Overview

Over the past half century, most Americans have experienced increased prosperity and improved quality of life. We are living longer, and advances in knowledge and technology have made medical care increasingly effective and are likely to continue to do so. But these triumphs pose serious challenges. As health care improves, Americans are spending higher proportions of their income to obtain it. Health care is crowding out other spending by individuals, businesses, and government. Moreover, our complex, fragmented health care system is demonstrably inefficient and unnecessarily costly. Americans are increasingly concerned that they are spending a great deal on medical care and not getting their money's worth. The rising cost of care is making health care coverage less affordable and adding to the already substantial ranks of the uninsured.

The health spending challenge shows up strikingly in the federal budget, where the cost of federal health programs, primarily health care promises to the elderly, is projected to grow substantially faster than

federal revenues at current tax rates. The projected growth of federal health spending will force tough decisions about the federal budget. If past trends in health care spending continue it will not be possible to keep promises made to the elderly and other vulnerable populations without large continuous tax increases, even if other federal spending is drastically curtailed. Indeed, if current programs remain in place and recent health spending trends continue, within a generation the cost of Medicare and Medicaid alone will exceed the amount of national resources historically devoted to financing the whole federal government. This rapid projected growth is partly attributable to demographics—the retirement of the large baby-boom generation and the fact that Americans are living longer. More important, it is due to the fact that Americans are consuming more and increasingly expensive health care, whether that care is financed by the government or the private sector. Health care spending dominates the future federal budget crunch. If health care could be delivered more efficiently, federal budget choices would be far less agonizing.

But federal health programs are only pieces of a larger picture. Health spending is putting pressure on the budgets of families, businesses, nonprofit enterprises, states, and communities. Total national spending for health care—now approaching 17 percent of all spending—continues to rise rapidly. Attempts to reduce federal spending by cutting Medicare and Medicaid benefits and restricting eligibility will only serve to shift the burden to other payers without reforming the system in ways that could improve the effectiveness of health care or slow the growth of total spending.

Although Americans devote a considerably higher proportion of total resources to health care than people in other advanced countries, their health outcomes are worse, millions remain without health insurance, and there is considerable evidence that the health care delivery system is inefficient and wasteful. The size of the federal health programs makes their leadership essential to systemic reform. The challenging question addressed in this book is: how can federal health care programs be reformed in ways that slow the growth of total health spending and move the whole system toward greater efficiency and effectiveness, broader coverage, and better health outcomes?

Rising Health Care Spending—Federal and National

In chapter 1 we focus on current projections of health care spending. We discuss why health care spending is rising so rapidly in the United States and other developed countries. We show the dramatic effect that current rates of growth in health care programs will have on the federal budget and why we believe such growth to be unsustainable.

Strategies for Slowing the Growth of Health Spending

In chapter 2 we assess a broad range of options that could slow spending or improve long-term performance of federal health programs, while taking into consideration the interconnectedness of the entire health system. Previous attempts to reform federal health programs have often been myopic, taking aim at short-term budget scores rather than long-term efficiency; these approaches often succeed only in shifting costs to the private sector, rather than reducing total health spending.

Comprehensive reform of the U.S. health system will eventually be necessary if we are to achieve efficient production of effective, high-value health care with a rate of spending growth that can be sustained well into the future. Most policy proposals to reduce growth in health spending take one of two approaches to reform—market based or regulatory based. Market strategies rely on informed consumers who respond to greater competition by making cost-effective choices that will improve quality of care and lower costs. Regulatory strategies, by contrast, promote active government intervention through administrative rules on reimbursement rates, provider performance, or total spending to achieve the same ends.

Whether reform should move toward universal health care under a single-payer system or greater competition among private health plans has long been debated by experts, including many of the authors of this volume. We argue in chapter 2 that the country should not wait to resolve the conceptual debate over health reform before taking actions that can squeeze out inefficiency and promote better functioning of federal health programs and the health system at large. The problems are both large and

complex, and solutions will inevitably involve a blend of regulatory and market elements. Consequently, many different approaches should be tried to improve efficiency, to slow health spending growth, and to promote a more equitable system. Improved information about treatment effectiveness, costs, and outcomes is critical to any strategy pursued.

