HEALTH POLICY REPORT

Mary Beth Hamel, M.D., M.P.H., *Editor*

The Affordable Care Act at 5 Years

David Blumenthal, M.D., M.P.P., Melinda Abrams, M.S., and Rachel Nuzum, M.P.H.

Just over 5 years ago, on March 23, 2010, President Barack Obama signed the Affordable Care Act (ACA) into law. Its enactment may constitute the most important event of the Obama presidency and could fundamentally affect the future of health care in the United States. From a historical perspective, 5 years is a very short time, far too short to assess definitively the effects of the ACA. Still, the 5-year mark seems to be a logical point to pause and take stock of how the ACA has fared to date — to review what we know now of its effect on Americans (U.S. citizens and legal residents) and their health care system and to pose questions that will demand our attention going forward.

In this article, we attempt this stocktaking by reviewing the two basic thrusts of the law: its expansion of health insurance, and its reforms of the health care delivery system. We concentrate much more on the delivery-system reforms of the law than on its coverage expansions because the latter have received the lion's share of attention and because many of the key insurance provisions in the law have been in effect only since October 2013, well short of 5 years. In contrast, most of the delivery-system reforms took effect with the passage of the law (although administrative rules implementing them often took time to finalize) and have received far too little attention in light of their potential consequences for the performance of our health care system and the lives of clinicians and patients.

As we review the implementation and effects of the law, some framing comments are in order. In the final analysis, the law will be judged on its cumulative effects on three critical dimensions of our health care system: adequacy of access to care, as measured by the proportion of Americans who lack meaningful protection against the cost of illness and the ability of Americans to get the care they need; the cost of care, as measured by the rate of increase in health care spending and the proportion of our national wealth devoted to health care services; and the quality of care experienced by Americans, as measured by national indicators of quality, such as those reported in the Agency for Healthcare Research and Quality annual report on quality.[1] As we review the implementation of the ACA, we will emphasize what is known about how the law has influenced these critical aspects of the performance of our health care system.

EFFECT ON AVAILABILITY OF AFFORDABLE HEALTH INSURANCE AND ACCESS TO CARE

The ACA has had its clearest and most measurable effects to date on the availability of health insurance to the American people and on their access to care. Estimates of the number of uninsured persons who have gained coverage since 2010, when young adults became eligible to join their parents' policies, range from 7.0 million to 16.4 million.[2-5] Variations in these estimates reflect, in part, differences in the timing and methods of the surveys on which they are based. Groups that have historically been at the greatest risk for lacking insurance — young adults, Hispanics, blacks, and those with low incomes — have made the greatest coverage gains. These changes are meaningful and unprecedented in the U.S. health care system (Fig. 1).

Surveys show that the newly insured are pleased with their coverage. Three quarters of those seeking new appointments with primary care physicians or specialists secured one within 4 weeks or less, and for the first time in more than a decade, slightly fewer Americans are reporting problems with medical bills and financial barriers to obtaining care.[4]

The law has improved the availability of health insurance by means of a variety of mechanisms. First, as of February 15, 2015, when the most recent open-enrollment period ended, 11.7 million Americans had selected a health plan through

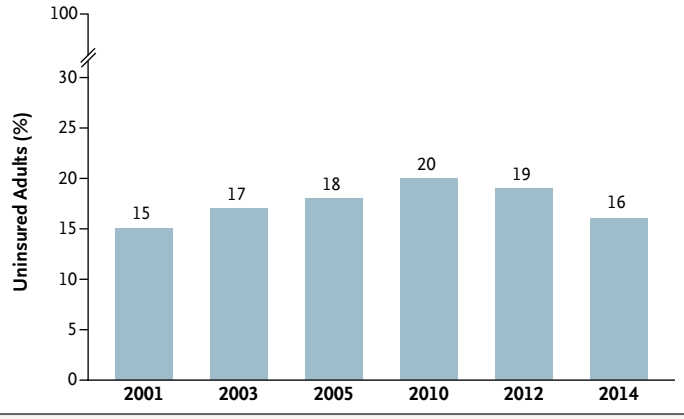

Figure 1. Percentage of Adults 19 to 64 Years of Age Who Are Uninsured.
Adapted from Collins et al.[4]

the health insurance marketplaces. Critical to making that insurance affordable are federal subsidies for which 87% of marketplace customers have qualified.[6] The legality of these subsidies in the states where the federal government operates insurance marketplaces is now before the Supreme Court, which is expected to rule on the matter soon.

