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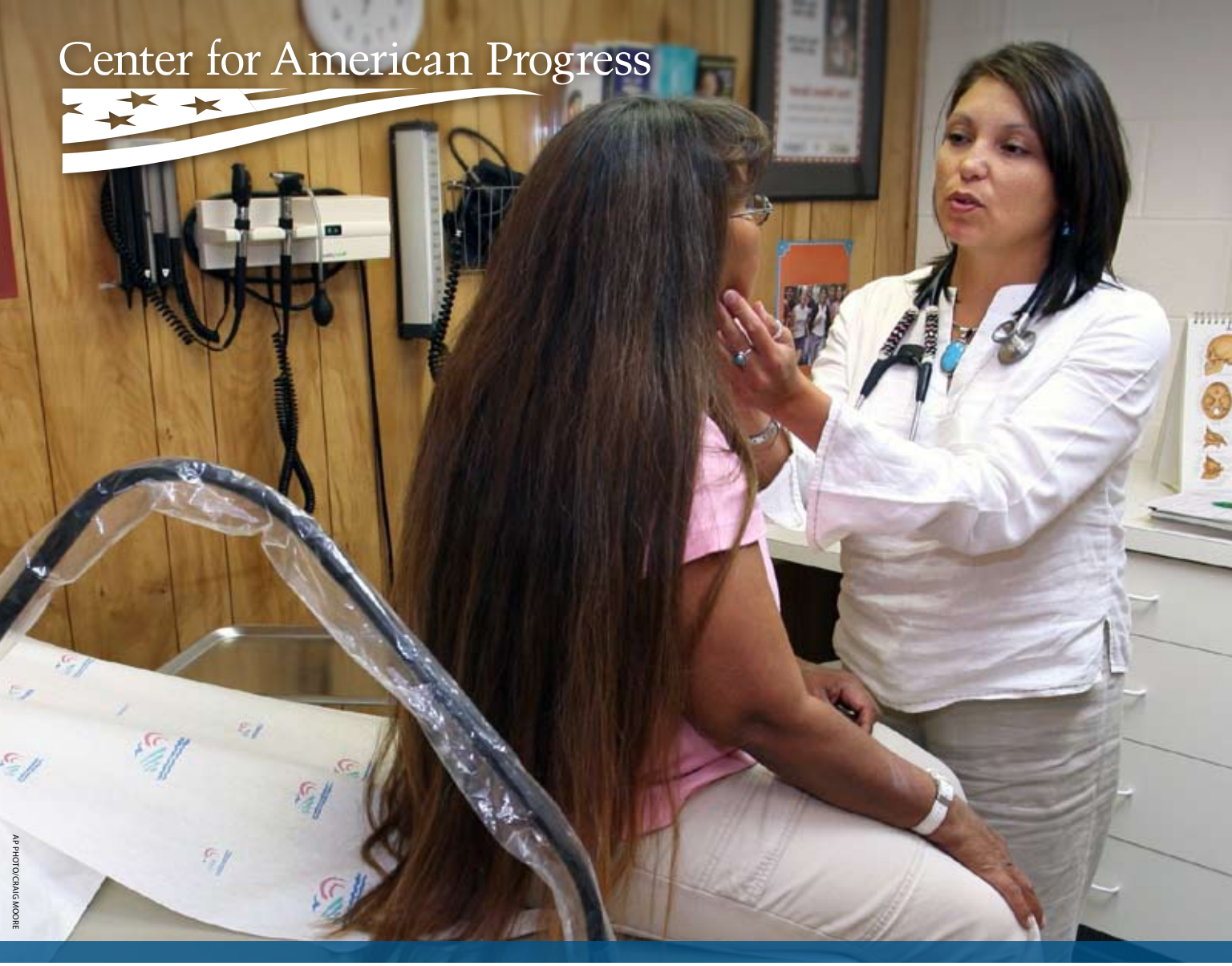

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Efficiency and Quality

Controlling Cost Growth in Health Care Reform

Paul B. Ginsburg, Ph.D. May 2009

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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.

Provider payment reform

The goal of reforming the way we pay for health care is to change the incentives for physicians, hospitals, and other health care providers to deliver care in ways that are more consistent with society's goals for medical care—quality coverage for all Americans at a cost the nation can afford. Two complementary approaches are involved.

