VIEWPOINT

Next Phase in Effective Cost Control in Health Care

Aaron Glickman, BA
Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia.

Sarah S. P. DiMagno, BA
Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia.

Ezekiel J. Emanuel, MD, PhD
Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia; and Department of Health Care Management, Wharton School, University of Pennsylvania, Philadelphia.

Author Audio Interview

There is some good news on cost control in the United States. In 2017, the last year for which data are available, health care expenditures were 17.9% of gross domestic product (GDP).[1] This is similar to the 2010 level of 17.3% when the Affordable Care Act (ACA) was signed into law. On April 22, 2010, one month after enactment of the ACA, the US Department of Health and Human Services' (DHHS) Office of the Actuary released a report.[2] Actual spending has been much better than the official estimates from the Office of the Actuary (**Table**).

In 2017, total health care costs were almost $650 billion less than anticipated (Table). Expenditures for Medicare were $72 billion less than the projections and Medicaid and the Children's Health Insurance Program (CHIP) were $250 billion less than the projections. Some of the Medicaid and CHIP savings may be because not all states expanded Medicaid under the ACA; however, that is a small fraction of the $250 billion. In recent years, government reports indicate that "overall healthcare spending growth slowed."[1] Importantly, this slowdown of cost growth and total spending occurred while insurance coverage increased to include an additional 20 million individuals in the United States through the exchanges, Medicaid expansion, protecting patients with preexisting conditions, and allowing children stay on their parents' health plan, among other mechanisms.

There is also troubling news. In 2017, the per-capita health care spending in the United States was $10 739, about 27% more than Switzerland, which is the country with the next most expensive health care expenditures. The average family premium for employer-sponsored health insurance was $19 616 in 2018, representing almost one-third of the median household income of $61 372.[3] Employees are paying more of that cost than ever because employers are shifting more of the premiums onto workers and increasingly adopting high-deductible plans. Simultaneously, prices for specialty drugs are increasing substantially, with the cost for some drugs and gene and cellular therapies exceeding $300 000 per course of treatment. In 2019, new gene therapy treatments may surpass $2 million per patient. According to a 2018 Gallup poll that included more than 1000 respondents, people in the United States believe that cost is "the most urgent health problem facing this country at the present time."[4]

Even though the United States is doing better on controlling cost growth, the extremely high costs of health care remain a significant financial and emotional strain. Although national trends suggest a significant slowdown in cost growth, those gains are not evenly distributed. Between 2007 and 2014, Medicare spending decreased by 1.2% per capita, whereas spending in private insurance increased by 16.9% per capita.[5] Consequently, the federal treasury may be feeling some financial relief, whereas many individuals in the employer-based and individual insurance markets are feeling financial pain.

Health care spending is a combination of use and prices. The 2018 Office of the Actuary report[2] suggests that health care use is moderating, but a real problem is continued price increases.[1] From 2007 to 2014, (1) private insurance prices for hospital inpatient services increased by 42% and outpatient services increased by 25% and (2) prices for physician services increased by 18% for inpatient care and by 6% for outpatient care.[6] Retail prescription drug spending increased by 12.4% in 2014, 8.9% in 2015, and 2.3% in 2016.[1] Those spending increases do not even include the rapidly increasing portion of drug spending for Part B specialty drugs for cancer, rheumatoid arthritis, and multiple sclerosis. Collectively, the rapid increases in prices for drugs and hospital services in the private market suggest 4 specific recommendations for the next phase of cost-control efforts.

First, the United States needs to do more about controlling drug prices. Spending for drugs accounts for nearly 17% of national health expenditures (inpatient, outpatient, and retail), and the future portends ever-increasing drug prices. Between 2012 and 2017, the proportion of total Medicare spending that went toward paying for drugs increased from 17% to 23%.[7] The Office of the Actuary projects annualized increases by 6.3% in drug spending until 2026, which is higher than projections for increases in hospital or physician costs.[8] The United States needs national drug price negotiation, not just for Medicare. It should cover all US residents and be pegged to standards of value-based pricing and social affordability. Such legislation looked impossible just a few years ago, but a bipartisan agreement is beginning to emerge. Fully 92% of Republican voters, along with President Trump and Freedom Caucus members, endorse the need for drug price legislation.

