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Bending the Curve: 12 Ways the New Health Care Law Will Tackle Runaway Costs

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When the President and progressive leaders in Congress took on the task of health care reform one year ago, they made three broad promises to the American people: (1) to cover the uninsured, (2) to make coverage more stable and secure for the middle class, and (3) to contain costs. Few dispute that the bills now before Congress deliver on the first two promises. But even though the health care law projects reductions in long-term federal deficits, there is still significant skepticism about the third promise of cost control. We examined the health care law and found 12 broad categories of cost-containment. We conclude that these measures will save American employers and employees approximately \$814 billion in the next 15 years.

America's health care system is like an old, drafty house on a hill. Wind pours through the doors and window jambs. Heat escapes through the attic. The boiler works far too hard and the radiators are clogged.

And like an old house that leaks heat and energy, our health care system "leaks" money in the form of wasted treatments, services and doctor time. Inefficiency is a principal reason Americans spent more than \$7,600 per person on health care in 2008.¹ Too much time is wasted on insurance forms, too much money is spent on extra tests that do nothing for a patient's health, and doctors must battle the perverse incentives created by a fee-for-service system that penalizes such simple acts as answering a patient's questions by e-mail.

The measures in the new health care law take major steps toward modernizing this antiquated system. And in the same way that an inefficient home demands a separate repair for every leak, the law works to bring down costs through not just one solution but many. Medical inflation is the sum of multiple and complex forces

involving every player in the system, from patients to doctors, hospitals, insurance companies, employers, Congress and the Administration.

Based on estimates by the Congressional Budget Office (CBO) and the Medicare actuary of the new law, we calculate the following savings:

For American employers and workers: Over the next 15 years, American businesses would collectively spend \$609 billion less on their share of health insurance premiums, and their workers would save a collective \$169 billion under the new health care law.² For a typical business with 500 employees, the cost of coverage would be \$2.3 million less than it would be otherwise over 15 years.³ In other words, these reforms will slow the annual growth rate of costs for job-based health care coverage over the next decade and a half from a projected increase of 5.8% to 5.0% per person.⁴ For American businesses, these savings will translate directly into higher wages for workers, more money to expand and invest, and a greater ability to succeed in a fiercely competitive global marketplace. For workers, these savings will lead to coverage that is more stable and more secure.

Savings from Reform: 2010 through 2024*

	Projected spending prior to reform	Projected spending under reform	Total projected reductions in spending from reform
Aggregate spending on employer share of premiums for job-based coverage	\$14.92 trillion	\$14.31 trillion	\$609 billion
Aggregate employee share of premiums for job-based coverage	\$4.14 trillion	\$3.97 trillion	\$169 billion
500-person employer offering coverage	\$56.4 million	\$54.1 million	\$2.3 million

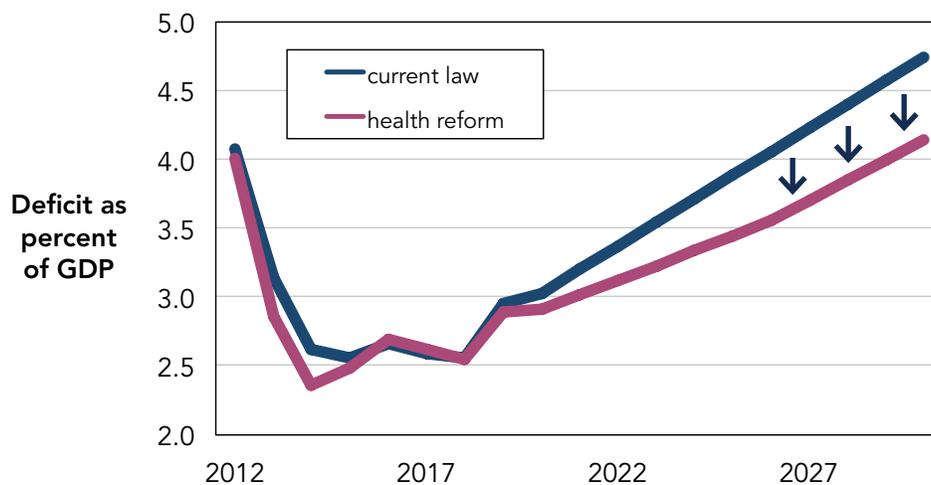
* We chose a 15-year time horizon in this report because much of the bill does not go into effect for four years. It is also important to note that these savings are based on savings in *per capita* spending—in other words, any reductions in job-based coverage are *not* counted as savings for purposes of this calculation.

