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**Electronic Record Keeping, Wellness Programs, and Care
Coordination—Would They Yield Real Savings, And When?**

The Obama Administration has proposed a number of changes aimed at increasing efficiencies in the nation's health care system. The most prominent of them, included in the economic stimulus legislation, authorizes funding to promote the use of computerized medical record keeping—better known as health information technology, or health IT.¹ Other related initiatives would provide funding for wellness programs and efforts to better coordinate care of patients with multiple conditions.²

As a reform strategy, enhancing health IT encompasses everything from computerizing the medical histories of individuals to creating better medical tracking and financial-management systems of doctors, hospitals, and insurers. Proponents believe that the proliferation of health IT will slow the growth of the nation's health care spending by reducing inappropriate or unnecessary tests and procedures, cutting paperwork and administrative costs, and decreasing the incidence of bad outcomes resulting from medical mistakes. Similarly, there is an expectation that expanding wellness programs and better coordinating care of people with multiple medical conditions will reduce costs while improving outcomes.

These three initiatives have been given considerable visibility by the Administration and congressional proponents, and expectations for their constructive effects on the nation's health care system are high. This attention is understandable. They have obvious benefits and minimal risks — making them generally acceptable in a political sense. But their potential to control rising medical costs should not be overstated. It is unclear whether on their own, or in combination, they would have a positive effect on the tendency of an entrenched fee-for-service health care system to encourage excessive services and other forms of volume driven expenditures.

¹ Public Law No. 111-5, the American Reinvestment and Recovery Act of 2009. The legislation contains considerable spending for health care, the majority of which is directed at the loss of medical coverage caused by the current economic downturn. Those measures temporarily increase federal support of mushrooming state Medicaid costs, make Medicaid available to some people who've lost their jobs, and subsidize COBRA health insurance coverage for unemployed workers who remain in their former employers' plans.

² Not discussed in this brief is another measure advocated by the Administration and authorized in the recently enacted stimulus legislation that would provide funding for research on the comparative effectiveness of alternative medical treatments and services. For a discussion of this proposal, see the brief in this series entitled, "Sowing Containment of Medicare Expenditures."

Even assuming that they would have a positive effect, it is unlikely to be seen for many years. To a large extent their success depends upon major changes in provider practice patterns, patient expectations and individual behavior. Such shifts will likely take time to occur. Meanwhile, the rise in health care costs over the next two decades will be amplified by a rapid growth in the senior population. Coupling those demographics with escalating prices, health care costs are projected to grow by \$2 trillion between now and 2018, and at an annual rate of 6.2 percent, or about one third faster than the economy.³

The Congressional Budget Office (CBO) projects that the current effort to promote health IT would reduce health care spending by less than half of one percent over this period.⁴ What this suggests is that given the time required to transition the nation's health care providers to more sophisticated IT systems, the effort would do little to ease rapidly growing health care costs at a time when population trends are expected to exacerbate them. And while promoting wellness programs and care coordination may prompt healthier life styles and better treatment outcomes, studies suggest their potential to create long-term savings has not been demonstrated.

Promoting Health IT

While the new age of computerized storage technology and communications has vastly changed virtually every sector of the economy, the practice of medicine has stubbornly lagged. The potential advantages of reducing the maze of paperwork generated by providers and insurers is evident to anyone making more than casual use of the nation's health care system. As a result, there has been growing interest among policymakers in spurring the conversion of patient paper files into computerized electronic records, preferably ones with sufficient uniformity to allow information to be readily transmitted among providers, insurers, and others involved in clinical medicine.

Health IT has been described as “information technology applications specifically designed for the practice of clinical medicine, including electronic health records (EHRs), personal health records, health information exchange, computerized physician order entry, clinical decision support systems, and electronic prescribing.” Proponents contend that its widespread adoption will not only slow health care spending, but that it will eventually “improve the quality of care provided to patients by improving the information available to clinicians at the time of treatment, by encouraging the use of evidence-based medicine, and by helping physicians manage patients with complex, chronic conditions.”⁵

The federal government has already taken a number of steps to promote its use, including endorsement of a certification process for computerizing health records; setting standards for how IT systems are to communicate with each other; providing grants and loans to purchase systems; and offering financial incentives through Medicare payments to

³ Centers for Medicare and Medicaid Services, National Health Expenditures, projection series from 2008-2018.