Second, the secretary of the DHHS should set national and state-level benchmarks for total health care cost growth that are linked to economic growth and population aging. Even voluntary cost growth limits can be effective in curbing cost growth. In 2012, Massachusetts established the Health Policy Commission, which monitors spending and establishes benchmark limits on health care cost inflation based on state GDP growth. The commission has limited enforcement resources. Its main power is to identify institutions that contribute to cost growth and make this information publicly available. This approach has been successful in that Massachusetts has had 7 years of below-average growth in health care costs, and commercial health care spending has declined by nearly $6 billion between 2012 and 2016.[9]

Rhode Island, Vermont, and most recently Delaware have adopted the Massachusetts approach. Admittedly this approach may have been effective in Massachusetts because the state has among the highest health care costs in the country, but the same can be said of the United States compared with the rest of the world. If the secretary of the DHHS issued annual benchmarks that allowed

Corresponding Author: Ezekiel J. Emanuel, MD, PhD, Perelman School of Medicine, University of Pennsylvania, 423 Guardian Dr, Blockley Hall, Ste 1412, Philadelphia, PA 19104 (mehpchair@upenn.edu).

Table. US Health Care Spending

	Estimated in 2010 With ACA[a]	Cost in 2017, $ in Billions[b]	
		Actual[c]	Savings
National health care spending	4139.6	3492.1	647.5
Medicare spending	778.1	705.9	72.2
Medicaid and CHIP spending	832.7	581.9	250.8
Health spending as percentage of GDP, %	20.2	17.9	2.3

Abbreviations: ACA, Affordable Care Act; CHIP, Children's Health Insurance Program; GDP, gross domestic product.

[a] Data are from Foster et al.[2]

[b] Unless otherwise indicated.

[c] Data are from Martin et al.[1]

health care costs to increase no faster than growth in the GDP, the national and state-based standards could serve as a powerful check on hospitals and other health care providers charging higher prices.

Third, the federal government should expand the adoption of alternative payment models in the private market. These models include bundled payments, accountable care organizations, and capitation. The government could require all private insurers that receive federal funds (through managed Medicaid, the exchanges, and other programs) to pledge to have 80% of payments as alternative payments within 5 years. This could convince those hospitals and physicians who have been reluctant to invest time and resources into transforming their care processes that value-based payment is occurring, and provide them an adequate path to this transformation.

The Centers for Medicare & Medicaid Services could also use the power granted by §1115A of the ACA to begin implementing bundled payments as a permanent part of Medicare reimbursement. Rigorous analyses show that bundled payments for lower-extremity joints lower costs without compromising quality, increasing use, or encouraging selection for healthier patients.[9] Completely switching to a bundled payment model for a high-priced procedure would send a powerful message to physicians about the inevitability of value-based payment, and evidence shows that physicians would change their practices accordingly.

Fourth, the government must wield antitrust powers to address hospital consolidation with other hospitals (horizontal) and through purchasing of physician groups (vertical). After years of mergers and acquisitions among hospital systems, the data now indicate that mergers decrease competition in a given market and increase prices. With consolidation, price increases can be substantial, often exceeding 20%; however, care coordination and patient outcomes are not necessarily improved. Historically, antitrust action against hospitals has been limited and haphazard. But with accumulating evidence that these mergers result higher prices, the government should take action to prevent more mergers.

Many other policies could be introduced to control health care prices and costs such as competitive bidding in Medicare Advantage. The overarching priority is to focus on reducing US health care cost growth. To paraphrase Newhouse, the terms "health care cost control" and "solution" should never be used in the same sentence.[10] Seven years of good news suggesting some improvement in controlling health care costs has not been enough to make health care more affordable to the average person in the United States, and to moderate the pressure of Medicaid costs on state budgets. Although the ACA has been effective in reducing the increase in health care costs, another set of cost-control policies that focus on reining in prices is necessary.

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