Second, the law provides states with the option to expand their Medicaid programs — entirely at federal expense through 2016 — to include all adults with incomes that are at or below 138% of the federal poverty level. A total of 28 states and the District of Columbia have taken advantage of this opportunity, but even in those that have not done so, Medicaid enrollments have grown as some persons seeking insurance through ACA insurance marketplaces have discovered they are, in fact, eligible for Medicaid under pre-ACA rules. A total of 10.8 million additional Americans have enrolled in Medicaid since the enactment of the ACA.[7]

Third, nearly 3 million previously uninsured young Americans have gained coverage under their parents' policies because the ACA requires all private insurers and employers that offer dependent coverage to cover children until they are 26 years of age, regardless of whether they are dependent for tax purposes.[4] And fourth, an estimated 8 million to 12 million Americans who have health insurance outside federal marketplaces are benefiting from ACA regulations that prevent insurers from discriminating against persons with preexisting conditions or from terminating policies once persons become ill.[8]

All told, more than 30 million Americans now have insurance under these new sources of coverage and consumer protections. Since some of them had insurance previously, the numbers of uninsured persons declined by a smaller number, the estimated 7.0 million to 16.4 million noted above.

Several major problems have hampered the implementation of the coverage provisions of the ACA. First was the troubled debut of the federally run insurance marketplaces and a number of state-run programs. The federal marketplaces now seem to be functioning adequately, and most states with problems have either fixed them or imported solutions from other states or the federal government. Second, a number of insured Americans were upset and surprised when companies canceled policies that did not meet minimum standards under the ACA. The numbers of canceled policies have declined over time, and cancellations have become less troublesome as better-functioning marketplaces have offered accessible and affordable alternatives.[9] Third, some new marketplace plans restrict access to providers so as to control costs. Although surveys do not yet show widespread discontent with these restrictions, constrained provider networks could cause a consumer backlash in the future. Fourth, some persons have purchased marketplace plans with substantial deductibles and copayments in order to minimize premiums. These choices could leave them with large out-of-pocket payments and limited access to services.[4]

THE ACA AND THE HEALTH CARE DELIVERY SYSTEM

Critics have claimed that the ACA overlooked the need to reform the delivery system in our nation so as to constrain its costs and improve its quality. A careful examination of the law, however, shows that it constitutes one of the most aggressive efforts in the history of the nation to address the problems of the delivery system.

Perhaps a fairer criticism of the law is that it tried to do too much — that it launched too many divergent experiments and lacks a coherent strategy. The number and diversity of the provisions in the ACA regarding delivery-system reform (see the Supplementary Appendix, available with the

full text of this article at NEJM.org) reflect the widespread uncertainty in 2010 — and today — about how, precisely, to improve the performance of our nearly $3 trillion health care enterprise.

To organize our review of these provisions regarding delivery-system reform, we lump them somewhat artificially into four categories on the basis of their approach to improving health care delivery: changes in the way the government pays for health care, changes in the organization of health care delivery, changes in workforce policy, and changes intended to make government more nimble and innovative in pursuing future health care reforms. In all these categories, space permits only brief descriptions of selected programs.

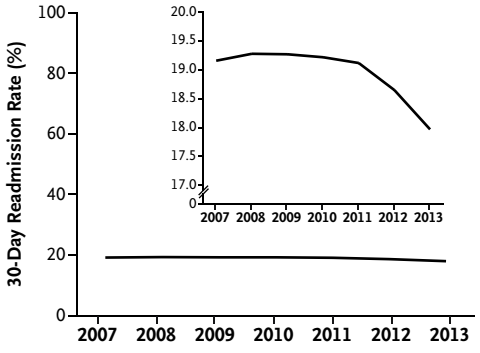

Figure 2. All-Cause, 30-Day Hospital Readmission Rate among Medicare Beneficiaries.