⁴ CBO, “Letter to Congressman Charles B. Rangel, Chairman, House Committee on Way and Means, Health Information Technology for Economic and Clinical Health (HITECH) Act,” January 21, 2009.

⁵ CBO, “Budget Options, Volume I, Health Care,” December 2008.

encourage its adoption. However, a recent survey shows that only about 5 percent of physicians have installed comprehensive systems, and most of those have been large group practices. Price has been a major impediment. Many health providers have not made the investment because the cost is greater than the potential savings in lower office costs or increased revenues. High-quality systems can cost \$20,000 to \$25,000 per physician, not including implementation and maintenance. Overall, startup costs can exceed \$40,000 per physician.⁶ Prior to the recent legislation, CBO assumed that eventually many physicians would have altered their practices, but absent further prompting and financial incentives, it estimated that even a decade from now more than a third would have been operating without substantive IT systems.⁷

The stimulus plan enacted in February creates payment incentives in Medicare and Medicaid to further encourage providers to adopt IT systems, and while the incentives will only pertain to those programs,⁸ all health care spending—both public and private—would be affected.⁹ From 2011 to 2019 the new incentives will cost the federal government an estimated \$17 billion more than the savings they generate.¹⁰ However, when savings projected for the private sector are factored in, health care costs overall would be 0.3 percent lower than they otherwise would be.¹¹ If spread equally over those years, the savings for the entire period would amount to about \$85 billion. In contrast, in 2019 alone, personal health care expenditures could reach \$4 trillion.¹²

No one really knows the true potential of health IT, not only to improve outcomes of medical care, but to control costs. Moreover, CBO's projections suggest that the development process would be lengthy with any real benefits not materializing for a

⁶ Ibid.

⁷ CBO, "Letter to Congressman Charles B. Rangel," January 21, 2009, loc. cit.

⁸ The legislation establishes a schedule of Medicare bonus payments beginning in 2011 that would be paid to hospitals and physicians that adopt and use qualifying health IT. Beginning in 2016, Medicare would reduce payment rates to hospitals and physicians that are not using qualifying health IT. In the Medicaid program, the bill provides only for bonus payments—not penalties—which would be financed entirely by the federal government.

⁹ CBO, "Letter to Congressman Charles B. Rangel," January 21, 2009, loc. cit. CBO projected that under pre-existing federal incentives to adopt IT systems, 65 percent of physicians and 45 percent of hospitals would have had them in place by 2019. With the government's new set of incentives, they are projected to rise to 90 percent for physicians and 65 percent for hospitals.

¹⁰ CBO estimates that the new incentives and other related spending will cost about \$33 billion cumulatively over the period, and would be offset by \$12.5 billion in lower benefit payments from Medicare and Medicaid. In addition, because accelerating the spread of IT systems also would lower health care costs for private payers, it would lower their health insurance premiums. As a result, employers would pay less of their employees' compensation in the form of non-taxable insurance premiums and more as taxable wages and salaries. Thus, federal tax revenues would rise by \$3.2 billion over the period. (See CBO, "Cost Estimate, H.R. 1," January 26, 2009, loc. cit.) Based on the conference agreement on H.R. 1, CBO estimates that overall the new effort to promote IT would increase federal budget deficits by \$38.3 billion cumulatively through 2015, but savings would arise in later years, and coupled with the new tax revenues the net 11-year cost of the measure would be reduced to \$19.5 billion through 2019. (See "Letter to Speaker of the House Nancy Pelosi," February 13, 2009, summarizing the budgetary effects of the conference agreement on H.R. 1.)

¹¹ CBO, "Letter to Charles B. Rangel," January 21, 2009, loc. cit.

