The ACA, the HITECH Act and the HDI are moving the US toward a health care system that can be more cost effective, more accessible, and deliver better outcomes.

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2009: The HITECH ACT Encourages Technology Adoption</td>
<td>6</td>
</tr>
<tr>
<td>2010: The Health Data Initiative Makes Data Available Publicly</td>
<td>7</td>
</tr>
<tr>
<td>2010: The Patient Protection and Affordable Care Act Moves Toward</td>
<td>8</td>
</tr>
<tr>
<td>Outcome-based Payments</td>
<td>9</td>
</tr>
<tr>
<td>Potential Outcomes of Health Care Reform</td>
<td>9</td>
</tr>
<tr>
<td>Outcome-based payments</td>
<td>9</td>
</tr>
<tr>
<td>Higher productivity</td>
<td>9</td>
</tr>
<tr>
<td>Lower demand for hospitals</td>
<td>10</td>
</tr>
<tr>
<td>Better functioning markets</td>
<td>10</td>
</tr>
<tr>
<td>Evolving Roles in the US Health Care System</td>
<td>10</td>
</tr>
<tr>
<td>The future of health plans</td>
<td>10</td>
</tr>
<tr>
<td>The future of hospitals</td>
<td>11</td>
</tr>
<tr>
<td>The race to employ doctors</td>
<td>12</td>
</tr>
<tr>
<td>Conclusion</td>
<td>12</td>
</tr>
<tr>
<td>References</td>
<td>13</td>
</tr>
</tbody>
</table>
Executive Summary

The US health care system today is fraught with wasteful spending that does not contribute to better outcomes for patients. Fortunately, many initiatives exist in both the public and private sector that are intended to increase the efficiency of the system. Three federal initiatives — the HITECH Act, the Health Data Initiative, and the Affordable Care Act — are designed to help make the US health care system more productive and to bring health care costs down for self-insured employers and individuals. Several trends may emerge as a result of these changes over the next several years, including movement toward outcome-based payments, higher productivity, decreased demand for hospital-based care and better, more efficient markets.

Introduction

Roughly half of US health care spending is from Medicare and Medicaid. Most of the other half is from commercially insured people, with the largest group being employees of large self-insured employers. Because public programs can manage medical cost increases in part by controlling provider reimbursement increases, the brunt of rising health care costs is passed along to commercially insured people in the form of premium increases and cost sharing. As a result, companies have experienced annual increases in health care spending of up to 8% in recent years, while the prices of their own products and services have increased by no more than 1-2% a year. Workers have experienced a 10% CAGR in health care costs over the past decade, and with health care costs rising faster than wages, many have seen their real income decrease.

These statistics are consistent with what we see when we compare the US health care system to those of other global economies. The health care system in this country is enormous and growing quickly, with the US spending more on health care than any other country in the world on a per capita basis. However, patient outcomes do not reflect the country’s extraordinary level of spending. In spite of newer hospitals and more varied technologies, average patient outcomes in the US are on par with Cuba and Slovenia. In fact, labor costs are so high — two-thirds of the $2.7 trillion goes to salaries and wages — that productivity in health care is negative year over year (see Figure 1). Put simply: the US is not getting its money’s worth in health care.
While there are many factors that contribute to the lack of alignment between spending and outcomes, a few are particularly acute:

- **Unnecessary admissions**: Utilizing high-cost hospital resources for patients with conditions that can be treated in low-cost settings.
- **Unnecessary readmissions**: Returning to a hospital within 30 days because of an avoidable event or because the original problem was not actually corrected.
- **Unnecessary doctor visits and referrals**: Getting care that may not require an in-person encounter, or referrals of marginal value.
- **Unnecessary tests**: Ordering unneeded or duplicative tests to reassure the patient, thereby simply increasing costs without adding clinical value to the treatment.

The Affordable Care Act (ACA) is expected to add about 30 million new patients to the health care system. Addressing the needs of these new patients by simply adding more labor will only increase health care spending and further reduce productivity without correcting underlying problems such as those outlined above. However, the ACA and two other initiatives — the HITECH Act and the Health Data Initiative — provide incentives and tools that are designed to help make the US health care system more productive and to reduce health care costs for employers and consumers (see Figure 2).
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Effects of these initiatives are already being experienced by patients and employers, and the next several years could see further movement toward outcome-based payments, higher productivity, decreased demand for hospital-based care and more efficient markets.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Provisions</th>
<th>Potential Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HITECH Act</td>
<td>Provides incentives for use of electronic health technology and records</td>
<td>Enables new payment models</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provides new ways for patients and providers to engage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduces medical errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increases use of latest research and evidence</td>
</tr>
<tr>
<td>Health Data Initiative</td>
<td>Releases government health data into the public sector.</td>
<td>Patients can compare provider value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providers can better evaluate appropriate use of drugs and treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manufacturers can optimize R&amp;D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insurers can design more engaging programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organizations can distill quality information and create products to inform consumers</td>
</tr>
<tr>
<td>Affordable Care Act</td>
<td>Enables coverage for about 30 million more patients</td>
<td>Providers focus on outcomes, perform fewer unneeded activities</td>
</tr>
<tr>
<td></td>
<td>Reduces reimbursement for readmissions</td>
<td>Providers increase productivity</td>
</tr>
<tr>
<td></td>
<td>Eliminates reimbursement for hospital-acquired infections</td>
<td>Demand for hospitals declines</td>
</tr>
<tr>
<td></td>
<td>Supports patient-centered medical homes</td>
<td>Patients become sensitive to value</td>
</tr>
<tr>
<td></td>
<td>Creates Accountable Care Organizations (ACOs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moves toward paying for full episodes of care rather than fee for service</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2: Provisions and Potential Outcomes of the HITECH Act, the Health Data Initiative and the Affordable Care Act.
2009: The HITECH ACT Encourages Technology Adoption

