

# Health Care Reform: Creating a Sustainable Health Care Marketplace



A Report to  
Business Roundtable  
By Hewitt Associates  
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**Contents**

*Executive Summary*..... 1

*The Status Quo Is Not Sustainable*..... 4

*Current Legislation Provides Opportunities  
for Real Savings*..... 7

*Risks Could Jeopardize Cost Reductions*.....15

*True Market Reform Can Yield Even Greater Savings...* 20

*Conclusion*..... 23

*Executive Summary*

As federal health care reform proposals work their way through Congress, companies and individuals are increasingly concerned about the price tag—not just to the federal budget, but to their own bottom lines and wallets. Will the proposed initiatives focused on expanding coverage and controlling federal health spending actually make matters better or worse for private-sector employers and the 160 million people who receive employment-based health insurance? The cost estimates for the different bills have primarily focused on the federal budgetary impact of health care reform.

Business Roundtable commissioned Hewitt to prepare this report to evaluate health care reform through the lens of the private sector and to project the likely effect of proposed legislative changes on employer health care costs. This report addresses four key questions:

- Of the reform initiatives currently being considered that intend to curb the rate of health care cost growth, which ones are likely to have a significant impact on the health care economy at large?
- What missing ingredients should be added to current proposals to enhance their potential to reduce future cost trends?
- What are the risks that could undermine the realization of these cost savings?
- What can be done longer-term to restructure the current health care delivery system in order to reduce annual health care cost trend to a sustainable rate, such as the overall rate of gross domestic product (GDP) growth (approximately 4% per year)?

**The Status Quo Is Not Sustainable**

In a report for Business Roundtable titled “Health Care Reform: The Perils of Inaction and the Promise of Effective Action,” Hewitt pointed out the

potential benefits of revamping the nation's health care system, if done wisely, and the pitfalls of inaction. Access concerns have rightfully been a big focus of recent national debates. However, for the 98 out of 100 companies (with 200 or more workers) that already provide coverage<sup>i</sup> and for their employees, rising health care costs are the primary concern. The current health care system continues to push spending upward at a pace faster than the growth in the overall economy. If U.S. companies are to remain competitive in an increasingly global marketplace, we must do more and do it faster to bring down the rate of increase in health care costs.

Without fundamental reform, there is little reason to expect that cost increases over the next 10 years will be different from the recent past. If the cost trends of the past 10 years repeat, by 2019, employment-based spending on health care at large employers will be 166% higher than today on a per-employee basis. This equates to an average of \$28,530 per employee when employer subsidies, employee contributions, and employee out-of-pocket costs are combined. We estimate that if enacted properly, the right legislative reforms could potentially reduce that trend line by more than \$3,000 per employee, to \$25,435. If we are able to enact broader market reforms that eventually lower future cost increases to an average of 4% per year, we could potentially reduce average per-employee costs further to \$23,151 per employee by 2019.

### **Current Legislation Provides Opportunities for Real Savings**

A number of the proposed reforms offer real promise, not only to save federal dollars, but also to reduce the rate of increase in private-sector spending if adopted and implemented appropriately. Promising ideas include proposed delivery system reforms such as value-based purchasing, Innovation Centers to experiment with alternative methods of provider reimbursement, accountable care

organizations, payment bundling, and financial penalties for avoidable hospital readmissions. We estimate that these and other sound reforms could potentially reduce the rate of future health care cost increases by 15% to 20% when fully phased in by 2019. This assumes the government implements the initiatives quickly, accurately, and consistently, and that private payers follow by implementing similar measures in a disciplined and timely way.

The current proposals are missing some ingredients needed to drive the type of system-wide change that can “bend the future trend” significantly and permanently. Most important, current reform provisions must be broadened if we hope to achieve a more “normal” market dynamic for health care costs across all stakeholders, both public and private. For example, value-based purchasing initiatives should be expanded beyond hospitals to include other services, such as outpatient services, rehabilitation services, and long-term care. Comparative effectiveness research is vital, but we must find ways to encourage providers to adhere to evidence-based guidelines and encourage purchasers to adopt evidence-based plan designs. And release of Medicare professional services claims data, with full protection of patient privacy, should be authorized in the final legislation. By making this broader set of claims data available to employer-provided health plans, consumers will be able to consider the cost and quality of services rendered by providers and make informed decisions about their treatment. The Innovation Center concept run by the Centers for Medicare & Medicaid Services (CMS) to test models for delivering and reimbursing care differently should be embraced and the scope expanded to assess the interactions with private health plans and create new options for both the public and private sectors. And medical liability reforms should be included, which are now largely missing from the leading health care reform proposals.

### **Risks Could Jeopardize Cost Reductions**

The cost-savings initiatives can only be fully realized as a part of comprehensive health care reform that is extended through the efforts of private insurers and the employer-sponsored system. The report identifies a number of risks that could undermine expected savings or shift more costs to the private sector, including:

- Delayed or watered-down implementations;
- Future legislative reversals of potential cost-saving provisions;
- Continuation of the practice and related costs of defensive medicine and the cost to providers of malpractice insurance;
- Failure to implement a strong individual mandate to minimize cost increases in the health insurance exchange plans due to adverse selection;
- Unintended consequences as health plans take steps to keep the cost of health coverage below the threshold for the proposed excise tax on high-cost plans or as employers are unable to live within the cap as it gets relatively tighter over time;
- Increases in the cost of health care to individuals from changes to flexible spending arrangements or actions that discourage consumer-engaged decision making; and
- Cost shifting to the private sector from reductions in federal reimbursements to providers and from a public plan option if included.

Avoiding these risks will require both changes to some of the current legislation and discipline in how reform is ultimately implemented in both the government and employer-sponsored health care system.

### **True Market Reform Can Yield Even Greater Savings**

Beyond the current legislative proposals, the biggest opportunities for cost savings in the long term would come from a continuous improvement process to make the current system function more like a true market system. This could lead to growth rates akin to the growth of the overall economy,

which we assume to be about 4% annually. The cost or savings from the current list of reform initiatives, as estimated for Congress, focus on the budgetary impact to the federal government. From the perspective of the private sector, this is really just the starting point of what is needed if businesses, as well as the government, are to realize sustained savings. If we can reduce employer (only) contributions to an annual growth rate of 4% per year through more comprehensive reform efforts, Hewitt estimates the cumulative savings to large employers by 2019 would be equivalent to the wage and benefit costs of 102,000 additional employees for each one million employees currently in the workforce.

If our collective goal as a nation is to “bend future trend,” the steps we take now must effectively manage the three key drivers of health care cost: price, utilization, and behavior. If not addressed, any one of these three forces could prevent the health care market from ever mirroring more traditional economic models. This report identifies a set of representative market-driven reforms. Most of these ideas are not new, but we believe that now is the time to take bolder steps to build decisively on the constructive legislative reforms under consideration. True market reform will:

- Encourage initiatives that give individuals greater accountability for discretionary health care spending decisions, including health reimbursement arrangements and health savings accounts;
- Make information on the cost and quality of care from physicians and hospitals readily available to patients so they can make more informed decisions as health care consumers;
- Develop payment system reforms that reward high quality and cost-efficiency;
- Eliminate regional variation in practice patterns to reduce overall spending by as much as 20% to 30%;
- Promote wellness and prevention programs and expand financial incentives to participate in specific programs to reduce lifestyle-related illness;

- Mandate an interconnected health care information system to lower administrative costs, reduce redundant tests, reduce medical errors, and improve coordination of care; and
- Create incentives to produce more primary care physicians before the looming shortage becomes a crisis.

Taken together, legislative reforms and broader market transformation can create the game-changing efficiencies needed in the health care sector. But the need to make the “right” decisions is more important than ever if we are to leverage legislation and the activities of the private sector to realize sustained reductions in future cost trends. The focus must not only encompass an analysis of the impact of reform on federal costs, but also incorporate an understanding of the potential risks and improvements that will flow to the employer-based system that provides coverage for the vast majority of Americans.