Adapted from the Geographic Variation Public Use File.[10] The inset shows the same data on an enlarged y axis.

CHANGES IN PAYMENT

The ACA embraced and accelerated several previous federal efforts to move away from volume-based, fee-for-service reimbursement and to link government payments for health services to providers' performance.

Incentives to Reduce Medicare Readmissions

Starting in October 2012, hospitals with higher-than-expected rates of readmissions of Medicare beneficiaries within 30 days have been subject to financial penalties. Since the initiation of the program, 30-day readmission rates nationally have declined from more than 19.0% to less than 18.0%, equivalent to approximately 150,000 fewer readmissions annually among Medicare beneficiaries (Fig. 2).[10,11] However, the appropriateness of current readmission measures has been questioned because of evidence that safety-net hospitals and large teaching hospitals may be unfairly penalized under the program owing to the social and medical complexity of their patient populations.[12,13]

Incentives to Reduce Hospital-Acquired Conditions

The ACA expanded a previous program of the Centers for Medicare and Medicaid Services (CMS) that penalized hospitals for egregious avoidable threats to the safety of Medicare patients (so-called never events). Under the ACA program, hospitals that perform in the lowest quartile with respect to rates of hospital-acquired conditions (including avoidable infections, adverse drug events, pressure ulcers, and falls) may lose 1% of their Medicare payments. This payment program complements other ACA-related initiatives designed to improve patient safety, notably the Partnership for Patients described below.

Recent data from the Department of Health and Human Services (DHHS) show the first-ever documented decline in composite rates of hospital-acquired conditions nationally: 17% from 2010 to 2013 (Fig. 3).[14] The DHHS estimates that these safety improvements prevented 50,000 deaths and saved $12 billion, although these calculations are probably somewhat imprecise. Whether ACA programs accounted for all or part of these gains is uncertain.

Pay-for-Value Programs for Hospitals and Physicians

The ACA creates Medicare payment incentives for hospitals and physicians to improve their performance on a variety of quality and cost metrics other than hospital-acquired conditions and readmissions. The program went into effect in 2013 for hospitals, with 1% of total Medicare payments being redistributed to those that performed well on a variety of cost and quality measures. By 2017, a total of 2% of Medicare payments will be redistributed under the program. On the physician side, the incentive program began in 2015 with large group practices on a voluntary basis and is progressing to a mandatory program that will include smaller and solo practices by 2017. Year 1 results show a modest financial effect on physicians. Payment adjustments range from a 1% decrease to a nearly 5% increase[15] — but results are too preliminary to draw any definitive conclusions about the effect of the program.

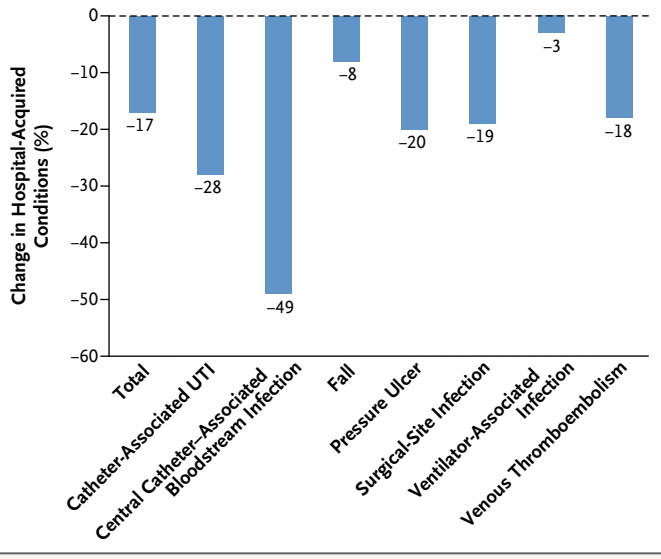

Figure 3. Percent Change in Hospital-Acquired Conditions from 2010 to 2013.
Adapted from the Agency for Healthcare Research and Quality.[14] UTI denotes urinary tract infection.