The first involves fixing our current payment systems so that inadvertent overpayments for some services are reduced. For instance, the degree to which performing technical procedures is more lucrative for physicians than for evaluation and management services spawns investments by physicians in specialty facilities and makes primary care specialties unattractive from a financial perspective. The second approach is to use existing but refined current payment systems to move toward paying for broader units of service, such as care required for an episode of care or care for a certain population of patients over a period of time.

An asset in pursuing provider payment reform in our fragmented health care system is that increasingly Medicaid programs and private insurers follow Medicare payment approaches, especially for physician services. Since 1992, Medicare has used a resource-based relative-value scale fee schedule to set payments for physician services on the basis of relative costs. The Medicare fee schedule relies on estimates of three components: physician work (time and intensity), practice expenses, and malpractice insurance expenses, with geographic adjustments to reflect cost variation. A conversion factor is used to translate the relative values into dollar amounts for each service.

Negotiation of payment rates between physicians and private insurers tends to be in terms of a percentage of Medicare rates. So changes in Medicare payment rates have the potential to influence not only the services paid for under Medicare but services paid by Medicaid plans and private insurers as well. Private insurers, however, generally have not adopted Medicare's inpatient hospital prospective payment system, so private payers following Medicare's lead is not a given. Regardless, revisions in Medicare payment methods should consider at least the feasibility of adoption by private insurers.

Fixing the Medicare physician fee schedule

A critical early priority for Medicare physician payment reform should be to increase the degree to which relative payments for different services line up with relative costs—in

other words, ensure that payment rates better reflect physicians' actual cost of providing particular services. This is needed to reduce the harm that comes from payment rates for some services being too high, which attracts too many physician and facility resources into providing those services, and to ensure that the payment rates for other services are not too low, which drives physician resources away.

Fixing the current fee schedule is also critical for more ambitious payment reforms based on broader units of payment to succeed. For one thing, the current payment structure will underlie the payment rates for broader payment units. But potentially even more critical is the risk that current payment structures substantially undermine broader provider payment reforms that use shared savings approaches. Consider this one example: If a doctor is not fully at risk for costs per episode or per enrollee but instead is offered only moderate rewards to reduce per-episode costs—and cost reduction involves disproportionate reductions in those services that are most profitable—then the incentives for cost reduction will be overwhelmed by incentives from the current distortions.

The process for updating the Medicare relative value scale needs to be revamped. Periodically, the Relative Value Update Committee, or RUC, an American Medical Association-sponsored entity with representatives from different specialty societies, advises the Centers for Medicare and Medicaid Services, or CMS, on changes to relative work values. Over time, relative values have defied gravity—going up or staying the same but rarely coming down to reflect changes in medical practice or physician productivity.

CMS could take more initiative without advice from the RUC, as some are urging, but it would be better to improve the RUC process by demanding reductions in the relative values for services that have experienced above-average productivity gains and supporting the RUC with better estimates than it gets from specialty societies of the time it takes physicians to perform various services. These reductions in relative value could be used to obtain savings or the savings could be applied to increase payment rates for other services, such as evaluation and management services. Another possibility is the establishment of a parallel advisory body of consumers and purchasers of medical care, an idea recently suggested by the Center for Payment Reform.

So-called practice expense relative values—resources that go to pay rent, staff, and equipment, which are outside the purview of the RUC—also suffer from a lack of accurate data. CMS, for example, assumes that major medical equipment is in use only 20 hours per week and justifies use of the assumption by its lack of data. CMS lacks adequate resources to develop needed cost data to improve payment accuracy.

With adequate funding, CMS could develop relationships with large medical practices that have sophisticated cost-accounting systems to gather data needed for more accurate practice expense relative values. As the AMA completes its Physician Practice Information Survey, which will replace a long out-of-date earlier survey, CMS should seize this

opportunity to make long-overdue changes in its calibration of indirect practice expense (expenses that cannot be directly associated with individual services).

Even with more resources going to increase the accuracy of relative values, it will be difficult to keep up with changes in technology. A process for cruder adjustments to the relative value scale will be needed as a backup. Congress could direct CMS to conduct an annual process to apply a percentage reduction in payment rates to all services (or groupings of services) that have experienced very high volume trends over the previous five years. Such a process is used in Japan, with one result being a substantial reduction in payment rates for major imaging procedures, such as magnetic resonance imaging tests and computed tomography, or CT, scans.

