5 Trends That Will Shape U.S. Health Care
(No Matter How the Politics Play Out)

by Naomi Freundlich
From the moment it was signed into law in March 2010, the Affordable Care Act (ACA)—popularly known as “Obamacare”—has sparked legal challenges and carved deep political schisms. In June, the United States Supreme Court ruled that the law was constitutional, removing a major hurdle to full implementation. But more challenges lie ahead: With Republicans vowing to repeal or defund much of the health law, the results of the 2012 election may ultimately determine the fate of many of its features.

Yet in some important ways, no matter which way the political winds blow, the course is set for fundamental changes to the U.S. healthcare system. The reason is simple: The current system is unsustainable. The nation faces a healthcare bill that hit $2.8 billion in 2011, up 31 percent from just a decade ago and equivalent to a whopping 17.9 percent of the gross domestic product. Per-capita spending on health care is the highest in the world (see chart), though by several measures—including infant mortality and life expectancy—the U.S. system is far from the best. What’s more, half of all spending goes to caring for just 5 percent of the population, the great majority of whom are elderly and suffering from chronic illness.

Several long-term trends make change even more urgent: The number of seniors eligible for Medicare is reaching historic levels, more Americans than ever are uninsured, insurance premiums are rising while many plans are getting skimpier, and state budgets are groaning under the burden of Medicaid. Faced with these challenges, the major players in the healthcare system have not waited for the election results; they have already begun taking steps to reshape the system. “There are important trends reshaping the healthcare system that will continue regardless of who is president, who controls the next Congress, and whether the ACA survives or is repealed,” says Michael S. Sparer, PhD, JD, chair of the Mailman School’s Department of Health Policy and Management. “Indeed, while the ACA supports and encourages many of these trends, there simply is no going back. A healthcare revolution is under way.”

While prediction is a risky business, here are five trends that will likely shape the future of health care for Americans.

**Healthcare spending**

*Per person in thousands of dollars*

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**Source:** Organisation for Economic Co-operation and Development, *OECD Health Data: Health Expenditures and Financing*
Today, most physicians and hospitals are paid on a fee-for-service basis, meaning that they are reimbursed for individual tests and procedures performed while treating a specific episode of illness. This system encourages overtreatment and duplication of tests, and leads to miscommunication and inefficiencies as patients shuttle among their primary-care doctor, specialists, and hospitals.

An increasingly appealing alternative is to pay providers a fixed monthly or yearly amount determined by the patient’s public or private insurance plan. Such “global payments” can be calculated on a per-patient basis or for a large group. This model, which rewards efficient, well-coordinated care, is at the heart of accountable-care organizations (ACOs)—a new healthcare delivery model fostered by the Affordable Care Act. The idea, which is already being tried in demonstration projects across the country, is to have a set of providers—including hospitals, primary-care doctors, specialists, and other health professionals—agree to be “accountable” for the quality and cost of care for a defined population of patients. If they achieve quality targets and reduce costs below a baseline level, the ACOs can share in the savings.

The ACO model differs in some important ways from the insurer-run “managed care” plans of the 1990s, which gained a reputation for shortchanging patients and denying care. Medicare requires ACOs to be run by hospitals or doctor groups—not insurers—and the government has mandated 33 publicly disclosed quality measures it will use to evaluate the programs. They include care coordination, patient safety, a focus on prevention, and use of evidence-backed treatments. Seven quality measures will come from patient surveys that include questions about the ease of scheduling appointments with physicians. Perhaps most important, when it comes to sharing in the cost

THE HOPE: AN EMPHASIS ON DISEASE PREVENTION AND BETTER COORDINATED CARE WILL CUT DOWN ON HOSPITALIZATIONS, OVERALL COSTS, AND SUFFERING.
savings, “you don’t get paid a dime if you don’t hit the quality metrics,” says Donald Fisher, president of the American Medical Group Association.

Sue Beder, a 65-year-old Massachusetts woman with multiple sclerosis, is participating in an ACO aimed at “dual eligible” patients, who receive both Medicare and Medicaid. In recent years, frequent falls and other preventable injuries sent Beder to the emergency room so many times that her medical expenses reached about $7,000 a month. Last year the Fire Department visited her Stoughton, Mass., home 40 times.

Beder’s care is now being managed by Senior Whole Health, an ACO that receives a lump payment of 20 percent less than what government payers spent on Beder in the past. With better coordination of care and a focus on prevention, the ACO hopes she can continue to live at home (versus in a costly nursing facility), cut down her emergency-room visits and hospitalizations, and reduce costs overall. Beder is pleased with her daily visits from a home health aide, 24-hour access to nurses who serve as care managers, free transportation to see her doctors, no co-pays for medication, and the new safety rails in her bathroom. It’s too soon to measure savings, but Beder’s calls to the Fire Department are now rare.