Some policy proposals—such as health information technology, disease prevention, malpractice reform, and pay-for-performance—have been touted as the keys to better health care at lower cost for everyone. Unfortunately, there are no silver bullets. Although those proposals have considerable merit, no single proposal can solve the entire spending problem by itself, and each proposal requires a considerable investment of money and effort to become effective. Such ideas should be part of a broader agenda of experimentation and reform.

Many policy options considered in this chapter are likely to yield one-time savings rather than a permanent reduction in the growth of federal health outlays. Although perhaps not ideal, at least adopting such an approach would buy time for further policy development and innovation. We argue that there is no lack of policy ideas to test, but there may be a lack of political will to proceed.

Broader health system reform is not possible without implementing changes in federal programs and health-related activities. Medicare and Medicaid account for such a large share of total health spending that they must be part of wider efforts to improve health care. Federal tax subsidies help millions of workers purchase private insurance through their employers, but those subsidies could be revamped to better target those in need and minimize incentives that promote inefficient use of health services. Regulatory agencies, including the Federal Trade Commission and the Food and Drug Administration, establish the legal framework for competition in the health sector and provide important consumer protections.

Federal leadership can provide a catalyst for developing and implementing significant reforms by public and private insurers and health plans. Medicare is testing ways to improve payment and delivery systems that could increase the quality of care and reduce program spending. Many states have undertaken projects to improve the operation of their Medicaid programs. The Veterans Health Administration has led the way

in developing electronic medical records and improving communications within the VA health system. Lessons from these efforts can be adopted by other health programs, both public and private.

The challenge of rising health care spending will not be resolved in the near term; at best, it will be mitigated and managed through many small but significant steps. Ultimately, Americans will be forced to decide how much of their individual and national resources to allocate to extending life and how increasingly expensive care will be allocated among citizens. A large number of reforms must be implemented over an extended period of time if we are to reduce growth in health spending while enhancing the effectiveness of care. Although some proposals in this book may preclude others, we believe that many can and should be pursued simultaneously.

The Challenge of Medicare

In chapter 3 Gail Wilensky emphasizes the interconnectedness of efforts to slow spending growth in Medicare and in the health system as a whole. The size of the Medicare program, coupled with the political unlikelihood that Medicare spending growth will be allowed to fall behind growth in total health care spending, means that future Medicare spending growth will help signal the success or failure of efforts to moderate spending growth across the system.

Medicare is currently undertaking several demonstration programs to change provider incentives in ways that will reward quality and encourage efficiency. If these prove successful, they could hold tremendous value for both Medicare and private health insurers. Political realities—a growing senior population that is unlikely to tolerate differences between Medicare and the private sector regarding access to new technologies or high-priced providers—suggest that Medicare and private-sector spending streams are likely to converge over time. Thus sustaining efficiency and lower spending growth in one system will occur only if there are comparable changes in the other system.

Wilensky reviews a range of proposals to slow spending in the Medicare program, including constraining provider payments and increasing the eligibility age and cost sharing by beneficiaries, and weighs the political likelihood and financial impacts of each. Similar to other authors in

this volume, she sees the most promise for moderating spending in promoting efficient, high-quality care. Specifically, she recommends development of a national performance measurement system that would use comparative clinical effectiveness information to reward providers for high-quality, appropriate care. Investing in such a system would be an important role for the federal government—one that would realign financial incentives and enable improved care throughout the health system.

The Role of Medicaid

While Medicaid represents a significantly smaller share of the federal budget than Medicare, its anticipated rate of growth is slightly higher than that of Medicare and substantially more than anticipated growth in federal revenues. In chapter 4 Alan Weil and Louis Rossiter explore a variety of approaches that could control Medicaid's rate of growth. They note that Medicaid was established out of recognition that low-income Americans could not adequately access the health care system—any attempts to cut costs by reducing covered services or program eligibility risk recreating those problems. Instead, they believe cost solutions must be found through greater efficiency and consider several policy levers to accomplish this.

