured out a structured way to harvest back some of those savings."<sup>78</sup> Eventually, Intermountain learned how to forge contracts with commercial purchasers that recognize and reward quality improvement efforts.

Now, under the Affordable Care Act, Medicare, too, will share savings with accountable care organizations and others that manage to provide the right care to the right patient, and at the right time—no more than she wants, no less than she needs.

## CONCLUSION

In the years ahead, will the Affordable Care Act be able to bring annual health care inflation down to a point where the nation's health care bills are no longer growing faster than GDP? No one can be certain.

What is known is that, when health care professionals and hospitals work together, they can change how care is delivered so that it is both less expensive and at least as effective. Often, outcomes are better. This has been demonstrated in communities throughout the nation that decided to implement some of the changes that the ACA calls for, even before Congress passed reform legislation.<sup>79</sup>

In the end, the ACA could generate less than \$950 billion—or it could save more. History shows that, in the past, the CBO has both overestimated and underestimated savings from health policy changes.<sup>80</sup>

As CBO director Douglas Elmendorf told the World Health Organization in April of 2010: “We have concerns in different directions: Subsidies will be more expensive than we project. Medicare reforms will save more money than we project. Our estimates reflect the middle of the distribution of possible outcomes, based on our professional judgment—including consultation with outside experts.”<sup>81</sup>

When it comes to projecting financial numbers ten years into the future—in any context—there are so many unknowns at play that a middle-of-the-road estimate is always best. This is another way of saying that, over ten years, there are so many unknowns that any estimate is a guesstimate.

The CBO could not even begin to project the savings that will result from the most critical changes in the Affordable Care Act—the structural reforms. Yet Medicare’s Trustees indicate that, even without these reforms, the \$950 billion that the CBO does score gives Medicare the breathing room it needs. As they point out in their 2011 report, the program’s “financial status . . . was substantially improved by the lower expenditures and additional tax revenues instituted by the Affordable Care Act.” Still they warn, “without fundamental changes in today’s health care delivery and payment systems,” by 2024, Medicare’s Hospital Insurance Fund will be able to pay only “90 percent” of its bills.

Over the next decade, the ACA ensures that there will be changes. The legislation grants Medicare the freedom to implement the “innovative payment and service delivery models” that the Trustees praise. Not all of them will succeed, but some will.

Without question, there is plenty of waste in our health care system in the form of medical mistakes, hospitalizations that could have been prevented, and unnecessary, sometimes unwanted treatments. If, over the next thirteen years, just some of that waste is removed, the savings are likely to more than cover any shortfall in the Health Insurance Fund.

To say that this cannot be done is to say that this country is incapable of doing what every other developed country in the world has done: guarantee and, when necessary, subsidize health care for all of its citizens. The Patient Protection and Affordable Care Act recognizes that this goal can be achieved only if health care is regulated in a way that puts patients ahead of profits while turning a fragmented cottage industry into a coordinated health care *system* that rewards providers when they work together to provide safer, more effective care.

## Appendix A

Deloitte explains that the new rules for medical savings accounts (MSAs), health savings accounts (HSAs), flexible savings arrangements (FSAs), and health reimbursement arrangements (HRAs) raise \$17.5 billion by:

- Increasing the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20 percent (from 10 percent for HSAs and from 15 percent for Archer MSAs) of the disbursed amount. The ten-year revenue estimate: \$1.4 billion.
- Limiting the amount of contributions to an FSA for medical expenses to \$2,500 per year, increased annually by the cost of living adjustment. The ten-year revenue estimate: \$13 billion.
- Making the definition of “medical expenses” for purposes of health FSAs, HRAs, HSAs, and Archer MSAs conform to the definition for the itemized deduction. Thus, the ACA eliminates on taxable reimbursements of over-the-counter medications unless the over-the-counter medications are prescribed by a doctor. Prescribed medicines, drugs, and insulin will still qualify for nontaxable reimbursements from those accounts. The ten-year revenue estimate: \$5 billion.<sup>82</sup>



## Appendix B

Below, a point-by-point rebuttal by Congressional Budget Office veteran Paul Van de Water<sup>83</sup> of charges leveled both by House Republicans<sup>84</sup> and former CBO director Douglas Holtz-Eakin<sup>85</sup> that CBO's analysis of how much the Accountable Care Act will save are simply false. Van de Water is now at the Center on Budget and Policy Priorities, a left-leaning think tank, while Holtz-Eakin is currently president of the American Action Forum, a conservative think tank.