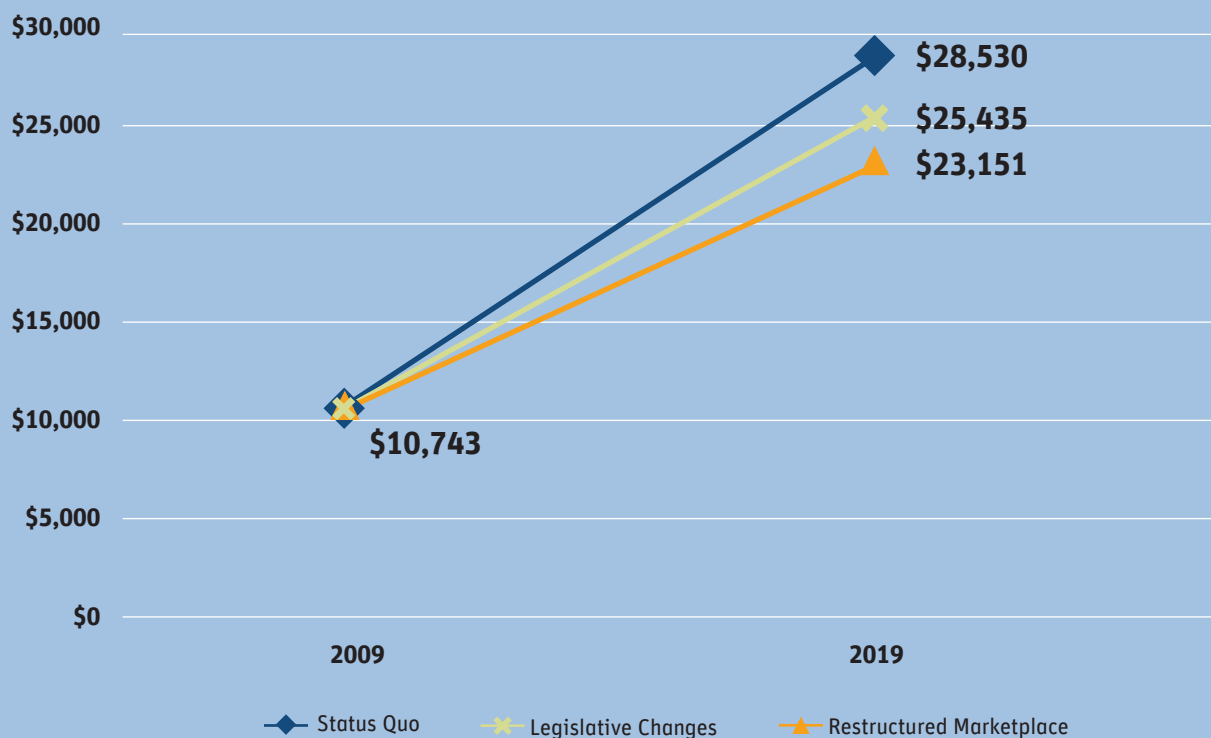
## The Status Quo Is Not Sustainable

A poorly functioning health care “market” is the cause of the rapid growth of health care costs well in excess of growth rates in other industries. In fact, the health care system does not act like a traditional market at all. Traditional forces of supply and demand are muted by a third-party, fee-for-service payment system and significant cost shifting between payers. By adopting significant market changes, it is possible to lower medical cost trends further than currently proposed reforms alone.

Exhibit 1 illustrates per-employee health care costs at large employers under three different scenarios:

- Continuation of the status quo, i.e., if the trends in growth in employer and employee contributions

**Exhibit 1: Comparison of Alternative Health Care Cost Rates: Status Quo, Legislative Changes, and Restructured Marketplace**



and employee out-of-pocket costs continue to rise at the same rate as they have in the past decade.

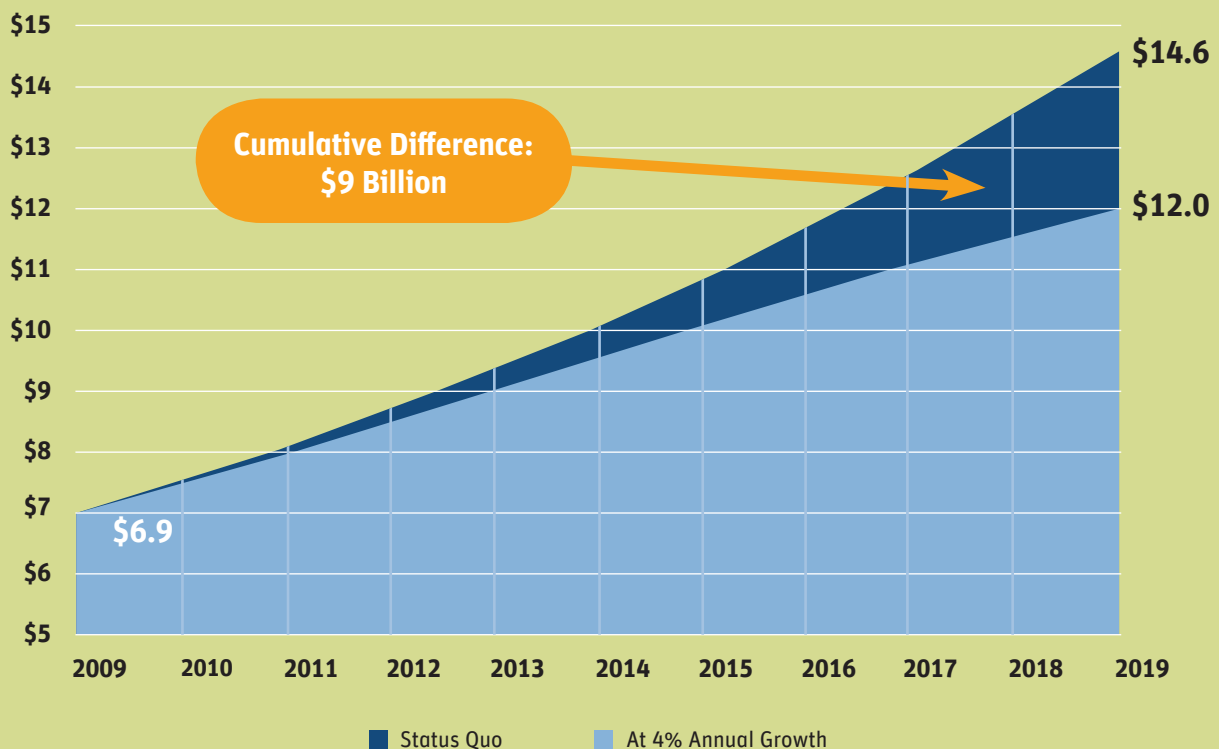
- A 15% to 20% reduction in those trends by 2019, assuming successful implementation of the legislative changes under discussion that offer the potential for real cost savings and avoiding the risk factors that could jeopardize such potential savings. Exhibit 1 illustrates the midpoint of that 15% to 20% reduction in future trend in 2019.
- Assuming broader restructuring beyond current legislative proposals that would lower future per-employee cost growth to an annual rate of 4% through more expansive improvements, resulting in a restructured health care marketplace.

Fundamentally changing a \$2.4 trillion industry will take time. As reflected in the chart above, the effects of market improvements may start out slowly. But with meaningful restructuring in place by 2019, the impact of a more efficient health

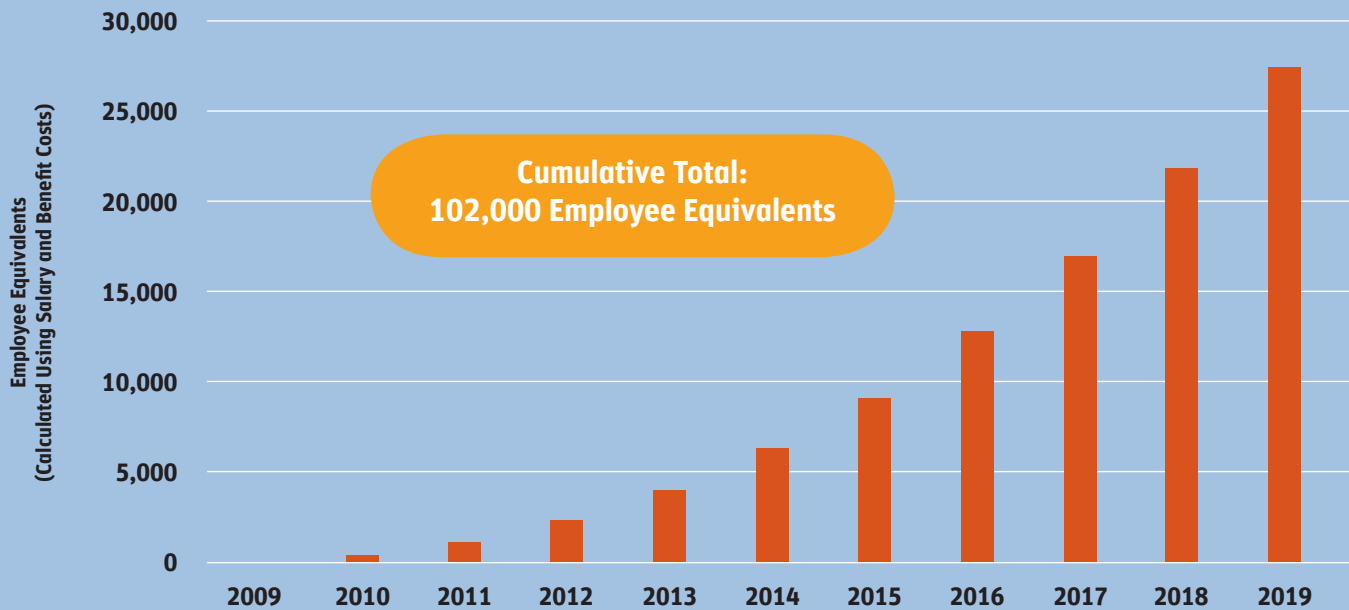
care marketplace on the global competitiveness of American business and the overall U.S. economy would be both measurable and significant.

