Throwing Darts: Americans' Elusive Search for Health Care Cost Control

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During the 2009–2010 health reform debate, secretary of Health and Human Services Kathleen Sebelius contended that "every cost-cutting idea that every health economist has brought to the table is in this bill" (Gregory et al. 2010).

That assertion had considerable merit. The Patient Protection and Affordable Care Act (ACA) contained numerous items on health services researchers' and health economists' wish lists, including policies to promote accountable care organizations (ACOs), primary care medical homes, bundled payment, pay for performance (P4P), comparative effectiveness research (CER), and health information technology (HIT). Even economists' longtime holy grail—limiting the tax exclusion for employer-sponsored insurance—made it, against the political odds, into the ACA. So too did proposals to create an independent Medicare commission and an innovation center, while the Obama administration additionally promised to authorize an Institute of Medicine study on reducing the geographic disparities in Medicare payment made (in)famous by Dartmouth researchers (Wennberg, Fisher, and Skinner 2002).

Not surprisingly, many policy analysts lavished praise on the new law's promise to "bend the cost curve." Before the ACA's enactment, a distinguished group of economists led by Henry Aaron, David Cutler, and Alice Rivlin (2010: 1) published a letter endorsing the legislation's "long list of measures that will control rising costs," including reforms that "move away from fee-for-volume payments to fee-for-value payments" and "tax

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highly generous insurance plans." Health economist Jon Gruber, commenting on an earlier Senate version of the law, remarked, "Everything is in here. . . . I can't think of anything I'd do that they are not doing in the bill" (Brownstein 2009). Meanwhile, Atul Gawande (2009) praised the diversity of cost-control approaches and the "battery of small experiments" embraced by the ACA, drawing a parallel between those efforts and pilot initiatives during the first part of the twentieth century that transformed U.S. agriculture through a process of trial, error, and adjustment.

The Congressional Budget Office (2008) is skeptical that such experiments will generate sizable savings anytime soon, but others are more optimistic. A Commonwealth Fund report estimates that the new health reform law will save, after accounting for the costs of expanding insurance coverage, about $600 billion over the next decade, slowing annual growth in national health expenditures from 6.3 percent to 5.7 percent. Much of that slowdown is attributed to proposals, like HIT, that facilitate "health system modernization," which the authors argue will allow us to realize "the enormous potential for productivity improvement that reform can drive if it makes health care operate more like other industries" (Cutler, Davis, and Stremikis 2010: 8).

Is there, then, reason to believe that the ACA will decisively rein in U.S. medical care spending? Alas, probably not. The enthusiasm for the cost-containment provisions in health reform is striking precisely because so many of those provisions are tepid. Put simply, the Affordable Care Act lacks systemwide, reliable cost control. It is in fact a retreat from the cost-control ambitions of the 1993–1994 Clinton plan, which had, whatever one thinks of managed competition, a serious theory of how to slow health care spending, and, beyond that, a National Health Board and a budget to enforce expenditure targets. That some analysts believe the new law encompasses all available cost-containment ideas says more about the parochialism of U.S. health policy and its inattention to international experience than it does about the robustness of the ACA's spending limits.

There is, of course, a compelling political logic to treading lightly on health spending: the greater a health reform plan's capacity to limit medical inflation, the smaller its chances of political adoption (Oberlander 2003). Cost containment means containing medical providers' income and profits, and that triggers opposition from well-heeled, influential interests that can sink reform legislation (Marmor 1983; Quadagno 2005). The Clinton health plan's demise during 1993–1994 vividly illustrated that dynamic, and understandably the Obama administration wanted to avoid

anything resembling a health care budget or centralized spending controls this time around. (The administration's decision not to fight hard for a Medicare-like public insurance option was consistent with this strategy.)