Broaden the "unit of payment" for inpatient care

Medicare since 1983 has paid for most inpatient hospital care on a per-case basis, with that unit of payment ending with the patient's discharge. Medicare uses Medicare Severity-Diagnosis Related Groups, or MS-DRGs, to group patients for payment purposes. If the beneficiary is readmitted to the hospital, then another case can be billed for. An option getting a great deal of attention in Congress today is a reduction in payments for hospitals that have higher rates of readmissions.

Conceptually, this broadens the unit of payment beyond the inpatient stay because the hospital would in effect be providing a limited warranty to patients and to Medicare for the hospital stay. Often readmissions stem from problems in the transition to outpatient care after discharge or the lack of adequate care in the community after discharge. Most readmissions for congestive heart failure, for example, are considered to be the result of inadequate care after discharge.

Hospitals would probably protest being put at risk for what happens after discharge. But having hospitals become responsible might have many benefits for the patients in question and for the need to control costs. It would certainly be a concrete step to address the extensive fragmentation of the care delivery system because it would oblige hospitals to work more closely with patients' other health care providers after discharge. Versions of this option proposed by the Medicare Payment Advisory Commission, or MedPAC, an independent congressional advisory agency, and discussed by CBO would apply penalties to hospitals with high rates of readmissions.

The downside to the MedPAC approach is that incentives to reduce readmissions would apply only to hospitals being penalized or to those close to the threshold for penalties. An alternative way to pursue this would be to draw on research that shows which MS-DRGs have high rates of readmissions reflective of poor care. A lower payment rate could then be attached to readmissions for patients in those MS-DRGs at all hospitals.

Since some of the readmissions would reflect developments outside of the control of well-run hospitals, it would be appropriate to pay more for the initial admissions for those MS-DRGs—in effect paying for the limited warranty. This would give all hospitals incentives to reduce readmissions and potentially lead to larger savings because change in behavior to avoid readmissions would probably lead to more long-term savings than the savings from the penalties for readmissions.

Well-run hospitals might even gain from this approach to readmissions. The reason: Higher payments for the initial admission could outweigh reductions in payments for readmissions. To the degree that transparency about readmissions and better financial performance by well-run hospitals increases their market share, this would be a positive step toward greater efficiency over time.

Longer-term payment reforms

The two payment reforms discussed above are feasible to describe in detail in legislation and to implement using existing mechanisms. But the greatest potential in payment reform comes from policies that would move the Medicare program further away from fee-for-service payments for health care providers. These options are less well-developed and will require extensive piloting as part of the implementation process. Should Congress want to pursue them, it will have to write less-detailed legislation and give more authority to the Obama administration to develop the details through experimentation and regulation.

Indeed, many believe that changes in the governance of the Medicare program may be needed to develop and implement the payment reforms that have the highest potential. An independent health advisory board, for example, could be created with authority for determining provider payments in the Medicare program. If led by highly regarded people, then Congress might be more comfortable delegating significant authority to conduct the challenging work of shaping these policies. Keeping in mind that all health care spending is someone's income, such a board would also have the advantage of greater insulation from parochial stakeholder interests.

But whether it is CMS or an independent board, additional funding will be needed to develop and implement the new payment methods. Although the funding needed is minuscule in relation to Medicare spending for medical services and the potential long-term savings, lack of funding has been the source of some of the current problems in Medicare payment policy.

But the funding problem for provider payment policies and other aspects of Medicare administration is a long-term problem rather than a transitional one. That's why this paper suggests several alternative ways to address long-term provider payment reforms:

- Multi-provider episode payments that broaden per-episode payments for health care
- Population-based approaches to health care for groups of health care plan enrollees for more comprehensive health care coverage
- A process to set rates for all payers

Let's consider each in turn.

Multi-provider episode payments

The medical care system has long experience with per-episode payments such as a global fee for surgery, which includes 90 days of postoperative care by the surgeon, and MS-DRG payments to hospitals by Medicare, Medicaid, and some private insurers. Per-episode payments change incentives away from providing more services toward providing efficient episodes of care. But current per-episode payments are limited to the services provided by a single health care provider. So a surgeon, for example, has no incentive to consider the cost of different hospitals or the amount of services provided by other physicians involved in a patient's episode of care. Creating a payment system that covers all of the services involved in a patient's episode of care would broaden the incentives to provide care efficiently.

