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A Road Map For Action:

Recommendations Of The Health Affairs Council On Health Care Spending And Value

EXECUTIVE SUMMARY

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| EXECUTIVE SUMMARY

For more than forty years, questions about health care spending levels and growth have been an important focus of *Health Affairs*. Recently, the journal announced a first-of-its-kind project intended to build on this rich history of scholarship on health care spending.[1] The Health Affairs Council on Health Care Spending and Value was charged with recommending ways that the United States can take a deliberate approach to moderating health care spending growth while maximizing value.[2]

The twenty-two-member council is a nonpartisan, multidisciplinary expert working group under the leadership of cochairs William Frist and Margaret Hamburg. This report contains the council's recommendations.

The Health Care Spending Problem And The Council's Goal

For decades, both the level and growth rate of US health care spending have diverged from international and domestic norms. Since the 1970s, health care spending growth has far outpaced growth in the US economy[3] as a whole, raising concerns about our continued ability to pay for other goods and services and leading some experts to call for the stabilization of the rate of health care growth as a percentage of gross domestic product (GDP).[4] At the same time, comparisons with health care spending in other developed nations with equal or better health outcomes lead us to ask whether we could be doing much better for our money.[5]

It is unclear what percentage of GDP would represent the ideal level to devote to health care. Nevertheless, the council believes that the current expenditure and rate of growth are higher than they should be, as they are disproportionate to the health they produce and represent a significant burden on families, employers, employees, and government.

The goal of the recommendations in this report is to achieve higher-value health care spending and growth in the US. The mechanism for achieving this goal involves four levers:

- price, or paying the most efficient price for care;
- volume, or ensuring the appropriate quantity of care;
- mix, or ensuring the appropriate types of services for patients and populations; and
- growth, or growing the price and volume sustainably and maintaining an appropriate mix over time.

Council Process And Areas Of Focus

The council examined literature and received input from experts in its inquiry into drivers of spending and growth that met the following criteria: a meaningful amount of money is potentially at stake, it is likely feasible to address the spending driver through policy intervention, and the council, drawing on the unique expertise and perspectives of its members, can make a powerful contribution to the debate.

On the basis of these criteria, the council offers recommendations in four priority areas:

- administrative streamlining,
- price regulation and supports for competition,
- spending growth targets, and
- value-based payment.

Exhibit ES-1 illustrates how these four sets of recommendations map to the four levers for high-value spending and growth.

Recommendations

Exhibit ES-2 lists the council's recommendations, which are offered in a spirit of optimism and humility. The council recognizes that the country's health care spending problems cannot be solved in a single stroke. Nevertheless, stakeholders must start where they are, with the tools currently available, and move forward. These recommendations contain a road map for doing so.

The council provides a range of recommendations that are designed to be compatible with various sets of values and political environments. Notably, the council did not have a formal consensus process. For one set of recommendations, a minority report is included (see recommendations C1–C4). In all other cases, readers may assume that all council members expressed at least some level of support for the recommendation.

A. Administrative Streamlining

Administrative waste is a meaningful detractor from health care value, accounting for close to 7.5 percent of national health spending, totaling several hundred billion dollars per year.[6]

EXHIBIT ES-1

Levers addressed by Council on Health Care Spending and Value recommendations

	Levers to achieve high-value health care spending and growth			
Council recommendations	Price	Volume	Mix of services	Growth
Administrative streamlining	✓		✓	
Price regulation and supports for competition	✓			
Spending growth targets	Potentially can address any of these if stakeholders set goals around them			✓
Value-based payment	✓	✓	✓	✓

SOURCE: Authors' analysis.

EXHIBIT ES-2

Council on Health Care Spending and Value recommendations to achieve higher-value health care spending and growth in the US

Administrative streamlining
A1: Standardization of four key "between" and "seismic" processes
A2: Longer-run harmonization of quality measures
Price regulation and supports for competition
B1: Increased state and federal monitoring of market competitiveness and scrutiny of proposed mergers
B2: Limited price regulation in markets that cannot be competitive
B3: Performance improvement plans and conditional price regulation in markets that could potentially be competitive
B4: Additional supports for competition in markets that are currently competitive
Spending growth targets
C1: Data-supported spending growth target setting
C2: Data-supported monitoring of spending growth
C3: Data-supported enforcement of spending growth targets
C4: Federal support for data infrastructure
Value-based payment
D1: Continued evolution of value-based payment models

SOURCE: Authors' analysis.

