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March 2013

Health Care Cost Containment: The Affordable Care Act

President Barack Obama, one month after he took office in 2009, announced his goal “to fundamentally reform our health care system, delivering quality care to more Americans while reducing costs for us all.”¹ After traversing a gauntlet of obstacles, including a polarized political environment and soaring budget deficits, the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act)—the President’s health reform initiative—was adopted by Congress in March 2010. Subsequent affirmation of the Act’s constitutionality by the U.S. Supreme Court in June 2012 and retention of a Democratic majority in the U.S. Senate following the 2012 national elections meant that attention of the nation would turn away from legislating health reform to implementing it.

The President’s twin goals of increasing access and containing the rate of growth of health care costs were—and remain—the central features of the lengthy (2700 pages) and complex Affordable Care Act (ACA). At the time the ACA was enacted, 50 million (17 percent) Americans between 18 and 64 years of age did not have health insurance. Health care spending in the United States represented 18 percent of the gross domestic product (GDP), and was projected to reach 20 percent by 2020.

Greater access to health care and bending the cost curve of health care are separate, but interrelated objectives. How does the ACA propose to achieve these objectives? State insurance exchanges and expanded eligibility for Medicaid are the two key methods in the ACA to increase access. Implementation of these two approaches involves not only administrative challenges for

participating states, but also calculations by individuals and small businesses whether to participate in the exchanges. [See information on Health Exchanges: <http://www.rma.org/healthcareexchange.php>] The challenges of designing and administering the state insurance exchanges are daunting. Even more intimidating, however, are the challenges of containing the growth of health care costs. That is because multiple actors and institutions whose motivations are often at cross purposes, contribute to increasing costs. Policies and programs to stabilize or reverse the cost curve are as complex as the varied actors in the health care system. The ACA contains many provisions “designed to modernize the delivery of services [to] ensure a more efficient, more effective and less expensive health care system.”² As stipulated in the legislation, such features to contain costs and increase access will not be fully implemented until 2014. Thus, it is too early to know whether, “*the true measure of health care reform’s success... whether it drives down medical costs over the long term*” will be met.³ Nonetheless, the promise of a transformed health care system bears ongoing attention.

This paper has four objectives. The first is to describe health-related spending in the United States from several perspectives. The second is to lay out the broad parameters that shape the delivery of health care in the United States. The third is to show how the decisions of many actors and institutions contribute to increasing health costs. Then fourth is to consider several key features of the Affordable Care Act intended to bend the cost curve.

Health Care Spending in Perspective

In 2010, the United States spent \$2.6 trillion on health care, or nearly 18 percent of gross domestic product (GDP)—the nation’s total economic activity. Calculated across the entire

population, this represented \$8,402 per capita (See Figure 1—“National Health Expenditures per Capita”).

Health care spending per capita has exceeded economic growth in every decade since the 1970s. Over the entire period, 1970-2010, while the annual rate of growth for GDP averaged nearly 6 percent, it was over 8 percent for national health expenditures. (See Figure 2—“Average Annual Growth Rates for NHE and GDP”).

Compared to other developed countries, the United States stands out both for growth over the last four decades in total per capita health expenditures, and for per capita amount expended (See Figure 3—“Growth in Total Health Expenditure Per Capita”). Per capita health care spending in 2009 in 19 developed countries, ranged from \$3,000 in New Zealand to \$7,600 in the United States. The U.S. per capita amount was 48 percent higher than for Switzerland, the next highest spending country at \$5,100.⁴

What kinds of services do these health expenditures represent? As shown in Figure 4 (“Distribution of National Health Expenditures”), more than half are for hospital care and physician services, with the balance a wide variety of other health goods and services. As discussed in *Health Care Costs: A Primer*, a 2012 publication of the Kaiser Family Foundation, rates of spending growth for these various services have fluctuated considerably over time. For example, hospital costs increased by 88 percent between 2000 and 2010, while prescription drugs (about 10 percent of total health spending in 2010) grew by an even higher rate of 114 percent.⁵

The Parameters: Federalism and Decentralization⁶

President Obama’s Affordable Care Act initiatives as well as other presidential health reform proposals attract much attention. Frequently overlooked is that health care in the American

federal system involves not only the national government, but also state governments and local communities. *The federal government* sets broad policy and provides funds such as Medicare and Medicaid to reimburse hospitals and physicians for services, and to academic medical centers to educate physicians and nurses and for research. *State governments* regulate insurers and providers and match federal health grants such as Medicaid. *Local communities* are the front lines where physicians, nurses and other health professionals organize and deliver health care in hospitals, clinics, and medical offices. Health care costs are largely incurred at the community level. In brief, responsibility for making, funding, and administering health policy is overlapping. It is not neatly divided under federalism.