To illustrate the potential impact, Hewitt estimates that for every one million people covered by large employer health benefit plans, large employer health contributions alone will be approximately \$6.9 billion in 2009, rising to \$14.6 billion in 2019 without meaningful reform. However, if trend rates for employer (only) contributions could be lowered from the current 7.7% annual rate to 4% by 2019, the cumulative savings to these companies would amount to \$9 billion (exhibit 2). Assuming a salary and benefit cost per employee of approximately \$69,000<sup>ii</sup> in 2009, by 2019 these cumulative savings would be roughly the equivalent of the wage and benefit costs of 102,000 additional employees (exhibit 3). This does not even measure the real wage growth that workers would enjoy over this same period. In fact, wage growth is currently

**Exhibit 2: Estimated Annual Large-Employer Health Care Spending per One Million Employees (\$ Billions)<sup>iii</sup>**



**Exhibit 3: Health Care Savings Relative to Employee Salary and Benefit Costs per Million Employees<sup>iv</sup>**



being stifled by double-digit annual increases in payroll contributions and out-of-pocket health care costs. This is the potential incremental power of health care reform—to stimulate business growth. Companies can then reinvest in jobs and innovation. Employees with higher take-home pay will spur consumer demand. And American companies can be more competitive in the global market.

To achieve such results, health care reform must be continuous and extend beyond the current list of “scored” initiatives that have been identified as potential cost-saving opportunities. Incremental efforts, like those proposed by House and Senate Committees, will undoubtedly be helpful over the long term. But on their own, they will not bend the cost curve as much as is needed to approximate the overall growth rate in the economy, and they could easily become sabotaged by the same risks that have plagued cost-control initiatives for decades. The current dynamics of the health care market

are often akin to “squeezing the balloon”—saving money in one area only to see costs reappear in another. This is the danger of making incremental changes without taking a total-systems view.

In this report, we identify the key proposed health care reform provisions that are likely to generate a measurable financial impact. We also propose additional reform initiatives that could drive true market change if enacted.

The report makes these assessments with several key questions to answer:

- What impact will the current reform initiatives being considered have on starting to control the rate of growth of health care costs, not just for the federal government, but for the economy at large?
- What missing ingredients should be added to the current proposals to enhance their potential to reduce future cost trends?

- What are the risks that could undermine or nullify the potential for cost savings for the private sector in the short term and in the long term?

The changes we identify are meaningful, but even with timely and complete implementation, they still leave health care cost trends significantly higher than growth rates in the rest of the economy. To avoid yet another missed opportunity for sustainable, long-term cost control, we must fundamentally restructure the way in which care is delivered. We must restore the connection between price and value with transparency of information, properly aligned financial incentives, and rewards for quality. We make suggestions below for what might be done longer-term to significantly modify the current health care delivery system.



## Current Legislation Provides Opportunities for Real Savings

In our previous report for Business Roundtable, “Health Care Reform: The Perils of Inaction and the Promise of Effective Action,” Hewitt identified a wide range of economic and social benefits that could result from effective health care reform. These included an important expansion of health insurance coverage and the introduction and creation of new markets in the form of health insurance exchanges

coupled with insurance market reforms. But we also said that simply expanding coverage without delivery system and other reforms to improve the efficiencies of the health care market could cause major problems: “Expanding health insurance coverage is critically important, but simply adding more people to an ailing system and spending more money will only make the existing cost problems worse.”

Now we are taking the analysis one step further and evaluating a broad range of legislative initiatives that could have a positive material impact on “bending” the future trend line for health care costs, to the order of 15% to 20% by 2019. This assumes the government implements the initiatives quickly, accurately, and consistently, and that private payers implement similar measures in a disciplined and timely way.

### Value-Based Hospital Purchasing

Proposed health care reforms can build on the success of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative. This hospital value-based purchasing (VBP) program in Medicare would move beyond pay-for-reporting on quality measures, to paying for a hospital’s *actual performance* on these measures. This would be a powerful incentive for reducing future health care cost increases.

For example, under the Senate Finance Committee’s America’s Healthy Future Act, funding for value-based incentive payments for qualifying acute-care hospitals would be generated by reducing Medicare inpatient prospective payment system (IPPS) payments to the hospitals. Predetermined IPPS rates that reimburse hospitals for acute-care hospital inpatient stays would be reduced to fund an incentive pool and would be phased in as follows: 1.0% in FY2013, 1.25% in FY2014, 1.5% in FY2015, 1.75% in FY2016, and 2.0% in FY2017 and beyond.

The Senate Finance Committee (SFC) bill also calls for expansion of a similar program for physicians—one that pays for *reporting* data, but not for actual *outcomes*. Other provider payment provisions call for reducing payments by 5% for providers at or above the 90th percentile in resource use and taking steps to pay providers based on quality measures.

The Congressional Budget Office (CBO) scores these actions as having the potential to save the federal government \$1.5 billion over the next 10 years. We believe that it will yield continuing savings beyond 2019. Neither CBO nor others have quantified the impact beyond 2019.

Changes in payment methodology under the Medicare program will act as a catalyst for broader market reforms. Once VBP becomes an accepted payment methodology under Medicare, private payers will be able to negotiate similar incentive structures for their commercial portfolios. This will create total savings from this initiative that would be a multiple of the savings accrued to the federal budget.

### **Incentives for Continuous Improvement and Innovation**

Some of the proposed health initiatives are aimed at achieving the kind of continuous improvement that is necessary to yield long-term savings. Comparative effectiveness research is a good example. Such research can lower cost and improve quality. And even though the “scores” associated with comparative effectiveness result in some cost to the federal government for conducting the research, the rewards are likely to be realized longer-term and in both the public and private sectors.

Another example of a step in the right direction can be found in the SFC provision that calls for the development of an “Innovation Center” run by the Centers for Medicare & Medicaid Services (CMS). This Center would be required to test models that drive change in at least one aspect of how care is

delivered and/or reimbursed. CBO scores the funding of this Center, and its resulting impact, as a net savings in Medicare spending of \$1.4 billion over 10 years. This projection is heavily back-end loaded, however, with early years showing a net cost.

The Innovation Center will build for the future by testing and improving the Medicare system on a continuous basis. The strategies can then be emulated by the private sector to produce multiples of Medicare’s benefit savings across the marketplace. Some of the models that would be tested under the Center include:

- Strengthening the primary care system and testing the concept of “medical homes”;
- Varying payments to physicians who order advanced diagnostic imaging studies, with payment based on the appropriateness of these studies;
- Supporting IT-enabled networks and tele-health capabilities;
- Funding nurse practitioners and physician assistants to manage chronically ill patients;
- Aligning evidence-based treatment guidelines with Medicare reimbursement levels; and
- Allowing states to experiment with all-payer systems to eliminate cost shifting between public and private sector programs.

These initiatives are all good examples of the kinds of practice innovations that will be required if reform is to accomplish its goals. As indicated by CBO, success will be measured over a long period of time and will likely involve successful local or regional demonstration projects before expanding to a national scale. The economic impact of these experiments on private-sector employers will depend on the priority of development, the speed of change, and the breadth of application.

## **Accountable Care Organizations**

The House and Senate health care reform bills include the creation of accountable care organizations (ACOs). Medicare has had practical experience with ACO-like organizations. The Medicare physician group practice (PGP) demonstration, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, created pay for performance incentives for physician groups (being paid fee-for-service) to coordinate the overall care delivered to Medicare patients.

CMS selected 10 physician groups on a competitive basis to participate in the demonstration, favoring multi specialty physician groups with well-developed clinical and management information systems. The 10 physician groups represented 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. Groups that were able to meet quality-of-care benchmarks and reduce their total expected Medicare spending by more than 2% were allowed to share in the savings they generated to the Medicare program.

In the most recent year of the PGP demonstration, all participants demonstrated improvements in quality and achieved below-average growth in costs. In addition, four were awarded with incentive payments for reducing costs below the 2% threshold. By 2019, CBO scores the SFC initiative as saving \$1.2 billion annually for the Medicare program.

Hewitt has conducted proprietary studies that find that private-sector savings from initiatives such as these can be very positive. These virtual adaptations of the original vision of coordinated-care plans offer reimbursements tied to overall performance and outcomes rather than to the amount and intensity of services. In 2007 and 2008, Hewitt conducted two proprietary studies of the financial efficiency of HMOs compared with other plans, based on data from the Hewitt Health Value Initiative (HHVI) database of large-employer plans

over a 10-year period. These studies showed that, in general, HMOs are 1% to 5% more efficient than PPOs, primarily because of greater provider discounts available in closed-panel models. However, the study also showed that specific HMOs—California HMOs in general and group/staff models in particular (Kaiser Permanente and Group Health of Puget Sound, for example)—were as much as 10% to 15% more efficient than PPOs.<sup>v</sup> These organizations shared several key characteristics that drove this additional efficiency:

- The presence of coordinated-care teams;
- Investments in health IT infrastructure to transfer information quickly and accurately across care teams;
- Financial arrangements with providers involving capitation payments per patient or straight salary; and
- Dissemination and adherence to evidence-based practice guidelines, including step therapy for branded medications.