The council's goal is not to reduce administrative spending to a level comparable to nations with single-payer systems but, rather, to present recommendations that can be actionable within a multipayer system to preserve the level of choice (of benefits, insurers, providers, treatments, and so on) that many US consumers value.

RECOMMENDATION A1: STANDARDIZATION OF FOUR KEY PROCESSES

The council identified four high-cost administrative processes as the highest-priority areas for intervention on the basis of their likely immediate effects on consumers' experience and on clinician frustration and burnout.[7-9] Although some of the reforms detailed here would admittedly produce relatively small savings on their own, the council believes that it is important to start with these actionable steps to build momentum for taking larger steps in the future.

- **Collection of data for provider directories**, including use of a standardized data platform or platforms to exchange directory information, potentially saving at least $1.1 billion per year for clinicians and an additional amount (estimates unavailable) for health plans.[10]
- **Collection of data to support credentialing of providers**, including use of a standardized data platform. Clinical practices using a single platform to facilitate credentialing with multiple health plans report spending, on average, $1,250 per month to do so, or almost 40 percent less than the $2,068 spent per month by those that used multiple approaches.[10]

- **Claims processing**, using a centralized claims clearinghouse for transmission of standardized billing information among providers and payers. This system could be modeled after the banking industry's automated clearinghouse and could save approximately $300 million per year, as a conservative estimate.[11]
- **Collection of data to support prior authorization**, including transition to full automation and standardization of the data submission process, which could potentially save $417 million annually.[12]

The goal of these recommendations is to standardize the data flow, not to standardize the decision-making criteria. For example, information used for credentialing would be centrally collected, but organizations would continue to make their own choices about whom to credential.

RECOMMENDATION A2: LONGER-RUN HARMONIZATION OF QUALITY MEASURES

In the longer run, the council strongly supports ongoing and additional work to harmonize quality measures across payers. The Centers for Medicare and Medicaid Services (CMS) lists more than 2,200 metrics used across its programs alone.[11] State and local agencies and private payers add hundreds more to the list. Harmonizing these measures would by no means be a simple task, but it holds the potential to improve clinician and patient experience and generate savings (up to $7 billion by one estimate[11]).

B. Price Regulation And Supports For Competition

There is compelling evidence that relatively high US private-sector prices are a key driver of relatively high US health care spending.[13-15] Also compelling is a lack of evidence linking consolidation-induced higher prices to higher quality of care.[16]

This set of recommendations focuses on negotiated health care prices in the private sector, rather than on administered prices in the public sector, as the former have historically grown more slowly than commercial prices.[17,18] The recommendations include regulatory and nonregulatory approaches focused on three categories of markets: those that cannot be competitive because of population size (natural monopolies), those that are not competitive now but could potentially be competitive with some intervention, and those that are currently competitive. Conceptually, these recommendations address hospital markets, although a similar framework could be applied to physician or insurance markets.

RECOMMENDATION B1: INCREASED STATE AND FEDERAL MONITORING OF MARKET COMPETITIVENESS AND SCRUTINY OF PROPOSED MERGERS

In all markets there is a need for increased monitoring of competitiveness, even in the absence of proposed mergers, as well as additional scrutiny of proposed mergers. These activities can be undertaken by states and the Federal Trade Commission or Department of Justice and should ideally be done collaboratively by state and federal entities.

RECOMMENDATION B2: LIMITED PRICE REGULATION IN MARKETS THAT CANNOT BE COMPETITIVE

In markets where competition is not feasible because smaller populations will not support multiple competitors, the council supports states in setting all-payer price maximums. However, non–Metropolitan Statistical Areas, which can be considered rural, account for about half the population in this category, potentially requiring special consideration.

The council recommends state, rather than federal, intervention in these markets because states differ in their markets and circumstances and are more likely than the federal government to be aware of particular rural access issues. In

addition, states already have regulatory authority over hospitals and physician practices, and this would be an extension of that role.

RECOMMENDATION B3: PERFORMANCE IMPROVEMENT PLANS AND CONDITIONAL PRICE REGULATION IN MARKETS THAT COULD POTENTIALLY BE COMPETITIVE

In certain currently noncompetitive markets, population size is, in fact, sufficient to support at least moderate competition. To increase the number of competitors, policy makers could either induce more market entrants or break up existing combinations in service lines where there could be more sellers of efficient size. The former is likely more palatable than the latter in most states, and it may be supported or encouraged by legislation that prohibits specific anticompetitive contracting clauses that are common in health care.