### ***Claims that the health reform law relies on budgetary gimmicks to reduce deficits are false.***

*Claim:* The law uses a gimmick to make it appear fiscally responsible: its biggest spending increases don't take effect for four years, so CBO's cost estimate for the first decade (2010–2019) includes *ten* years of revenue increases but only *six* years of significant spending. The unstated implication of this charge is that in subsequent decades, when ten years of revenue increases are accompanied by ten years of spending increases, the law will greatly increase deficits.

*Fact:* There is no gimmick here, and this charge is groundless. CBO estimates that the law will reduce deficits *not only over the 2010-2019 decade, but in the second decade and subsequent decades*. In fact, the law will reduce deficits by *more* in subsequent decades than in the first decade, because its most important cost-saving measures are phased in and produce larger savings over time.

*Claim:* CBO's cost estimate double-counts the Medicare savings and additional Social Security payroll tax collections that the law will generate, because these savings and revenues could not both help pay for health reform and improve Medicare's and Social Security's finances.

*Fact:* This, too, is a canard. In estimating the law's impact on the deficit, *CBO counted the Medicare savings and Social Security revenues only once*. The financial status of the Medicare or Social Security trust funds is a different matter, distinct from CBO's estimate of the impact of the legislation on the budget deficit. The skilled CBO experts did not double count, as anyone familiar with budget estimates knows.

*Claim:* CBO's cost estimate is misleading because it doesn't include \$115 billion in additional discretionary spending that Congress must provide to implement health reform.

*Fact:* The health reform law contains *authorizations* for a variety of grant and other programs, and CBO has estimated that *if* future Congresses *chose* to fully fund these authorizations—which Congress is under no requirement to do—the total expenditures involved would amount to \$115 billion over ten years. But the large bulk of this amount is neither required nor necessary to implement the health reform law, and much of it doesn't even reflect new expenditures. As CBO has stated, more than \$86 billion is “for activities that were already being carried out under prior law or that were previously authorized.” CBO has noted that the law's actual implementation costs—that is, the cost that federal agencies will incur to administer the law—will be roughly \$10–20 billion over the first decade.

*Claim:* CBO's cost estimate inappropriately includes savings from the new CLASS long-term care insurance program.

*Fact:* Congressional leaders deliberately crafted the health reform bill so that it would be fully paid for *without* relying on savings from CLASS Act premiums. The CBO estimate clearly shows that if one excludes the net revenues of \$70 billion from CLASS Act premiums, health reform still reduces the deficit by \$73 billion over the first ten years.

*Claim:* CBO's cost estimate for health reform is misleading because it doesn't include the cost of the "doctor fix," or fixing the sustainable growth rate (SGR) payment formula for physicians.

*Fact:* The cost of fixing the SGR formula is entirely unrelated to health reform, as can easily be proved—all of the cost of fixing the SGR formula *would remain if health reform were repealed*. None of that cost can be attributed to health reform.

***House Republican leaders' attacks on CBO are unprecedented and inaccurate.***

When CBO estimated this week that the House Republican proposal to repeal the Affordable Care Act would increase the deficit by roughly \$145 billion over 2012–2019 and by about \$230 billion through 2021, House Speaker Boehner described the estimate as merely CBO's "opinion" and implied that Democrats had forced CBO to produce misleading figures, saying that "CBO can only provide a score based on the assumptions that were given to them."

In fact, over several decades, the House and Senate Budget Committees, along with presidential administrations of both parties, have developed procedures that CBO uses to prepare cost estimates. In estimating the cost of health reform or its repeal, as with any estimate, CBO uses these longstanding, bipartisan procedures—*not* assumptions specified by the sponsor of the legislation. Thus, Speaker Boehner's charge is flatly incorrect.

Up until now, congressional leaders of both parties have acknowledged CBO's professionalism and recognized its critical role as a neutral arbiter in budget matters. They have accepted CBO's cost estimates, even when those estimates have proved inconvenient for their side. This wholesale attack on, and rejection of, a CBO estimate for a major piece of legislation by the leadership of the House or Senate is unprecedented.