Bundled Payments

Almost 7000 hospitals, physician organizations, and post–acute care providers have signed up to participate in bundled-payment initiatives created under the ACA.[16] These provide a single payment for a specified set of hospital, physician, and post–acute care services related to a given procedure or condition. The effects of this bundled-payment experiment remain to be assessed.

CHANGES IN THE ORGANIZATION OF HEALTH CARE DELIVERY

Accountable Care Organizations

The ACA encourages health care providers to form new organizational arrangements called accountable care organizations (ACOs) that are intended to promote integration and coordination of ambulatory, inpatient, and post–acute care services and to take responsibility for the cost and quality of care for a defined population of Medicare beneficiaries. Under the Medicare Shared Savings Program (MSSP) of the ACA, providers who create such organizations and who also maintain or improve the quality of care can share part of any savings they achieve.

Providers can also elect to become so-called Pioneer ACOs, which not only share savings but also accept substantial risk if expenses for Medicare patients are greater than expected. Recently, CMS announced still other variations on the ACO theme, including arrangements in which ACOs function very much like Medicare Advantage plans.[17] Indeed, many observers see ACOs as a bridge from fragmented fee-for-service care to integrated, coordinated delivery systems that resemble the tightly organized Medicare Advantage plans.

The two existing varieties of ACOs have spread with considerable speed. The MSSP has 405 participating ACOs serving 7.2 million Medicare beneficiaries (14% of the Medicare population).[18] Quality measures have generally improved for the 33 indicators tracked by MSSP, and patients report better care experiences in some respects than Medicare beneficiaries who are not part of ACOs.[19] CMS estimates the savings at approximately $700 million, as compared with control populations not enrolled in MSSP. A total of 32 organizations started in the Pioneer program; 11 transitioned to the MSSP track, and 2 withdrew entirely. The secretary of health and human services reports that the Pioneer program saved $385 million in the first 2 years, as compared with fee-for-service Medicare beneficiaries.[20] These cost and quality results are early and modest, and further evaluation is needed before definitive judgments can be made.

Primary Care Transformation

The ACA has supported a variety of programs to improve the delivery of primary care. An example is the Comprehensive Primary Care Initiative, in which 30 payers and 492 primary care providers serving 2.5 million patients in seven markets are testing whether an innovative payment and organization model can control expenses and improve quality of care. The projects emphasize care coordination, improved chronic disease management, greater access to primary care, and administrative simplification. Initial evaluations show that the program overall has reduced monthly Medicare expenditures per beneficiary by $14, or 2%. Although the practices showed a significant reduction in emergency-department visits and inpatient hospitalizations, early results show no meaningful improvement in quality of care after 1 year.[21] As with ACOs, it is too early to draw firm conclusions about the effects of the Comprehensive Primary Care Initiative experiment. Although it is promising that savings occurred in the first year, the real test will be to see whether the savings persist.

CHANGES IN WORKFORCE POLICY

Among several workforce initiatives under the ACA, perhaps the most notable areas of focus are on increasing the attractiveness of primary care as a career and enhancing its availability to Medicaid populations. With full federal funding, one ACA provision required all state Medicaid programs to pay primary care physicians at Medicare rates (a considerable increase in many states) for 2 years. A study of 10 participating states showed that the availability of primary care appointments for Medicaid patients rose by nearly 8% among providers already accepting Medicaid patients, as compared with an increase of only approximately 1% among privately insured patients.[22] However, the pay increase had no discernible effect on the proportion of providers participating in the Medicaid program.[23] A total of 15 states have decided to extend the increased primary care payments beyond the 2 years with the use of only state funds, 23 states and the District of Columbia have decided to revert to pre-ACA payment rates, and 12 states have not yet decided about next steps.[24]

The ACA also added $1.5 billion to a venerable program, the National Health Service Corps, which has offered scholarships and loan forgiveness for decades to young primary care clinicians who volunteer to practice in underserved areas. From 2009 through 2013, this additional funding supported more than 14,000 new providers, including 8900 primary care clinicians.