But broadening episodes of care raises the question of who should get the Medicare payment. Fortunately, integrated delivery systems, where physicians and hospitals are already closely aligned, are already set up to do this. Large physician practices could easily develop an arrangement with the hospitals at which they practice to allocate the payment. But integrated delivery systems and large physician practices are the exception, not the rule, in today's fragmented delivery system, where most of the spending takes place. Still, a move toward multi-provider episode payments would create incentives for physicians and hospitals to develop closer relationships with each other. Indeed, the potential to do better financially under this new payment system would foster greater integration.

A default mechanism could be established for cases in which there is no relationship among different health care providers to work together. Each care provider could be paid a portion of the per-episode payment based on historical experience for that type of episode. For instance, if orthopedic surgeons historically received 15 percent of total Medicare provider payments for a hip replacement episode, then they would get 15 percent of the per-episode payment.

Applying this approach to major episodes involving surgery and hospitalization would be easiest because the episodes are easiest to define and already involve bundled payments at the level of the surgeon and the hospital. But the potential gains are probably smaller than in other areas. Potential efficiencies and quality improvements, for example, are available by applying the approach to more minor episodes, such as low-back pain, where magnetic resonance imaging is overused, and organizing delivery to evaluate patients earlier after onset of the condition.[4] But such a program could be abused by creating payment episodes for patients with mild low-back pain that normally would not be treated. The approach can be applied only to minor episodes where the criteria for whether treatment is warranted are clear.

Developing per-episode payment rates for management of chronic diseases also has potential. Since these diseases, such as congestive heart failure, are typically managed rather than "cured," the episode would have to be defined as a period of time. Some refer to this

approach as condition-specific capitation, meaning that the fixed, per-patient payment applies only to the treatment of the condition in question.

The chronic disease with the greatest potential for cost reduction might be congestive heart failure, where many patients are hospitalized because of inadequate outpatient care. But the challenges are large. Chronic conditions come with an infinite range of severity, from cases dealt with effectively with routine primary care to those requiring a much higher intensity of care. So episodes of different severity would have to be defined, both to be fair to health care providers dealing with severe cases and to avoid incentives for increased reporting of minor conditions to generate more per-episode payments.

More limited versions of per-episode payment can be pursued that are less subject to the challenges outlined above—but also have less upside. They will provide opportunities to work on many of the technical issues. And if the financial incentives are strong enough to be noticed by providers, then they might influence behavior. One approach, known as shared savings, would continue fee-for-service payments to physicians and MS-DRGs for inpatient care, but Medicare would calculate spending per episode and provide limited rewards and penalties for physicians with spending per episode that is lower or higher than average.

This would also avoid the problem of deciding which provider to pay. Assuming that it would be most productive to place the incentives on the physician providing or directing the care for the episode, providing the rewards and penalties to that physician would best accomplish the goals of episode-based payment. Not that hospitals would be unaffected. Physicians would have an incentive to admit their patients to lower-cost hospitals to gain rewards, so hospitals would have an additional incentive to reduce their costs and to limit the costs of post-acute care.

This approach is sometimes used in the private sector. Many private insurers have "high-performance networks" to differentiate physicians on the basis of quality and costs. Insurers analyze episodes of care provided by specialty physicians, and those deemed higher-performing receive a special designation. Most often, the results are used only to inform consumers, but, in some cases, consumers have incentives, such as reduced copayments, to use the higher-performing physicians. This approach has not been implemented very effectively, with each insurer using different methods to assess physicians—often without input from physician leaders—and relying on small sample sizes that reflect each insurer's enrollment in a market.

But a Medicare approach could avoid many of these problems and even improve private insurer initiatives. CMS could develop methods with input from physicians, hospitals, and private insurers, leading to greater credibility. Sharing Medicare physician claims files with private insurers would increase the reliability of their estimates of physician efficiency and quality.

