



## Will Health Reform Slow Cost Growth?

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## About The Lewin Group

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To many Americans, health care reform is more about preserving the status quo than it is about change. Surveys show that most of the 85 percent of Americans who have insurance like the coverage they have and do not want to change it. Consequently, advocates have promised that the newly passed Patient Protection and Affordable Care Act will protect the coverage Americans now have by slowing the growth in health care costs.

However, it appears that cost control has taken a back seat to expanding coverage for the 15 percent of Americans who do not have insurance. In fact, Americans are being asked to pay \$900 billion for a program to cover the uninsured, with little assurance that the act will provide the cost control needed just to maintain existing coverage.

To be fair, most of the 2,700 page bill is actually devoted to changes that increase the emphasis on prevention and quality in both public and private health plans. It also includes controversial changes in Medicare payment policy designed to slow the growth in spending under the program, which is expected to be bankrupt by 2017.

David Cutler, a Harvard economics professor and advisor to President Barack Obama, predicts \$600 billion in savings to consumers and governments under the act over the next 10 years.<sup>1</sup> He argues that the act promotes efficiency through an excise tax on high-cost health plans and increases competition through new “exchanges” that offer a selection of comparable health coverage options. It also creates a Medicare advisory board to fast track refinements in payment systems for the program.

While savings of \$600 billion is impressive, it only represents savings of approximately 1.5 percent of health spending over 10 years. Even with these savings, health spending will continue to grow about twice as fast as the average family income. Since most of the savings under the act will be from Medicare, it will have little impact on spending for people under age 65, which is the group most at risk of losing coverage due to uncontrolled cost growth.

The Lewin Group’s analysis of the act shows some savings, including a modest shift to lower-cost health plans through increased competition in the exchange and excise tax on high-cost plans. However, these savings would be more than offset by the cost of increased health services utilization for newly insured people, which would be up to \$50 billion per year. We estimate that national health spending would actually increase by about \$265 billion during the act’s 2010 through 2019 time period, despite these cost savings.<sup>2</sup>

Proponents of the act often point out that many Americans will see their premiums go down under the act. Premiums will go down for many, but mainly because the act provides new subsidies for the purchase of coverage. Little of these premium reductions can be attributed to

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<sup>1</sup> David Cutler, “Health Reform Passes the Cost Test,” Wall Street Journal. March 9, 2010: A21.

<sup>2</sup> “Comparing the House and Senate Health Reform Bills,” Staff Working Paper # 10, The Lewin Group, January 13, 2009.

actual reductions in the cost of services or increased efficiency, and as we all know, premiums will go up for younger and healthier people who now must pay a community-rated premium.

There is a growing consensus that meaningful cost control will require changing our fee-for-service (FFS) system to reward quality and efficiency. Under the FFS system, physicians are paid based upon the number of services provided. The FFS system creates incentives for physicians to provide more and more billable services even if they are unnecessary or are of minimal value. It also creates incentives for providers to acquire new capital such as imaging equipment to help establish additional streams of revenue for the patients they treat.

Some researchers believe that the overuse of services under FFS medicine is extreme. A recent report from the *New England Journal of Medicine* showed that Medicare spends twice as much for beneficiaries in some areas of the country than in other areas, even though there is no measurable difference in patient health status.<sup>3</sup> This report also suggested that up to 30 percent of the care provided to the Medicare population could be eliminated without a negative impact on health.

The act does begin to realign provider incentives under Medicare. For example, it funds demonstrations of variations on the medical home and pay-for-performance (P4P) models, which pays providers a bonus for reducing costs and meeting target quality measures. It also introduces a “bundled” payment system that provides a single payment for individual episodes of care encompassing the inpatient stay, related readmissions within 30 days and other post-acute care services occurring within 30 days of discharge. These payment models create new incentives to improve quality and reduce costs. However, the evidence from these payment models is mixed:

- Medicare funded a demonstration of a P4P program that reduced costs by about 1.8 percent, although 80 percent of those savings were returned to physicians in incentive bonuses.<sup>4</sup>
- Another Medicare demonstration showed that bundled payments reduced costs by about 10 percent for patients receiving coronary artery bypass graft (CABG) surgery.<sup>5</sup>
- The Geisinger Health System found savings of 5 percent for commercial patients under their bundled payment system.<sup>6</sup>

While bundling creates incentives to provide services more efficiently, it does little about the fact that we appear to be providing too many health care services in the first place.

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<sup>3</sup> Fisher, E., et al, “Slowing the growth of health care costs- lessons from Regional Variation,” *New England Journal of Medicine*, 360 (2009): 849-852 Number 9.