¹² Based on the trend reflected under National Health Expenditures projections for the 2008-2018 period.

number of years. And even if the rise in health care spending is slowed, after the new systems have been adopted any such effects would eventually diminish. CBO further points out that by improving adherence to treatment protocols, the proliferation of health IT could increase the amount of care provided, and thus offset the potential savings.¹³

None of this suggests that federal government efforts to promote wider use of health IT is a waste of time and money. It does suggest, however, that standing alone, health IT is not likely to greatly rein in projected costs. The initial investment and subsequent maintenance of health IT systems, along with the potential that improved efficiency will lead to greater utilization, must be factored against potential savings.

Looking beyond the question of how health IT would affect health care spending, one major issue hanging over the effort is privacy. In recent years the public has been saturated with stories of how hackers have been able to access many personal record sites of businesses and government. With the proliferation of health IT, any number of people can be expected to access the medical records of patients once an integrated system of physician and hospital electronic files is in place. Already, there are complaints that computerized health records of providers and insurers are potentially accessible online with as little information as a name, social security number, and address.

Privacy safeguards have been built into the stimulus legislation, but little is known about how effective they will be.¹⁴ For health IT to succeed, the security of those records is paramount. What's in those records is confidential—the substance of which is accorded privacy by law. Ultimately, public acceptance of converting their medical records to an automated transmittable format will rise or fall on their comfort that the information will not be disclosed for anything but their benefit and only with their permission.

Wellness Programs

Promotion of wellness programs represents another area where expectations for savings are high. Wellness programs are intended to alter lifestyle choices that people make which contribute to ill health and disease, and that eventually may require medical intervention to ease or remedy.

Some policymakers have suggested that discouraging those choices through public awareness campaigns, financial incentives and penalties affecting individual behavior, and regulatory actions can save money while improving the public health. Much of the serious illness that plagues society—heart disease, diabetes, cancer, obesity and the like—have their roots in life patterns that people follow. They may smoke, consume too much alcohol, overuse prescription medication, use illegal drugs, overeat, fail to exercise, drive without wearing a seat belt, or habitually speed. They have little awareness of the risks or choose to ignore them. Encouraging the public to adopt better lifestyles could

¹³ CBO, “Budget Options,” December 2008, loc. cit.

¹⁴ See, for instance, Anita Husin, “Online Health Data in Remission,” *The Washington Post*, February 16, 2009.

improve their health, improve their economic well-being, and most importantly extend their longevity. The actions required could be as simple as getting flu vaccinations, regularly checking blood pressure, and getting annual physicals and other readily available screenings (e.g., pap smears and mammograms), or as difficult as giving up smoking or becoming committed to exercising regularly and adopting a better diet.

As with efforts to promote health IT, expectations of savings from wellness programs may be inflated. It may seem counter intuitive that promoting wellness programs wouldn't necessarily save large sums of money. They have been adopted by too many businesses, insurance companies, and health care providers with success to dismiss their significance in improving the nation's health. Absenteeism, fewer sick days, and lower insurance premiums are behind many such efforts. And on their own, millions of people belong to health clubs and have committed themselves to maintaining personal fitness. But the prevalence of unhealthy lifestyles is just as striking.

The conditions most associated with adverse health are obesity and smoking.¹⁵ In a survey of the research, CBO found that health care spending by those considered obese was more than a third higher than people of normal weight, and more than two-thirds higher among the most obese (what is termed "morbidly obese").¹⁶ Another study found that health care spending was 21 percent higher among current or past smokers than people who never smoked.

Most significant is that recent trends are not encouraging. Adult obesity rates have more than doubled over the past 40 years, and particularly troubling is that nearly one in five children ages 6 to 11 is overweight, representing a 4-fold rise over the period. Overweight children have the propensity to become overweight adults and a greater likelihood of developing type-2 diabetes, high blood pressure, and high cholesterol (even at their younger ages). Moreover, while smoking rates have fallen sharply, CBO found that about one-fifth of adults and one-quarter of high school students continue to smoke. The prevalence of obesity and smoking among low-income and less educated segments of the population may account for a major part of their lagging rise in life expectancy.¹⁷ One study estimates that different trends in smoking related diseases explain at least 20 percent of the increasing gap in life expectancy between groups with different levels of education. And increasing obesity, which began among the less educated, could now explain part of the widening income-related disparity in mortality rates.¹⁸

On the one hand, the existence of those conditions reveals an opportunity to greatly impact the nation's overall health. On the other, it reveals that the impediments are large and not easy to overcome. However, whatever the health impacts may be of increased

¹⁵ Ali H. Mokdad, et. al., "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association*, March 10, 2004.