The ACO experiment is well under way. Michael Millenson, a healthcare consultant and president of Health Quality Advisors, notes that there are 59 Medicare ACOs already serving more than 1.1 million beneficiaries across the country, with 150 more awaiting the government’s nod. Administrators at the U.S. Department of Health and Human Services predict that the Medicare ACO project will save up to $1.1 billion over five years, while improving care for many beneficiaries. Private insurers like Cigna, Aetna, and Humana are also on board, teaming up with physician and hospital groups to coordinate care and global payments.

“Every major private insurance company already has a demonstration project to show how accountable care will work,” observes John W. Rowe, MD, Mailman professor of Health Policy and Management and former chairman and CEO of Aetna. “They have concluded that the fee-for-service system, with its incentives to increase volume of care and its lack of accountability for quality, has failed, and that we must reform the way healthcare services are delivered and paid for.”

Playing Up Prevention

Among the changes that arrived with Obamacare is a bigger emphasis on the prevention of disease and disability. The law requires all new private health plans to cover vaccinations, mammograms, wellness visits, prenatal care, and other preventive services without co-payments or deductibles. These policies also went into effect for Medicare recipients. The law provides stepped-up funding for community-level interventions like smoking-cessation programs, efforts to fight childhood obesity, and programs that support wellness at work. Though such public health programs have almost never been reimbursed by private insurance, there’s growing evidence to suggest that they can be valuable cost savers.

And that’s why the emphasis on prevention seems destined to stay. For ACOs and similar global-payment plans, preventive care is the key to keeping costs from spiraling out of control. Take diabetes, which currently affects 11.3 percent of American adults. The Centers for Disease Control and Prevention (CDC) estimates that as many as 1 in 3 U.S. adults could have diabetes by 2050 if current trends continue. A recent report from IMS Health found that it costs about $12,000 a year to cover a diabetic whose disease is stable. But if the condition is uncontrolled, a diabetic can rack up expenses
averaging $102,000 a year. Providers in an ACO have a vested interest in offering lifestyle coaching and prompting patients to take medications, check their blood-sugar levels, and employ other preventive strategies to avoid dangerous—and costly—diabetic crises.

Even more effective would be to prevent high-risk individuals from developing diabetes in the first place. Last year, UnitedHealth became the first private insurer to pay for an evidence-backed diabetes-prevention program offered at 247 YMCAs in 26 states. Studies funded by the CDC found that among predabetics (people with risk factors such as obesity, elevated blood-sugar levels, hypertension, and/or a family history of disease), participating in a 16-week nutrition-counseling and exercise program similar to the one offered at the Y prevented some 60 percent of expected diabetes cases over nearly three years of follow-up.

Expanding this one program could have huge benefits. Nearly 79 million American adults are prediabetic. “The Urban Institute has said that by making this program available nationwide with organizations like the Y, we can save $190 billion over ten years,” says Lynne Vaughan, senior vice president and chief innovation officer at YMCA.

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Without more emphasis on prevention, the CDC warns that 1 in 3 U.S. adults could have diabetes by 2050.

Rewarding Quality, Punishing Carelessness

Another way to put the brakes on unnecessary spending—and suffering—is to create incentives that reduce the kind of medical errors that lead to complications and hospital readmissions. One tactic: Reward providers that demonstrate a greater focus on quality, safety, and best practices, and penalize those that don’t.

For example, the Centers for Medicare and Medicaid Services (CMS) adopted a policy in 2008 that withholds Medicare payments for hospital costs related to preventable infections. Since then, the CDC has recorded a 32 percent drop in the incidence of bloodstream infections related to improper insertion of intravenous lines in hospital patients. As part of the health law, CMS is also developing a National Patient Safety Initiative that includes a $70 billion “pay for performance” system to provide incentives for hospitals to meet standardized measures for patient safety, such as reducing surgical errors and the number of antibiotic-resistant infections acquired in the hospital. Hospitals are now facing a loss of 1 percent of their Medicare payments if they readmit an excessive number of patients due to inadequate care or poor follow-up after discharge.

Early results have been promising, but warns Rowe, savings from pay-for-performance efforts may be hard to sustain: “The bottom line is that it is very difficult to change behavior, especially in large organizations where many of the providers are free agents and are not employed by the hospital or health system.” He sees a greater potential for quality improvement in ACOs that “effectively align the interests of all the players.”
Evidence is the Best Medicine

Medicare data analyzed over many years reveals that spending on patients varies greatly among cities, neighboring towns, and even hospitals in the same community. Much of this variation is due to ingrained physician practice patterns that do not necessarily represent evidence-backed care.

The health-reform legislation sets up the independent Patient-Centered Outcomes Research Institute to “provide information about the best available evidence to help patients and their healthcare providers make more informed decisions.” This still-nascent effort will require researchers to analyze head-to-head comparative clinical studies as well as data gleaned from scores of electronic health records to identify the most effective treatments.

Sherry A. Glied, PhD, who returned to Mailman this fall as a professor of Health Policy and Management after serving as Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, believes this institute will provide evidence that has the potential to improve quality of care and reduce costs. But, she cautions, “we don’t yet know whether and how this evidence will be used by ACOs and others in making care decisions.”