Financial efficiency was not due to age, sex, geography, plan design, or health risk of the population. These plans performed better because the controlled environment allowed them to realign the incentives for superior performance. The Hewitt data shows the savings potential for private-sector employers to be much greater than the federal savings scored by CBO, especially as prevalence of these models increases to cover more geographies and employee populations.

## **Payment Bundling**

The prevailing payment system under Medicare (especially Part B) is to reimburse providers on a fee-for-service basis, rather than paying for services based on an episode of care. Similarly, under private health insurance, where the group health plans with the largest enrollments tend to be PPO plans, services are also accessed, charged, and

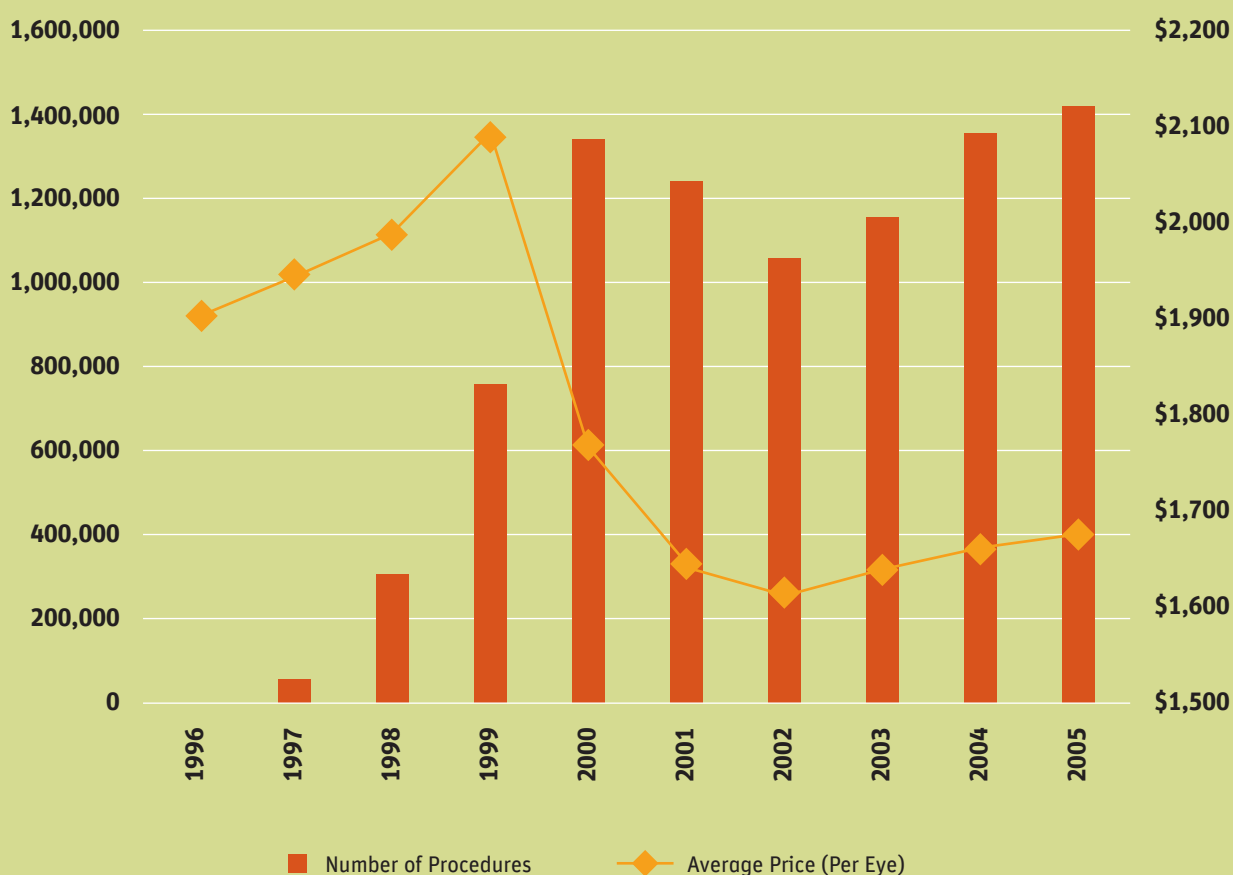
reimbursed on a fee-for-service basis. Establishing bundled payments would create more incentives for efficient treatments and could be adjusted based on outcomes. Health care reform proposals are moving toward bundled payments. Both the House and the Senate include provisions that focus on improved quality of care and patient outcomes. The SFC plan requires the Secretary of Health and Human Services to develop, test, and evaluate alternative payment methodologies through a national, voluntary pilot. The program is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013.

The pilot program may cover the following services: acute-care inpatient hospitalizations; physician services delivered inside and outside of the acute-

care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute-care hospital readmissions; home health care; skilled nursing; inpatient rehabilitation; and long-term care. The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge.

The Secretary of Health and Human Services would test alternative payment methodologies, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems but are held jointly accountable for the quality and cost of care provided to Medicare patients.

**Exhibit 4: Market Maturity of LASIK Surgery**



The pilot program's bundled payment would be made to a Medicare provider or another entity composed of multiple providers to cover the costs of acute-care inpatient and outpatient hospital services, physician services, and post-acute care. The comprehensive bundled payment would include the costs of any readmissions that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute-care payments made over the hospitalization period for the patient.

CBO does not score savings for this provision, mainly because the language above suggests that Medicare will pay the same as it would otherwise have paid, instead of some lower amount per episode. Over time, however, we believe substantial savings can be achieved by both removing the financial incentive to provide marginally effective services, as well as through the active management of the rate of increase in the bundled reimbursement rate.

The market for cosmetic surgery, particularly LASIK eye surgery, provides a real-market example of this effect. Unencumbered by a third-party payment system, LASIK surgery has developed as its own consumer market. Fees are bundled because this is how consumers purchase the procedure. As demand increased, competition also increased, driving prices down and quality up—just like any other “rational” consumer market (exhibit 4).

At least for discretionary services, the health care market can behave like a consumer marketplace—but only if the financial incentives are aligned to provide quality and value. The private sector is eager to move to a bundled payment arrangement to reward quality and shift away from fee-for-service-based payments, creating an efficient and consumer-centric health care marketplace.

### **Preventable Readmissions**

The pending health care reforms in the House and Senate include provisions to reduce hospital payments for preventable readmissions. For example, the SFC bill includes provisions to reduce hospital payments by 10% to 20% if a preventable readmission occurs. This applies only to the hospitals with the 25% worst readmission rates. CBO expects this action to save about \$2.1 billion over 10 years, with \$500 million per year in 2019, coupled with another \$500 million in federal savings per year from a transitional care program to reduce preventable readmissions.

The House Tri-Committee bill includes a more aggressive provision to reduce hospital discharge payments by up to 5% for the occurrence of preventable readmissions. This adjustment will apply to the payment for all discharges from any hospital that has excessive readmissions, as defined in the bill. CBO expects this payment adjustment to save about \$19.1 billion over 10 years, with \$3.6 billion per year in 2019.

While the rate of hospital admissions is highest in the elderly population, systemic improvements to minimize hospital readmissions will produce savings for the private sector as the programs put in place to avoid these readmissions are applied to all patients.

### **Medicare Commission**

Congress is also considering the idea of creating an independent Medicare Commission that recommends changes in provider reimbursement. Details vary, but the Commission's recommendations would go into effect unless Congress acts to prevent it. Under the SFC bill, beginning with the 2013 report of the Medicare Trustees, the CMS Office of the Actuary (OACT) would be required to project whether the Medicare per-capita growth rate in 2015 will exceed the average of the growth rates in the Consumer Price Index (CPI) and the Consumer Price Index for Medical Care (CPI-M) projected for 2015.

If the projected excess cost growth is estimated to be greater than the average of CPI and CPI-M, the Commission would be required to submit a proposal to Congress by January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015, as estimated by the OACT. The SFC plan would require the Commission to make additional proposals on January 1 of 2015, 2016, and 2017, based on the procedures described above. However, the targeted level of Medicare savings would increase each year. The proposal delivered to Congress in 2015 would be required to reduce excess cost growth by 1.0 percentage point in 2016. The proposal delivered to Congress in 2016 would be required to reduce excess cost growth by 1.25 percentage points in 2017. The proposal delivered to Congress in 2017 would be required to reduce excess cost growth by 1.5 percentage points in 2018. The growth target in 2019 and beyond would be GDP per capita plus 1%.