When these markets are identified, policy makers may choose to impose performance improvement plans on firms that engage in anticompetitive behavior, requiring them to divest facilities or take actions that enable new entrants. If competitiveness does not improve in a specified period, states should move on to maximum price setting, as described in recommendation B2.

RECOMMENDATION B4: ADDITIONAL SUPPORTS FOR COMPETITION IN MARKETS THAT ARE CURRENTLY COMPETITIVE

In currently competitive markets, the council does not recommend regulation of prices, but rather increased federal or state monitoring of competitiveness and merger activity, supported by appropriate funding. In addition, as in recommendation B3, states should consider limiting or prohibiting anticompetitive contracting practices.

C. Spending Growth Targets

A missing ingredient in US efforts to moderate health care spending growth is a locus for collective action. The council therefore encourages states, with federal support, to convene stakeholders to engage in data collection, analysis, and discussion about health care spending. Such convenings may lead to the establishment, monitoring, and enforcement of spending growth targets. Examples of such multistakeholder work can be found in Maryland and Massachusetts and in a small number of additional states.[19-21]

RECOMMENDATION C1: DATA-SUPPORTED SPENDING GROWTH TARGET SETTING

All states, either individually or in concert with other states or the federal government, are encouraged to develop a mechanism to establish health care spending growth targets relative to the size of the economy and in the context of other state goals concerning equity, affordability, and access. One such mechanism would be to create a dedicated commission, similar to those implemented in Massachusetts and Maryland. States may find other ways to accomplish the same goal using existing structures.

RECOMMENDATION C2: DATA-SUPPORTED MONITORING OF SPENDING GROWTH

States that choose to set spending growth targets should develop a mechanism to monitor performance relative to the target (both in aggregate and by stakeholder) by analyzing and publicly reporting on health spending and growth data. Analysis should focus on high levels and growth of spending and on variation, further disaggregating these trends by specific drivers such as prices, practice patterns, or population characteristics.

The monitoring entity must have power, granted through legislation or executive action, to compel stakeholders to share necessary data with the state or with a centralized, federally led data collection entity, as described under recommendation C4.

RECOMMENDATION C3: DATA-SUPPORTED ENFORCEMENT OF SPENDING GROWTH TARGETS

States that have established spending growth targets and are actively monitoring progress against them should develop a mechanism to enforce these targets, although the type of enforcement that might be feasible or desirable in any given state will vary. Enforcement mechanisms lie along a spectrum from simple transparency (public reporting of data), to public justification of prices or spending, to performance improvement plans, to direct fines or other penalties.[22] All states should formally evaluate the efficacy of enforcement mechanisms and adjust as needed.

RECOMMENDATION C4: FEDERAL SUPPORT FOR DATA INFRASTRUCTURE

Collecting and analyzing state-level, payer-reported aggregate spending data is costly and requires expertise. The council therefore recommends federal support and guidance for states undertaking this work. As more states gather these data, policy makers should support comparability across states, and thus ease the administrative burden on payers and providers operating in multiple states, by advancing national-level minimum, common data standards.

A national-level entity should convene immediately to determine what data are required, how best to centralize them, and how to leverage the work of states already collecting these data. Ideally, CMS could play a lead role in convening stakeholders for this purpose, leaning heavily on states that are already engaged.

D. Value-Based Payment

In this report, *value-based payment*—often called advanced Alternative Payment Models—refers to a variety of arrangements, all of which are best defined in opposition to open-ended fee-for-service payments. Conceptually, these models run the gamut from fee-for-service with bonuses for quality to more advanced models, including bundled payment and accountable care organizations, and to full global capitation. They vary in the extent to which they maintain an element of fee-for-service payment and in the degree of clinical and financial risk imposed on the payee, which can be a health plan, a delivery system, or an individual clinician.

Despite compelling theory, use of prominent value-based payment models put forth by the Center for Medicare and Medicaid Innovation (CMMI) has not yet resulted in significant savings to payers, providers, or patients. However, the fact that savings have been more modest than initially expected may primarily be a consequence of design and implementation challenges,[23-25] rather than fundamental flaws in this approach to payment reform.