¹⁶ CBO, "Technological Change and the Growth of Health Care Spending," January, 2008.

¹⁷ Charles L. Baum and Christopher J. Ruhm, "Age, Socioeconomic Status, and Obesity Growth," Working Paper No. 13289, National Bureau of Economic Research, August 2007.

¹⁸ CBO, "Key Issues In Analyzing Health Insurance Proposals," December, 2008.

spending on wellness programs, the prospect that it will significantly slow the rise in national health expenditures seems doubtful at least in the near term.

Expanding information campaigns about the risks of smoking and poor nutrition have been amongst the more prominent approaches suggested, and much of what's known about their effectiveness comes from past efforts to curb smoking. The release of a landmark Surgeon General's report in 1964 on the link between smoking and lung cancer and other diseases was followed by government imposed warnings on cigarette packages and limitations on tobacco media advertising. Both were thought to have raised public understanding of the risks. And smoking rates did drop. However, the evidence is mixed on how much of that was due to information campaigns. One study conducted in the early 1990s found that a comprehensive community-based information initiative had no measurable impact,¹⁹ while another done in 2007 found that the greater awareness of the risks associated with tobacco did affect individual decisions about smoking.²⁰

Considerable evidence does show that imposing cigarette taxes reduces smoking. A large such increase recently enacted will raise the federal cigarette taxes from \$.39 to \$1.01 a pack.²¹ Studies have found that a 10 percent increase in the price of cigarettes decreases consumption among adults by between 4 percent and 6 percent and larger amounts among teenagers. Other studies have found that imposing taxes on unhealthy foods would reduce their consumption as well and help lessen the prevalence of obesity. Subsidizing counseling and clinical interventions can also be somewhat effective, but most studies do not show sustained changes in behavior.²²

Tougher governmental measures would actually restrict the availability of unhealthy products and mandate preventive strategies. CBO elaborates, "The federal government, for example, requires that schools serve meals that meet nutrition guidelines in return for receiving lunch subsidies. At the state and local level, governments have banned the sales of soft drinks in schools and the use of trans fats in restaurants and bakeries."²³ Research shows that bans on workplace smoking can cut smoking prevalence as well as the amount of cigarettes consumed on a daily basis.²⁴ Other strategies could make healthy foods the default option in federal nutrition programs, such as Food Stamps (now called the Supplemental Nutrition Assistance Program, or SNAP), or even exclude payments for food products thought to be the most unhealthy. Still other mandates could require health

¹⁹ COMMIT Research Group, "Community Intervention Trial for Smoking Cessation: I. Cohort Results from a Four-Year Community Intervention," *American Journal of Public Health*, February 1995.

²⁰ W. Kip Viscusi and Jahn Karl Hakes, "Risk Beliefs and Smoking Behavior," *Economic Inquiry*, January 2008.

²¹ As one of its first acts in the 111th Congress, Congress substantially raised various federal excise taxes on tobacco products as part of P.L. 111-3, the Children's Health Insurance Reauthorization Act of 2009. CBO estimated that the higher taxes would raise federal revenues by \$72 billion over the 2009-2019 period, offsetting increased expenditures authorized under the legislation. See CBO, "Cost Estimate: H.R. 2, Children's Health Insurance Reauthorization Act of 2009," February 11, 2009.

²² CBO, "Key Issues...", December 2008, loc cit.

²³ Ibid.

²⁴ William N. Evans, Matthew C. Farrelly, and Edward Montgomery, "Do Workplace Smoking Bans Reduce Smoking?" *American Economic Review*, September 1999.

insurers to cover vaccinations, preventive screenings, dietary counseling, and weight loss programs (albeit the latter have not shown much long-term success).²⁵

By making people more aware of their ability to take responsibility for their own health, thus reducing out-of-pocket spending, many options for promoting better health habits show promise to improve the public's well being and perhaps minimize or avoid expenditures to treat illness or disease brought on by poor life choices. However, they too carry costs, and other factors can limit or offset their potential to contain the nation's health expenditures.