The American Recovery and Reinvestment Act of 2009 included a $25 billion provision — the Health Information Technology for Economic and Clinical Health (HITECH) Act — to reward health care providers for meaningful use of computing technology. As a result, the meaningful use of electronic health care technology and health records (EHRs) has increased from 10-15% of doctors in 2008 to nearly 40% of doctors today, and from 20% of hospitals to more than 50% (see Figure 3).7

Among many other benefits, the adoption of technology in health care enables new payment models and ways for patients and providers to engage. For example, doctors can email patients, share data across care teams, avoid duplicating tests, and enable patients to view, download and transmit their health care information. Access to electronic medical records can reduce medical errors, including those related to drug prescriptions, dosing and allergies as well as increase the likelihood that clinicians are incorporating the latest research and evidence into care plans.
2010: The Health Data Initiative Makes Data Available Publically

In 2010, the Institute of Medicine (IOM) and the US Department of Health and Human Services (HHS) launched the Health Data Initiative (HDI) and released valuable data from HHS, including:

- Medicare claims data: De-identified claims from Medicare Parts A, B and D were put into the public domain to enable researchers to evaluate the costs and benefits of care that patients receive over time.
- Physician Quality Reporting Initiative (PQRI): Medicare will release the PQRI data in January 2013, which will show how doctors perform on approximately 65 Medicare quality measures on which doctors must report.
- Medicare EHR Incentive Program: This program measures the meaningful use of health care technology and EHRs.

The availability of these data sets enables a wide range of new capabilities:

- With access to more information about providers, patients can begin to assess provider value in a much more consumer-like fashion.
- Providers can evaluate (in a much more nuanced way than clinical trials) which drugs and treatments work best for certain subsets of patients.
- Medical device manufacturers and pharmaceutical makers can optimize R&D efforts by determining demand and unmet needs for products.
- Insurance companies can design benefits that better engage patients in their health.
- Innovative organizations can distill useful provider quality information beyond the narrow sets of consensus measures that previously existed in the public domain, and create applications and products with this data to help engage and inform consumers (see Figure 4).

Such information could ultimately lead to a more consumer-directed, market-based system in which patients can be better shoppers, and providers can compete based on actual performance rather than subjective reputation.
The Affordable Care Act (ACA) is designed to be a major step toward a system that is more cost effective, higher quality and more accessible. By enabling coverage for about 30 million more patients, the ACA increases demand for healthcare that will reward providers for improving productivity.
More importantly, the ACA takes a step toward paying providers differently. The health care system is currently based on fee-for-service reimbursement, which is a major driver of negative labor productivity and variation in costs and outcomes. Providers are paid more for seeing a patient more often, and may sometimes order tests of marginal value or overutilize high-cost resources such as hospitals.

The ACA begins to address this problem by reducing reimbursement for readmissions, no longer paying for hospital-acquired infections, supporting patient-centered medical homes, creating Accountable Care Organizations (ACOs) and moving toward paying for full episodes of care, not for each activity performed by a doctor. Such changes should encourage providers to think about how to make episodes of care more coordinated, team based and cost effective. One major strategy is the formation of ACOs, which increase their margins when they deliver better outcomes for patients at lower cost.

Potential Outcomes of Health Care Reform

Consumers and employers should be prepared for four major changes as a result of these national initiatives.

Outcome-based payments

The ACA moves US health care toward a system in which doctors will be paid for the outcomes they generate, as opposed to the individual activities in which they engage. This should benefit consumers because a doctor’s success will be contingent on their patients doing better. It may also lead to more convenience for patients, because doctors will likely perform fewer activities that are unnecessary and do not directly lead to better outcomes.

The HITECH Act enables this movement toward outcome-based payments, because today’s paper-based health care system can only work in a fee-for-service context. Outcome-based care increases the importance of care coordination, so providers will need increased technological capabilities to share data, form teams of care or perform predictive modeling to figure out which patients are at higher risk.