***Claims that health reform will destroy jobs by harming the economy are sharply at odds with the findings of leading non-partisan experts.***

House Republicans have charged that the bill will destroy jobs by adding greatly to businesses' costs. In fact, health reform is unlikely to raise most businesses' health insurance premiums. CBO estimates that it will *reduce* premiums for employers with more than 50 workers—who account for 70 percent of the total

insurance market—by up to 3 percent by 2016. For small employers, the estimated change in premiums ranges from an increase of 1 percent to a reduction of 2 percent.

Similarly, Moody's Analytics says that the Affordable Care Act's "net long-run impact on the economy will be minor" and that any disincentives from higher Medicare payroll taxes "will hardly make a difference." Moody's also points out that "there is the potential for the new law to reduce 'job lock,' when workers stay in a particular job because they are afraid of losing their insurance. . . . If the bill works as planned, Americans will be more able to switch jobs and open new businesses." The result would be a more productive economy.

The health reform law may also have other positive impacts on the economy. Expanding health coverage improves health outcomes by helping people obtain preventive and other health services and improving continuity of care. CBO has suggested that this could enhance the nation's economic productivity.

While health reform will "reduce the amount of labor used in the economy by a small amount," according to CBO, this will happen because some workers who now work mainly to obtain health insurance will decide to work somewhat less, not because employers will eliminate jobs.

## Appendix C

**Average Tax Rate, 1980-2008 (Percent of AGI paid in income taxes)**

Year	Total	Top 0.1%	Top 1%	Top 5%	Between 5% & 10%	Top 10%	Between 10% & 25%	Top 25%	Between 25% & 50%	Top 50%	Bottom 50%
1980	15.31		34.47	26.85	17.13	23.49	14.80	19.72	11.91	17.29	6.10
1981	15.76		33.37	26.59	18.16	23.64	15.53	20.11	12.48	17.73	6.62
1982	14.72		31.43	25.05	16.61	22.17	14.35	18.79	11.63	16.57	6.10
1983	13.79		30.18	23.64	15.54	20.91	13.20	17.62	10.76	15.52	5.66
1984	13.68		29.92	23.42	15.57	20.81	12.90	17.47	10.48	15.35	5.77
1985	13.73		29.86	23.50	15.69	20.93	12.83	17.55	10.41	15.41	5.70
1986	14.54		33.13	25.68	15.99	22.64	12.97	18.72	10.48	16.32	5.63
<b>Tax Reform Act of 1986 changed the definition of AGI, so data above and below this line not strictly comparable</b>											
1987	13.12		26.41	22.10	14.43	19.77	11.71	16.61	9.45	14.60	5.09
1988	13.21		24.04	21.14	14.07	19.18	11.82	16.47	9.60	14.64	5.06
1989	13.12		23.34	20.71	13.93	18.77	12.08	16.27	9.77	14.53	5.11
1990	12.95		23.25	20.46	13.63	18.50	12.01	16.06	9.73	14.36	5.01
1991	12.75		24.37	20.62	13.96	18.63	11.57	15.93	9.55	14.20	4.62
1992	12.94		25.05	21.19	13.99	19.13	11.39	16.25	9.42	14.44	4.39
1993	13.32		28.01	22.71	14.01	20.20	11.40	16.90	9.37	14.90	4.29

1994	13.50		28.23	23.04	14.20	20.48	11.57	17.15	9.42	15.11	4.32
1995	13.86		28.73	23.53	14.46	20.97	11.71	17.58	9.43	15.47	4.39
1996	14.34		28.87	24.07	14.74	21.55	11.86	18.12	9.53	15.96	4.40
1997	14.48		27.64	23.62	14.87	21.36	12.04	18.18	9.63	16.09	4.48
1998	14.42		27.12	23.63	14.79	21.42	11.63	18.16	9.12	16.00	4.44
1999	14.85		27.53	24.18	15.06	21.98	11.76	18.66	9.12	16.43	4.48
2000	15.26		27.45	24.42	15.48	22.34	12.04	19.09	9.28	16.86	4.60
2001	14.23	28.20	27.50	23.68	14.89	21.41	11.58	18.08	8.91	15.85	4.09
2002	13.03	28.49	27.25	22.95	13.87	20.51	10.47	16.99	7.67	14.66	3.21
2003	11.90	24.64	24.31	20.74	12.22	18.49	9.54	15.38	7.12	13.35	2.95
2004	12.10	23.09	23.49	20.67	12.28	18.60	9.26	15.53	7.01	13.51	2.97
2005	12.45	22.52	23.13	20.78	12.37	18.84	9.27	15.86	6.93	13.84	2.98
2006	12.60	21.98	22.79	20.68	12.60	18.86	9.36	15.95	7.01	13.98	3.01
2007	12.68	21.46	22.45	20.53	12.66	18.79	9.43	15.98	7.01	14.03	2.99
2008	12.24	22.70	23.27	20.70	12.44	18.71	9.29	15.68	6.75	13.65	2.59