But the private insurers' experience with per-episode incentives also shows vividly how physician payment reform sets the stage for successful broader reforms. A study documented how Seattle-based Virginia Mason Medical Center's projected success in reducing costs per episode of care hurt the hospital's bottom line precisely because of the large variation in profitability across physician services, especially the contrast between primary care services and imaging procedures.[5]

Population-based approaches

These challenges with per-episode payments lead some health care experts to advocate instead for payments that are population based, meaning that either payments or incentives are based on a population of health care plan enrollees. The so-called medical home approach, which designates a physician practice to coordinate patients' care across their conditions and care settings, is a potential first step in this direction, although it could also be viewed as a partial per-episode approach. The concept behind the medical home approach is that many of the services that are a valuable part of managing chronic disease, such as educating patients on self-management and communicating with other providers, are not paid for under fee-for-service payment systems. So a capitated—or fixed, per-patient—payment is made to a qualifying medical practice for each chronically ill patient enrolled in a medical home. This payment supplements regular fee-for-service payments.

Medical home approaches are being piloted in Medicare and by many Medicaid programs and private insurers. The approaches vary a great deal, but most involve qualifying a practice as a medical home and offering an additional per-patient payment for enrolled patients, typically those with a chronic condition. A key design feature is whether to make payments only for patients with relatively severe chronic disease, where the likelihood of reduced spending is greater, or apply payments at different levels depending on disease severity to more patients to better motivate practices to invest the resources and time to qualify as a medical home.

At this point in the debate in Congress, there is a great deal of enthusiasm about the potential of medical homes to improve the quality of care, but a lot of uncertainty about whether medical homes can reduce spending. Outsized expectations for medical homes today may set the stage for disappointment down the road.

The other major option that involves population-based payment is accountable care entities, or ACEs. Conceived initially by Elliot Fisher and his colleagues at Dartmouth Medical School and labeled accountable care *organizations*, hospitals and a group of physicians in a community would band together to attempt to improve patient care quality and efficiency.[6] Payment would continue under current methods, but spending for enrollees attributed to the ACE—either by analyzing claims data or by enrollee

designation of a physician—would be compared to a projection of their spending based on trends, with rewards given to ACEs to the degree that spending is lower than the projection by a specified margin.

In contrast to the per-episode approaches, which focus only on spending per episode, the ACE approach focuses on the frequency of episodes as well as on spending per episode. A few pilots are being undertaken at present.

The major question with ACEs, however, is whether they can succeed outside of integrated delivery systems, or IDSs, where hospitals and physicians in most specialties are part of a single organization. For IDSs, ACE payment would potentially reward the efficient delivery that many IDSs believe they already have achieved—and an incentive to do even better. To the degree that ACE payment is favorable to effective IDSs, it will enable them to grow and serve a larger proportion of patients.

But stimulating growth in the market share of current IDSs can only go so far, since they are not present in many communities where most people live. ACEs need to foster new IDSs or looser organizations of hospitals and physicians that work to change patterns of care delivery. Track records for endeavors such as physician-hospital organizations, which became commonplace in the 1990s, are not encouraging. The opportunities for such organizations to change patterns of care delivery did not last long after the move away from tightly managed care, so we never learned about the effectiveness of second generations of these organizations.

Future organizations may have some advantages over earlier efforts. Tools to measure the quality and efficiency of care have advanced a great deal in recent years. Indeed, there is a much better understanding of what quality means, increasing the potential to motivate improvements in care. Independent practice associations in California have proved themselves to be capable of effectively implementing functions related to quality and efficiency that are delegated to them by health maintenance organizations. Hospitals have gained a lot of experience, for example, in how to employ physicians and get good performance. Hospital employment of physicians is growing rapidly at this point. In addition, health information technology is also increasing the potential for virtual organizations to be successful.[7]

Health policy analysts often characterize per-episode payments and ACEs as competing approaches to payment reform. They may well be, at least in the sense that each will require substantial policy resources to further develop, forcing government to assign priorities for its limited resources to implement new policies. But the two approaches could fit together in practice because the ACE approach can be overlaid on any other payment system, whether fee for service or per episode. So payments for some services could be made on a per-episode basis, but population-based payment incentives would also be in place. The latter might be used to guard against the incentive in the former to increase the number of episodes.