For Medicare: Cost savings in Medicare over the next 15 years would be even greater. Its annual growth rate would fall from 4.9% to 3.7% per person over the next 15 years under the new law. As a result, Medicare spending during that period would be \$1.4 trillion less than currently projected.⁵

For national health care spending: Because of slower growth rates, the cost of covering more than 30 million additional Americans will also mean that, as a share of the overall economy, health care spending under the health care reform law will increase by two-tenths of one percentage point by the end of the decade.⁶ That means more health care for more people at a lower cost per person.

At the same time, the combination of lower annual growth rates plus the revenue measures in the bills would provide some downward pressure on the federal deficit. According to the Congressional Budget Office, the first decade of reform would reduce the deficit by \$119 billion, which is about one-tenth of one percent of GDP. In the second decade, CBO estimates reform will reduce the deficit by about one-half percent of GDP.⁷

Health Reform Will Lower Projected Deficit



In the remainder of this report, we describe how the health care law will achieve these results. We identify 12 ways in which the bills will tackle the issue of cost control while protecting the quality of care. We separate these measures into three categories of repairs to the system—immediate fixes, long-term repairs and works in progress—depending on how quickly and significantly the effects of a particular reform will be felt.

12 Ways Health Reform Will Bend the Curve		
Immediate fixes	Long-term repairs	Works in progress
<ul style="list-style-type: none"> • Warranties on care and medical error reporting requirements • The insurance exchange • Individual mandate and increased access to primary care • Comparative effectiveness research 	<ul style="list-style-type: none"> • Excise tax on high-cost plans • Bundling, accountable care organizations and value-based purchasing • Medical home, performance bonuses and patient outcome reporting • Health IT • Medicare productivity adjustments 	<ul style="list-style-type: none"> • Malpractice reform • Wellness incentives • Administrative simplification

Bending the Curve: Immediate Fixes

■ #1: Spend less money fixing treatment mistakes.

Hospitals now spend between \$17 billion and \$29 billion per year to fix medical errors.

Health reform will create incentives to reduce the number of errors, such as by putting “warranties” on care so mistakes aren’t rewarded and by requiring hospitals to report their errors to increase accountability. The result will be fewer medical errors, including fewer preventable readmissions, fewer infections acquired in the hospital and fewer patient deaths.

Enacted reforms: warranties on care quality and reporting requirements

Tens of thousands of medical errors are committed every year, ranging from gross errors such as the amputation of the wrong leg to infections in the hospital because someone didn’t take the time to wash his or her hands. As many as 98,000 Americans die each year from these errors—a figure higher than the death toll from car accidents or breast cancer.⁸

Part of the reason the error rate is so high is because mistakes are rewarded. Unlike a car or a refrigerator, medical services don’t come with a warranty. Instead, doctors are paid for the services they provide, not for the results.

This “fee for service” system means that doctors are paid twice if they make a mistake: once for the original procedure and again for fixing it. Another reason errors are high is that no one is keeping track. Doctors and hospitals are not required to report most kinds of mistakes, which means there are few public records by which to hold providers accountable.

Health reform will reduce medical errors and costs in two ways. First, it will limit the payments hospitals can get from Medicare or Medicaid if a patient is readmitted to the hospital for what is considered a preventable reason. For example, if a patient is back in the hospital because a cardiac stent was improperly implanted, a hospital won’t get paid the full amount (or may get nothing) for fixing this mistake. The health care law also contains proposals to limit or bar Medicare or Medicaid payments for health conditions acquired as a result of care. For example, a hospital would not get paid (or be paid less) for treating an infection a patient acquires as a result of hospitalization.