*Notes:* 1. All tax returns that have a positive AGI are included, even those that do not have a positive income tax liability.

2. The only tax analyzed here is the federal individual income tax, which is responsible for about 25 percent of the nation's taxes paid (at all levels of government). Federal income taxes are much more progressive than payroll taxes, which are responsible for about 20 percent of all taxes paid (at all levels of government), and are more progressive than most state and local taxes (depending upon the economic assumption made about property taxes and corporate income taxes). Thus, if one looked at all taxes, one would find greater inequality

*Source:* "Summary of Latest Federal Income Tax Data," The Tax Foundation, October 6, 2010, Table 8, <http://www.taxfoundation.org/news/show/250.html#table8>.

## NOTES

<sup>1</sup> This is the most recent estimate, replacing a projection of deficit reduction through 2019. See Statement of Douglas W. Elmendorf, Director, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 before the Subcommittee on Health, Committee on Energy and Commerce*, U.S. House of Representatives, March 30, 2011, <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>.

<sup>2</sup> *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 13, 2011, <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>.

<sup>3</sup> Ibid.

<sup>4</sup> Douglas W. Elmendorf, Letter to Nancy Pelosi, Speaker of the House of Representatives, March 18, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf>.

<sup>5</sup> "Prescription for Change Filled: Tax Provisions in the Patient Protection and Affordable Care Act," [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Tax/us\\_Carroll\\_Prescription%20for%20change%20filled\\_v4.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Tax/us_Carroll_Prescription%20for%20change%20filled_v4.pdf).

<sup>6</sup> "Innovations for Better Health and Stronger Medicare," Centers for Medicare and Medicaid Services, November 16, 2010, [http://www.cms.gov/apps/docs/Innovations\\_for\\_Better\\_Health\\_and\\_Stronger\\_Medicare.pdf](http://www.cms.gov/apps/docs/Innovations_for_Better_Health_and_Stronger_Medicare.pdf).

<sup>7</sup> "Prescription for Change Filled."

<sup>8</sup> Ibid.

<sup>9</sup> Elmendorf, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 before the Subcommittee on Health, Committee on Energy and Commerce*.

<sup>10</sup> "Prescription for Change Filled."

<sup>11</sup> Ibid.

<sup>12</sup> "How the \$938 Billion Health Care Bill Is Financed," Tax Foundation, March 26, 2010, <http://www.taxfoundation.org/research/show/26066.html>.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> "Prescription for Change Filled."

<sup>16</sup> "How the \$938 Billion Health Care Bill Is Financed,"

<sup>17</sup> Mark Muchow, "Patient Protection and Affordable Care Act Tax Provisions," Governor's Office of Health Enhancement and Lifestyle Planning, West Virginia, September 17, 2010, <http://www.gohelp.wv.gov/AdvisoryCouncil/Meetings/Documents/Patient%20Protection%20and%20Affordable%20Care%20Act%20Tax%20Provisions.pdf>.

<sup>18</sup> "Prescription for Change Filled."

<sup>19</sup> Muchow, "Patient Protection and Affordable Care Act Tax Provisions."

<sup>20</sup> In an e-mail, Tax Foundation economist Mark Robyn explains:

"Interactions between Medicare programs' likely has to do with eligibility for certain benefits being partially dependent on other benefits received. So when one changes it can affect the other. The Act lists 'interactions' and amounts but they are not very specific about what exactly those interactions are. They list things like 'Part D [Medicare's prescription drug benefit] interactions' with 'Medicare Advantage Provisions' and 'Medicare Advantage Interactions.' As for the 'Associated Effects' they note that: 'Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise with respect to specific elements of the proposal (such as the tax credits for small employers), and those effects are included within the estimates for those elements.'" In other words, if employers stop offering health insurance (knowing that their employees will be able to purchase insurance in the exchanges), they are likely to make up for reduced benefits by raising wages. Unlike the benefits, wages are taxable, so the government would reap additional revenues.