There is no single American health care “system.” Rather, there are many decentralized and fragmented “systems” organized at the community level. Just as communities are diverse, so, too, are community health systems and associated health care costs. Because Americans look mainly to local physicians and hospitals for care, local health care markets produce “different results in different communities. [They] also influence how change occurs.”⁷ Variations in health care costs among communities have been investigated since 1970 by the Dartmouth Institute for Health Policy and Clinical Practice. One of the Institute’s key findings is that discretionary choices of physicians regarding patient treatments have a large influence on community health care costs.⁸

These considerations of federalism and decentralized decision-making complicate the challenge of bending the cost curve. “Decisions by one program may shift costs or affect payment decisions by other payers, usually in an uncoordinated fashion....Lack of coordination across public and private spending programs makes coordinating efforts to reduce costs and increase efficiency system-wide a challenging proposition.”⁹

Drivers of Health Care Costs: Actors and Institutions

The Academy of Medicine, in its 2012 report, *Best Care at Lower Cost*, points out the challenges to reform a “complex and constantly changing” health care system.

Health care in America has experienced an explosion in knowledge, innovation, and capacity to manage previously fatal conditions. Yet, paradoxically, it falls short on such fundamentals as quality, outcomes, cost, and equity....The full extent of these shortcomings is visible when considering how other industries routinely operate compared with many aspects of health care. Builders rely on blueprints to coordinate the work of carpenters, electricians, and plumbers. Banks offer customers financial records that are updated in real time. Automobile manufactures produce thousands of vehicles that are standardized at their core, while tailored at the margins. While health care must accommodate many competing priorities and human factors unlike those in other industries, the health care system could learn from these industries how to better meet specific needs, expand choices, and shave costs.¹⁰

There is no single villain in the challenge to bend the cost curve. Factors contributing to increases in costs of health care are multiple. They involve decisions by patients, providers, payers, and producers of drugs and medical devices. Incentives as well as penalties to control the growth of health care costs must focus individually on each factor and simultaneously on all of them—and in the context of public and private sector responsibilities.

Patients

Patients, knowingly and inadvertently, affect the costs of health care. The characteristics that drive up health care costs derive from demography, health conditions, and behaviors:

- an aging population, whose need for health care increases with age;
- a substantial part of the population (nearly half) with one or more chronic conditions, among them asthma, heart disease or diabetes, drive up costs; and
- two-thirds of adults are either overweight or obese, which can also lead to chronic illness and additional medical spending.¹¹

Patients who make decisions on their medical care on the basis of inadequate information, who demand new drugs, technologies, services and procedures, and who fail to get routine, preventive care, and inappropriately resort to emergency care contribute to health care costs. Patients, who, quite rationally, take advantage of low co-pays as well as tax breaks when buying health insurance, are unaware of the real costs of health care. Havighurst describes the “regulatory, legal and tax subsidies that deprive consumers of both the incentive and opportunity to demand value from medical providers” He concludes that “the market failure most responsible for economic inefficiency in the health-care sector is not consumer ignorance about the quality of care, but rather *their ignorance of the cost of care* [italics added], which ensures that neither the choices they make in the marketplace nor the opinions they express in the political process reveal their true preferences.”¹²

Providers

Hospital care accounted for 31 percent of total health expenditures in 2010, with physicians second at 20 percent. Hospitals are motivated to increase revenue by filling beds, especially intensive care beds, and by aggressively marketing newest and most expensive technology, beautifully performing tests and treatments that patients often do not need. And the ways in which costs are billed by hospitals to Medicare, Medicaid, and private insurers are opaque and arbitrary.¹³

Physicians, who neither practice evidence-based medicine nor include all costs (e.g., tests, procedures) in their decisions, underestimate total costs of care.¹⁴ Threats of law suits with high jury awards drive MDs to practice “defensive medicine” with more tests and procedures. Many physicians join hospital-owned practices as salaried employees to avoid practice management business costs, for quality of life benefits, and/or to avoid high malpractice insurance premiums or law suits, with lower insurance costs.¹⁵ While “mergers or partnerships among medical providers may improve efficiency and help drive down prices, consolidation can also have the opposite effect, allowing near-monopolies in some markets and driving up prices.”¹⁶ Finally, payment methods such as fee-for-service reward doctors, hospitals, and other medical providers for doing more, rather than for efficiency or effectiveness.

Payers

Who pays for health care? Payers encompass federal, state, and local governments, private and nonprofit insurance companies and patients. Private payers have been the largest source of health payments over the past 50 years, but their share has decreased over time. For example, in 1960 (5 years before enactment of Medicare and Medicaid) 48 percent of national health spending came from the “pockets” of patients, and 21 percent from private health insurers. Ten years later, patient direct spending dropped to 33 percent, as Medicare paid for 10 percent and Medicaid for 7 percent of total health expenditures. Fifty years later, in 2010, Medicare paid for 20 percent, Medicaid for 16 percent, patients, 12 percent, and private insurers, 33 percent. The ratio between spending by total private and public (including the Departments of Defense and Veterans Affairs) in 2010 to 55/45 is largely because the share of costs by Medicare and Medicaid has risen (see Kaiser Family Foundation, *Health Care Costs*, Figure 9).

