SOUNDING BOARD

ELECTION 2012

In this election year, U.S. national spending on health care will reach $2.8 trillion, or about 18% of total spending on all goods and services. This high level of spending reduces our ability to invest in other important parts of the economy and also adds to our unsustainable national debt. There is wide agreement that we must find ways to bend the health care cost curve. Taking different approaches, the two articles that follow present a range of options, including reducing both the prices and quantity of services for public and private payers, reducing administrative costs, implementing new market-based incentives, and reforming the tax subsidy for employer-sponsored health insurance. It is our hope that these articles will stimulate discussion and debate on the best ways to address the cost problem and to place our health care system on a more sustainable path.

A Systemic Approach to Containing Health Care Spending

Ezekiel Emanuel, M.D., Ph.D., Neera Tanden, J.D., Stuart Altman, Ph.D., Scott Armstrong, M.B.A., Donald Berwick, M.D., M.P.P., François de Brantes, M.B.A., Maura Calsyn, J.D., Michael Chernew, Ph.D., John Colmers, M.P.H., David Cutler, Ph.D., Tom Daschle, B.A., Paul Egerman, B.S., Bob Kocher, M.D., Arnold Milstein, M.D., M.P.H., Emily Oshima Lee, M.A., John D. Podesta, J.D., Uwe Reinhardt, Ph.D., Meredith Rosenthal, Ph.D., Joshua Sharfstein, M.D., Stephen Shortell, Ph.D., M.P.H., M.B.A., Andrew Stern, B.A., Peter R. Orszag, Ph.D., and Topher Spiro, J.D.

National health spending is projected to continue to grow faster than the economy, increasing from 18% to about 25% of the gross domestic product (GDP) by 2037.[1] Federal health spending is projected to increase from 25% to approximately 40% of total federal spending by 2037.[1] These trends could squeeze out critical investments in education and infrastructure, contribute to unsustainable debt levels, and constrain wage increases for the middle class.[2,3]

Although the influx of baby boomers will increase the number of Medicare beneficiaries, growth in per capita health costs will increasingly drive growth in federal health spending over the long term.[1] This means that health costs throughout the system drive federal health spending. Reforms that shift federal spending to individuals, employers, and states fail to address the problem. The only sustainable solution is to control overall growth in health costs.

Although the Affordable Care Act (ACA) will significantly reduce Medicare spending over the next decade,[4] health costs remain a major challenge. To effectively contain costs, solutions must target the drivers of both the level of costs and the growth in costs — and both medical prices and the quantity of services play important roles. Solutions will need to reduce costs not only for public payers but also for private payers. Finally, solutions will need to root out administrative costs that do not improve health status and outcomes.

The Center for American Progress convened leading health-policy experts with diverse perspectives to develop bold and innovative solutions that meet these criteria. Although these solutions are not intended to be exhaustive, they have the greatest probability of both being implemented and successfully controlling health costs. The following solutions could be implemented separately or, more effectively, integrated as a package.

PROMOTE PAYMENT RATES WITHIN GLOBAL TARGETS

Under our current fragmented payment system, providers can shift costs from public payers to private payers and from large insurers to small insurers.[5] Since each provider negotiates payment rates with multiple insurers, administrative costs are excessive. Moreover, continued consolidation of market power among providers will increase prices over time.[6] For all these reasons, the current system is not sustainable.

The New England Journal of Medicine
Downloaded from nejm.org at PRINCETON UNIVERSITY on August 11, 2019. For personal use only. No other uses without permission.
Copyright © 2012 Massachusetts Medical Society. All rights reserved.

Under a model of self-regulation, public and private payers would negotiate payment rates with providers, and these rates would be binding on all payers and providers in a state. Providers could still offer rates below the negotiated rates.

The privately negotiated rates would have to adhere to a global spending target for both public and private payers in the state. After a transition, this target should limit growth in health spending per capita to the average growth in wages, which would combat wage stagnation and resonate with the public. We recommend that an independent council composed of providers, payers, businesses, consumers, and economists set and enforce the spending target.