Foremost is that modification of the public's adverse behavior can take years of costly information campaigns and financial incentives, so the immediate impact on health spending may be limited. Proposals, for instance, that seek to prevent children from developing unhealthy habits, while having the greatest potential impact on health spending over the long term, would be unlikely to have a substantial effect in the near term.

Moreover, those efforts can lead to greater expense. Getting people to believe in and practice preventive medicine, for example, can lead to additional services for some who are generally in good health and don't need costly medical care. And many people now take regular preventive steps in the absence of financial incentives to do so—hence, some portion of spending on incentives would be unnecessary. Additionally, while reductions in smoking and consumption of unhealthy food would have sizeable health benefits, receipts from the federal and state taxes that helped create those reductions would fall. The amounts they generate today are large. Lastly, spending on diseases caused by unhealthy behavior could decline substantially in the long run, but the impact on federal entitlement spending would rise as people live longer and receive Social Security and Medicare benefits for more years. The heart attack that is avoided at age 65 by a healthy lifestyle may result in a degenerative disease at age 80. Individuals and society as a whole would be better off but that does not necessarily translate into aggregate savings.

And although people who drop their harmful habits would likely become healthier, they would probably not be as healthy as people who had never engaged in that behavior. Thus, their consumption of late-life health care is apt to exceed the norm.

The challenge with wellness promotion is containing expectations about its potential, and approaching it more from the context of how better living will make for better public health, and not as a panacea for tempering health care spending. As with health care IT, the investment in wellness is better justified as a public good than as a strategy for controlling overall costs.

Care Coordination

Yet a third initiative suggested by the Administration involves efforts to better manage care for people who suffer from multiple conditions. Typically, the chronically ill are the

²⁵ CBO, "Key Issues..." December 2008, loc cit.

frail elderly who have multiple impairments or conditions requiring treatment over a prolonged period of time. This initiative falls under a broad heading called “care coordination,” and over the past two decades, Medicare has supported a number of projects seeking to demonstrate ways to better organize and harmonize the various treatments of those recipients.

The goal is to improve medical outcomes, limit hospital and nursing home stays, and reduce cost by changing the way health care is delivered. Under those experiments, instead of randomly seeking and receiving treatment from one specialized practice or provider to another for each of the individual’s conditions, various means are being used to approach the individual’s medical needs earlier and in a more comprehensive or holistic fashion.

Researchers have found that the incidence of multiple health conditions among Medicare recipients has risen sharply over the past two decades, and it is those recipients who account for the vast majority of Medicare expenditures. Part of the rise is attributed to improved diagnostics (conditions are being identified that previously wouldn’t have been); part to medical advances; and part to better preventive medicine—the net result being more treatments provided per recipient. One study found that in 1987, 31 percent of recipients received services for five or more conditions, and they accounted for more than half of all Medicare spending. Ten years later their number had risen to 40 percent, and they accounted for 65 percent of Medicare spending. By 2002, more than half had five or more conditions, accounting for three-fourths of Medicare spending. Moreover, multiple conditions tend to bunch around one or more serious forms of chronic illness—80 percent of those with congestive heart failure and 56 percent of those with diabetes had four or more additional conditions. To make the point more poignant, in 2002, 93 percent of the benefits paid by Medicare went to treat people with three or more conditions. And the concentration of those expenditures was even more pronounced—5 percent of Medicare enrollees accounted for 43 percent of the program’s total spending.²⁶

The many high-cost Medicare recipients and the disproportionate share going to a concentrated number of them makes the need for some sort of overall case management self evident. It has long been recognized that the elderly who suffer from multiple conditions have complex medical needs not readily addressed by traditional modes of health care delivery.