<sup>21</sup> Douglas W. Elmendorf, Letter to Nancy Pelosi, Speaker of the House of Representatives, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

<sup>22</sup> *Health Care Spending and the Medicare Program: A Data Book* (Washington, D.C.: Medicare Payment Advisory Commission, June 2010), <http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf>.

<sup>23</sup> Medicare actuary Richard Foster has suggested that CBO's estimates in this area are "unrealistic." Richard S. Foster, "Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended," Memorandum, Centers for Medicare and Medicaid Services, April 22, 2010, [https://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf). For a rebuttal, see full discussion of "A Closer Look at the \$196 Billion in Less-Certain Savings" below.

<sup>24</sup> "Quest: High Performing Hospitals Collaborative Year 2 Results," Premier, November 22, 2010, <http://www.premierinc.com/quality-safety/tools-services/quest/year2/quest-year-2-results.pdf>; "157 Hospitals in National Collaborative Save 22,164 Lives, \$2.13 Billion over Two Years," Press Release, Premier, September 10, 2010, <http://www.premierinc.com/about/news/10-nov/quest.jsp>.

<sup>25</sup> "157 Hospitals in National Collaborative Save 22,164 Lives, \$2.13 Billion over Two Years."

<sup>26</sup> *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

<sup>27</sup> See note 57, below.

<sup>28</sup> "Prescription for Change Filled: Tax Provisions in the Patient Protection and Affordable Care Act."

<sup>29</sup> "Income Inequality and the Great Recession," Report by the U.S. Congress Joint Economic Committee, Representative Carolyn B. Maloney, Chair, Senator Charles E. Schumer, Vice Chairman, September 2010, [http://jec.senate.gov/public/?a=Files.Serve&File\\_id=91975589-257c-403b-8093-8f3b584a088c](http://jec.senate.gov/public/?a=Files.Serve&File_id=91975589-257c-403b-8093-8f3b584a088c).

<sup>30</sup> "U.S. Federal Individual Income Tax Rates History, 1913–2011," Tax Foundation, <http://www.taxfoundation.org/publications/show/151.html>.

<sup>31</sup> "Federal Capital Gains Tax Rates, 1988–2011," Tax Foundation, <http://www.taxfoundation.org/publications/show/2088.html>.

<sup>32</sup> "U.S. Federal Individual Income Tax Rates History, 1913–2011."

<sup>33</sup> Marsha Gold, "Medicare Advantage in 2006–2007: What Congress Intended?" *Health Affairs*, May 15, 2007, <http://content.healthaffairs.org/content/suppl/2007/05/14/hlthaff.26.4.w445v1.DC1>. Also see "The High Cost of Medicare Advantage," HealthBeat blog, April 11, 2008, <http://www.healthbeatblog.com/2008/04/the-high-cost-o.html>.

<sup>34</sup> See "Complaints about Medicare Advantage Mount . . . While Congress Contemplates Slashing Fees Traditional Medicare Pays Docs," HealthBeat blog, December 13, 2007, <http://www.healthbeatblog.org/2007/12/complaints-abou.html>.

<sup>35</sup> Steven Pizer, Austin Frakt, and Roger Feldman, "Nothing for Something? Estimating Cost and Value for Beneficiaries from Recent Medicare Spending Increases on HMO Payments and Drug Benefits," *International Journal of Health Care Finance and Economics* 9, no. 1 (March 2009): 59–81, <http://ideas.repec.org/a/kap/ijhcf/v9y2009i1p59-81.html>.

<sup>36</sup> Marsha Gold, "Medicare Advantage: Facts, Fallacies, and the Future," HealthAffairs blog, March 14, 2011, <http://healthaffairs.org/blog/2011/03/14/medicare-advantage-facts-fallacies-and-the-future/>.

<sup>37</sup> "Whose Advantage?" Editorial, *New York Times*, October 10, 2010, <http://www.nytimes.com/2010/10/11/opinion/11mon3.html>.