We suggest that the federal government award grants to states to promote this self-regulation model. States could phase in this model, one sector (e.g., hospitals) at a time. To receive grants, states would need to publicly report measures of quality, access, and cost and would receive bonus payments for high performance. For providers, the negotiated rates would be adjusted for performance on quality measures, which should be identical for public and private payers.

Funding for research, training, and uncompensated care — currently embedded in Medicare and Medicaid payments — should be separated out and increased with growth in the global spending target. These payments must be transparent and determined through negotiations or competitive bidding.

ACCELERATE USE OF ALTERNATIVES TO FEE-FOR-SERVICE PAYMENT

Fee-for-service payment encourages wasteful use of high-cost tests and procedures. Instead of paying a fee for each service, payers could pay a fixed amount to physicians and hospitals for a bundle of services (bundled payments) or for all the care that a patient needs (global payments).

Payers will need to accelerate the use of such alternative payment methods. As soon as possible, both public and private payers should adopt the bundles for 37 cardiac and orthopedic procedures used in the Medicare Acute Care Episode program.[7,8] The bundles will also need to include rehabilitation and postacute care for 90 days after discharge. Within 5 years, Medicare should make bundled payments for at least two chronic conditions, such as cancer or coronary artery disease. Within 10 years, Medicare and Medicaid should base at least 75% of payments in every region on alternatives to fee-for-service payment.

Together, these policies would remove uncertainty about transitions from fee-for-service payment, allowing sufficient time for investment in infrastructure and technology by payers and providers.

USE COMPETITIVE BIDDING FOR ALL COMMODITIES

Evidence suggests that prices for many products, such as medical equipment and devices, are excessive.[9] Instead of the government setting prices, market forces should be used to allow manufacturers and suppliers to compete to offer the lowest price. In 2011, such competitive bidding reduced Medicare spending on medical equipment such as wheelchairs by more than 42%.[10] The ACA requires Medicare to expand competitive bidding for equipment, prosthetics, orthotics, and supplies to all regions by 2016.[11]

We suggest that Medicare immediately expand the current program nationwide. As soon as possible, Medicare should extend competitive bidding to medical devices, laboratory tests, radiologic diagnostic services, and all other commodities.[12] Medicare's competitively bid prices would then be extended to all federal health programs.[13] To oversee the process, we recommend that Medicare establish a panel of business and academic experts. Finally, we recommend that exchanges — marketplaces for insurance starting in 2014 — conduct competitive bidding for these items on behalf of private payers and state employee plans.

REQUIRE EXCHANGES TO OFFER TIERED PRODUCTS

The market dominance of select providers often drives substantial price variation.[14] To address this problem, insurers can offer tiered plans. These insurance products designate a high-value tier of providers with high quality and low costs and reduce cost sharing for patients who obtain services from these providers. For instance, in Massachusetts, one tiered product lowers copayments by as much as $1,000 if patients choose from 53 high-value providers.[15]

We suggest that exchanges and state employ-

The New England Journal of Medicine
Downloaded from nejm.org at PRINCETON UNIVERSITY on August 11, 2019. For personal use only. No other uses without permission.
Copyright © 2012 Massachusetts Medical Society. All rights reserved.

ee plans offer at least one tiered product at the bronze and silver levels of coverage. This requirement can be implemented by 2016 or sooner if feasible. To encourage participation in the tiered product, it must achieve a minimum premium discount. For instance, in Massachusetts, insurers must offer at least one tiered product with a premium that is at least 12% lower than the premium for a similar nontiered product.[16]

Transparency and consumer education are essential.[17] Quality and cost measures must be standardized and publicly disclosed, and standards must be set for how these measures are used to create tiers. Whenever possible, quality measures should use data from all payers. Finally, in contracts between insurers and providers, clauses that inhibit tiered products must be prohibited.

REQUIRE ALL EXCHANGES TO BE ACTIVE PURCHASERS

If exchanges passively offer any insurance product that meets minimal standards, an important opportunity will be lost. As soon as reliable quality-reporting systems exist and exchanges achieve adequate scale, it is critical that federal and state exchanges engage in active purchasing — leveraging their bargaining power to secure the best premium rates and promote reforms in payment and delivery systems.