After all, expanding access to health insurance and adopting the mandates, subsidies, regulations, insurance-pooling mechanisms and taxes necessary to move closer to universal coverage are by themselves formidable tasks. As Jon Kingsdale argues (2009: W589), trying to do everything in one national health reform big bang, so that controlling costs is a simultaneous goal, "would be more than Herculean — it would be Sisyphean," with proponents trapped in an endless cycle of attempted reform and failure. Indeed, the all-American formula of expanding coverage without controlling costs has been used to great effect previously, from Medicare in 1965 to Massachusetts in 2006.

Deviating too far from that formula during 2009–2010 would likely have resulted in legislative failure. Given political constraints, the furor over "death panels" and rationing, and the thin margins by which health reform ultimately passed through Congress, it is hard to see how the Obama administration could have achieved much stronger limits on medical spending. To be sure, the ACA adopts significant cost-control measures in Medicare, largely by reducing payments to hospitals and private insurers that operate as Medicare Advantage plans. The Obama administration and congressional Democrats wrung over $400 billion in projected savings out of Medicare, an amount that proved crucial to financing expanded coverage. Those savings also represented a major political achievement, one presumably enabled, in the case of hospitals, by the judgment that they will earn back the lost money as the uninsured are covered (Abelson 2010). Furthermore, the establishment of the Independent Payment Advisory Board, whose recommendations Congress must consider under special legislative rules, could lead to even stronger controls on Medicare spending down the road, though the board's long-term impact and effectiveness remain highly uncertain.

But slowing federal expenditures on Medicare is not the same as controlling spending in the broader U.S. health care system that encompasses private insurance and other public programs (Marmor and Oberlander 2009). Outside of asserting Medicare's powers, the ACA has three major policies that purport to control costs. The establishment of health insurance exchanges is expected to generate savings by concentrating purchasing power, reducing administrative costs, and promoting competition among health insurers. Yet the scope of the exchanges, and consequently their likely impact on national health expenditures, is limited: the Con-

gressional Budget Office (CBO 2010) projects 24 million Americans will participate in them by 2019 (though enrollment could expand significantly over time). Moreover, Massachusetts's experience to date with its Health Connector program provides little ground for believing that the exchanges will slow spending in the broader health system.

The second major cost-control instrument is the 40 percent marginal tax that will be imposed on high-cost insurance plans (policies exceeding $10,200 for individuals and $27,500 for families). The so-called Cadillac tax reflects many economists' deeply held belief that insulating patients from costs leads to overconsumption of and higher spending on medical care (Vladeck and Rice 2009). That other nations spend much less than the United States on health care despite having comprehensive benefits and, in some cases, no cost sharing has so far not disturbed the view that moral hazard is the root of our high costs. Tax health insurance, advocates believe, and insurers and employers will trim overly generous benefits, patients will consume less medical care, and national health spending will slow.

Even if the Cadillac tax works as envisioned, it is hardly reassuring that the cost-control instrument most often cited as the centerpiece of health reform is not scheduled to go into effect until 2018. Given the controversy surrounding the tax (taxing health benefits is an idea popular with economists, not the public), it is far from certain that this policy will even be implemented then. There are also the disquieting distributional issues raised by the prospect of taxing plans that are high cost not because they offer "Cadillac" coverage but because they have sicker, older enrollees.

The final piece of the ACA's cost-control strategy is delivery system reform. Here the idea is to "modernize" U.S. medical care (Buntin and Cutler 2009) by providing better information and new incentives (CER, HIT), reorganizing how care is delivered (ACOs, medical homes), and changing how it is paid for (bundled payment, P4P). In addition, the law embraces prevention, including a new requirement that insurers must cover recommended preventive services without any cost sharing.[1]

However, little evidence exists that any of these reforms — as politically appealing as their promise to improve health outcomes and health care delivery may be — will generate sizable savings in the short term (Marmor, Oberlander, and White 2009; Tanenbaum 2009). Moreover, in many cases the reforms are initially envisioned only as Medicare pilots and demonstrations, with the hope that they would spread throughout the

1. For another analysis comparing tax incentives (the "Cadillac tax") with delivery reforms (ACOs), see Pauly's essay in this issue. See Gusmano's essay in this issue for more on CER.

program and then to the rest of the health system.[2] This strategy for controlling costs is akin to throwing darts. Evidently, the idea is that since we don't know how well any of these policies will work, we should try them all at once and see which ones actually stick.