All-payer rate setting

Discussions about payment reforms often focus on Medicare, but with the expectation that these reforms will influence Medicaid payments and private insurance payments as well. This would presumably benefit purchasers as well as magnify the reach of the carefully designed reform incentives for health care providers. But two problems could arise. Health care providers could refuse to contract with private insurers on other than current payment terms, depending on the market power of each provider. Large prominent hospital systems and large physician groups tend to have a great deal of leverage with health insurance plans at present, but less-dominant hospitals and physicians in small practices tend to have little leverage. Or providers simply could try to shift any losses experienced from new Medicare payment methods to private insurers by demanding higher rates.

All-payer rate setting, in which a public body sets rates for both public and private insurers, was used for hospital payment in a number of Northeast and Mid-Atlantic states in the 1970s. It was subsequently abandoned in all but Maryland for reasons that included the implementation of Medicare inpatient prospective payment, which was seen by some to be sufficient to constrain hospital costs, and the advent of managed health care, which led some health insurance plans to believe that they could negotiate lower rates by using their leverage at the time with hospitals. The nationwide movement away from regulation and toward markets was another factor.

Maryland may have stood apart from this trend because of its distinct governance. Since its initiation, the Maryland system has been run by an independent board appointed to long terms by the governor—and has enjoyed long-term political support from the state's hospital industry. This system also is believed to have been effective at controlling costs, with analyses by the rate-setting commission showing a reduction of hospital costs per case over time in relation to the national average.

By having all payers use the same payment methods, health care providers for the first time would face consistent incentives so payment reforms would have a larger impact on provider behavior. Rate setting would also address the market leverage enjoyed by some dominant hospitals and large physician practices. Indeed, it would address a disadvantage that has been raised with payment reforms that motivate providers to work together in larger organizations—the potential for such organizations to be able to exercise even more market power.

Although the creation of a public plan to compete with private plans as an element of health care reform is outside of the scope of this paper, all-payer rate setting could accomplish one of the goals of public plan advocates—lower provider payment rates. Presuming current differences in payment rates among Medicare, Medicaid, and private insurers were initially maintained, a public plan for the non-Medicare population could then pay the same rates as private insurers. All-payer rate setting would also remove any disadvantages a public plan would face in negotiating rates in the marketplace and could avoid the explosive issue of the large competitive advantage a public plan would have if allowed to pay Medicare rates.

Tax treatment of private health insurance

The federal government in 2009 is projected to forgo $192.4 billion in tax revenues by excluding employer contributions to employee health benefits (and some employee contributions as well) as employee income, according to a recent report by the Senate Finance Committee.[8] The reason: Compensating an employee with health insurance is not taxed, while compensating an employee with cash is taxed.

The result is an incentive to shift compensation toward health insurance, especially for employers with more highly paid workforces. The consequence is a higher proportion of workers covered by health insurance—a good thing—and more expensive forms of health insurance, which is not so good. The current tax treatment is believed to promote insurance plans with less patient cost sharing and less administrative oversight on the use of care. Some visions of consumer-driven health care incorporate notions of consumers supported with information on provider costs and quality along with incentives, but current tax treatment of health insurance discourages such approaches.

But people disagree strongly about whether such influence on the type of insurance is a good thing or not. Many people believe that engaging consumers with financial incentives or greater administrative controls affecting their use of health care is essential to creating a health care system that is affordable for our nation. Others are concerned about the disproportionate impact of increased patient cost-sharing on lower-income people and look to the experience of other developed countries, such as Canada and the United Kingdom, where financial incentives for patients are used less extensively and spending is controlled by limiting the resources allocated to the health care system.

A potential compromise would design policy changes in the tax treatment of health insurance so that they have less of an impact on lower-income people. Given the need to pay for health care reform, changing the tax treatment of health insurance is likely to arise mostly as a revenue issue. Reducing the loss of revenue from above average insurance for higher-income people might be an attractive way to fund either public coverage expansions for lower-income people or tax credits for lower-income people to purchase private coverage.

The key challenge in designing policies in this area is to retain the incentives for employers to offer coverage and workers to be insured. So limits on the ability to exclude health insurance contributions from taxation should not apply to contributions to fund basic coverage but rather only to contributions that increase the elaborateness of coverage. Historically, most health care experts suggest approaching this challenge by proposing a dollar limit on contributions excluded from taxation.