The new law also requires providers to report the number of hospital-related infections to the Centers for Disease Control. This measure would encourage hospitals to do what Dr. Atul Gawande, a surgeon at Harvard Medical School and a medical writer for *The New Yorker*, proposed in Boston. Everyone involved in a surgical procedure runs through a simple, two-minute safety checklist that has significantly reduced mistakes:

“There are a thousand ways things can go wrong...We miss stuff. We are inconsistent and unreliable because of the complexity of care... [Using checklists] we get better results. Massively better results.”⁹

■ #2: Create more head-to-head competition among insurers.

Most workers can’t choose among competing health plans based on price and quality, which means less pressure to hold down costs.

Reform will create an electronic marketplace where plans will compete for business. This will mean more choices for consumers and more competition among plans to keep prices lower while providing better benefits.

Enacted reform: the exchange

If you are healthy and are buying coverage on your own, shopping for insurance is easy. Online services offer a wide array of plans and make comparison shopping simple and painless. But you would be in the minority.

Because employers pay for most of the health care coverage in the United States, the vast majority of private-sector employees don't have the chance to save money for themselves by choosing more economical health plans. Unlike the federal government, which offers its employees a broad choice of plans, most workers in America who have access to employer-provided health care have only one choice of plan. Choices are even fewer for those in the individual market with a pre-existing condition. These individuals may have trouble simply obtaining a quote, let alone being issued a policy.

As a result, health insurance plans don't have strong incentives to adopt delivery system reforms such as the accountable care organizations described above.

The health care law will create a new mechanism to inject more competition into the insurance market by providing all Americans, including those with pre-existing conditions, with more options for buying coverage. The law will create an electronic marketplace (an "exchange") where currently uninsured individuals and small businesses can choose a health insurance policy from a competing array of plans. The exchange will provide individuals, insurance agents, and employers information that compares the benefits, prices, and quality of care offered by each health plan in the exchange. It will provide a low-cost way for individuals to enroll in a health plan and to use federal subsidies for coverage without the creation of a separate bureaucracy. Initially, exchanges will serve small employers and those without coverage at work. Subsequently, the states or the federal government could expand the chance for larger employers to join the exchange.

A successful precedent for the exchange is in Madison, Wisconsin, where the market is dominated by state employees who can make their own choices about their coverage and the cost they pay. Health insurance in the Madison area costs 14% less than the statewide average.¹⁰

■ #3: Steer people away from emergency rooms to routine care.

In 2008, hospitals provided \$36 billion worth of unpaid health care services, most of which started with an emergency room visit.¹¹

The increase in coverage for mostly low-income people and young people will dramatically reduce the amount of expensive and unnecessary medical care that occurs in emergency rooms. The financial incentive for people to visit the emergency room rather than a primary care physician will be largely ended. Hospitals, taxpayers and the insured will pay less to subsidize the cost of free emergency care to uninsured people.

Enacted reforms: individual mandate and increased access to primary care

Emergency room visits are significantly more expensive than visits to a family doctor because of the costs of maintaining expensive infrastructure, equipment and 24-hour staffing. For example, one press report found that stitches cost \$1,121 in an emergency room versus \$222 at an urgent care facility.¹²

Nevertheless, uninsured patients overuse emergency rooms because it is illegal under federal law to deny someone emergency care because they can't pay for it. Many uninsured people go to emergency rooms because they lack a primary care doctor.¹³ They have no one to provide continuity to their treatment and avoid expensive re-testing, especially if they have a chronic disease such as diabetes that requires careful management. These patients are less likely to receive preventive care and more likely to show up when something goes significantly (and expensively) wrong. Over a two-year period, one in five patients with a chronic disease go to the ER for a problem that they would otherwise have taken to a regular doctor had one been available.¹⁴

55% of the care provided in emergency rooms is never paid for by the patient.