CBO estimates that this concept could yield substantial savings of \$22 billion over 10 years and \$7 billion per year in 2019. Unfortunately, there do not appear to be any specifics on what would actually have to occur to achieve those results. It is also unclear whether the efforts to reduce Medicare spending in accordance with the SFC bill would be accomplished through direct or indirect cost shifting to the employer-driven private insurance market, a risk that could increase non federal health care costs. Private employers can, however, take additional steps to ward off the potential for full cost shifting, and it is possible (though impossible to quantify) that some of the same provisions that would reduce Medicare spending would also help to keep Medicare payroll taxes lower than what they otherwise might have been in their absence. Such savings would accrue to employers and employees who share the payroll tax, or fully to employees if, as economists often assert, health care subsidies by employers are reflected in forgone wages.

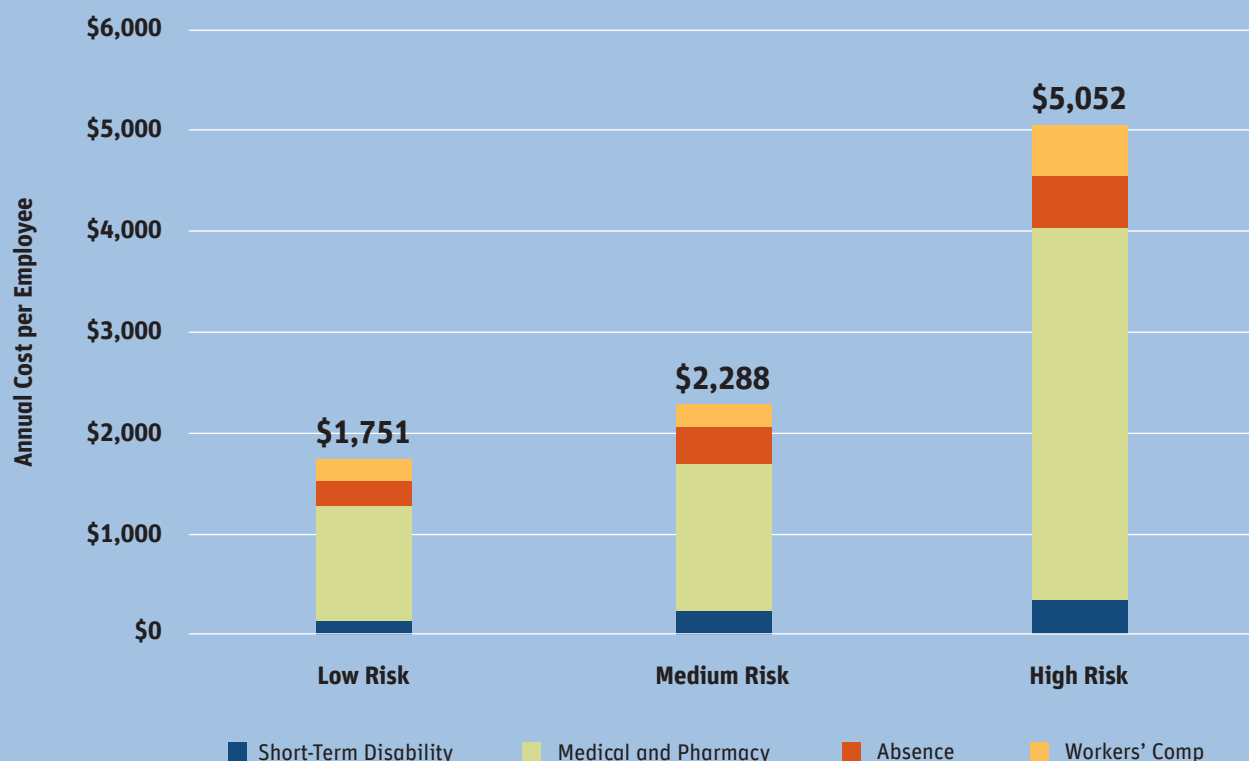
The proposed Medicare Commission—combined with the other provisions for delivery system reforms and for continuous improvement and innovation in Medicare—sets a framework for positive reforms of the Medicare payment system and, by extension, enhances the ability of commercial payers to adopt these reforms system-wide.

### **Promoting Wellness and Prevention**

Over the long term, the largest potential savings in health care may come from behavioral change. The idea is that individuals become personally engaged in maintaining their health by taking appropriate actions to avoid preventable conditions and detect other conditions as early as possible. Health care reform proposals take a step in this direction. Under the SFC bill, Medicare will reimburse for a personal wellness planning visit each year, which includes the administration of a health risk questionnaire (HRQ). The SFC bill also calls for the removal of cost sharing for preventive services in Medicare. In addition, there is a provision that Medicare will fund a small healthy lifestyle incentives program, giving beneficiaries credits for participating in these programs. Overall, CBO scores these provisions at about a \$4 billion cost over 10 years. We believe that while the costs of additional services can be easily quantified, the savings that will likely accrue from improved prevention and wellness relative to chronic health care conditions are important to recognize—even if they would be harvested over a longer period of time and probably outside the 10-year CBO budget projection period. Large employers have come to believe that targeted improvements in wellness and prevention can improve health outcomes and reduce the costs of chronic illness, improving not only the company's cost profile, but also the productivity of their workforce.

In addition, the provisions of the SFC and Senate HELP Bills that permit health plans to grant higher discounts from premiums for those who participate

**Exhibit 5: Increased Employment-Based Costs for Lifestyle-Related Illness<sup>vi</sup>**



in programs that promote healthy behaviors can provide a powerful incentive for healthy behaviors. Employers use wellness programs and incentives to encourage individuals to improve lifestyle risks, such as eliminating tobacco use and increasing physical activity. Exhibit 5 demonstrates how lifestyle-related illnesses directly affect the cost of employment-based benefits. Individuals with high risks have benefit costs that are nearly three times that of low-risk individuals. Prevention of lifestyle-related risk and associated illness can have a significant impact not only on the cost of providing employment-based *health care* benefits, but also on the cost of providing *all* employment-based benefits.

#### **Strengthening Primary Care and Other Workforce Improvements**

The SFC bill proposes to pay physicians and health care systems more to encourage primary care and general surgery versus specialty care. This is a

change that is directionally positive for improving the health care system. These and similar initiatives have costs associated with them, estimated by CBO at about \$4.2 billion over 10 years, but these are also changes that will be needed if health care is to be moved in the direction of more coordinated care and an emphasis on treating more patients with greater efficiency.

#### **Missing Reform Elements Needed to Drive System-Wide Change**

Many of the health care reform initiatives under consideration will have a positive material impact on “bending the future trend” line for health care costs. But the current bills exclude some ingredients necessary to drive the type of system-wide change that can lower costs significantly and permanently. Current reform provisions must be broadened if we

hope to achieve a more “normal” market dynamic for health care costs across all stakeholders, both public and private. For example:

- Value-based purchasing (VBP) initiatives should be expanded beyond hospitals to include other services, such as outpatient services, rehabilitation services, and long-term care. CBO has scored these as having only a minimal impact on costs in the 10-year projection period. However, when coupled with hospital and physician initiatives, these VBP efforts further underscore the notion that health care dollars should be spent where outcomes are favorable and value is high. This is a key directional change pointing to more of a health care *market* in which price (or reimbursement) reflects value and quality.
- Health providers must be encouraged to adhere to evidence-based guidelines and encourage purchasers to adopt evidence-based plan designs. Health care cost increases occur when more expensive technologies and treatments are prescribed without solid evidence identifying which treatments work best for which patients. Comparative effectiveness research can close that gap, but the savings are contingent upon actually changing provider behavior in ways supported by the evidence.
- Release of Medicare professional services claims data, with full protection of patient privacy, should be authorized in the final legislation. By making this broader set of claims data available to employer-provided health plans, consumers will be able to consider the cost and quality of services rendered by providers and make informed decisions about their treatment.
- The Innovation Center concept run by the Centers for Medicare & Medicaid Services to test models for delivering and reimbursing care differently should be embraced and the scope expanded to assess the interactions with private health plans and create new options for both the public and private sectors.

- Medical liability reforms should be included, which are now largely missing from the leading health care reform proposals. In the “Health Care Reform: The Perils of Inaction and the Promise of Effective Action” report, we discussed the potential merits of medical liability reform and provided examples of how certain state reforms have enabled medical providers to redirect savings from lower medical malpractice premiums toward safer and better patient care for more people. We also suggested a system in which physicians who practice according to evidence-based guidelines would enjoy a “safe harbor” from litigation to eliminate the growing tendency to practice defensive medicine. Effective tort reform could directly reduce federal spending. In response to a request from Senator Orrin Hatch (R-UT), CBO released its score of tort reforms that would include a cap for economic damages, a cap on punitive damages, offsets for income from other savings, and a statute of limitations. CBO has estimated the direct and indirect value to federal programs of these tort reforms at \$54 billion over 10 years. The impact on the total health care system could easily reach \$100 billion over this same period.