<sup>38</sup> Hinda Chaikind and Chris L. Peterson, "Summary of Potential Employer Penalties under the Patient Protection and Affordable Care Act (PPACA)," Congressional Research Service, May 14, 2010, <http://www.shrm.org/hrdisciplines/benefits/Documents/EmployerPenalties.pdf>.

<sup>39</sup> This provision does not apply to doctors, only to institutions such as hospitals and nursing homes. The Affordable Care Act does not call for any across-the board cuts in physicians' fees, and the Congressional Budget Office estimates do not assume any such cuts. For example, the CBO estimates do not include the 20 percent cut in reimbursements to physicians that the sustainable growth rate (SGR formula) calls for. The SGR cuts—which Congress has rejected repeatedly for many years—have nothing to do with recent health reform legislation.

The SGR formula was passed in the late 1990s—before President Obama came to office, and long before the Affordable Care Act was passed. What is most important to understand is that, when estimating savings as a result of health reform, the CBO does not include savings that would be realized if we whacked doctors' fees with an axe, and applied the SGR formula.



<sup>40</sup> Richard S. Foster, “Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended,” Memorandum, Centers for Medicare and Medicaid Services, April 22, 2010, [https://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf).

<sup>41</sup> “Communication from the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,” May 13, 2011, <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>.

<sup>42</sup> Researchers at Dartmouth have been studying the waste in the system for more than two decades. See [www.dartmouthatlas.org](http://www.dartmouthatlas.org). Today the majority of health care experts outside of Dartmouth agree about the waste, much of it driven by “new therapies that . . . don’t work very well” (Dr. Robert Califf, Duke University); embarrassing variations “in how much care a patients receives which have nothing to do with medical evidence or how ill he is, but instead are determined by where he happens to live” (Boston surgeon and New Yorker writer Dr. Atul Gawande); excess capacity in the form of too many hospital beds and “the many services a hospital provides that do little or no good in improving a patient’s health” (UCLA health care economist Thomas Rice); “medical technologies based on uncertain science” (former JAMA editor and MedPage editor-at-large, Dr. George Lundberg). As a result “the waste level in American medicine approaches 50%” says Dr. Donald Berwick co-founder of the Institute for Healthcare Improvement and director of the Centers for Medicare and Medicaid Services. These comments and a discussion of the problem can be found in Maggie Mahar, *Money-Driven Medicine: The Real Reason Health Care Costs So Much*, chapter 2, (New York: Harper/Collins, 2006).

<sup>43</sup> Jon Shreve et al., *The Economic Measure of Medical Errors* (Schaumburg, Ill.: Society of Actuaries, June 2010, <http://www.soa.org/research/research-projects/health/research-econ-measurement.aspx>.

<sup>44</sup> Parija Kavilanz, “U.S. to Hospitals: Clean Up Your Act,” CNN, April 29, 2010, [http://money.cnn.com/2010/04/29/news/economy/healthreform\\_hospital\\_fines/index.htm](http://money.cnn.com/2010/04/29/news/economy/healthreform_hospital_fines/index.htm).

<sup>45</sup> Mark Graban, *Lean Hospitals: Improving Quality, Patient Safety, and Employee Satisfaction* (New York: Productivity Press, 2008).

<sup>46</sup> Mark Graban, “Notes from My First IHI National Quality Forum (#ihi09),” Lean Blog, December 9, 2009, <http://www.leanblog.org/2009/12/notes-from-my-first-ihl-national-quality-forum-ihl09>.

<sup>47</sup> Ibid.

<sup>48</sup> Atul Gawande, *The Checklist Manifesto: How to Get Things Right* (New York: Metropolitan Books, 2009).

<sup>49</sup> Steve Findlay, “Hospital Errors Still Common,” *Consumer Reports Health.org*, November 16, 2010, <http://news.consumerreports.org/health/2010/11/hospital-infection-rates-hospital-errors-still-common-preventing-hospital-infections.html>.

<sup>50</sup> Gawande, *The Checklist Manifesto*.