Higher productivity

Increased patient demand on the system will require more creativity about how to meet that demand, which in turn should cause providers to address labor productivity. Almost every other sector of the US economy has improved labor productivity, achieved better value and, in some cases, reduced prices. Health care providers that develop more productive ways to deliver care may improve margins, gain market share and improve the competitiveness of their businesses.
Lower demand for hospitals
Even considering the nation’s aging demographic, most hospitals will continue to have excess capacity. As reimbursement systems increasingly reward cost efficiency and reductions in readmissions and complications, many markets may become over-bedded. Additionally, alternative, less expensive treatment settings may become more common, including urgent care centers, high intensity primary care and extensivist models, and home-based care models.

Better functioning markets
The combination of a growing, more engaged patient base and a reduction in information asymmetry should lead to a more efficient health care market. A little known fact in health care reform is that the Silver plans – the plans to which subsidies are indexed – require 30% cost sharing before cost-sharing subsidies take effect for some individuals at the lower end of the income distribution, with an out-of-pocket maximum of $11,500. As a result of this increased accountability, millions of newly covered health care consumers — like the millions today in small and medium-sized employer plans— will be sensitive to differences in price and value.

Patients will also have access to more data and applications to help them be more effective consumers, which could cause the market to become more competitive. In a more competitive market:

• Individuals could shop for health care based on price, quality and convenience, so they can make tradeoffs regarding the proximity of care and experience of care against differences in cost and quality.
• Hospitals may compete on outcomes, including their ability to get patients back to work (or baseline level of functioning) more quickly.
• Doctors could offer retail-like hours, including evening and weekend appointments, so that patients would not have to take time off of work.
• Electronic visits, video visits and visits with non-physician clinicians could increase, providing easier access at lower cost.

Evolving Roles in the U.S. Health Care System
Health care reform will also cause the roles of health plans, hospitals and doctors to evolve in several ways.

The future of health plans
When health care premiums rise, many people assume that all the money is going to the insurance company. In reality, insurance company margins are among the lowest in the health care system. Most of the premiums are passed directly through to providers to pay for members’ care.
For example, health plans often include virtually every hospital in their networks because their customers place great importance on giving workers flexibility in where services are administered. Because many hospitals have substantial market power, they are able to command higher prices with health plans that have a strong desire to offer broad networks. Over the past several years, this has contributed greatly to higher premium increases.10

Several provisions of the ACA will further change the role of health plans, including:

• Guaranteed issue, requires health plans to offer coverage to people regardless of pre-existing conditions.
• Community ratings dictate the premiums that health plans can charge instead of age, gender and health status.
• Age bands restrict premium variations based on age to a factor of 3:1 between young and old.

These factors and others are designed to create a consumer-focused system that encourages health plans to invest in creating unique attributes and experiences to provide a basis for differentiation, above and beyond price.

In fact, health plans are already beginning to respond by:

• Creating engaging, consumer-friendly ways to get people to care about and improve their health, such as by sponsoring wellness programs and member education.
• Developing their own health care delivery systems where they can offer unique member care experiences.
• Offering analytic support for providers to help them better achieve population health goals cost effectively.

**The future of hospitals**

Until now, a major strategy for many hospitals has been to develop a large local market share. This often involves major investments that are designed to attract and retain doctors but that also contribute to high fixed costs. In a health care system where consumers have easy access to information on hospital cost and quality, it may be difficult for hospitals to compete on factors such as the newness of the facility or the breadth of services offered. They may instead need to compete on their ability to deliver superior outcomes at a better cost.

Community hospitals are likely to become more specialized and discriminating about which doctors they credential based on a physician’s ability to enhance clinical outcomes cost effectively. We anticipate that all hospitals will take action to assure that their doctors more often adhere to evidence-based practices, comply with cost-effective care processes and support efforts to reduce complications and readmissions.
The race to employ doctors

The need to control costs and produce better outcomes is already driving hospitals to seek tighter alignment with doctors (the ones who deliver care, order tests, initiate referrals and so on). Today, slightly more than half of all practicing doctors in the US are employed by hospitals. In some specialties, hospitals employ the vast majority of doctors. For example, more than 75% of cardiologists are employed by hospitals.

Employing physicians helps hospitals by enabling them to:

- Better manage what happens to patients before and after the hospital.
- Encourage the use of cost-effective supplies and medical devices.
- Implement clinical pathways so that doctors more often follow evidence-based practices and provide the right care.
- Follow team-based care models and better integrate hospital and/or health-plan based clinicians.

Hospitals aren’t the only organizations adopting this strategy. Health plans are also beginning to employ doctors to better manage risk, to enable population health management and to help create unique products. Doctors will need to become accustomed to working with larger organizations to adapt to employment by hospitals and health plans.

Conclusion

The ACA, the HITECH Act and the HDI are moving the US toward a health care system that can be more cost effective, more accessible, and deliver better outcomes. Further improvements in health care productivity could come from focusing even more on outcomes, new payments models, standardization and personalization of care.

In addition, improvements in data transparency will give patients a wealth of actionable information about provider costs, the best treatments for their particular set of conditions, and the relative risk and reward of various options that has not been available in the past. Employers should be ready to offer their workers new products that tap into this information and make their workers’ health choices as well informed as their choices for every other product and service that they buy.
References


8. American Hospital Association, AHA Hospital Database.