The ACA will provide bonus payments to Medicare Advantage plans with four- or five-star ratings on the basis of their performance on measures of clinical quality and patients' experience.[18] We recommend that exchanges adopt this or a similar pay-for-performance model for participating plans and award a gold star to plans that provide high quality at a low premium.

SIMPLIFY ADMINISTRATIVE SYSTEMS FOR ALL PAYERS AND PROVIDERS

The United States spends nearly $360 billion a year on administrative costs,[19] accounting for 14% of excessive health spending.[20] Section 1104 of the ACA requires uniform standards and operating rules for electronic transactions between health plans and providers.[11] Although plans must comply with these standards and rules, the law does not require providers to exchange information electronically.

First, we suggest that payers and providers electronically exchange eligibility, claims, and other administrative information as soon as possible. Second, public and private payers and providers should use a single, standardized physician credentialing system. Currently, physicians must submit their credentials to multiple payers and hospitals. Third, payers should provide monthly explanation-of-benefits statements electronically but allow patients to opt for paper statements. Fourth, electronic health records should integrate clinical and administrative functions — such as billing, prior authorization, and payments — over the next 5 years. For instance, ordering a clinical service for a patient could automatically bill the payer in one step.

Most important, we recommend that a task force consisting of payers, providers, and vendors set binding compliance targets, monitor use rates, and have broad authority to implement additional measures to achieve systemwide savings of $30 billion a year.[21]

REQUIRE FULL TRANSPARENCY OF PRICES

Prices for the same services vary substantially within the same geographic area.[14] Yet consumers almost never receive price information before treatment. Price transparency would allow consumers to plan ahead and choose lower-cost providers, which may lead high-cost providers to lower prices. Although price transparency could facilitate collusion, this risk could be addressed through aggressive enforcement of antitrust laws.

Moreover, both private and public models can achieve meaningful price transparency without leading to collusion.[22] Aetna provides the price it negotiated with a specific provider to members through an Internet website. Similarly, New Hampshire has a public website that provides the median price paid by an insurer to a specific provider on the basis of claims data.

It is important that all private insurers and states provide price information that reflects negotiated discounts with specific providers. The information should include one price that bundles together all costs associated with a service, individualized estimates of out-of-pocket costs at the point of care, and information on quality of care and volume of patients so that consumers can make informed decisions on the basis of value.

The New England Journal of Medicine
Downloaded from nejm.org at PRINCETON UNIVERSITY on August 11, 2019. For personal use only. No other uses without permission.
Copyright © 2012 Massachusetts Medical Society. All rights reserved.

In contracts between insurers and providers, many providers prohibit insurers from releasing price information to their members.[22] These so-called gag clauses and other anticompetitive clauses must be prohibited. Finally, we recommend that state insurance commissioners and exchanges collect, audit, and publicly report data on prices and claims.

MAKE BETTER USE OF NONPHYSICIAN PROVIDERS

Restrictive state scope-of-practice laws prevent nonphysician providers from practicing to the full extent of their training. For instance, 34 states do not allow advanced-practice nurses to practice without physician supervision.[23] Making greater use of these providers would expand the workforce supply, which would increase competition and thereby lower prices.

We recommend that the federal government provide bonus payments to states that meet scope-of-practice standards delineated by the Institute of Medicine. Medicare and Medicaid payments to nonphysician providers should allow them to practice to the full extent permitted under state law.

EXPAND THE MEDICARE BAN ON PHYSICIAN SELF-REFERRALS

Many studies show that when physicians self-refer patients to facilities in which they have a financial interest, especially for imaging and pathology services, they drive up costs and may adversely affect the quality of care.[24,25] Under the so-called Stark law, physicians are prohibited from referring Medicare and Medicaid patients to facilities in which they have a financial interest. However, an exception allows physicians to provide "in-house ancillary services," such as diagnostic imaging, in their own offices.[26]

We believe that the Stark law should be expanded to prohibit physician self-referrals for services that are paid for by private insurers. In addition, the loopholes for in-office imaging, pathology laboratories, and radiation therapy should be closed. Physicians who use alternatives to fee-for-service payment should be exempted because these methods reduce incentives to increase volume.