But the impact of such a limit is not that highly focused on elaborate coverage. Any dollar limit, for example, will have a greater impact on coverage in geographic areas where health spending per capita tends to be very high, such as Miami. This could discourage the pur-

chase of fairly basic coverage in those areas. A company or union with an older workforce also would be disproportionately affected by a set dollar limit because premiums would be higher in recognition of higher expected health spending by older enrollees. Although some aspects of the uneven pressure by geographic areas are positive—higher-cost areas on average have less efficient health care systems—the unevenness of such pressure will make enactment of changes in tax treatment much more difficult.

A better approach would be to apply limits not to the amount of money spent for insurance but to a direct measure of how rich the coverage's benefit structure is. Such a measure is the so-called actuarial value of a benefit structure. Usually expressed as a percentage, actuarial value represents the proportion of the dollar amount of approved claims that a benefit structure would pay on average. So an actuarial value of 80 percent means that a benefit structure, though defined in terms of deductibles and coinsurance, will in the aggregate pay 80 percent of the cost of approved claims.

A change in tax treatment of employer-sponsored coverage could limit the actuarial value of coverage that would not be subject to taxation. So if, for purposes of illustration, the limit were set at 90 percent, which is above the 80 percent to 84 percent estimated for most employer policies and the 87 percent estimated for the Federal Employees Health Benefits Program, it would mean that any policy with an actuarial value lower than 90 percent would not be taxed at all.[9] Policies with higher actuarial values would be taxed on the portion of the premium attributable to increasing the actuarial value above that threshold.

This approach would be targeted directly to the issue of the richness of insurance and would avoid disproportionate consequences on those who live in areas with relatively high health care spending and on employee groups that are older or had more members with chronic diseases. It would be possible to shape the policy into one that provided more restraint for higher-income than lower-income people, for example, by not taxing those with incomes below a certain threshold regardless of the actuarial value of their coverage.

There is precedent in using this approach in federal policy. In Medicare Part D, insurers are permitted to change the benefit structure for prescription drug coverage from the one specified in legislation as long as the actuarial value is at least as high. Indeed, in the Senate Finance Committee's recent blueprint for expanding coverage, plans offering coverage through insurance exchanges would offer four options—high, medium, low, and lowest—with the options defined by specified actuarial values.[10]

Comparative effectiveness research

Improving the evidence base for medical practice theoretically has the potential to slow the growth in health care spending, although the actual results will depend on how the research priorities are set and, of course, what the research shows. Analyses of geographic

variations in health care spending within the United States show that much of the variation is in services where there is no consensus about what constitutes best practice.

Dartmouth researchers, for example, found four-fold variation in the rate of coronary artery bypass graft surgery, but the differences were not correlated with the rate of heart attacks.[11] There also is substantial variation in admissions to the hospital for joint-replacement surgery, an elective procedure, but little variation in admissions for hip fracture, where there is no alternative to hospitalization.

Comparative effectiveness research is a true public good in the sense that additional people benefiting from it does not detract from the benefits of others. Like many other public goods, the market tends not to devote enough resources to effectiveness research because charging people who benefit —even when possible—reduces the benefits without reducing the costs. So public funding is likely needed to get adequate comparative effectiveness research.

Whether effectiveness research helps slow spending growth will depend on how research priorities are set and how the results are used. Priorities should focus on the diseases and disabilities that result in the greatest number of deaths, disabilities, or costs to society and conditions where there is the greatest uncertainty in the medical care profession about what is effective treatment.

Comparative effectiveness research also should focus on conditions where the data are most readily available and can be quickly gathered and analyzed. The growth of health information technology will likely open up many opportunities for inexpensive effectiveness research by making information in patient medical records much less costly for researchers to access.

Much of the impact of medical technology on spending comes not from brand-new technologies but instead from expanding applications of older technologies. Advanced imaging techniques, for example, have been in common use for decades, but applications continue to expand.

Effectiveness research likely offers greater opportunities to affect spending by focusing, at least initially, on established technologies that might be applied to far too many patients. Assessing very new technologies poses a risk of precluding refinements and efficiencies that come in the early years of application.

Evidence is increasing about instances in which established technologies have substantial value for some patients but much lower value—or even lead to poorer outcomes—for other patients. Research on cardiac interventions, for example, has cast doubt on whether they improve outcomes in patients who are asymptomatic, even though they are effective for patients who have had heart attacks.[12] Knee arthroscopy, while very effective for some conditions, has been shown to be ineffective for arthritis.[13]

The most contentious discussions of effectiveness research to date are focused on whether research results should be used by Medicare or other insurers to make coverage decisions. But well-targeted research is likely to have consequences on the delivery of care even without its use in coverage decisions. In many cases, simply getting research published and into the hands of physicians and the public will have a major impact on use of treatments. Note the enormous impact that effectiveness research has had on use of hormone replacement therapy.