To change the incentives that states face in making Medicaid policy decisions, Weil and Rossiter consider the consequences of converting Medicaid into a block grant to states. They conclude that, while this would certainly help control federal Medicaid spending, such an approach would simply shift the financial risk to states and their beneficiaries. Another possibility is to design a generalized response to reduce the degree of fiscal gaming practiced by states. Medicaid costs could also be reduced by adopting reforms to change provider behavior, such as disease management, pay-for-performance, and managed care. These reforms are being used and showing promise in the private health sector. The authors also see possibility in a pair of policies designed to change the behavior of individual beneficiaries: Defined contributions allow beneficiaries to choose among plans that have the same costs but varying benefits, and financial incentives can encourage health-promoting behaviors, such as keeping doctor's appointments, adhering to drug treatment

regimens, and lessening use of emergency rooms. Finally, they explore two ideas that could help reduce demand for Medicaid. One, establishing national eligibility standards based on financial need, would eliminate cross-state disparities and simplify program administration. The other, promoting private long-term care insurance through partnership programs, is still relatively untested but would likely remove some of the cost burden from both states and the federal government.

Leveraging Other Federal Health Systems

In chapter 5 Susan Hosek explores the growth of the Veterans Health Administration (VHA) and the Military Health System (MHS). Both systems face rising cost pressures resulting from the increasing attractiveness of their services relative to private health coverage. Over time the scope of benefits provided to veterans and military beneficiaries has grown, reaching a point today where these packages are significantly better than most private employer health plans. With these programs providing care that is of equal quality and lower cost, potential beneficiaries are increasingly switching out of private plans. Both the Department of Veterans Affairs and Department of Defense (DoD) have proposed modest increases in cost sharing to moderate the demand for care by current enrollees and to discourage additional eligible beneficiaries from shifting into these systems from private coverage. However, with so many military personnel deployed and at risk overseas, Congress has not supported these changes. One way to generate sizable cost savings for these programs is to update prescription co-pays to employer-plan levels, an approach that is less likely to encounter political resistance. VHA and MHS must also generate cost savings through improved efficiency.

VHA and MHS innovations—in efficiency and quality of care—could act as examples for the rest of the U.S. health sector. Development of electronic medical records (EMR) systems can improve care and save money. VHA pioneered the Veterans Health Information System and Technology Architecture (VistA), which it has made available to private-sector providers at nominal cost. DoD is close to full implementation of its EMR system, the Armed Forces Health Longitudinal Technology Application (AHLTA). Both systems can make valuable contributions to the entire

health sector by sharing information on cost-effective design, implementation, and training requirements, as well as methods to exploit the systems to improve health outcomes. VHA has also become a leader in quality-of-care improvements, with its adoption of a quality improvement initiative that has resulted in higher standards of care by holding providers and managers accountable for measured quality performance. The federal government would be well served to encourage VHA and MHS to continue aggressively developing and testing new approaches to providing quality, lower-cost care, and disseminating this information to the broader health care sector.

Private Payer Roles in Moving to More Efficient Health Spending

In chapter 6 Paul Ginsburg emphasizes the links between the activities of private and public health insurers. He argues that not only will developments in private insurance have direct effects on the federal budget but that they will also have indirect effects by their influence on the degree to which reforms aimed directly at federal health programs can succeed. The exclusion from taxation of employer contributions to health insurance has an enormous effect on federal revenues, while direct subsidies for purchase of private insurance, especially for Medicare Part D prescription drug plans, represents another large federal health expense. Ginsburg highlights important indirect effects as well, which grow out of the reality that many providers treat patients with different kinds of health insurance coverage, both public and private. The result of this common delivery system is that strong initiatives from either payer—for instance, a change in payment policies to hospitals and physicians—will influence care across the board.

Given this interconnectedness, Ginsburg argues that tools to contain spending that are used in one sector can make the other sector more effective as well. Private payers are currently focused on the potential of patient financial incentives—higher co-payments, deductibles, and coinsurance—to reduce costs. These strategies could have an impact on federal health programs as well, especially their most successful feature—creating incentives for generic drug use. Another option, which better addresses the problem of concentrated expenses in a small number of enrollees, is the

use of high-performance networks, where patients are directed toward high-performing physicians on the basis of quality and costs per episode of care. The federal government could spur development of this savings tool by providing data, such as access to Medicare claims, to create a larger sample for assessments of physician efficiency and quality. Pay-for-performance (P4P) is another potential incentive to promote higher quality care. For private insurers, the challenge is coordinating choice of measurements. Measures chosen by Medicare, which is currently conducting P4P demonstrations, would likely be agreed to by private insurers, thereby creating system-wide standards. The public and private health sectors should be open to adopting reform tools that reinforce cost-saving behavior across the entire system.