<sup>4</sup> “Medicare Physician Group Practice Demonstration: Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay for performance Demonstration,” The Centers for Medicare and Medicaid Services, August 2009

<sup>5</sup> Cromwell, J., and D.A. Dayhoff, et al, “Medicare Participating Heart Bypass Demonstration: Final Report,” CMS, (1998)

<sup>6</sup> Casale, A, and RA Paulus, et al “ProvenCareSM: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care,” *Annals of Surgery*, 246(4) (October 2007): 613-621

The irony of the cost containment debate is that we know what works: capitation. Under a capitated system, health plans are paid a fixed amount to cover the cost of health services for plan enrollees. In this model, provider net income is maximized by eliminating unnecessary services and by being more efficient with the delivery of care. The most common form of capitation is the Health Maintenance Organization (HMO). Bundled payments are also a form of capitation that provides incentives for quality and efficiency in the delivery of a given bundled service (e.g., CABG).

To illustrate, in 1989, employer costs per worker grew by over 18 percent. Employers responded with a huge shift to managed care, resulting in over one-third of workers enrolling in an HMO. By 1996, the rate of growth in costs per worker was slowed to just eight-tenths of one percent. Adjusted for inflation, this was an actual reduction in health spending. Several studies also showed that as HMO market share in an area increases, the rate of growth in spending actually slows for all payers, which effectively compounds savings over time.<sup>7</sup> A system that slows the rate of growth in spending is the “Holy Grail” of health care reform.

However, the emergence of HMOs was followed with a public backlash against managed care that led to reduced enrollment and an eventual return to rapid cost growth. The backlash was fueled by three factors:

- Limits on patients as to which providers they could see;
- Suspicions that some managed care plans were skimping on care to increase profits; and
- Worker support for managed care was weak since most of the savings went to the employer rather than the individual worker.

In addition, many physicians objected to a loss of autonomy in their medical practice, and those who accepted risk as part of their capitated arrangements tended to do poorly. An increased demand for labor and rising incomes during that period also increased the willingness to adopt less restrictive forms of coverage, even though the coverage was more expensive. In our currently depressed economy, workers might be more open to accepting the HMO model.

This finds us in search of effective ways of replicating the savings found through capitation in a way that does not alienate consumers and providers.

Accountable care organizations (ACOs) have been proposed as a way for providers to band together to share in the savings that can be realized by improving the quality and efficiency of health care. ACOs would be composed of a group of physicians and at least one hospital. ACOs would continue to bill for services on a FFS basis,<sup>8</sup> but the ACO would receive an end-of-year bonus if they meet target quality measures and reduce patient costs below expected levels. This

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<sup>7</sup> Robinson, J.C., “HMO Market Penetration and Hospital Cost Inflation in California,” *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

<sup>8</sup> “Improving Incentives in the Medicare Program,” Report to Congress, Medicare Payment Advisory Commission (MedPAC)

replicates some of the cost control incentives found in HMOs without actually putting the ACO at risk for patient costs.

The Brookings Institute is jointly sponsoring a pilot ACO project with the Dartmouth Institute for Health Policy and Clinical Practice. The pilot ACO project begins in 2010 and will measure its impact on costs and quality.<sup>9</sup> However, the cost containment potential of ACOs is reduced because there is nothing to prevent patients from seeing non-ACO providers who do not share their incentives to reduce costs. Also, the share of savings returned to the provider as a bonus must be great enough to overcome the FFS incentive to maximize volume. Moreover, sharing the savings in the form of bonuses also greatly reduces savings to payers and consumers.

Another proposal is to provide bundled payments to an ACO-like network of providers for patients with selected health conditions such as diabetes or cancer. The bundled payment would cover the full cost of care for these patients, including inpatient and outpatient services. Geisinger Health Plan and Prometheus, Inc. are currently developing such systems. This patient based bundling methodology differs from bundling in the act, which is paid on a service-by-service basis. However, like the ACO model, savings will be limited because there is nothing in this model to prevent patients from seeing providers outside a given network.

An alternative approach is to create financial incentives for people to enroll in less costly health plans such as HMOs or Health Savings Accounts. The Healthy Americans Act, sponsored by Senators Ron Wyden and Bob Bennett, would have rewarded consumers for enrolling in more efficient health plans by allowing them to retain the full amount saved, as opposed to splitting savings with their employer. However, this approach was bypassed in favor of the bill passed by the Senate and the House of Representatives.

Although the Patient Protection and Affordable Care Act is perhaps a disappointment to those who wanted more aggressive cost containment, it may be the best bill that our political system is capable of at this time. Americans are not ready to submit to any system that interferes with unrestrained access to health providers and services, which eliminates most of the options that might make a significant difference. We may learn a lot from the Medicare demonstrations in the act, but it will be up to the private sector to engineer the next generation of cost containment.

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<sup>9</sup> “Shared Savings: Payment Reform that Promotes High-Quality Care and Reduces Medicare Spending Growth,” Brookings Institute, January 27, 2009.