The consequence of these cost overruns falls directly on patients in the form of higher bills from hospitals, higher premiums from insurers and higher taxes to make up for the cost of unpaid care. Many emergency room bills go unpaid, which means that hospitals and staff doctors shift the costs of these visits to people who have coverage. 55% of the care provided in emergency rooms is never paid for by

the patient.¹⁵ As a result, the cost of caring for Americans who don't currently have coverage adds about \$1,000 to a typical family health insurance policy.¹⁶

The health care law addresses this problem in two ways. The law requires that everyone obtain health coverage (the "individual mandate"), with certain exceptions. The individual mandate will put millions into the ranks of the insured, and they will shift away from using expensive emergency room care, which usually has higher copayments in a typical insurance policy.

In addition, the law includes several measures to increase the number of primary care providers. Provisions such as improved repayment terms for medical school loans and higher reimbursement rates will help eliminate the shortage of family doctors. Another provision discussed in greater detail below to create "medical homes" would also improve continuity of care and reduce emergency room visits.

■ #4: Take the guesswork out of treatment.

Too much money is spent on ineffective therapies and expensive, new technology that may not benefit patients.

Health reform will fund "comparative effectiveness" research that can help doctors determine which therapies work best. Reform will also make this research broadly available to all doctors across the country—from solo practitioners in rural areas to those at the Mayo Clinic—so that all doctors can make diagnosis and treatment decisions based on up-to-date, cost-effective scientific research.

Enacted reform: permanent funding for comparative effectiveness research

Rightly so, the practice of medicine is as much art as it is science. But what it shouldn't be is trial and error. Too often, doctors today don't have enough scientific evidence at hand to make the best diagnosis and treatment decisions. As a result, they waste time and resources on ineffective therapies, or a patient misses out on a cutting-edge option.

For example, some breast cancer patients respond well to chemotherapy but others do not. The cost of not knowing what types of patients would respond best to which treatments means people stay sicker longer and incur higher costs than necessary.

One unfortunate result of this lack of research is that doctors are biased toward using expensive new technologies even though newer isn't always better. For example, many doctors still implant metal stents to expand clogged arteries

even though research now shows that patients with stable hearts do just as well with less expensive and less invasive drug treatment.¹⁷

A principal reason that many doctors don't currently have the best possible research on effective patient care is that there's no broad incentive to conduct head-to-head ("comparative") research. New drugs and new devices only have to prove they are safe and effective, not whether they are better than existing therapies. Second, there is no infrastructure in place to collect research findings and disseminate it to doctors and hospitals.

The health care law will fix both problems by providing more funding to comparative effectiveness research and creating a new center that would collect, organize and share the data.

The health care law will provide over \$110 million annually toward comparative effectiveness research. This investment would build on the \$1.1 billion in funding for comparative effectiveness research included in the economic recovery package passed earlier this year. The funding would come from an annual fee of roughly \$2 per person paid by public and private health plans. The bills also create a Center for Quality Improvement that would spread the adoption of best practices developed from effectiveness research and other sources.

Estimates of savings from comparative effectiveness range widely from \$8 billion to \$480 billion over ten years.¹⁸ This uncertainty about the extent of potential savings stems from uncertainty over how the research will be used. Indeed, in some cases, comparative effectiveness research may increase costs in cases where it shows that newer, more expensive technology is in fact better. For that reason, the aim of this research is most appropriately targeted toward improving patient care, not just reducing costs.

Bending the Curve: Long-term Repairs

■ #5: Limit taxpayer subsidies for runaway benefit packages.

Taxpayers spent \$226 billion in 2008 to subsidize employer-provided insurance without regard to the size of the benefits, the efficiency of the health insurance plan or the income of the employee.¹⁹

The new health care law will reduce the size and the rate of growth in taxpayer dollars spent on subsidizing certain health care coverage.

Enacted reform: excise tax on high-cost plans

After Medicare and Medicaid, the next biggest federal health care cost derives from the tax subsidy for employer-provided health care coverage. Under current law, employers provide health care benefits without it counting as income to their employees. This means that health benefits are paid for with pre-tax dollars—a subsidy that amounts to 35 to 40% of the total cost of premiums.