Cost Containment and the Politics of Health Care Reform

Reforming the health care system in this country has long been of interest to policymakers and citizens alike. However, despite much public debate, little of real substance has been accomplished. In chapter 7 Judith Feder and Donald Moran explore several major barriers to large-scale health reform and how they have played out recently in national politics. The Clinton administration's failed effort to implement reform faltered on a central reality of health care financing—unless policymakers are willing to spend more money, it is not possible to cover the uninsured without placing at least some restrictions on the already-insured. As the cost of existing care rises, it becomes increasingly difficult to expand coverage. First, rising costs create a larger uninsured population, as public and private insurance reduce coverage and some individuals opt out of these more limited options. Second, rising costs means greater subsidies are necessary for the uninsured to afford care, a redistributive situation that raises the political, as well as economic, costs of expanding coverage. The Clinton experience also demonstrated that even if new revenues can be identified to finance expanded coverage, the already-insured population will still be affected by whatever cost containment strategy is implemented to contain spending within this new health care budget.

Moving past the efforts during the Clinton era, health care reform continues to be debated in a highly charged environment. Beyond the

generally perceived increase in polarization and interparty factionalism, the political environment holds particularly strong challenges for health care reformers. First, several of the hot button issues that engage and enrage ideological opposites fall within the health care realm, most notably abortion and stem cell research. Second, the fiscal importance of health spending as part of federal and state budgets has raised the stakes for reform efforts. Finally, the loss of moderates from the political scene strongly affects health care policy, as the size and complexity of the health care system require substantial legislative and regulatory action simply to ensure that the existing framework runs smoothly. As Feder and Moran note, the fractious efforts to implement the Medicare Modernization Act make it difficult "to visualize how to grow a political center large enough to take concerted action to restore fiscal sanity before the financial divide between promises and resources proves unbridgeable."

Building upon and validating the recommendations made in the preceding chapters, Feder and Moran conclude that the best hope for meaningful health reform lies with serious efforts to contain costs. In their opinion, this means recognizing that creation of a more economical health system will require many people to economize, and to do so efficiently will require policymakers to develop the evidence and processes to enable the system to rationally and acceptably say no. The generation of balanced, scientifically rigorous research to inform decisionmaking on coverage and reimbursement policies can help the public and private health systems to internalize incentives that promote cost-conscious care.

Building Public Support for Slowing the Growth of Health Care Spending

In chapter 8 Stuart Butler discusses the practical political considerations of transforming policy proposals into successful legislation. He observes that public opinion about health care policy is particularly complicated because people tend to view proposals in very personal and financial terms, as well as in terms of basic values. This volume discusses two approaches to spending control: improving the efficiency with which we spend health dollars and designing incentives or controls to limit

expenditures. When addressing health care costs and spending, we are forced to consider obligations and responsibilities, how they are distributed in society, and who makes decisions. The market allows individuals choice, but it may not capture our social values.

Butler considers why our efforts focus on reducing health care costs, rather than simply improving efficiency in delivery of care. He identifies an important public policy reason for these efforts—health care spending is in competition with other policy goals and long-term promises made. Currently, the true costs of health spending are hidden from public consideration. Budget tradeoffs must be made more transparent and more public to assist difficult decisionmaking.

Butler raises a range of questions that force consideration of existing health obligations, and he sets forth possible paths in a cost-constrained future. He wonders what would happen if policymakers reconsidered the current promise of the Medicare social contract. Would Americans be willing to alter it to free up resources for other social goals? Perhaps we would tolerate transforming Medicare into income insurance that would protect an individual's ability to afford health care during retirement but that required higher-income retirees to pay a premium for coverage. As we work to balance the financial risks associated with health, decisions will have to be made on allocating resources. One approach is to allocate resources according to a community-wide sense of fairness and efficiency. Another supports investing control mainly with individual users of services and allowing the market to allocate resources in a manner that maximizes individual preferences. Butler argues that efforts to pursue policy refinements are more likely to succeed if proposals can be made more compatible with the underlying values of Americans—or at least proposed in ways that force the public to consider the moral trade-offs involved. Engaging citizens in serious discussions about these issues and values can strengthen efforts to generate strong public support for the necessary steps to rein in health care costs.

The rest of this book explores options for restoring fiscal sanity to our health care spending. By presenting a broad range of proposals, we hope to emphasize that solutions to this spending challenge are possible and that to have an impact the country needs to vigorously pursue a multipronged approach.