<sup>51</sup> “Deadly Infections: How Good Is Your Hospital at Preventing Them?” *Consumer Reports Health.org*, June 2011, <http://www.consumerreports.org/health/doctors-hospitals/hospital-infection/deadly-infections-hospitals-can-lower-the-danger/overview/deadly-infections-hospitals-can-lower-the-danger.htm>; Kevin McCarthy, “New Infection Data from 4 New States, 40 New Hospitals,” *Consumer Reports Health.org*, September 28, 2010, <http://news.consumerreports.org/health/2010/09/new-infection-data-from-4-new-states-40-new-hospitals.html>.

<sup>52</sup> Ken Terry, “Twofer: How Hospitals Can Lower Costs by Improving Patient Safety,” CBS BNET, September 7, 2010, <http://www.bnet.com/blog/healthcare-business/twofer-how-hospitals-can-lower-costs-by-improving-patient-safety/2180>.

<sup>53</sup> When MedPAC looked at all hospitals that had cost reports on file with Medicare in 2009, and adjusted for patient mix, local wages, the number of Medicaid patients, the effects of being a teaching hospital, and other factors, it discovered that those hospitals that had been losing money on their non-Medicare patients (private patients, Medicaid patients and uninsured patients) from 2003 to 2007 had reined in their costs to a point that by 2008 they were turning a profit of 3.7 percent on Medicare patients. By contrast, hospitals that were under little or no financial pressure because they making 9 percent on their non-Medicare patients were losing 12 percent on seniors. See *Health Care Spending and the Medicare Program*.

<sup>54</sup> A 2009 study done by the Institute for Healthcare Improvement (IHI) for the Commonwealth Fund reveals that more than a quarter (28 percent) of initial hospitalizations are avoidable. According to the IHI report, it is patients with chronic illnesses like heart failure and chronic obstructive pulmonary disease; the frail elderly; patients residing in nursing homes or who receive home health care services; patients nearing the end of life; and individuals with psychiatric illness, substance abuse, and complex social challenges, including poverty are most likely to be hospitalized when they don’t need to be

there. Often, this is the path of least resistance. These patients need care, but not hospital care. Many would do better at home, with regular visits from nurse-practitioners, or in community homes for the chronically ill. Nevertheless, they land in the hospital because the beds are available. “We have overbuilt our hospital system,” says CMS director Dr. Donald Berwick, and because the beds are there, we fill them. Needless hospitalizations are hard on patients, because they often compromise health and emotional well-being. Meanwhile, according to the IHI study, avoidable hospitalizations cost approximately \$29 billion annually.

<sup>55</sup> “5 Myths and Facts about Medicare—In Pictures,” HealthBeat blog, July 22, 2010,

<http://www.healthbeatblog.com/2010/07/5-myths-and-facts-about-medicarein-pictures-.html>.

<sup>56</sup> The most recent June 2011 MedPAC report makes this point: “The gap between Medicare and private-payment rates does not necessarily imply that Medicare rates are set incorrectly, especially when higher private-payer rates reflect market conditions rather than differences related to cost and quality.” When hospitals have market leverage, they use it. *Medicare and the Health Care Delivery System* (Washington, D.C.: Medicare Payment Advisory Commission, June 2011), [http://www.medpac.gov/documents/Jun11\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun11_EntireReport.pdf)

<sup>57</sup> “Innovative Communities: Breaking Down Barriers for the Good of Consumers and Their Family Caregivers,” Long Term Quality Alliance, December 10, 2010, <http://www.scribd.com/doc/49471144/LTQA-Innovative-Communities-Report>.

<sup>58</sup> Peter Orszag, “The Affordable Care Act and the Deficit,” The White House Blog, June 2, 2011, <http://www.whitehouse.gov/blog/2010/06/02/affordable-care-act-and-deficit>.

<sup>59</sup> Local experiments prove that changing financial incentives can encourage collaboration, and change how health care is delivered. See “Proof that American Physicians and Hospitals Can Lift Quality and Reduce Costs,” Health Beat blog, August 13, 2009, <http://www.healthbeatblog.com/2009/08/proof-that-american-physicians-and-hospitals-can-lift-quality-and-reduce-costs.html>. In the summer of 2009, a conference titled “How Do They Do That? Low-Cost, High Quality Health Care in America” highlighted success in ten very different cities across the nation: Sacramento, California; Cedar Rapids, Iowa; Portland, Maine; Ashville, North Carolina; Sayre, Pennsylvania; Temple, Texas; Richmond, Virginia; Everett, Washington; La Crosse, Wisconsin; and Tallahassee, Florida. John Iglehart, “Low-Cost, High-Quality Care in America,” Health Affairs blog, July 28, 2009, <http://healthaffairs.org/blog/2009/07/28/low-cost-high-quality-care-in-america/>.