### Summary

While the preceding discussion presents those reform initiatives that are likely to have a favorable financial impact, there are other key reform provisions that will add costs to the system. These include expanded health insurance access and coverage, federal subsidies to make premiums affordable for more people, and, in some cases, richer benefits than individuals may be able to purchase in the individual market today.

But when all savings opportunities (and corresponding investments) are taken into account, the delivery system changes as scored by CBO can potentially generate more than \$30 billion in

Medicare savings over 10 years and align Medicare spending with the growth rate of GDP plus 1%. In the decade beyond 2019, CBO has also projected that the SFC bill, for example, will reduce the federal budget deficits by one-quarter to one-half of GDP, which translates into several hundreds of billions of dollars in deficit reduction.

But the current reform provisions must be broadened if we hope to achieve a more “normal” market dynamic for health care across all stakeholders, public and private. The private sector will need to take additional steps to translate the government savings to private-plan savings. And private-sector employers and their health plans will need to be especially diligent to guard against increased pressure on providers to shift costs to private plans, thereby “squeezing the balloon” and failing to generate sustainable cost savings for the overall system.



## *Risks Could Jeopardize Cost Reductions*

The cost-saving initiatives under discussion can be fully realized only as a part of comprehensive health care reform that is extended through the efforts of private insurers and the employer-sponsored system. The final bill will need to be carefully crafted and subsequently implemented to minimize the risks to achieving meaningful health care reform. Following are key risks that could undermine or nullify efforts to bend the cost curve, or potentially aggravate the current cost problems:

- **Modifying timelines or requirements or reversing legislative actions could dilute savings.** The projected savings assume that programs are implemented as described in the various bills. If the implementation timeline is delayed, so too will be the savings. Furthermore, if Congress loosens requirements for quality improvements or payment reforms throughout the implementation process, the savings opportunities could be significantly diluted. For example, the sustainable growth rate (SGR) provisions for Medicare provider payments were enacted in 1997 to protect the Medicare program’s fiscal sustainability. But Congress has consistently overridden the payment cuts required by SGR. If similar triggering mechanisms envisioned in the proposed legislation do not occur on schedule and in full, health care reform is at risk for increasing federal deficits and failing to curb costs for employers and employees.
- **Without medical liability reform, providers will not have the protections needed to reduce unnecessary care.** Medical liability reform would foster greater freedom to create alternative treatment models for routine triaging that rely less on direct physician involvement. These models would not only affect cost favorably by encouraging greater use of lower-cost providers, but also enable primary care physicians (PCPs) to spend more time on patient care management. Unless actions are taken to bolster the ranks of PCPs, such alternative treatment models may prove critical to enhance overall care management and encourage the type of patient-physician interaction that leads to true behavior change. Absent tort reform, creative advancements could be tempered or abandoned altogether.
- **Without a strong individual mandate, adverse selection will raise costs for those enrolling in exchange plans.** Today, individual health insurance is either not available or not affordable to those who need it the most. In each of the

health care reform bills, health insurers would be required to offer guaranteed-issue coverage with no preexisting condition exclusions, eliminating discrimination against individuals with prior or existing health risks. For this new guaranteed-issue insurance to be affordable, insurers must be able to spread risk across a diverse population, including the young and healthy. By requiring all Americans to purchase health insurance, a robust individual mandate will guarantee that this risk spreading occurs. If the penalty for ignoring the individual mandate is too weak, individuals who have limited health risks may still choose to go without insurance. This raises the cost of insurance for those who do buy insurance, because the overall risk pool is more costly. In the SFC bill, only 23 million individuals are expected to enroll in the exchanges, compared to the House Tri-Committee bill, where 30 million individuals are expected to enroll in the exchanges, according to CBO.

In addition to stabilizing the insurance premiums in the individual market, a robust individual mandate that significantly reduces the number of uninsured Americans will also reduce the cost shifting of uncompensated-care costs to employer-provided insurance.

Under the current system, the cost of health care for employers offering good health coverage to their employees is higher than it should be. One of the reasons for this is the cost of uncompensated care. A recent CBO report put the cost of uncompensated care at 5% of hospital costs and 1% of physician costs.<sup>vii</sup> We believe it is reasonably conservative to assume that the additional cost incurred by private plans to offset provider costs for uncompensated care is about 2% to 3% of an employer's health care costs. Based on the current data, economists do not agree, with some projecting higher ranges and some projecting lower ranges.<sup>viii</sup>

Ultimately, a weak requirement for individuals to purchase coverage could result in less savings from reductions in the costs of uncompensated care, as well as higher premiums and higher federal subsidies in the health insurance exchanges as the younger and healthier individuals choose to decline coverage.

There is an active debate about how much individual insurance costs will increase without a strong individual mandate, and we will not attempt to quantify this amount with any degree of certainty. We are confident, however, that insurance costs *will* rise without a plan that spreads risk across the pool. Every attempt should be made to encourage even the healthiest individuals to purchase coverage. This will minimize cost shifting from uncompensated care to employer-based coverage and result in more affordable coverage for everyone.

- **Revenue raisers such as the high-cost tax may make health insurance costs worse for affected plans and employees.** The most important controllable factors affecting an employer's health plan costs are the amount that employees contribute toward the cost of the plan, the plan design itself (e.g., coinsurance, copays, and deductibles), geographic location, and the health status of the covered population. The proposed tax on high-cost plans does not take into account that some health plans may exceed the cap because of factors like the age, health status, and geography of their workforce, rather than an overly generous plan design. Employer plans with participants in these situations could see their health-related costs increase as the costs of the high-cost tax are paid by the health plan, passed directly to employers, and then passed on to health plan participants.

There is little doubt that the tax paid by the health plan will be passed to the employer in full. In fully insured plans, one need only look at state

premium tax assessments as evidence that insurers include taxes in their expense formulae. In self-insured plans, third-party administrators do not collect enough in administrative fees to offset any portion of tax payments, and the taxes paid would undoubtedly be assessed directly to the plan sponsor. If the employer pays the tax, it would be at the expense of wage growth or normal increases in employer subsidies for health care. If the employer assessed the employee participating in the plan, it would translate into a direct reduction in take-home pay, further restraining economic growth.

There would also be effects on existing coverage. Some of these effects are aligned with the intent of the tax—to provide incentives for employees to elect lower-cost plans—and as this occurs, it will lower overall system costs as long as the modified plan under the cap does not create financial barriers to getting preventive and maintenance care. While the health care reform proposals all admirably seek to expand use of prevention and wellness in the coverage options, changes in tax treatment could inadvertently undermine or nullify this effort. The tax also changes the relative efficiency of employer-provided health insurance as a part of the employer's total rewards package. Under the current tax code, the preferred tax treatment of employer-provided health insurance means that a dollar of health insurance benefit is worth 20% to 30% more than a dollar of wages. The high-cost tax will dilute this relative efficiency and could cause some employers to eliminate health insurance benefits.

Furthermore, the current interpretation of this tax will cause disparities among employers and employees relative to geographic location, age, and health status. Most large employers price at least one of their options on a national basis, without regard to geographic variation. There may be other options, such as local HMOs, that have some built-in geographic disparity. Any

high-cost tax cap proposal that does not account for wide geographic variation could be considered inequitable by enrollees. This could lead to unintended shifts in coverage, with complex and unpredictable effects.

Unless exceptions are made, a dollar-denominated tax cap would have a disparate impact on employers with an older workforce and could also raise intergenerational equity issues. Health care costs typically rise with age, and that alone would tend to push the cost of health coverage above the cap in companies with relatively older workforces. Even within the same company, the high-cost tax could raise equity issues, as younger employees would receive more premium increase passed through than they otherwise would if the pass-through tax were imposed on the cost of coverage for their age group. Small companies may pay age-related premiums, unlike large employers where premiums are expressed as a flat dollar amount by coverage tier.

Assuming that the indexing of the cap would not keep pace with medical inflation, the impact of the high-cost tax will get tighter and tighter over time. Employers and employees would be forced to decide which benefits to drop or curtail to remain beneath the tax threshold. Dental and vision plans might be dropped without regard to the effects on health status. Flexible spending arrangements and health reimbursement arrangements would be another likely target, further increasing employee costs and taking away a key tool in the consumer health movement.

Clearly, the impact will vary based upon how the tax is applied and on how insurers and employers respond. CBO and others believe the cap would have a powerful effect on reducing the future rate of increases in health care costs, based on the assumption that most employer health plans will try to stay below the cost threshold that would

trigger the tax. But regardless of the method, this tax imposes extra costs on employer-sponsored plans, which will likely lead to two unintended consequences: Employers will raise out-of-pocket costs for employees to mitigate the impact of the tax, and certain employers will drop employer-sponsored coverage as the cost of providing additional benefits exceeds the cost of paying their employees more in cash.

- **Changes to flexible spending arrangements will raise costs for individuals.** Almost all large employers, including the federal government, offer a flexible spending arrangement through which employees can pay health care and dependent care expenses on a tax-free basis. The Flexible Spending Accounts for Federal Employees (FSAFEDS) program offers three different flexible spending accounts (FSAs): a health care flexible spending account, a limited expense health care flexible spending account, and a dependent care flexible spending account.

