What to Do When Health Care Costs Start to Rise Again

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Claims abound that we have permanently bent the health-spending curve. The growth of health spending has indeed declined to historically low rates, driven largely by the Great Recession and the subsequent slow recovery. But slower spending growth does not guarantee an increase in value — sometimes less *is* less. Waste and inefficiency won't evaporate just because we enthusiastically adopt new ideas — or re-label old ones. Even sensible changes can backfire if they address only part of a much larger problem.

Furthermore, as the economy rebounds, growth in health spending is likely to follow suit. The critical question as the curve starts to bend upward again: Will we get our money's worth?

Actuaries at the Centers for Medicare and Medicaid Services (CMS) predict that growth in health spending will begin to increase this year, returning by 2019 to 1990s-level rates of about 6.5% annually, sharply higher than the 3.6% growth estimated for 2013. And that is not a worst-case scenario. How will federal policymakers react to runaway health spending? Not well, if the Affordable Care Act (ACA) is any indication.

To pay for expanded coverage, sponsors of the ACA had a strong incentive to find spending reductions. The savings come primarily from cuts in Medicare payments that will be unsustainable as revenues increasingly fall below the cost of treating Medicare patients. A "good score" on federal spending from the Congressional Budget Office is not the same as real spending reductions, and cuts in payments do not amount to truly systemic reform.

Other ACA provisions aim to directly address how health care is delivered. For example, the hospital readmission reduction program penalizes hospitals with excessive rates of re-hospitalizing patients for pneumonia, heart attacks, and heart failure within 30 days.

Although the penalty reduced readmissions by about 1% last year, other conditions (including sepsis, pulmonary disease, problems with medical devices, and mental disorders) are responsible for far more readmissions. Truly reducing readmission rates requires hospitals to coordinate their efforts with other providers in the health system and home caregivers. Instead of promoting a real solution, the ACA imposed a tax.

Accountable care organizations (ACOs) might offer greater potential to change health care delivery within traditional fee-for-service Medicare. However, the CMS's ACO program, called Pioneer, is laden with rules that discourage provider participation. Recently, 13 of the original 32 Pioneer program participants dropped out because they faced nearly certain losses. The problem is the way CMS sets the payments, not the performance of the ACOs. Because of the complexity of the ACO program and its poor financial incentives, many are finding that Medicare Advantage programs or ACOs with commercial insurers are more advantageous. Instead of creating an atmosphere that encourages entrepreneurs to challenge conventional thinking, government officials hewed closely to the limitations of the traditional Medicare program.

So for smart solutions in a growing economy, we will need to look to the private sector rather than the government.

Unlike the government, private purchasers — individual consumers and employers — cannot run ever-growing budget deficits and defer tough decisions about health care spending. Employers rely on health benefits to attract and hold good workers. However, workers' wages have stagnated as more of their total pay goes toward health benefits. Given the choice of more expensive health coverage or higher wages, many workers would take the money — if they could.

Employers and employees alike have a strong incentive to seek value for their dollars by trying new approaches that shift greater control and responsibility for health spending to consumers. That shift is more likely to move us to a system that promotes better health, not just more health services.

The private sector is already responding to rising health costs in a variety of ways. Here are a few:

- Employers are increasingly offering their workers consumer-directed health plans, which combine high-deductible insurance with a tax-preferred savings account for health expenses. Enrollment in such plans increased from 4% of all employer-sponsored coverage in 2006 to 13% in 2010.
- Interest in shifting from a defined benefit to a defined-contribution approach to employer-sponsored health insurance is growing. Under such an arrangement, employers contribute a fixed amount toward the plan premium, and workers who select more expensive plans pay the full additional premium.
- Value-based insurance design offers financial incentives (such as lower copayments) to beneficiaries who manage their chronic conditions (for example, by taking

medication or increasing exercise to meet blood pressure targets).

- Some employer plans have adopted a "centers of excellence" program that offers high-quality elective surgery at renowned medical centers at a lower cost.

In implementing new delivery approaches, the private sector has greater flexibility than the government and can more quickly make mid-course corrections or drop a project that fails to meet expectations. Firms are realizing that business as usual, with employees absorbing rising health costs through smaller wage increases, is no longer viable. Consumers are becoming active purchasers of health care who want to get their money's worth — because it *is* their money. They are the force that will drive value in the next chapter of health reform — a chapter that will be written in a growing economy.

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