This subsidy insulates both workers and employers from the true cost of buying health care, so neither are motivated to find the best deal for the money and are less conscious about the cost of overusing health care. The subsidy is also unlimited, which means that taxpayers are effectively subsidizing health care cost inflation. In addition, the subsidy is regressive because higher-income employees get a bigger tax break (since they're in higher tax brackets).

Health reform limits this subsidy by levying a 40% excise tax in 2018 on the annual premium amount over \$27,500 for family coverage and \$10,200 for individuals (adjusted for inflation, age, professional risk, and location). The levy would be paid by insurance companies or by the plan administrator in the case of companies that self-insure.

The Congressional Budget Office believes most of the revenue generated by the provision would not come from the tax itself. Instead, it would come from employers eliminating bloated benefits, which in turn would mean higher wages that are subject to taxation. Thus, this provision will not only reduce health care costs, it will increase worker wages.

■ #6: Eliminate unnecessary tests and procedures.

As much as 30% of our annual health care spending—or \$700 billion a year—goes toward treatments, tests and hospitalizations that do nothing for our health.²⁰

Health reform would create more incentives for doctors and hospitals to provide efficient high quality care by replacing fees for service with fees for outcome. This will reduce the number of unnecessary tests and procedures and bring high-cost areas of the country more in line with lower-cost areas that have equally good patient outcomes.

Enacted reforms: Bundling, accountable care organizations, value-based purchasing and payment reform

The health care system's current approach to treating patients is more is better.

Doctors automatically order up "routine" batteries of tests and check-ups, even if some of these tests are duplicative or won't improve someone's health. This extra care means more trips to the doctor as well as higher costs.

The fee-for-service system rewards doctors who provide both more services and the most expensive services. That's one reason the U.S. health care system provides some of the most intensive level of treatment among developed nations in the world. For example, U.S. patients have nearly twice as many heart surgeries as patients throughout developed countries, even though for many patients, far less expensive and invasive alternatives are equally effective.²¹

Costs also vary dramatically within our country. For example, Medicare beneficiaries in McAllen, Texas get \$15,000 of health care per year on average, which is twice as much as what seniors living in nearby El Paso receive, yet they are no healthier.²²

Some unnecessary tests and treatments are harmful to patients' health. The General Accountability Office has found wide variations in the use of imaging services such as CT scans in doctors' offices for Medicare patients, which suggests a great deal of overuse.²³ According to new research, the radiation from CT scans will cause as many 29,000 cases of cancer each year.²⁴

The new health care law proposes a variety of initiatives to replace fee-for-service reimbursements in Medicare with arrangements that reward quality over volume. As the single-largest payer in the health care system—accounting for 19% of all health care costs in America²⁵—Medicare's example is often followed in the private sector. The initiatives in the new law include:

- **"Bundling."** Both bills offer incentives for doctors to "bundle" a package of related services. The effect is a flat fee for certain procedures, such as a heart surgery or treatment of a chronic disease like diabetes.
- **Accountable care organizations.** Another measure would encourage doctors and hospitals to create "accountable care organizations" (ACO's) that would accept blocks of payments to care for a group of patients. For example, Hospital X might receive \$500 per year per patient. Because these flat payments would act as a "budget" for providing care, these organizations would be well-positioned to shift care to more efficient treatments such as using drugs instead of surgery for heart disease. If an ACO spends under its budget, it would be allowed to keep some of the savings itself and share the rest with patients and payers such as Medicare.
- **Value-based purchasing.** Health care reform includes provisions to create new payment systems based on whether hospitals and doctors provide

care that meets certain quality standards. These provisions aim to ensure that providers are paid for value, not volume.