In general, these programs have never had large participation, primarily because of the annual use-it-or-lose-it requirement. Employees who do choose to participate find the benefit very valuable. In 2008, the average enrollment percentage in the plans that Hewitt administers was 3% for dependent care flexible spending accounts and 23% for health care flexible spending accounts. The average pay of workers using these accounts is approximately \$72,700. The health care FSA balances may be used for other covered dependents of the employee and for the employee's spouse. Note, however, that accounts used for health care expenses will be widely tested for nondiscrimination for the first time in 2009. This means that these accounts must follow strict rules so that workers who are highly compensated (for 2009, those making more than \$110,000 annually) do not receive more generous benefits than those making less than that amount. In other

words, these accounts are required to benefit a broad cross-section of workers.

According to Hewitt data, three-quarters of FSA expenses are for prescription drugs and medical treatments, which is an important source of funds for maintenance care and medications. Reducing the availability of the benefit will make care more costly for the employee, particularly for those needing maintenance care related to chronic conditions and for those whose health needs are not covered by the medical plan, such as dental and vision care.

Recommendations to place statutory limits on health care FSA contributions are probably not necessary. Employers have both economic and policy reasons for voluntarily adopting such limits. Hewitt data shows that 92% of large employers allow \$5,000 or less to be contributed to a flexible spending arrangement that is used for health care, and there is a statutory limit of \$5,000 already in place for dependent care.

- **Discouragement of health reimbursement arrangements.** Health reimbursement arrangements (HRAs) were introduced through an IRS ruling in 2002 and were the first arrangement to allow a rollover of funds from year to year. HRAs do not allow employee salary reduction contributions.

However, because they allow an employee to save employer contributions over time, they provide a strong incentive to avoid unnecessary care and create a potential future source of funds that can be directed toward future expenses or for retiree medical coverage if the employer provides that coverage. Including HRA employer contributions toward the high-cost tax threshold could create additional disincentives for employers to offer such plans, eliminating one of the powerful ways employers can reinforce good consumer behaviors and for employees to begin saving money for retiree health care expenses.

- **Cost shifting from the public plan option.** There has been much heated debate about the merits of a public health insurance option to compete with private insurance plans. While some legislative proposals would create a public plan option for both individuals and small businesses through the exchanges, the market dynamics of any public plan will likely extend to large employers outside the exchanges.

It is well known that private payers are subject to higher costs because hospitals and doctors charge them more to compensate for below-market reimbursements from Medicare and Medicaid.

Economists vary in their views about how much of the difference between employer-sponsored and public payments truly represents “cost shifting” from public to private plans. But the fact remains that Medicare and Medicaid reimburse providers at much lower levels than commercial payers. For example, according to a 2008 Milliman actuarial study,<sup>ix</sup> Medicare reimburses hospitals at an average of 70% of private-plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 67% of private-plan rates and pays physicians at an average of 53% of private-plan rates. And the Lewin Group estimates that Medicare reimburses hospitals 71% of private-plan payments (for doctors it is 81%).<sup>x</sup> Structuring a public plan option with payments equal to or slightly greater than Medicare rates risks exacerbating current cost shifting. As private-plan costs continue to rise under this pressure, more employers will be squeezed out of the employer health care system as coverage becomes unaffordable. Over time, this cost-shifting cycle could risk unraveling the entire employer-based system. Even if it is not fiscally feasible to close this gap in public-private reimbursement rates to providers, at a minimum, health care reform should ensure that the payment differential does not worsen further, because this would create even more cost-shifting

pressure on private payers and potentially lead to a two-tier system where employers offering their own plans are at a significant cost disadvantage.

In light of the significant risks to private health insurance coverage associated with a public plan and the expected availability of competitive options through the exchanges, the potential savings from reductions in federal spending could have the adverse impact of significantly raising private health plan costs for employers and for employees.

- **The impact of reform will be limited without adoption by employers and private insurance companies.** The cost-saving opportunities in the proposed reform bills are directed at the Medicare program. This will directly serve to reduce federal health care spending. It is natural for Medicare to lead these reform changes. Medicare has proved that it can demand payment reform and quality-of-care reporting from its provider base. However, if trends in the employer system are going to be reduced, these initiatives need to be implemented in the private insurance market as well. (In fact, employers have been at the forefront of innovation for improved quality of care, as well as cost and quality transparency.) Only then will total health care expenditures moderate and true health care market reform be possible.

Expansion of health care reforms beyond Medicare programs requires aggressive actions on the part of employers and private insurance companies. Employers and private insurance companies must build on health care reform by taking positive action to adopt and fully leverage the improvements that Medicare brings forth as a result of health care reform. This includes such aggressive changes as defining an acceptable cost trend and limiting provider reimbursements to those increases, including such factors as increases in utilization and intensity of services.

Such changes in the private system would seem completely revolutionary were it not for Medicare leading the way. Employers must be willing to follow Medicare's lead and pursue uncompromising cost and quality management in order to bring about meaningful and sustainable trend mitigation. This means accepting the consequences of providers dropping out of their networks if they are not willing to accept new payment methods such as bundled payments and limited budget increases for accountable care organizations.

### Summary

These risks do not represent an exhaustive list of factors that could impede realization of the cost-saving potential of pending health care reforms. They are also not a justification to halt health care reform. Rather, they suggest that the cost-saving components of any final legislative measure, and of any subsequent legislative and regulatory changes, must be implemented in a way that minimizes the very real risks that could undermine or nullify overall savings across the system.



## *True Market Reform Can Yield Even Greater Savings*

In a well-functioning market, a prospective buyer chooses among competing sellers to purchase a product or service. Information is gathered with

respect to relative quality and cost, and the buyer pays the seller directly. The dynamics of supply and demand govern the market price for a particular product or service. In the current health care system, the dynamics of supply and demand, as well as information transparency, break down. The seller (the physician) tells the buyer (the patient) what and how much needs to be purchased, sets the price, and submits the bill to an outside third party for payment. At no point in this exchange do the buyer and seller discuss price. And the patient does not have a choice to make a value-based purchase decision even for services for which the physician has no financial interest, such as hospital services, laboratory, imaging, and prescription drugs. Under this economic model, double-digit growth in costs is inevitable.

Current reform efforts seek to address access issues, certain aspects of provider payment, and some elements of how services are delivered. While these are important, they do not by themselves create a shift in the underlying economic structure of health care delivery. To successfully reduce future health care cost trends to something approximating the overall rate of growth in the economy, more is required than the 15% to 20% reduction in future trend that Hewitt estimates may result from full implementation of the delivery system reforms and related changes in the various health care reform bills. Using the basic tenets of reform, employers need to embrace and drive a broader set of changes that can begin to create greater economic balance to our flawed health care model.

To further underscore this issue, many of the ideas being considered in reform legislation can serve as “enablers” that enhance the ability of private payers to realize greater efficiencies and improvements in quality. However, they are not sufficient to radically bend the cost curve to levels that the private sector may consider desirable and attainable. This is not to say that the elements of constructive

health care reforms should not be adopted, but rather that they should be considered in concert with a broader vision.

The following represent the market-driven reforms that we believe are necessary for a well-functioning health care marketplace:

- **Individual accountability.** As Nobel Prize-winning economist Milton Friedman once said, “Nobody spends someone else’s money as wisely as he spends his own.” A third-party payment system that insulates both the provider and the consumer of care from the financial consequences of purchase decisions is doomed to perpetuate a cost-rising spiral. Some would argue that health care spending is not a consumer good—it is emergent, it is often life-threatening, and the purchase decision must be made when the patient is in a vulnerable state of mind. However, many health care decisions are discretionary: whether to take a generic or brand-name drug, which imaging center to use, and which physician provides the best balance of high quality and cost efficiency for routine care. These discretionary decisions should require active participation of the patient, with financial incentives aligned for the best possible outcome at a reasonable cost. There comes a point where health care is not discretionary, and health benefits should provide protection from catastrophic loss. But well-structured benefit plans should contain cost-sharing provisions that encourage patients to seek the right care at the right time in the right place.

Empirical evidence is emerging from consumer-driven experiments using health reimbursement arrangements and health savings accounts as consumer-enabling vehicles. In many of these studies, utilization levels have dropped signifi-

cantly without any corresponding decrease in quality of care. Efforts to mandate minimum benefit levels without the right incentives for providers and consumers will ultimately contribute to uncontrolled utilization that will drive the cost of these benefits to unaffordable levels.

Individual accountability also extends to the responsibility to purchase and maintain comprehensive health insurance coverage. There can be no “free riders” in an efficient marketplace. The cost of health care has reached a level where sometimes not even higher-income employees can afford to pay for acute-care services directly, and medical bankruptcy is a term that has unfortunately become all too real for many Americans. To deliver on health care reform’s goal of eventual universal coverage, every participant in the health care system must be required to maintain insurance coverage sufficient to pay for the services he or she may consume that his or her own assets cannot cover.