LEVERAGE THE FEDERAL EMPLOYEES PROGRAM TO DRIVE REFORM

The Federal Employees Health Benefits Program (FEHBP) provides private health insurance to 8 million federal employees and their families. Although the FEHBP has encouraged various reforms to improve the quality of care,[27] it could be much more innovative.

We recommend that the FEHBP align with Medicare by requiring plans to transition to alternative payment methods, reduce payments to hospitals with high rates of readmissions and hospital-acquired conditions, and adjust payments to hospitals and physicians on the basis of their performance on quality measures. In addition, the FEHBP should require carriers to offer tiered products and conduct competitive bidding on behalf of plans for all commodities. Finally, the FEHBP should require plans to provide price information to enrollees and prohibit gag clauses in plan contracts with providers.

REDUCE THE COSTS OF DEFENSIVE MEDICINE

More than 75% of physicians — and virtually all physicians in high-risk specialties — face a malpractice claim over the course of their career.[28] Regardless of whether a claim results in liability, the risk of being sued may cause physicians to practice a type of defensive medicine that increases costs without improving the quality of care.

Strategies to control costs associated with medical malpractice and defensive medicine must be responsible and targeted. These strategies must not impose arbitrary caps on damages for patients who are injured as a result of malpractice. According to the Congressional Budget Office, arbitrary caps on damages would reduce national health spending by only 0.5%.[29] But although such caps would have a barely measurable effect on costs, they might adversely affect health outcomes.[30,31]

A more promising strategy would provide a so-called safe harbor, in which physicians would be presumed to have no liability if they used qualified health-information-technology systems and adhered to evidence-based clinical practice guidelines that did not reflect defensive medicine. Physicians could use clinical-decision support systems that incorporate these guidelines.

The New England Journal of Medicine
Downloaded from nejm.org at PRINCETON UNIVERSITY on August 11, 2019. For personal use only. No other uses without permission.
Copyright © 2012 Massachusetts Medical Society. All rights reserved.

Under such a system, the physician could use the safe harbor as an affirmative defense at an early stage in the litigation and could introduce guidelines into evidence to avoid a courtroom battle of the experts. The patient could still present evidence that the guidelines were not applicable to the particular situation, and the judge would still determine their applicability.

It is critical to develop guidelines with credibility. A promising step is an initiative called Choosing Wisely, in which leading physician groups released guidelines on 45 common tests and procedures that might be overused or unnecessary.[32] Given the important role of guidelines, physicians who participate in developing them must be free from financial conflicts of interest.

CONCLUSIONS

These are the types of large-scale solutions that are necessary to contain health costs. Although many in the health industry perceive that it is not in their interest to contain national health spending, it is a fact that what cannot continue will not continue.

Americans therefore face a choice. Payers could simply shift costs to individuals. As those costs become more and more unaffordable, people would severely restrict their consumption of health care and might forgo necessary care. Alternatively, governments could impose deep cuts in provider payments unrelated to value or the quality of care. Without an alternative innovative strategy, these options will become the default. They are not in the long-term interests of patients, employers, states, insurers, or providers.

We present alternative strategies to contain national health spending that allow Americans to access necessary care. Our approach addresses the system as a whole, not just Medicare and Medicaid. It is the path to rising wages, a sustainable federal budget, and the health system that all Americans deserve.

The opinions expressed in this article are those of the authors and may not reflect the opinions of the organizations that they represent.

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

From the Center for American Progress (E.E., N.T., D.B., M. Calsyn, D.C., T.D., E.O.L., J.D.P., A.S., T.S.), DLA Piper (T.D.), and Brookings Institution (B.K.) — all in Washington, DC; the University of Pennsylvania, Philadelphia (E.E.); Brandeis University, Waltham, MA (S. Altman); Group Health Cooperative, Seattle (S. Armstrong); Health Care Incentives Improvement Institute, Newtown, CT (F.B.); Harvard Medical School (D.B., M. Chernew) and Harvard School of Public Health (M.R.) — both in Boston; Harvard University, Cambridge, MA (D.C.); Johns Hopkins Medicine, Baltimore (J.C.); Venrock, Palo Alto (B.K.), Stanford University School of Medicine, Stanford (A.M.), and the University of California, Berkeley, School of Public Health, Berkeley (S.S.) — all in California; Princeton University, Princeton, NJ (U.R.); the Department of Health and Mental Hygiene, State of Maryland (J.S.); and Columbia University (A.S.) and Citigroup and the Council on Foreign Relations (P.R.O.) — all in New York.