The weakness in the system stems from how physicians conventionally practice. Whether it be the education base from which they emerge, the compression of medical specialties that has evolved over the years, the erosion of the primary care practice, the narrowing of practice standards that specialty physicians follow, or the emphasis on meeting the immediate symptoms manifested, physicians often tend not to take a comprehensive approach in addressing the complex nature of the health of those with multiple

²⁶ “Cost Containment in Medicare; A Review of What Works and What Doesn’t,” prepared by The Urban Institute and Health Policy Alternatives, Inc., for AARP (written by Robert Berenson, Michael Hash, Thomas Ault, Beth Fuchs, Stephanie Maxwell, Lisa Potetz and Stephen Zuckerman), and Sarah Thomas, project manager for AARP’s Public Policy Institute. December 2008.

conditions. The cardiologist treats the heart condition, not the arthritis that keeps the patient from exercising, the leg weakness from their diabetes, or the depression that makes them lethargic and unmotivated. They treat them mostly from their specialties and the condition that they are most familiar with, and with or without a “referral slip,” it is often left to the ill-equipped patients and their families to meander through the system seeking to properly sequence and balance treatment and services—too often ineffectively.

Medicare experiments and demonstrations with care coordination, disease management, and case management, have shown some positive impacts on the quality of service and patient satisfaction, but none yet has been sufficiently successful to be advanced as a framework for a broad scale change. And none yet has conclusively shown it can reduce program costs significantly.²⁷

However, with the dramatic rise in the number of multiply-impaired Medicare enrollees, the need for change persists. Two ideas that concentrate on greater care coordination are the medical home model and accountable care organizations (ACOs).

The medical home model

The basic concept of the medical home model is to have a designated primary care physician coordinate all types of care and services needed by a patient—preventative, acute, and chronic—from a full range of potential providers, whether they be medical specialists, hospitals, rehabilitation facilities, laboratories, or other.²⁸

The American Academy of Family Physicians describes the medical home as—

*... an ongoing partnership between each person and a specially trained primary care physician. This new model provides modern conveniences, like e-mail communication and same-day appointments; quality ratings and pricing information; and secure online tools to help consumers manage their health information, review the latest medical findings and make informed decisions.*²⁹

In effect, the primary care physician assembles and in de facto fashion leads a team of health care professionals on behalf of the chronically-impaired patient. While the primary physician’s role is characteristic of the HMO gatekeeper, the medical home model embodies a modern concept of medical practice, including greater use of health IT, disease management tools, and preventive services. In its best application it envisions “24/7” patient access to, or contact with, the primary physician or a trained triage nurse outside of normal office hours.

Proponents believe that the continuity of oversight and better coordination of care will yield health care savings. Notably, they contend that improving coordination could

²⁷ Ibid.

²⁸ CBO, “Budget Options,” December 2008, loc. cit.

²⁹ Ibid.

reduce health care spending by ensuring that services and treatments are based on a comprehensive view of the patient, follow evidence-based guidelines, and avoid unnecessary or duplicative tests and procedures.³⁰

However, the idea is not without problems—foremost being that it relies on an adequate supply of primary care physicians, which appears to be lacking today. In addition, the steps thus far taken to model care coordination have not involved large universes, have not been a catalyst for broad-scale application, and whether the idea will really result in savings has not been demonstrated. A Medicaid pilot project of the medical home model—Community Care of North Carolina—was found to produce savings among enrollees with asthma and diabetes. However, it is unclear whether those savings were the result of its gatekeeper element or its disease management, clinical guidelines, or patient education components.³¹

The medical home model could actually lead to increases in health care spending if patients responded by seeking more services—or if payments to primary care physicians merely added to Medicare expenditures. The American Medical Association estimated that the additional time and equipment required for physicians and nurses to provide the coordination, track patients’ progress, and extend outreach would be about \$650 per Medicare enrollee in 2009—an increase of more than 20 percent over the current amount of Medicare spending per enrollee for physicians’ services.³² Spending could also rise if the primary physicians do not receive financial incentives to limit their patients’ use of specialists. Additionally, costs could rise because of increased patient access to their primary physicians through extended hours on evenings and weekends, “24/7” telephone triage, and the like. And while that access might create some reductions in the use of specialists and emergency room care, the savings would probably be small.³³

The bottom line is that the impact on spending from improved care coordination of the chronically and multiply impaired patient remains unclear. The Medicare program plans further testing of the medical home concept over the next few years.³⁴

Accountable care organizations (ACOs)

Another strategy receiving considerable attention is the creation of voluntary accountable care organizations to serve Medicare recipients. This approach would allow groups of providers meeting threshold requirements to share in the savings they achieve from serving a minimum number of patients. There would be no “gatekeeper” or other change

³⁰ Ibid.