The council believes that value-based payment models have the potential to be a chassis supporting its other sets of recommendations regarding administrative streamlining, competitive pricing, and spending growth targets. There are reasons to be optimistic that continued experimentation with value-based payment will yield positive results. There is also strong CMMI support for addressing many of the challenges identified by experts.[23,25-27]

RECOMMENDATION D1: CONTINUED EVOLUTION OF VALUE-BASED PAYMENT MODELS

The council strongly supports the continued evolution of value-based payment models in both the public and private sectors. Future implementation should focus on the following elements:

- fewer models and better alignment among payers;
- stronger incentives for patients to obtain care from accountable delivery systems or provider groups, potentially including patient or member “lock-in”;
- increased levels of financial and clinical risk for payees, giving them more flexibility in choosing what services are provided, and where and how; and

- exploration of incentives for addressing health-supporting social needs (for example, some payers and health systems are experimenting with providing support for patients to access services such as housing, food, and transportation assistance).

Concluding Thoughts

As part of the commission's internal work to understand members' level of support for specific recommendations, members rated their confidence, based on the empirical evidence, that individual recommendations would produce either savings or slowed growth.

As shown in exhibit ES-3, all of the recommendations clustered together with average confidence ratings in the medium range, with the exception of two outliers for which members had high confidence. These were recommendations A2 (longer-run harmonization of quality measures) and B1 (increased state and federal monitoring of market competitiveness and scrutiny of proposed mergers).

Exhibit ES-3 also rates the recommendations on two additional factors: level of resources needed and difficulty of implementation, and the expected dollar magnitude of impact if successful. Ideally, recommendations would

EXHIBIT ES-3

Key attributes of recommendations of the Council on Health Care Spending and Value

Recommendation	Member confidence that recommendation can produce savings or slowed growth (high [H] or medium [M])	Level of resources and difficulty of implementation (high or medium)	Expected magnitude of $ impact if successful (high or medium)
A1: Standardization of four key "between" and "seismic" processes	M	M	M
A2: Longer-run harmonization of quality measures	H	H	H
B1: Increased state and federal monitoring of market competitiveness and scrutiny of proposed mergers	H	H	H
B2: Limited price regulation in markets that cannot be competitive	M	H	H
B3: Performance improvement plans and conditional price regulation in markets that could be competitive	M	H	H
B4: Additional supports for competition in markets that are currently competitive	M	M	M
C1: Data-supported spending growth target setting	M	M	$ impact as yet unknown
C2: Data-supported monitoring of spending growth	M	M	
C3: Data-supported enforcement of spending growth targets	M	M	
C4: Federal support for data infrastructure	M	M	
D1: Continued evolution of value-based payment models	M	M	M

SOURCE: Authors' analysis.

be low cost and high impact, but this is not case with respect to the council's recommendations—greater impact will require greater effort. The level of collaboration and compromise that will be required to implement these recommendations is significant. However, in steering policy makers toward a set of recommendations that has been vetted and supported by a diverse group of experts with divergent interests, the council hopes to provide a strong starting point for action.

Endnotes

1. Weil A. Health Affairs launches council on health care spending and value. Health Affairs Blog [blog on the Internet]. 2018 July 12 [cited 2022 Sep 18]. Available from: https://www.healthaffairs.org/content/forefront/em-health-affairs-em-launches-council-health-care-spending-and-value
2. Health Affairs. Council on Health Care Spending and Value [home page on the Internet]. Washington (DC): Health Affairs; [cited 2022 Sep 18]. Available from: https://www.healthaffairs.org/council-on-health-care-spending-and-value
3. Centers for Medicare and Medicaid Services. National health expenditure data: projected [Internet]. Baltimore (MD): CMS; 2022 Apr 27 [cited 2022 Oct 21]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected
4. Skinner J, Cahan E, Fuchs VR. Stabilizing health care's share of the GDP. N Engl J Med. 2022;386(8):709–11.
5. Kurani N, Wager E. How does the quality of the U.S. health system compare to other countries? [Internet]. Peterson-KFF Health System Tracker; 2021 Sep 30 [cited 2022 Oct 10]. Available from: https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/
6. Tollen L, Keating E, Weil A. How administrative spending contributes to excess US health spending. Health Affairs Blog [blog on the Internet]. 2020 Feb 20 [cited 2022 Oct 19]. Available from: https://www.healthaffairs.org/do/10.1377/forefront.20200218.375060/full/
7. Sinsky CA, Brown RL, Stillman MJ, Linzer M. COVID-related stress and work intentions in a sample of US health care workers. Mayo Clin Proc Innov Qual Outcomes. 2021;5(6):1165–73.
8. Frogner BK, Dill JS. Tracking turnover among health care workers during the COVID-19 pandemic: a cross-sectional study. JAMA Health Forum. 2022;3(4):e220371.
9. Dzau VJ, Kirch D, Murthy V, Nasca T, editors. National plan for health workforce well-being. Washington (DC): National Academies Press; 2022.
10. CAQH. The hidden causes of inaccurate provider directories [Internet]. Washington (DC): CAQH; 2019 [cited 2022 Oct 19]. Available from: https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf

11. Cutler DM. Reducing administrative costs in U.S. health care [Internet]. Washington (DC): Hamilton Project; 2020 Mar [cited 2022 Oct 19]. Available from: https://www.brookings.edu/wp-content/uploads/2020/03/Cutler_PP_LO.pdf

12. CAQH. 2020 CAQH Index: closing the gap: the industry continues to improve, but opportunities for automation remain [Internet]. Washington (DC): CAQH; 2021 [cited 2022 Oct 20]. Available from: https://www.caqh.org/sites/default/files/explorations/index/2020-caqh-index.pdf

13. Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Aff (Millwood). 2019;38(1):87–95.

14. Health Care Cost Institute. 2020 health care cost and utilization report [Internet]. Washington (DC): HCCI; 2022 May [cited 2022 Oct 20]. Available from: https://healthcostinstitute.org/images//pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf

15. Dieleman JL, Squires E, Bui AL, Campbell M, Chapin A, Hamavid H, et al. Factors associated with increases in US health care spending, 1996–2013. JAMA. 2017;318(17):1668–78.

16. Schwartz K, Lopez E, Rae M, Neuman T. What we know about provider consolidation [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2020 Sep 2 [cited 2022 Oct 20]. Available from: https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/

17. Congressional Budget Office. The prices that commercial health insurers and Medicare pay for hospitals' and physicians' services [Internet]. Washington (DC): CBO; 2022 Jan 20 [cited 2022 Oct 20]. Available from: https://www.cbo.gov/publication/57422

18. Selden TM. Differences between public and private hospital payment rates narrowed, 2012–16. Health Aff (Millwood). 2020;39(1):94–9.

19. Maryland Health Services Cost Review Commission [home page on the Internet]. Baltimore (MD); [cited 2022 Oct 26]. Available from: https://hscrc.maryland.gov/Pages/default.aspx

20. Massachusetts Health Policy Commission [home page on the Internet]. Boston (MA); [cited 2022 Oct 26]. Available from: https://www.mass.gov/orgs/massachusetts-health-policy-commission

21. Melnick G. Health care cost commissions: how eight states address cost growth [Internet]. Oakland (CA): California Health Care Foundation; 2022 Apr [cited 2022 Oct 21]. Available from: https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf

22. Lipson D, Berk S, Lane K, Block R. How states are holding payers and providers accountable for health cost growth: evidence to date and policy implications. Health Affairs Forefront [blog on the Internet]. 2022 Oct 31 [cited 2022 Oct 31]. Available from: https://www.healthaffairs.org/content/forefront/states-holding-payers-and-providers-accountable-health-cost-growth-evidence-date-and

23. Brooks-LaSure C, Fowler E, Seshamani M, Tsai D. Innovation at the Centers for Medicare and Medicaid Services: a vision for the next 10 years. Health Affairs Blog [blog on the Internet]. 2021 Aug 12 [cited 2022 Oct 21]. Available from: https://www.healthaffairs.org/do/10.1377/forefront.20210812.211558/full/

24. Chernew ME, Conway PH, Frakt AB. Transforming Medicare's payment systems: progress shaped by the ACA. Health Aff (Millwood). 2020;39(3):413–20.

25. Jacobs D, Rawal P, Fowler L, Seshamani M. Expanding accountable care's reach among Medicare beneficiaries. N Engl J Med. 2022;387(2):99–102.

26. Seshamani M, Jacobs DB. Leveraging Medicare to advance health equity. JAMA. 2022;327(18):1757–8.

27. Seshamani M, Fowler E, Brooks-LaSure C. Building on the CMS strategic vision: working together for a stronger Medicare. Health Affairs Forefront [blog on the Internet]. 2022 Jan 11 [cited 2022 Oct 21]. Available from: https://www.healthaffairs.org/do/10.1377/forefront.20220110.198444/full/

The Health Affairs Council on Health Care Spending and Value is a nonpartisan, multidisciplinary, expert working group charged with recommending ways that the United States can take a deliberate approach to moderating health care spending growth while maximizing value.