It is impossible to know how this potpourri of initiatives will perform. Perhaps they will interact in a way that produces more savings than the CBO believes is likely (Gabel 2010). Bundled payment, among the solutions du jour, has the most cost-saving potential since it at least directly addresses payment. But to put the Commonwealth Fund's projected savings of $600 billion during 2010–2019 in context, consider that actuaries forecast the United States will spend about $35 trillion on medical care during that decade (Foster 2010).

There is good reason to be skeptical that delivery system reform will by itself provide reliable cost control. After all, other Organisation for Economic Co-operation and Development nations that spend less on medical care than the United States do so largely through concentrated purchasing, budgeting, and price regulation (Jost, Dawson, and den Exter 2006; Marmor, Oberlander, and White 2009; Vladeck and Rice 2009; White 1995, 2010). The ACA does not move the United States closer to that international standard (White 1995) as much as it maintains the American tradition of searching for technical fixes to the fundamentally political problem of slowing the flow of income to the health care industry (Barer and Evans 1992; Morone 1990; Reinhardt 1990; Vladeck and Rice 2009).

Thus many American policy analysts continue to lament fee-for-service payment and argue for the "necessity" of switching to a "fee-for-value" system if costs are to be controlled—never mind that other nations that pay doctors fee-for-service, including Canada, control costs much better than we do. The American debate has lost sight of a crucial fact: it is not just about how you pay for medical care, but how much you pay for services. Rather than emulating policies that actually work to constrain spending abroad (e.g., global budgets, fee schedules) the United States seems intent on reinventing and reorganizing its way out of the cost crisis. Yesterday's conviction that capitation and integrated delivery systems held the key to stemming medical costs has been resurrected in the current fad for accountable care organizations and bundling, with scant acknowledgment that we have been down this road before. An ever-increasing list of abbreviations (HMOs, HSAs, HIT, P4P, and so on) bear witness to Americans' elusive, and now four-decade-long, search for magic bullets.

2. See Laugesen's essay in this issue for more on Medicare payment reform.

Proponents of the ACA have attempted to turn the absence of reliable cost control into a strength. The law is, they contend, diverse and flexible. By trying many approaches, "it does not rely on just one policy for effective cost control" (Orszag and Emanuel 2010: 603). Yet combining a series of potentially ineffective reforms does not make them any more effective. Moreover, the rationale for experimenting with an array of delivery systems and payment reforms reflects a sort of policy agnosticism, since, as Jon Gruber argues, "health policy experts can't really say for sure how governments should best go about slowing cost growth" (Gruber 2010: 189). But international experience suggests that other nations do know how to slow medical spending; the United States is simply unable or unwilling to adopt those policies. Americans are, in other words, determined to try all available cost-control options—except those that actually succeed elsewhere. Ultimately, the insistence that the United States has to try everything because nothing is certain to contain medical costs sounds less like agnosticism or intellectual curiosity and more like ignorance.

Still, health reform could spark an unintended revolution by transforming the politics of cost control. The new law gives the federal government, if the ACA survives the repeal fight, a greater stake in controlling health care spending. As costs continue to rise, policy makers will confront growing pressure to hold down increases in health insurance premiums, and that in turn could create an environment where greater price regulation, more ambitious payment reform, or even an all-payer system become more politically palatable. Such a cycle is already evident in Massachusetts, and Medicare previously followed a similar trajectory toward greater price regulation. Pressures to reduce the federal budget deficit will only intensify the government's interest in controlling medical spending. And the ACA could also accelerate movement among private insurers to adopt more aggressive payment reforms, such as bundled payment, that shift financial risk to medical providers.

Paradoxically, it may turn out that expansion of insurance coverage, made politically possible only by avoiding tougher spending limits, is a crucial step toward the United States finally adopting a reliable system of effective cost control.

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