One unfulfilled promise of the ACA has been the failure to establish a National Health Care Workforce Commission authorized by the law for the purpose of developing policy on the appropriate supply and distribution of health professionals. The President has appointed members, but the Congress has not appropriated the funds necessary for the operation of the commission.

MAKING GOVERNMENT MORE NIMBLE AND INNOVATIVE

To critics of government, trying to make it nimble or innovative may sound like a fool's errand. Nevertheless, since government now pays for 43% of our national health bill, improving its ability to innovate and respond to our ever-changing health care environment seems worthwhile, no matter how difficult the task.[25]

In this regard, the ACA took a meaningful step by creating the Center for Medicare and Medicaid Innovation (CMMI) within CMS. Funded at $1 billion per year for 10 years, CMMI has the authority to undertake a wide variety of experiments for the purpose of improving quality and reducing cost within the Medicare and Medicaid programs. If the Office of the Actuary of CMS certifies that any of these experimental programs has increased quality without raising costs, or has reduced costs without reducing quality, the secretary of health and human services has the authority to implement the new idea throughout Medicare or Medicaid without prior congressional approval. This new capability to spread proven programs quickly could markedly enhance the nimbleness of federal policymaking.

The secretary has not yet invoked this authority, but CMMI has undertaken a wide variety of experiments that have involved tens of thousands of clinicians nationwide. One of the most notable is the Partnership for Patients, which is providing technical assistance to 3700 hospitals across the country in efforts to reduce hospital-acquired conditions and Medicare readmissions. As noted, the Partnership complements payment reforms that provide incentives for improvements in patient safety and avoidance of preventable Medicare readmissions.

TAKING STOCK

Even this select list of ACA initiatives may seem overwhelming, especially to clinicians and patients who are not immersed in the arcane details of current health policy discussions. The heated political debate over the ACA and the lack of definitive evaluations for so many of its numerous programs further complicate efforts to assess its track record at the 5-year point.

To gain a greater perspective on the ACA at 5 years, it may help to recall the three basic criteria that, in our opinion, will ultimately be used to judge the effects of the legislation: its effects on access to health insurance and services, on cost of care, and on quality of care. From these three perspectives, the following observations seem reasonable.

First, the ACA has brought about considerable improvements in access to affordable health insurance in the United States. On the basis of their own reports, newly insured Americans are

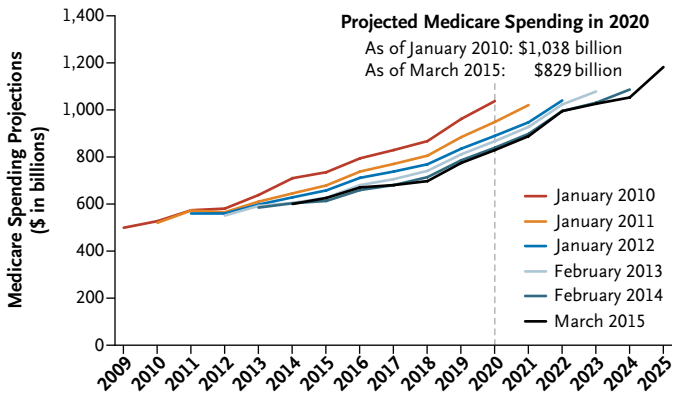

Figure 4. Ten-Year Medicare Spending Projections, January 2010 through March 2015.

Adapted from the Congressional Budget Office.[26,27]

also able to see physicians within reasonable periods of time, and anecdotal reports about restricted access to out-of-network providers, although a concern, have not yet caused a major backlash. Restrictions on provider networks may not cause as much discontent now as they did during the managed-care era in the 1990s, because in that earlier time they affected persons who already had insurance and thus had established provider relationships. In contrast, newly insured Americans today often lack such preexisting relationships and may be grateful just to have access to services. In any case, the effects of narrow networks deserve close attention going forward, as do the potential effects of the high deductibles and copayments that characterize many of the new plans purchased in ACA marketplaces.