COCHAIRS

William Frist, former US Senate majority leader

Margaret Hamburg, former commissioner of the Food and Drug Administration

MEMBERS

Toyin Ajayi, chief health officer and cofounder, Cityblock Health

Hassan Azar, executive advisor, Employer Health Innovation Roundtable

Tanisha Carino, partner, the Brunswick Group

John M. Colmers, vice president, Health Care Transformation and Strategic Planning, Johns Hopkins Medicine (retired)

Toby Cosgrove, executive adviser, former president and chief executive officer, Cleveland Clinic

David Cutler, Otto Eckstein Professor of Applied Economics, Harvard University

Randy DeFrehn, chief executive officer, DeFrehn and Associates LLC; former executive director, National Coordinating Committee for Multiemployer Plans

Paul J. Diaz, president and chief executive officer, Myriad Genetics, Inc.

Delvecchio Finley, president and chief executive officer, Atrium Health Navicent

Craig Garthwaite, director of health care, Kellogg School of Management, Northwestern University

Sherry Glied, dean, Robert F. Wagner Graduate School of Public Service, New York University

Penny Kaye Jensen, liaison for national APRN policy, Department of Veterans Affairs

Jennifer Kowalski, vice president, Public Policy Institute, Elevance Health

Sharon Levine, vice chair, Patient Centered Outcomes Research Institute

George Miller, institute fellow, Altarum Center for Value in Health Care

John O'Brien, president and chief executive officer, National Pharmaceutical Council

Mark Pauly, professor emeritus, Wharton School, University of Pennsylvania

L. Wade Rose, senior advisor to the chief executive officer, CommonSpirit Health (retired)

Nora Wells, executive director, Family Voices

STAFF

Laura Tollen, director, Health Affairs Council on Health Care Spending and Value; senior editor, *Health Affairs*

Elizabeth Keating, consultant, Health Affairs Council on Health Care Spending and Value

ADVISER

Alan Weil, editor-in-chief, *Health Affairs*

FORMER MEMBERS

Robert W. Dubois, executive vice president and chief science officer, National Pharmaceutical Council (retired)

Stephen Friedhoff, former chief medical officer, Anthem, Inc.

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Sarah Bartelmann, cost growth target program manager, Oregon Health Authority

Robyn Begley, chief executive officer, American Organization for Nursing Leadership; chief nursing officer, American Hospital Association

Robert Berenson, senior fellow, Urban Institute

William Bleser, assistant research director of health care transformation for population health, social needs, and health equity, Duke-Margolis Center for Health Policy

Rachel Block, program officer, Milbank Memorial Fund

Debbie Boylan, director of events, *Health Affairs*

Lawrence Casalino, Livington Farrand Professor, Department of Healthcare Policy and Research, Weill Cornell Medical College

Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School

Carrie Colla, professor, Dartmouth Institute for Health Policy

Joshua Ewing, vice president of legislative affairs, Colorado Hospital Association

Claire Ewing-Nelson, editorial consultant, *Health Affairs*

Bianca Frogner, director, Center for Health Workforce Studies, University of Washington; member, Washington Health Care Cost Transparency Board

Anders Gilberg, senior vice president for government affairs, Medical Group Management Association

Tina Grande, executive vice president for policy, the Healthcare Leadership Council

Grace Kim, doctoral candidate, Robert F. Wagner Graduate School of Public Service, New York University

Rob Lott, deputy editor for special content, *Health Affairs*

Julianne McGarry, director of projects and research, Catalyst for Payment Reform

Renee McLaughlin, national medical director for value-based relationships, Cigna; chair of AHIP Value-Based Care Workgroup

Gregg Meyer, president of the Community Division and executive vice president of value based care, Mass General Brigham

Farzad Mostashari, cofounder and chief executive officer, Aledade

Kavita Patel, managing director of clinical transformation, Center for Health Policy, Brookings

Rocco Perla, cofounder, The Health Initiative

Robert Saunders, senior research director, health care transformation, Duke-Margolis Center for Health Policy

Richard Scheffler, director, Petris Center on Health Care Markets and Consumer Welfare, University of California Berkeley

Mohan Suntha, president and chief executive officer, University of Maryland Medical System

Robin Thomashauer, president, CAQH

Jeanette Thornton, senior vice president, product, employer, and commercial policy, AHIP

Patrick Tigue, Rhode Island Health Insurance Commissioner

Sophia Tripoli, director of health care innovation, Families USA; director, Consumer First Coalition

Reed Tuckson, Tuckson Health Connection

Brandon Wilson, director, Center for Consumer Engagement in Health Innovation, Community Catalyst

Steffie Woolhandler, distinguished professor, School of Urban Public Health, Hunter College, City University of New York

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