³¹ Stephan Wilhide and Tim Henderson, “Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries,” American Academy of Family Physicians, June 2006.

³² American Medical Association, Specialty Society RVS Update Committee, “Medicare Medical Home Demonstration Project,” letter to Kerry N. Weems, Administrator of the Centers for Medicare and Medicaid Services, April 29, 2008.

³³ CBO, “Key Issues...,” December 2008, loc cit.

³⁴ The demonstration has been authorized by law and is expected to begin in 2010, with results expected by 2013.

from current payment systems or benefits. Instead, the ACO as a whole would be responsible for the overall cost and quality of care for those patients assigned to it. Savings to be shared by ACO members would be calculated from an estimated baseline for serving its assigned recipients, who would remain free to seek medical care beyond the ACO, distinguishing this concept from provider plans under the Medicare Advantage program. As described in one version of this concept published by the Senate Finance Committee:

The spending baseline for an ACO would be determined on an organizational level by using the most recent three years of total per beneficiary spending (Parts A and B) for those beneficiaries assigned to the ACO. The prospective spending target would be set using the expected national growth rate in fee-for-service Medicare, as determined by CMS. ACOs whose two-year average Medicare expenditures for assigned beneficiaries (Parts A and B) are at least 2 percent below their benchmark for the corresponding period would be eligible to share in 50 percent of the savings generated to the Medicare program.³⁵

Providers who form ACOs would need to establish a legal entity for receiving the bonus payments (their share of cost savings). They would also need to agree to be held accountable for a series of quality and cost reporting measurements so that bonus payments would not be made for simply reducing needed care.

Proponents believe that ACOs would provide a flexible approach to fostering cost control by creating an incentive, not currently in existence, for providers to reduce unnecessary volume of services while improving quality of care. According to one leading proponent:

Because the groups receive a share of the savings beyond a threshold level, steps like care coordination services, wellness programs, and other approaches that achieve better outcomes with less overall resource use result in greater reimbursement to the providers. These steps thus “payoff” and are sustainable in a way that they are not under current reimbursement systems. In addition, the shared savings approach provides an incentive for ACOs to avoid expansions of health care capacity that are an important driver of both regional differences in spending and variations in spending growth, and that do not improve health. The ACO approach also builds on current reform efforts that focus on one key group of providers, as in the medical-home model, or on a discrete episode of care, as in bundled payments. On their own, these initiatives may help strengthen primary care and improve care coordination, but they do not address the problem of supply-driven cost growth.... If adopted within a framework of overall accountability for cost and quality as is envisioned in the ACO model, both the medical home and bundled payment reforms would have added incentives to support not only better quality, but also lower overall spending growth. By shifting the emphasis from volume and intensity of services to

³⁵ Senate Finance Committee, “Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs,” April 29, 2009, p.18.

*incentives for efficiency and quality, ACOs provide new support for higher-value care without radically disrupting existing payments and practices.*³⁶

While the general concept has shown promise in a related Medicare demonstration project³⁷ and in simulations by researchers at the Dartmouth Institute for Health Policy and Clinical Practices,³⁸ success in broader applications would depend on several factors that are far from certain. The flexibility for providers and beneficiaries that could ease implementation could also undermine sustainability.