Second, the implementation of the ACA has coincided with another important development — a slowdown in the rate of increase in national health care spending. From 2010 through 2013, per capita U.S. health care expenditures increased at the historically low rate of 3.2% annually, as compared with 5.6% annually over the previous 10 years. As a percentage of the gross domestic product, health spending has stabilized at approximately 17%.[25] Within the Medicare program, which most directly affects federal health spending and deficits, per-beneficiary expenditures have actually decreased in real terms. These trends have caused the Congressional Budget Office to reduce projected Medicare spending dramatically: its current estimate of Medicare spending in 2020 is more than $200 billion (20%) lower than it was immediately before the enactment of the ACA (Fig. 4).[26,27]

Economists disagree about the reasons for moderating health spending, which began before the enactment of the ACA, and recent trends may foretell a resurgence in spending. The 2008 recession probably played an important role,[28] and it is certainly premature to assess the effects of the delivery-system reforms. However, fragmentary early data do suggest that the ACA could be playing a role. The law's reductions in payments to Medicare providers are probably helping to moderate increases in Medicare spending, and reductions in Medicare readmissions, hospital-acquired conditions, Medicare spending on ACO enrollees, and spending within primary-care initiatives are all encouraging signs. Furthermore, the implementation of the ACA does not seem to have resulted in the dramatic escalation of health care spending that some critics have predicted.

Ultimately, if costs do moderate over a prolonged period, it may be impossible to assign definitive credit to the ACA, any of its programs, or any other particular influence. What is more, if the ACA is having an effect, this may result as much from its psychological effect on providers and health plans as from any of its particular initiatives. The provisions in the ACA regarding delivery-system reform have reinforced the impression that Americans are determined to bring health care costs under control and that providers would be well advised to help guide that process. The recent announcement by Sylvia Mathews Burwell, Secretary of Health and Human Services,[29] that the federal government is planning to reduce dramatically its use of traditional fee-for-service payments for Medicare services and increase its reliance on various pay-for-value approaches and on new organizational models, such as ACOs, will probably reinforce this impression.

Third, if it is premature to draw conclusions about the cost effects of the ACA, it is doubly so for the quality effects of the law. The reductions in hospital-acquired conditions and Medicare readmissions since the enactment of the ACA are unprecedented and encouraging, but here again,

the causes of these favorable trends are uncertain. It may be some time before we can assess the quality effects of this major new legislation.

An assessment of the ACA at 5 years would not be complete without acknowledging the effects of the law on the relationship between the American people and their government and on the balance of power within our society. In the view of some ACA critics, the law has intruded impermissibly on Americans' individual freedoms by, for example, requiring that all residents have insurance or pay a financial penalty. Other Americans find a number of other federal authorities under the ACA, such as its regulation of the individual and small-group private health insurance markets, to be unacceptable intrusions on the prerogatives of states.

Such profound philosophical objections to federal initiatives in health and other policy areas have deep roots in American political discourse and will probably persist, guaranteeing that the ACA will remain controversial. Time will tell whether the contributions of the ACA to the health and health care of Americans will moderate these philosophical objections and create the kind of broad public support for the ACA that Medicare and Medicaid — also controversial when they were passed — now enjoy.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Commonwealth Fund, New York.

This article was published on May 6, 2015, at NEJM.org.