This article was published on August 1, 2012, at NEJM.org.

1. Congressional Budget Office. The 2012 long-term budget outlook. June 2012 (http://cbo.gov/publication/43288).
2. Emanuel EJ, Fuchs VR. The perfect storm of overutilization. JAMA 2008;299:2789-91.
3. Emanuel EJ. What we give up for health care. New York Times. January 21, 2012 (http://opinionator.blogs.nytimes.com/2012/01/21/what-we-give-up-for-health-care).
4. Sisko AM, Truffer CJ, Keehan SP, Poisal JA, Clemens MK, Madison AJ. National health spending projections: the estimated impact of reform through 2019. Health Aff (Millwood) 2010;29:1933-41.
5. Reinhardt UE. The many different prices paid to providers and the flawed theory of cost shifting: is it time for a more rational all-payer system? Health Aff (Millwood) 2011;30:2125-33.
6. Berenson RA, Ginsburg PB, Christianson JB, Yee T. The growing power of some providers to win steep payment increases from insurers suggests policy remedies may be needed. Health Aff (Millwood) 2012;31:973-81.
7. Cutler DM, Ghosh K. The potential for cost savings through bundled episode payments. N Engl J Med 2012;366:1075-7.
8. Mechanic RE. Opportunities and challenges for episode-based payment. N Engl J Med 2011;365:777-9.
9. Government Accountability Office. Lack of price transparency may hamper hospitals' ability to be prudent purchasers of implantable medical devices. January 13, 2012 (http://www.gao.gov/products/GAO-12-126).
10. Centers for Medicare and Medicaid Services. Competitive bidding update — one year implementation update. April 17, 2012 (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf).
11. The Patient Protection and Affordable Care Act, Public Law 111-148, 111th Congress, March 23, 2010, Section 6410.
12. Office of Management and Budget. Major savings and reforms in the President's 2009 budget. February 2008:154 (http://www.whitehouse.gov/sites/default/files/omb/assets/omb/budget/fy2009/savings_reform.html).
13. Office of Management and Budget. Living within our means and investing in the future: the President's plan for economic growth and deficit reduction. September 2011:40 (http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf).
14. Commonwealth of Massachusetts. Recommendations of the Special Commission on Provider Price Reform. November 9, 2011 (http://www.mass.gov/eohhs/docs/dhcfp/g/p-r/special-comm-ppr-report.pdf).
15. Commonwealth of Massachusetts, Office of Attorney General Martha Coakley. Examination of health care cost trends and cost drivers: report for annual public hearing. June 22, 2011:33 (http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf).
16. Commonwealth of Massachusetts. S.2585, an Act to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses:

The New England Journal of Medicine
Downloaded from nejm.org at PRINCETON UNIVERSITY on August 11, 2019. For personal use only. No other uses without permission.
Copyright © 2012 Massachusetts Medical Society. All rights reserved.