Support for the dissemination of effectiveness research will increase its influence on both physicians and the public. Investment in shared decision-making processes, in which patients are provided educational materials reflecting known benefits and risks of alternative therapies to support their making make more informed decisions, will also increase the impact of research.

Issues such as how to use comparative effectiveness research in coverage decisions for Medicare might be easier to resolve a few years down the road—when stakeholders will be much more familiar with the research that is being produced by the program. In the meantime, private insurers will make their own decisions about how to use the information. One potential direction is value-based insurance design, where benefit structures are created with little or no cost-sharing for highly effective services—eye exams for diabetics—but higher cost-sharing for services with limited effectiveness—rapid imaging for uncomplicated low-back pain.

Comparative effectiveness research has the potential to have negative—but appropriate—consequences for some health care stakeholders that experience a decline in the use of their services or products. This could threaten the integrity of effectiveness research since some aggrieved stakeholders might seek to punish the messenger. Consequently, it will be important to insulate comparative-effectiveness research endeavors from stakeholders unhappy with the results.

Conclusion

Health care spending will continue to consume a greater percentage of the nation's economy if nothing is done to stem rapidly rising costs, and the costs to society of failing to initiate effective cost-containment strategies are growing rapidly. Yet there is more consensus today about what can be done to increase the efficiency of health care delivery and improve the quality of care.

The upshot: Society can accomplish a lot on both fronts without making draconian trade-offs. Of course, some of the most-promising policy options need further development and will require a great deal of judgment in effectively implementing them. This means 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.

Notwithstanding the urgency and the opportunity to address spending, policymakers also need to recognize how difficult the job will be. All health care spending is someone's income, and those whose incomes are threatened by steps to control health costs will resist attempts to diminish their income—even if the impact is going to come in slower growth rather than absolute declines. Our political leaders have not prepared the public for this debate, telling the public for years that containing costs means reducing fraud or reducing insurer profits.

The notion that slowing the growth in spending means fewer services, even if fewer services means higher quality and more effective care, is something that few members of the public realize. This paper points the way toward clear examples of ways for Congress to do this, both today and as part of comprehensive health care reform over the coming years and decades.

Endnotes

1 Robert Pear, "Obama Push to Cut Health Costs Faces Tough Odds." *New York Times,* May 11, 2009.

2 Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (Congressional Budget Office, November 2007), No. 3085.

3 One area of important potential that is not included in this paper is reversing the trend toward obesity. Research has documented that rising obesity is a key driver of health care spending trends, mostly through its role in diseases such as diabetes, heart disease, and cancer. (See K.E. Thorpe and others, "Trends: The Impact of Obesity on Rising Medical Spending," *Health Affairs*, Web Exclusive, October 20, 2004, available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.480.) Action to reverse this trend is likely to come from many directions, including wellness features of health plans, school nutrition policies, and product labeling. Without an apparent silver bullet, policies will have to come in many forms and would be too complex to take up in this paper. Similarly, this paper will not delve into those steps that can save money but do not have the potential to reduce the trend of health spending over time. Examples would include reductions in payment rates for Medicare Advantage plans or in Medicare provider payment rates. Such steps can be useful to cover some of the costs of expanding coverage in the early years of such a program but do not have the potential to contribute to the critical task of slowing the long-term rate of increase in spending that will also be required.

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7 For a comprehensive view of the potential for health information technology to boost provider payment reform, see "A Historic Opportunity: Wedding Health Information Technology to Care Delivery Innovation and Provider Payment Reform," Center for American Progress, May 2009.

8 Senate Finance Committee, *Financing Health Care Reform: Proposed Health System Savings and Revenue Options,* May 20, 2009.

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13 Alexandra Kirkley and others, "A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee," *New England Journal of Medicine,* Vol. 359, No. 11, September 11, 2008; J. Bruce Moseley and others, "A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee," *New England Journal of Medicine*, Vol. 347, No. 2, July 11, 2002.

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