Meanwhile, private payers as well as Medicare are already starting to monitor how well providers adhere to known evidence-backed measures—such as providing flu shots to the elderly and antibiotics after certain surgeries—and paying bonuses for meeting quality targets.

There is also a noticeable shift among some providers to discourage the overuse of tests and expensive treatments. The recent “Choosing Wisely” campaign is a good example: Nine physician specialty groups, along with the American Board of Internal Medicine and Consumer Reports, created a list of 45 common tests and procedures that should be used less often. “Don’t do imaging for uncomplicated headache” was one recommendation from the American College of Radiology. Cardiologists, meanwhile, advised against stress cardiac imaging or coronary angiography in patients without cardiac symptoms “unless high-risk markers are present.” Donald Berwick, the former director of CMS, calls the campaign a “game changer” because it is physician-driven yet will also be targeted to the public through Consumer Reports.

Better and more universal use of electronic health records is a key part of the movement toward evidence-based care. Beginning in 2011, the federal government offered up to $44,000 per physician over five years from Medicare, or nearly $64,000 over six years from Medicaid, if medical practices adopted “meaningful use” of information technology. The ACA continues this support, and contains initiatives designed to help create a vast, interconnected network of patient data.

Despite a slow start, almost 46 percent of doctors are now using electronic medical records. But meaningful use of information technology requires more than just digitized patient files, notes Rick Lopez, chief medical officer for Atrius Health, a nonprofit alliance serving a million patients in Massachusetts. “It’s sharing information across clinicians and institutions and truly understanding patients,” he says. In a group practice or ACO, for example, new software systems can generate a list of all enrolled diabetics or hypertensives and make sure care reminders are sent out to patients, blood-pressure targets are met, and follow-up care starts immediately after hospitalization.

As more and more providers coordinate care, smart digital tools will help prevent duplication of testing, alert doctors to dangerous drug interactions, and provide guidance on the best treatments for a given condition. Atrius, for example, scans electronic data for patterns of utilization, and can spot errors and excesses. “If a doctor is ordering a hundred CT scans, he might be asked to sit down with the medical director to talk about why,” says Lopez.

Expanding the Reach of Medicaid

Medicaid is the joint federal-state program that administers health benefits for the poor and disabled. From 2007 to 2010 the recession caused many Americans to lose their jobs and their employer-provided insurance. Medicaid enrollment grew by 19 percent to include almost 67 million Americans in 2010, at a cost of $390 billion. With state budgets also stretched thin by the recession, Medicaid became a target for cuts—both in terms of who qualifies and in reimbursements to providers.

If the Medicaid provisions in the Affordable Care Act stand, the program could expand to cover 15 million more Americans who earn up to 133 percent of the federal poverty line, and include single adults and the working poor, who have not qualified for benefits in every state.
The Supreme Court ruled that states may opt out of the Medicaid expansion. The governors of Texas, Florida, Louisiana, Mississippi, and South Carolina have threatened to do just that. But other states, with the blessing of federal officials, are already overhauling Medicaid programs with the goal of expanding coverage while cutting costs. Oregon, for example, received an additional $1.9 billion in federal funding to test a program that will use global payments and coordinated-care organizations (essentially ACOs) to manage the medical, mental-health, and dental care of virtually all of the state’s Medicaid enrollees. The state, led by Governor John Kitzhaber, a physician, believes it can cut health costs by two percentage points over two years, saving $11 billion over the next decade, while also improving health outcomes for beneficiaries.

Indiana, meanwhile, has created a Chronic Disease Management Program that involves some 50,000 Medicaid patients suffering from asthma, diabetes and/or heart failure. These high-risk enrollees receive one-on-one care management by nurses, have access to a nurse-staffed call center and primary care centers, and receive reminders to take medications and set up appointments. Studies have shown that the program is already helping decrease government costs and improving care for these chronically ill patients.

What’s Next?

While these five trends seem well established, other aspects of U.S. healthcare reform remain uncertain. “We need to be careful of assuming Medicare will emerge unscathed after the election,” says Glied. “The traditional Medicare program is the lever we are using to change the whole healthcare system. If we decide to dismantle Medicare and provide vouchers for seniors to purchase insurance, then the leverage is gone and the system isn’t going to transform in the same way.”

Also uncertain is the the fate of state health-insurance exchanges—a key feature of the ACA—that are supposed to bring affordable coverage to 30 million of the uninsured beginning in 2014. A number of states have been waiting for the election results before creating these exchanges, says Heather Howard, former commissioner of health for New Jersey and current director of the State Health Reform Assistance Network: “States that are stalling are going to find it nearly impossible to set up exchanges by 2014.”

Even so, there are encouraging signs that the ongoing shift will continue toward a more coordinated, evidence-based system of care that emphasizes prevention and cost effectiveness. These trends, together with the weak economy, have already helped contain the growth of U.S. healthcare spending to just 4 percent over the past year, down from an average annual rate of 6.8 percent between 2000 and 2010. No wonder that “from the point of view of reform,” as Rowe puts it, “the train has left the station.”

NAOMI FREUNDLICH is a Brooklyn-based journalist who specializes in covering health care.