- **Medicare payment reform.** Reform will create a more centralized process for tracking health care spending, discovering what works to bring down costs and encouraging the implementation of systemic change. The new Independent Payment Advisory Board would be tasked with submitting legislative proposals for reducing Medicare costs if payments grow above a certain target rate. The health care law includes provisions for a Center for Medicare and Medicaid Innovation to test and evaluate new payment structures and reforms. It also changes the payment formulas that today produce reverse geographic variations where high quality providers such as the Mayo Clinic get hit with lower payments when they find ways to deliver better care that costs less.²⁶

■ #7: Prevent chronic health problems from blowing up into crises.

About \$55 billion is spent every year on preventable complications from chronic conditions such as diabetes, high blood pressure and heart disease.²⁷

Reform would pay doctors to better manage a person's overall health, such as by ensuring that patients get the right preventive care. This would reduce the number of preventable complications, increase the percentage of chronic disease patients who get recommended preventive care and reduce the annual cost per patient of treating chronic diseases.

Enacted reforms: medical home, performance bonuses and patient outcome reporting

The cost of treating patients with chronic diseases consumes three out of every four health care dollars.²⁸ Chronic diseases are the number one killer in the United States and the most frequent cause of disability.²⁹

But much of the cost and pain is preventable. For example, less than half of diabetes patients receive recommended care such as blood tests to prevent kidney failure.³⁰ This tale of poor care and high costs is repeated over and over for other chronic health care problems: asthma, heart disease, lower back pain, and obesity, to name a few.

The human toll of these failures is enormous. When a patient with diabetes has a leg amputated because no one was checking for sores and infections, the

costs go well beyond the cost of the amputation. She is now disabled and will need home care or nursing home care for the rest of her life.

These failures are yet another consequence of the current fee-for-service system of paying doctors. Doctors are not currently paid to coordinate a patient's care or to manage their health. Doctors receive a fee for each separate service, but nothing for the overall result—better health. This is why, for example, patients can't e-mail their doctors with questions about their treatment—doctors can only bill for office visits, not e-mails. In addition, doctors aren't currently rewarded for proactively looking after a patient's health. Instead, they wait to treat patients until after they show up with a medical problem.

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The health care law promotes a more active style of medicine in which doctors and nurses would take a leadership role in a patient's care to ensure the best possible outcome for each patient. This means charting patients' progress with computerized records, following up with patients who miss preventive care measures, and counseling patients about how to take care of themselves. Measures include:

- **Medical home.** The law will create a "medical home" or "health home" in which a primary care professional receives a flat monthly fee for all the basic services that a patient might need. Results would be measured to ensure that patients fare well. Once these new models prove successful, the Administration would have the authority and obligation to expand the program under Medicare and Medicaid to every patient who could benefit.
- **Shared savings from better care.** Shared savings programs will reward doctors who work as a team and become a "accountable care organization" that help patients control their ailments at reasonable cost. Doctors will be able to share in the savings that accrue from preventing the need for expensive care because of a crisis.
- **Reporting of patient outcomes.** The new law also includes measures that would allow the public reporting of patient outcomes by groups of doctors so patients can choose the team of doctors with the best results. For example, patients will be able to choose an oncology team with the highest survival rate in treating their kind of cancer.

■ #8: Computerize doctors' offices and hospitals.

The lack of information technology costs \$81 billion a year in lost productivity and errors.³¹

Reform will build on existing health information technology legislation by extending its reach to nursing homes and other facilities. It will also create a system for tracking improvements in the quality of care by using electronic health records. Eventually, electronic health records and e-prescribing will be universal among doctors, mistakes due to illegible handwriting should be virtually eliminated, and doctors will have broad access to computer-aided treatment decision support tools that can improve treatment.

Enacted reform: Expanded health information technology

Netflix makes better use of a person's movie rental records than a doctor does of a patient's medical history. Our health system juxtaposes 21st century medical breakthroughs with a 19th century method of delivery. A physician's illegible scrawl on a paper prescription pad is just one obvious example. Another is the standard practice of having patients fill out paperwork describing what they can recall of their medical history whenever they visit a new office.