A key consideration is whether sufficient numbers of providers would see an advantage in joining ACOs, and subjecting themselves to collective benchmarks, rather than remaining in the traditional go-it-alone setting. The incentives for giving up their current method of practice may not seem sufficient, unless perhaps they perceived that voluntary change would be better than an inevitable change imposed upon them by a government running out of money. It would certainly require a high level of trust among ACO members that each was doing his or her best to achieve cost savings while improving quality. Success may also depend on the level of trust that patients have regarding the advice of their ACO providers. Since patients would be free to seek treatments beyond the ACO, some providers might question whether they were being held accountable for treatments they did not prescribe. Questions may also arise regarding the appropriate benchmarks for savings. As the CBO has observed in evaluating this type of plan, “there is a substantial and somewhat unpredictable degree of variation in the growth of Medicare’s spending from year to year, even among large groups of Medicare beneficiaries. Thus, Medicare would be paying bonuses, in some cases, for slowdowns in spending that would occur even in the absence of policy change.”³⁹

For all these reasons, in addition to the novelty alone, it is quite difficult to assess the savings impact of ACOs over time. In the variation modeled by CBO, saving amounted to a modest \$5.3 billion over 10 years. Still, according to CBO, “By encouraging providers to begin developing more efficient systems for delivering care, this option could be an initial step toward changing providers’ current systems of delivering care and could pave the way for greater changes in the future.”⁴⁰

Conclusion

The three initiatives discussed in this brief fall on the easier side of the health care reform effort. They certainly don’t run into the same political crosshairs as explicit provider or consumer constraints. However, with the exception of ACOs, they also don’t address head on the proclivity of our fee-for-service systems to profit from more rather than less service. And even with ACOs, the effort would be voluntary and would likely maintain

³⁶ Statement to Senate Finance Committee, Reforming Provider Payment, Mark B. McClellan MD, PhD, Director, Engelberg Center for Health Care Reform, The Brookings Institution, April 21, 2009, p.3.

³⁷ The Physician Group Practice (PGP) Demonstration.

³⁸ “Fostering Accountable Health Care; Moving Forward in Medicare,” Elliott S. Fisher et. al., Health Affairs, January 27, 2009, w219.

³⁹ CBO, Budget Options Volume I, Option 37, p73-74.

⁴⁰ Ibid., p.73.

fee-for-service payment. For the most part, the predisposition of the nation's health care providers will still be to spend whatever the public's mélange of health care financing options permits, which in the aggregate operates with few dictates of what constitutes the most cost-efficient care.

The advancement of diagnostic and treatment technologies is thought to be the largest contributor to the rapid rise in health care spending. The spread of health IT may create efficiencies and lessen misinformation that creates health care mistakes, but it will do little to change the incentives of fee-for-service medicine to seek out those technologies and practice increasingly expensive forms of medical care.

Moreover, there is still the political mindset to use any savings generated by policy changes to expand governmental entitlements. The latest example is the SCHIP expansion enacted as one of the first measures taken up by the 111th Congress—higher cigarette taxes were used to fund expanded health insurance coverage of low-income children. As worthy as that may be, it illustrates the political penchant to squeeze savings out of the system only for expansions and liberalizations of federal programs, not for cost containment on its own merits. The President's campaign proposal to expand coverage of the uninsured represents another example. It called for funding by cutting excessive Medicare contractor payments. Again, a noble effort, but not one intended to temper the overall rise in health care costs.

To the extent that the three Administration initiatives discussed here increase efficiency and improve health care, they will represent a promising start to reforming the nation's health care system. While they all can be viewed as independent measures, they are compatible and the benefits of each can overlap yielding considerable potential as an integrated cluster of changes to advance the practice of medicine. For example, making a single health record electronically accessible to all health care providers through the oversight of a primary practitioner managing a wellness regimen and coordinating specialized services for a patient with chronic care needs has the potential to greatly improve the individual's well being, and perhaps save money. But realistically, these initiatives are probably best seen as only the beginning of what likely will be a complex and stressful search for health care savings.

Given the relative certainty that our current path is unsustainable, change is inevitable. And yet, before making major new spending commitments, the relative uncertainty of savings from various cost containment strategies should be tested. If the gamble is made that savings will occur sometime off in the future, and that gamble fails, our nation's economy will suffer as a result. If, on the other hand, we first ascertain that various cost strategies work, we will be in a better position to expand coverage and improve quality care without putting our future at risk.