approved August 10 2010 (http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288).
17. Sinaiko AD, Rosenthal MB. Consumer experience with a tiered physician network: early evidence. Am J Manag Care 2010;16:123-30.
18. The Health Care and Education Reconciliation Act of 2010, Public Law 111-152. 111th Congress. 30 March 2010, Section 1102(c).
19. Institute of Medicine. The healthcare imperative: lowering costs and improving outcomes: workshop series summary. Washington, DC: National Academies Press, 2010.
20. Farrell D, Jensen E, Kocher B, et al. Accounting for the cost of US health care: a new look at why Americans spend more. McKinsey Global Institute, December 2008 (http://www.mckinsey.com/insights/mgi/research/americas/accounting_for_the_cost_of_us_health_care).
21. US Healthcare. Efficiency index: national progress report on healthcare efficiency 2010:7 (http://www.ushealthcareindex.org/resources/USHEINationalProgressReport.pdf).
22. Government Accountability Office. Health care price transparency: meaningful price information is difficult for consumers to obtain prior to receiving care. September 2011.
23. Pittman P, Williams B. Physician wages in states with expanded APRN Scope of Practice. Nurs Res Pract 2012;2012:671974.
24. Medicare Payment Advisory Commission. Report to the Congress: Improving Incentives in the Medicare Program. June 2009 (http://www.medpac.gov/documents/jun09_entirereport.pdf).
25. Mitchell JM. Urologists' self-referral for pathology of biopsy specimens linked to increased use and lower prostate cancer detection. Health Aff (Millwood) 2012;31:741-9.
26. 42 CFR § 411.355.
27. U.S. Office of Personnel Management. FEHB program carrier letter: letter no. 2012-09, March 29, 2012 (http://www.opm.gov/carrier/carrier_letters/2012/2012-09.pdf).
28. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med 2011;365:629-36.
29. Congressional Budget Office. Letter to the Honorable Orrin G. Hatch: CBO's analysis of the effects of proposals to limit costs related to medical malpractice ("tort reform"). October 9, 2009:3 (http://www.cbo.gov/publication/41334).
30. Lakdawalla DN, Seabury SA. The welfare effects of medical malpractice liability. Cambridge, MA: National Bureau of Economic Research, September 2009 (working paper w15383) (http://www.nber.org/papers/w15383).
31. Congressional Budget Office. Letter to the Honorable John D. Rockefeller IV: additional information on the effects of tort reform. December 10, 2009:5-6 (http://www.cbo.gov/publication/41812).
32. Cassel CK, Guest JA. Choosing wisely: helping physicians and patients make smart decisions about their care. JAMA 2012;307:1801-2.

DOI: 10.1056/NEJMsb1205901
Copyright © 2012 Massachusetts Medical Society.

Bending the Cost Curve through Market-Based Incentives

Joseph R. Antos, Ph.D., Mark V. Pauly, Ph.D., and Gail R. Wilensky, Ph.D.

The high and rising cost of U.S. health care is a growing burden on families and businesses and a threat to the fiscal stability of the government. This year, national health spending will total $2.8 trillion, or 18% of the gross domestic product (GDP).[1] By 2021, national health spending will account for nearly one fifth of our economy, reflecting major expansions in health insurance coverage under the Affordable Care Act (ACA) and increased numbers of people on Medicare resulting from the ongoing retirement of the baby-boom generation.

The ACA expands eligibility for Medicaid, creates new subsidies for coverage for large numbers of the uninsured, and changes the terms under which insurance can be sold to persons in the nongroup market. The new federal spending, amounting to $1.2 trillion through 2022, is offset primarily through reductions in Medicare provider payments.[2] The ACA also contains provisions that, it is hoped, will ultimately slow health care spending, including accountable care organizations, value-based purchasing programs, and bundled-payment pilot projects. However, the payment provisions and pilot projects fail to address a flawed financing system whose incentives promote more spending, not better spending.

In a market-based approach, open-ended subsidies to beneficiaries and price-controlled reimbursements to providers should be replaced with fixed dollar subsidies — effectively shifting Medicare from a defined-benefit to a defined-contribution approach. The business model would shift from one that is driven by the volume and intensity of services to one that rewards cost-effective and efficient care.

Under this approach, Medicare would adopt a premium-support model, which provides a fixed subsidy for each beneficiary's purchase of insurance. Health plans, including traditional Medicare, would compete with each other on equal terms. Beneficiaries could purchase more expensive coverage if they felt the extra cost was worth it to them.

Similarly, the principle of defined contribution should be applied to the currently unlimited tax subsidy for employer-sponsored insurance. Employer contributions to health insurance are not counted as part of the employees' taxable income. That subsidy encourages the purchase of health insurance, but it also provides an incentive to increase the amount of coverage, which helps fuel the growth of private health spending. Con-

The New England Journal of Medicine
Downloaded from nejm.org at PRINCETON UNIVERSITY on August 11, 2019. For personal use only. No other uses without permission.
Copyright © 2012 Massachusetts Medical Society. All rights reserved.