The lack of computers and digital records can mean many failures: failures to check for medication errors, missed opportunities for preventive care, duplicative testing, the lack of standards for identifying failed medical devices after they have been inserted into patients, and the failure to provide digital updates to doctors with the latest and best research as they make treatment decisions about the right care for their patients.

The economic recovery package passed by Congress in 2009 invests \$19 billion toward creating the infrastructure necessary for health information technology, including financial assistance to individual doctors to purchase health IT. The health care law builds on this foundation in several ways: (1) by extending health information technology into nursing homes, home health care, and other long term care facilities; (2) by expanding the use of information technology for improving public health through new standards and uses of data; and (3) by requiring the automatic generation of reports from electronic health records on care quality.

■ #9: Let Medicare share in cost savings from improvements in productivity.

Rigid Medicare payment formulas mean that taxpayers don't benefit if services become less expensive.

Reform will change what Medicare pays for services to reflect lower prices due to increased productivity. This will help slow the rate of Medicare spending over time.

Enacted reform: Medicare productivity adjustments

Consumers regularly benefit from lower prices when businesses learn how to do more with less. Under Medicare, however, such productivity increases don't automatically translate to lower prices. This is because Medicare prices are set under government formulas, many of which don't account for increases in productivity. For example, if a nursing home can order supplies over the Internet, payments to nursing homes should be slightly reduced to account for those efficiencies. Effectively, taxpayers should share in the cost savings gained by these providers. But that is not what happens today.

The new health care law includes provisions to make the Medicare payment system more modern and flexible. It adjusts payments to providers if those payments don't already have productivity changes included in their payment formulas. These providers include acute care hospitals, nursing homes, long term care hospitals, rehabilitation facilities, psychiatric hospitals, and hospice care. These changes to Medicare payment formulas will save taxpayer money without reducing the quality of care for patients.

Bending the Curve: Works in Progress

■ #10: Reduce “defensive” medicine in anticipation of malpractice lawsuits.

Between 0.5% and 9% of total health care spending or—\$12 billion to \$211 billion a year—is spent on “defensive” medicine intended to avoid lawsuits.³²

Reform would allow states to experiment with alternative ways of settling disputes over injuries from medical mistakes and of dealing with doctors in constructive ways to prevent mistakes from happening to others. This will help reduce the amount of defensive medicine, ensure that more patients who are injured by medical negligence receive fair compensation and reduce what doctors pay in medical malpractice insurance premiums.

Enacted reform: state experimentation in medical malpractice reform

The nation’s medical malpractice system is clearly broken. It’s unfair to patients because most people who are injured by medical errors never receive compensation. Only 2% of injured patients file a suit, and the chance of success for patients who file a claim is about roughly one-third. The average award is about half a million dollars, and well over half of that amount goes to attorney fees and court costs. Cases also take three to five years to resolve.³³

The system is also unfair to doctors. Although juries are perfectly capable of dealing with complex issues, they are not given clear standards for determining if a patient’s injury was caused by negligence or was simply bad luck. Judges and juries also do not have any standards for the size of an award based on other awards to similarly injured patients. In contrast, other areas of the law have clear legal standards. The difference between “murder” and “manslaughter,” for example, is very clearly defined.

This lack of standards is what leads to “defensive medicine.” Doctors order extra tests and procedures that do not help patients but may protect them against a lawsuit if something should go wrong. For example, a doctor may order a brain scan on a patient with a headache when prescribing a painkiller might have been sufficient.

Finally, there’s little or no evidence that malpractice settlements and awards prevent injuries. Settlements are generally sealed at the request of the doctors, which prevents research and discussion about how to prevent future injuries.

Juries do not explain their decisions to doctors, and no precedents are set that could be used to build a set of clear legal standards.

The health care law takes some experimental steps toward encouraging medical malpractice reform. The law appropriates \$50 million over five years for states to experiment with malpractice reforms that aim toward giving injured patients better access to swift justice, reducing legal costs, and encouraging providers to make early offers when mistakes occur. Such programs can help prevent blatant legal abuses and streamline payments to patients when there is a mistake.