<sup>60</sup> William B. Weeks et al., “Higher Health Care Quality and Bigger Savings Found at Large Multispecialty Medical Groups,” *Health Affairs* 29, no. 5 (May 2010): 991–97, <http://content.healthaffairs.org/cgi/content/full/29/5/991?ck=nck>.

<sup>61</sup> Donald M. Berwick, “Launching Accountable Care Organizations,” *The New England Journal of Medicine*, March 31, 2011, <http://healthpolicyandreform.nejm.org/?p=14106&query=OF>.

<sup>62</sup> B. Kelly and R. Fabius, M.D., *A Path to Eliminating \$3.6 Trillion in Wasteful Healthcare Spending* (Ann Arbor, Mich: Thomson Reuters, June 2010), [http://healthcare.thomsonreuters.com/thought-leadership/testimony/WP\\_6\\_15\\_10.pdf](http://healthcare.thomsonreuters.com/thought-leadership/testimony/WP_6_15_10.pdf).

<sup>63</sup> Ibid.

<sup>64</sup> “Patient Centered Medical Homes,” Health Policy Brief, Robert Wood Johnson Foundation, September 14, 2010, [http://www.healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_25.pdf](http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_25.pdf).

<sup>65</sup> Kelly and R. Fabius, M.D., *A Path to Eliminating \$3.6 Trillion in Wasteful Healthcare Spending*.

<sup>66</sup> Ezra Klein, “Can We Control Costs without Congress?” Washington Post blog, March 26, 2010, [http://voices.washingtonpost.com/ezra-klein/2010/03/can\\_we\\_control\\_costs\\_without\\_c.html](http://voices.washingtonpost.com/ezra-klein/2010/03/can_we_control_costs_without_c.html).

<sup>67</sup> See the Dartmouth-Hitchcock Center for Shared Decision Making website, [http://patients.dartmouth-hitchcock.org/shared\\_decision\\_making.html](http://patients.dartmouth-hitchcock.org/shared_decision_making.html).

<sup>68</sup> Annette M. O’Connor et al., “Toward the ‘Tipping Point’: Decision Aids and Informed Patient Choice,” *Health Affairs* 26, no. 3 (May 2007): 716–25, <http://content.healthaffairs.org/cgi/content/full/26/3/716>.

<sup>69</sup> *A Path to Eliminating \$3.6 Trillion in Wasteful Healthcare Spending*.

<sup>70</sup> “Palliative Care and Hospice Care: Transforming the American Way of Dying (In Iowa, If Not in New York) Part 1,” Health Beat blog, November 24, 2010, <http://www.healthbeatblog.com/2010/11/palliative-care-and-hospice-care-transforming-the-american-way-of-dying-in-iowa-if-not-in-new-york-p.html>.

<sup>71</sup> Amy S. Kelley, M.D., M.S.H.S., and Diane E. Meier, M.D., “Palliative Care—A Shifting Paradigm,” Editorial, *New England Journal of Medicine* 363, no. 8 (August 19, 2010): 781–82, <http://www.nejm.org/doi/full/10.1056/NEJMe1004139>.

<sup>72</sup> S. R. Connor, B. Pyenson, K. Fitch, C. Spence, and K. Iwasaki, “Comparing Hospice and Nonhospice Patient Survival among Patients Who Die within a Three-Year Window,” *Journal of Pain Symptom Management* 33, no. 3 (March 2007): 238–46, <http://www.ncbi.nlm.nih.gov/pubmed/17349493>.

<sup>73</sup> R. Sean Morrison et al., “Cost Savings Associated With US Hospital Palliative Care Consultation Programs,” *Archives of Internal Medicine* 168, no. 16 (September 8, 2008): 1783–90, [http://www.capc.org/costsaving\\_aim092008.pdf](http://www.capc.org/costsaving_aim092008.pdf).

<sup>74</sup> *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

<sup>75</sup> *A Path to Eliminating \$3.6 Trillion in Wasteful Healthcare Spending*.

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