1. 2013 National healthcare quality report. Rockville, MD: Agency for Healthcare Research and Quality, 2014 (http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/index.html).
2. Health insurance coverage and the Affordable Care Act. Washington, DC: Office of the U.S. Assistant Secretary for Planning and Evaluation, 2015 (http://www.aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.cfm).
3. Carman KG, Eibner C. Changes in health insurance enrollment since 2013: evidence from the RAND Health Reform Opinion Study. Santa Monica, CA: RAND, 2014 (http://www.rand.org/pubs/research_reports/RR656.html).
4. Collins SR, Rasmussen PW, Doty MM, Beutel S. The rise in health care coverage and affordability since health reform took effect. New York: The Commonwealth Fund, 2015 (http://www.commonwealthfund.org/publications/issue-briefs/2015/jan/biennial-health-insurance-survey).
5. Long SK, Karpman M. Shartzer A, et al. Taking stock: health insurance coverage under the ACA as of September 2014. Washington, DC: Urban Institute, 2014 (http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.html).
6. Health insurance marketplaces 2015 open enrollment period: March enrollment report. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, 2015 (http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf).
7. Medicaid and CHIP: December 2014 monthly applications, eligibility determinations and enrollment report. Baltimore: Centers for Medicare and Medicaid Services, 2015 (http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2014-enrollment-report.pdf).
8. How many individuals might have marketplace coverage after the 2015 open enrollment period? Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, 2014 (http://www.aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf).
9. Clemans-Cope L, Anderson N. QuickTake: health insurance policy cancellations were uncommon in 2014. Washington, DC: Urban Institute, 2015.
10. Geographic Variation Public Use File. Baltimore: Centers for Medicare and Medicaid Services, 2015 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html).
11. Brennan N. Findings from recent CMS research on Medicare. Baltimore: Centers for Medicare and Medicaid Services, 2014.
12. Joynt KE, Jha AK. A path forward on Medicare readmissions. N Engl J Med 2013;368:1175-7.
13. Joynt KE, Jha AK. Characteristics of hospitals receiving penalties under the Hospital Readmissions Reduction Program. JAMA 2013;309:342-3.
14. Interim update on 2013 annual hospital-acquired condition rate and estimates of cost savings and deaths averted from 2010 to 2013. Rockville, MD: Agency for Healthcare Research and Quality, 2014 (http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.pdf).
15. 2015 Value Modifier results. Baltimore: Centers for Medicare and Medicaid Services, 2015 (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-Value-Modifier-Results.pdf).
16. CMS innovation center model participants. Baltimore: Centers for Medicare and Medicaid Services (https://data.cms.gov/dataset/BPCI-Initiative-Filtered-View/e5a5-c768).
17. Conway P. Building on the success of the ACO model. Washington, DC: The CMS Blog. March 10, 2015 (http://blog.cms.gov/2015/03/10/building-on-the-success-of-the-aco-model).
18. Cavanaugh S. ACOs moving ahead. Washington, DC: The CMS Blog. December 22, 2014 (http://blog.cms.gov/2014/12/22/acos-moving-ahead).
19. McWilliams JM, Landon BE, Chernew ME, Zaslavsky AM. Changes in patients' experiences in Medicare accountable care organizations. N Engl J Med 2014;371:1715-24.
20. Nyweide DJ, Lee W, Cuerdon TT, et al. Association of Pioneer accountable care organizations vs. traditional Medicare fee for service with spending, utilization, and patient experience. JAMA May 4, 2015 (http://jama.jamanetwork.com/article.aspx?articleid=2290608&resultClick=3).
21. Taylor E, Dale S, Peikes D, et al. Evaluation of the Comprehensive Primary Care Initiative: first annual report. Princeton, NJ: Mathematica Policy Research, 2015 (http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf).
22. Polsky D, Richards M, Basseyn S, et al. Appointment availability after increases in Medicaid payments for primary care. N Engl J Med 2015;372:537-45.
23. Report to Congress on Medicaid and CHIP. Washington, DC: Medicaid and CHIP Payment and Access Commission, 2015 (https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicaid-and-chip).
24. Snyder L, Paradise J, Rudowitz R. The ACA primary care increase: state plans for SFY 2015. Washington, DC: Kaiser Family Foundation, 2014 (http://kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015).

25. National Health Expenditure Accounts (NHEA). Baltimore: Centers for Medicare and Medicaid Services, 2014 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html).
26. The budget and economic outlook: fiscal years 2010 to 2020. Washington, DC: Congressional Budget Office, 2010.
27. Updated budget projections: 2015 to 2025. Washington, DC: Congressional Budget Office, 2015 (https://www.cbo.gov/publication/49973).
28. Roehrig C. What is behind the post-recession bend in the health care cost curve? Bethesda, MD: Health Affairs Blog. March 23, 2015 (http://healthaffairs.org/blog/2015/03/23/what-is-behind-the-post-recession-bend-in-the-health-care-cost-curve).
29. Burwell SM. Setting value-based payment goals — HHS efforts to improve U.S. health care. N Engl J Med 2015;372:897-9.

DOI: 10.1056/NEJMhpr1503614