President Obama has provided a great deal of leadership on this issue and will create opportunities to do more. He launched a program for state-based experiments with malpractice reforms prior to the passage of the new law. Near the end of the Congressional debate, he called specifically for funding to create "health courts."³⁴ As these experiments take shape, the President could further expand funding sources by sharing Medicare savings with states whose legal reforms improve patient safety and lower costs.

■ #11: Create more incentives to keep people healthy.

Obesity and smoking cost \$175 billion a year in medical costs.³⁵

Reform will allow employers to provide discounts on health insurance premiums for workers who maintain healthy habits. This reform will help reduce the percentage of people who are overweight or obese, lower the number of Americans who smoke and help raise the percentage of Americans who exercise regularly.

Enacted reform: wellness incentives

Poor health habits, including smoking, poor diets and no exercise, account for 11% of the nation's health care costs.³⁶ To help people break these bad habits, many employers such as Safeway have found that incentives and counseling can be effective. Under Safeway's program, for example, employees receive financial rewards for healthy habits. Such financial incentives can be a discount off of copayments and deductibles or can take the form of direct payments.

Prior law allowed employers to provide limited discounts or rebates of premiums or reduce cost-sharing requirements if employees participate in programs that require them to meet certain goals. Health reform would give employers more freedom to offer more generous incentives.

The new health care law will increase the amount of discounts that employers can provide from 20% to 30% of an employee's share of premiums.

The law will also ensure that proven preventive care services would be free to all Americans regardless of the type of coverage they have. These steps are among the many that would be needed as part of a national strategy to improve the nation's health. In the future, the nation also needs a national plan to deal with obesity and to create more accountability for public and private wellness programs so they deliver results cost-effectively.

■ #12: Waste less time processing paperwork.

Between \$50 billion and \$70 billion a year is spent on administrative tasks such as filling out multiple variations of insurance forms and processing claims.³⁷

Reform will create a process for paperwork simplification that will reduce the amount of time doctors spend on paperwork and help them transition to a paperless system for claims and billing.

Enacted reform: administrative simplification

Too much of each dollar that goes to pay for health care coverage gets diverted to paying for processing piles of paperwork and red tape. Prior to reform, each doctor's office had to deal with separate billing and administrative procedures for receiving payments from insurers, Medicare, Medicaid or CHIP. These procedures include a variety of tasks: confirming patients' insurance benefits, submitting claims for payments, checking on the status of claims, receiving payments, and reconciling the payments with the claims.

Only one of these processes—claims submission—is regularly performed electronically. Even then, however, the electronic process breaks down. "A claim has to jump through so many hoops, you can end up with a paper claim even when you initially sent an electronic claim," as one analyst explains.³⁸

Nearly two-thirds of doctors report that such paperwork means they have less time to spend with their patients. This "hassle-factor" also spills over on patients when disputes arise between providers and insurers over paying a claim. Patients and doctors are not only frustrated with the paperwork, they are paying an enormous financial price.

Reform will simplify this paperwork by establishing a process under which all key stakeholders will work out a common platform for similar administrative activities. That means one standardized form for everyone, not several, and pro-

cessing would happen online. The goal of this effort will be to eliminate most, if not all, of the paper-based transactions that today clog the information system.

However, the law lacks an effective mechanism to ensure these reforms will occur in a timely way, and Congress should consider creating a system that would keep these reforms on track.

Conclusion—Building on a Strong Foundation

The new health care law has ambitiously taken on the task of reforming an entrenched and inefficient system with bad habits that have accumulated over decades. This law will bring a level of accountability to the health care system that has heretofore been non-existent. Everyone will have a role to play in controlling costs, whether it is doctors changing wasteful practices, insurers eliminating paperwork or patients adopting healthier personal habits.

The result is a solid start toward a more efficient, less costly and ultimately, more stable, health care system for America's middle class. Together, these measures will create a modernized health care system that fulfills the three central promises of reform: (1) to cover the uninsured, (2) to make coverage more stable and secure for the middle class, and (3) to control costs.

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■ ENDNOTES

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