



Efficiency and Quality

Controlling Cost Growth in Health Care Reform

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Introduction and summary

Expanding health insurance coverage to the more than 45 million uninsured Americans is a key U.S. policy goal, but expanding coverage without steps to contain rapidly rising health care costs is a recipe for failure. For years, federal initiatives to reform health care focused mostly on expanding the proportion of Americans covered by health insurance. That is a key part of this year's health reform agenda, but most policymakers recognize that provisions to address rising health care spending are an important component of health care reform.

President Obama and his budget director, Peter Orszag, continually stress the importance of lowering the trend of health spending increases. In early May, a consortium of key health care stakeholders responded by pledging to help reduce rising health care costs by 1.5 percentage points per year for 10 years, with estimated savings of \$2 trillion over this period.¹ Few health care experts have confidence that such voluntary efforts can slow the trend by a substantial amount, but the pledge by organizations representing physicians, hospitals, insurers, drug makers, device makers, and organized labor is important, reflecting the emerging consensus that controlling health care costs is essential to ensuring access to affordable health care coverage.

Controlling costs and ensuring access to affordable coverage are inexorably intertwined. Over the past 30 years, the growth in health care spending has outpaced growth in our nation's gross domestic product—the value of all goods and services produced in the U.S. economy—by more than 2 percentage points a year. Over time, the gap between health care cost growth and the nation's wherewithal to pay its health care tab leads to more Americans losing health insurance and increased stress on federal and state budgets.

What's worse, as spending growth for Medicare and Medicaid exceeds growth in government revenues, which tend to parallel GDP growth, pressure to expand public coverage increases as Americans lose private coverage, putting even more stress on government budgets. A recent Congressional Budget Office analysis shows that the long-term fiscal outlook of the federal government is dominated by the degree to which health care spending trends exceed growth in GDP.²

Expanding coverage without reining in health costs will inevitably result in coverage losses down the line as rising costs make coverage less affordable. Case in point: Tax credits to support the purchase of coverage for people with incomes up to 300 percent of the poverty level, or \$66,150 for a family of four in 2009, would become more expensive over time. Before long, families with incomes at 325 percent of poverty would have problems affording coverage akin to those with incomes at 300 percent of poverty are having today.

Looking at this positively, a government-mandated health care program that expands the number of people with coverage provides an ideal opportunity to address spending growth. If steps are taken to slow the growth in services provided to already-covered people, then the concerns of physicians, hospitals, and other health care providers about declines in service volume would be allayed to some degree by increases in service volume generated by newly covered Americans. Moreover, meeting newly insured Americans' need for health care services may pressure providers to become more efficient—a main goal of government policies to slow spending growth in the first place.

Traditionally, Congress approaches the need to constrain spending by writing sufficiently detailed legislative language that allows CBO to estimate the savings. The results are often policies that capture opportunities for short-term savings but with little potential for long-term results. Congress can achieve savings, for example, by squeezing Medicare inpatient hospital payment rates—something that CBO can easily score. But much greater long-term potential for savings could come from encouraging physicians' efforts to improve ambulatory care so that fewer Medicare beneficiaries require hospitalization in the first place.

At this point in the current debate over health care reform—as in the past—policies with potential for substantial long-term reductions in the spending trend are not yet developed and detailed enough to be scored by CBO. But enacting policies with long-term potential is more important now than ever. Congress needs to unite to produce a vision for health care cost containment and provide the Obama administration with the direction and authority to pilot promising policies and expand initiatives that appear to be working.

This paper focuses on steps that can be taken as part of health reform to slow the trend of health spending, including steps that Congress can take now, as well as direction for developing and implementing longer-term policies. Rather than attempt to treat the topic comprehensively, this paper will focus on five areas that appear to have the greatest potential:

- Increasing the accuracy of the Medicare physician fee schedule
- Developing payment systems that broaden the focus of physicians, hospitals, and other providers from delivering piecemeal, individual services to patients to providing the care patients need for an entire episode of illness or that an entire population needs
- Encouraging and fostering use of Medicare's provider-payment methods by private insurance companies and Medicaid, the joint state-federal health program for low-income people

- Reforming the tax treatment of employer-based health benefits in a way that encourages employers to keep offering coverage but not excessively comprehensive benefits
- Expanding comparative effectiveness research, with a particular emphasis on assessing technologies already in broad use

Each of these options has potential to help slow excessive health care spending growth and improve the overall quality of health care.

The Medicare fee schedule for physician services is riddled with distortions, causing some medical services to be highly profitable and others unprofitable. The existing fee schedule generally rewards specialty procedures at the expense of primary care services, causing too many patient procedures and too little evaluation and management of patients and their problems. Over time, the payment distortions have undermined the financial viability of primary care practices and created incentives for provider behavior that fragments the delivery of care. The Medicare physician fee schedule can be fixed with concerted action and enough resources. Similarly, a more accurate physician fee schedule would also support the development and implementation of broader payment units that focus less on the volume of services and more on providing episodes of care efficiently and maintaining the health of a population of health care plan enrollees.

For payment reform to reach its potential, Medicaid programs and private payers of medical care such as insurance companies should participate in developing new Medicare payment methods and follow them to the extent possible. Many health care providers have substantial market power and the ability to offset Medicare payment reductions with increases for private payers, so creating payment structures that are uniform across payers can increase the potential of payment reform to change provider behavior. If a public health insurance plan is a part of health reform, then an all-payer rate-setting structure could help establish a level playing field for all health insurance plans.

The tax treatment of employer-based health insurance also contributes to rapidly rising costs by subsidizing highly comprehensive insurance, especially for higher-wage workers. Limiting this subsidy could encourage health benefit structures that make consumers more sensitive to costs and, at the same time, raise some of the revenue needed to pay for the expansion of coverage and make the tax system more progressive. Applying the limit to the so-called actuarial value of insurance policies—a measure of how rich the benefits are—would have fewer unintended consequences than an absolute-dollar limit.

Finally, providers and consumers need much better information about what medical care does and doesn't work. Comparative effectiveness research can expand the knowledge base of medical decision making and, ideally, reduce care that does not benefit patients but costs a great deal. The key will be thoughtful targeting of research.

Some of these policy options need further development and will require a great deal of judgment for effective implementation. Congress will need to spell out clearly the direction of long-term policies to address costs and delegate substantial authority to either the Obama administration or a newly created independent health review board. If the health care reform package about to be taken up by Congress achieves this, then our nation can significantly expand health care coverage and limit the overall cost of doing so through gains in efficiency and effectiveness.³

If this is not achieved, then expansions in health care coverage will be undermined and the fiscal health of the federal and state governments will darken considerably. Fortunately, expanding health insurance coverage is the ideal time to address spending, since doctors and hospitals and other health care providers may be less resistant to the need to deliver care more efficiently as newly insured patients seek care.

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