- **Full transparency and dissemination of cost and quality information.** Active participation by patients in discretionary purchase decisions is possible only when there is full transparency of cost and quality information. Most providers are well educated on the efficacy of various treatments but do not necessarily know the full cost of these treatments. Patients deserve to know the quality of the physician and hospital providing treatment to them and their families. Ironically, the federal government has within its power the ability to significantly advance this effort by making available the comparative quality information on physicians reimbursed through the Medicare program. This robust data set, if available in a way that preserves patient privacy, would transform the measurement of physician quality far beyond any private effort that has been attempted to date.

- **Reducing the variation in practice patterns.** For more than 20 years, the Dartmouth Atlas Project has measured the variation in Medicare spending across every major market in the United States. The discrepancies are wide and often explained by differences in the geographic cost of providing services, by differences in health, and by variance in available technology. However, the study's authors conclude that differences in spending are largely due to "discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other resources—and a payment system that rewards growth and higher utilization."<sup>xi</sup> As Princeton economist Uwe Reinhardt aptly said, "How can the best health care in the world cost twice as much as the best health care in the world?" The pending health care reform proposals take steps to encourage comparative effectiveness research, but a broader effort to eliminate regional variations in practice patterns could reduce overall health care spending by as much as 20% to 30%.
- **A focus on health, not illness.** The most effective way to control health care costs is to prevent or reduce the need for health care in the first place. Upwards of 50% of all health care spending is related to lifestyle-related illness. To realize the potential of an efficient health care system, we must reverse that trend. Promoting workplace wellness and prevention, strengthened by the provisions in the SFC and the Senate HELP Bills to expand financial incentives to participate in specific wellness programs, is an important first step—but it is only a first step. The very behaviors that create chronic disease need to change, and this will take efforts beyond what is possible by any one employer or federal program. We need to embrace a public health revolution around changing the way we live our daily lives.
- **Further investments in adoption of information technology.** The fact that the United States uses more sophisticated technology to ship packages across the country than it uses to transmit medical records across town is a reflection of how far the health care system needs to go to realize the efficiencies that information technology investments can bring. There has been no mandate to create these efficiencies because there has been insufficient price competition to demand it. While one of the primary beneficiaries of health information technology would be insurers, the burden of investing in this technology has fallen to providers. A fully wired and interconnected health care system would not only significantly lower administrative costs, but also reduce redundant tests, speed effective treatment, reduce medical errors, and improve coordination of care. The technology is available—but to fully enable a digital health care system, it will take uniform federal standards for interoperability and data exchange, safeguards to protect patient privacy, and financial incentives for compliance.
- **Addressing professional service capacity.** According to The American Academy of Family Physicians (AAFP), the United States will have a shortage of 40,000 primary care physicians by the year 2020. Long hours, low relative compensation, and an average debt burden of \$150,000 per graduate have driven medical school students toward higher-paid specialty practices instead of primary care. As we cope with the baby boom generation entering its high health care consumption years, the current shortage of primary care physicians will only get worse. A national strategy for addressing the looming primary care physician shortage is required. This should include greater equity between primary care and specialty care reimbursements, increased payment for evaluation and management services, debt relief for students entering primary care services, and greater utilization of nurse practitioners, physician assistants, and other allied health professionals.

If our collective goal is to “bend the future trend,” the steps we take now must effectively manage the three key drivers of health care cost: price, utilization, and behavior. If left unchecked, these elemental forces will prevent the health care market from ever mirroring more traditional economic models. To reach a successful market reform solution, an optimal set of outcomes will be to:

- Transition from paying for volume to paying for value;
- Differentiate provider performance based on objective data;
- Hold providers accountable for managing their patients’ overall health; and
- Encourage individuals to take more ownership of the lifestyle and health care purchasing decisions they make.

Together, these principles are “game changing” events. The pending health care reforms may embrace these concepts incrementally and, depending on their provisions, point us in the right direction. However, meaningful and sustainable improvements in the cost and quality of health care will require a continuous improvement process focused on more sweeping changes to how care is acquired, delivered, and reimbursed.

## Conclusion

The health care reform legislation being considered by Congress contains some critical components that will address several of the key limitations of our current health care model. If fully implemented and sustained, they will eventually permit a potential reduction in future cost trend of an estimated 15% to 20% if private payers also leverage the effects of potential cost saving and quality improvement measures and the legislative and implementation risks of jeopardizing such cost reductions are avoided.

With the reform effort focused primarily on health programs delivered by the federal government, we should not expect these efforts on their own to create the system-wide changes needed to drive substantive costs out of the private system. However, the legislative underpinnings will—if adequately, accurately, and consistently implemented—encourage employers and other payers to leverage these same concepts into the private insurance market. These changes will have a material impact in four ways:

- Transition to a value-based delivery/payment model;
- Create the ability to differentiate providers based on performance;
- Implement models that hold providers accountable for effective care; and
- Provide incentives and an infrastructure that enable individuals to make more informed health care purchasing and lifestyle decisions.

But as noted in this report, cost savings of a significant magnitude are by no means guaranteed. Some of the potential will not be realized if policy-makers do not also pay close attention to the risk that health care reform may deviate from the form analyzed in this report, either in final legislation this year or in subsequent years when continued tough choices are needed.

If current health care reform is the enabling event that facilitates substantial change, we can begin to transform health care into a “more normal” economic model with a cost structure that approximates the overall trend in GDP. Clearly, doing so requires bold actions that may force individual constituencies out of their comfort zone. Health care has evolved into a \$2.4 trillion enterprise. Any efforts to shrink that business enterprise means that some parties will suffer income erosion, even if partially offset by the movement toward more universal coverage. The degree of change needed to create a healthy health care market that can achieve and sustain a 4% cost trend must be far

more than incremental. One should expect that there will be pockets of significant resistance as the process proceeds. That said, without comprehen-

sive reform, it is difficult to foresee circumstances under which win-win combinations will otherwise be achieved.

## Methodology and Endnotes

### Methodology

Hewitt reviewed proposed health care legislation (as amended) to identify health care reform provisions that offer the potential for real cost savings. Where they were available, we relied on estimates from the Congressional Budget Office (CBO) to quantify the cost or savings to the federal budget associated with a particular provision or amendment.

Future modified health care costs were projected in two ways:

- We assumed that discretely identified savings opportunities found in health care reform could, when fully implemented, reduce the overall health care trend by 15% to 20%. Using the historical annual health care trend of 10.2% for per-employee costs of large employers from 2001 to 2009, the revised trend rate would be 8.3% to 8.8%, including employer and employee contributions and employee out-of-pocket costs. This assumes the government implements the initiatives quickly, accurately, and consistently, and that private payers implement similar measures in a disciplined and timely way.
- Going beyond discrete health care reform proposals and assuming implementation of structural changes in health care delivery and reimbursement, such changes could enable the health care marketplace to behave more like a “normal” market, growing at a rate similar to the long-term growth rate of GDP (approximately 4% annually).

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<sup>i</sup> Kaiser Family Foundation/HRET, Employer Health Benefits Annual Survey, September 2009.

<sup>ii</sup> This assumption is not dissimilar from estimated salary and benefit costs for large employers like BRT member companies.

<sup>iii</sup> **Notes:**

a) Status quo trend from 2009 to 2019 assumed at 7.7% annual increase in employer contributions only (and not including employee contributions and employee out-of-pocket expenses).

b) With reforms, trend assumed to decrease from 7.7% in 2009 to 4.0% in 2019 on a straight-line basis.

c) Major-employer employment assumed static at 10 million full-time employees.

d) Source for cost data: Hewitt Health Value Initiative™ database of 325 employers representing \$50 billion of health care spending.

<sup>iv</sup> **Note:** Estimated wage and benefit costs calculated based on an approximate \$69,000 average total compensation (salary + benefits) for major employers in 2009, indexed at 3% annually to 2019, and savings from health care programs noted above.

<sup>v</sup> Hewitt Associates LLC, Hewitt Health Value Initiative proprietary data, 1997–2008.

<sup>vi</sup> Chart based on data drawn from Wright, Beard, Edington, *Journal of Occupational and Environmental Medicine*, 44(12): 1126–1134, 2002.

<sup>vii</sup> Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* report, December 2008.

<sup>viii</sup> For different views on the degree to which uncompensated care increases the cost for private payers, see, for example, The Kaiser Family Foundation analysis at <http://www.kff.org/uninsured/upload/7809.pdf> and the Families USA report at <http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html>.

<sup>ix</sup> Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers study, December 2008.

<sup>x</sup> The Cost and Coverage Impacts of a Public Plan: Alternative Design Options, The Lewin Group, April 2009.

<sup>xi</sup> Dartmouth Institute for Health Policy & Clinical Practice, “Health Care Spending, Quality and Outcomes,” 2009.

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