Costs to administer health insurance vary considerably among private, nonprofit and public sector payers. This is partly because what counts as administrative costs is not consistently applied in such calculations. “We all agree that paying the bills count. But does profit? What about disease management? Advertising? A nurse who dispenses health advice over the telephone?”¹⁷ Medicare administrative costs estimated at 2 percent are generally agreed to be lower than for private insurers, which range from 7 to 12 percent for employer-based insurance plans to 30 percent for the individual market. Some studies comparing Canada and the United States conclude that a single payer reduces administrative spending. However, slashing administrative costs may not reduce the rate of increase of overall health spending. According to Richard Kronick, “most of the answers to why health care costs are going up ... faster than GDP...have nothing to do with administrative costs. The answers are that we do more stuff and have more technology.”¹⁸ As discussed in the next section of this paper, restraints on health insurance rate increases may have a greater effect on containing health expenditures than on administrative costs.

Pharmaceutical companies and producers of medical devices.

Medical and surgical interventions and diagnostic modalities have increased dramatically since 1970. “including a vast expansion of pharmaceuticals to treat acute and chronic conditions. In part, costs [have risen] because of the increase in absolute availability of treatments and diagnostic treatments that did not exist previously...[Other] diagnostic, therapeutic, and surgical techniques [underwent] revolutionary changes resulting from the availability of new equipment and computer-aided technologies.”¹⁹ Aggressive, direct marketing of new drugs to providers and patients to cover at a profit research and development costs to bring drugs to market reinforces the growth in spending for drugs and medical devices already noted.

Cost Containment Initiatives in the Affordable Care Act

Programs to modernize and improve Medicare that are under the purview of the federal government appear to dominate the Affordable Care Act. However, the Act also engages state governments and local communities in containing costs. Irrespective of locus of responsibility, these cost containment programs share a common purpose--to change behavior by patients, producers, and payers in the short-term and the long-term.

Short-term initiatives

Payments by the federal Medicare program to physicians and hospitals are generally recognized to set the patterns for private and non-profit insurers. Changes in Medicare payments to providers from “reducing payments to Medicare Advantage plans, reducing the update factor for Medicare hospital payments, increasing the rebates that pharmaceutical companies pay to Medicaid plans” are expected to have immediate effects.²⁰ Others—“simplifying health insurance administration by creating uniform electronic standards and operating rules for all private insurers, Medicare, and Medicaid, implementing hospital value-based purchasing programs, and establishing an approval process for generic biologic agents”—are also intended to hold down health care costs in the short-term.²¹

The behavior of payers, in this case, private health insurers in the individual market, has already been affected by ACA requirements. State governments have long had responsibility and considerable discretion in regulating health insurers and providers. The Affordable Care Act has brought “an unprecedented level of scrutiny and transparency to health insurance rate increases. [Under] the law, for the first time ever, insurance companies in all states cannot raise rates without accountability or transparency. By requiring insurance companies to document, submit for review, and publicly justify rate increases of 10 percent or more, requests for rate increases

above that level receive greater scrutiny than they had prior to the Affordable Care Act... In 2010, 75 percent of rate filings requested increases of 10 percent or more, a proportion that dropped to 34 percent in 2012.... And the average premium increase in 2012 was 30 percent that in 2010.²² Payers, moreover, have been directed by the ACA to “spend at least 80 percent of premiums on medical care,” capping administrative costs at 20 percent.²³

Longer-term initiatives

Health system changes that incorporate more efficient and less costly health delivery are intended to bend the cost curve over the longer term. The Center for Medicare and Medicaid Innovation (CMMI) was created in the Act “to free communities and local health systems from existing payment codes and [let] them experiment with ways to deliver better care at lower costs.”²⁴ CMMI is charged with developing new payment and service delivery models, at both local (e.g., accountable care organizations, bundled payments for care improvement, comprehensive primary care, Medicaid incentives for prevention of chronic disease, avoidable hospitalizations for dual, Medicare/Medicaid eligible patients) and state levels.²⁵

The Finger Lakes Health Systems Agency (FLHSA) in 2012 was one of 13 successful applicants for a CMMI award to be implemented wholly or partially in New York State. The \$26.8 million FLHSA project, “Transforming Primary Care Delivery: A Community Partnership,” was the largest of the 13 New York awards.

Other long-term approaches include “a new Independent Payment Advisory Board which, in addition to its Medicare responsibilities, is required to develop recommendations to slow the growth in private national health expenditures while preserving or enhancing quality of care. The ACA [also] creates a private Patient-Centered Outcome Research Institute to identify research priorities and conduct and disseminate research on the comparative effectiveness, risks, and

benefits of different treatments and services so that those providing little or no value can be determined.”²⁶

Conclusion

The jury is still out as to whether the Affordable Care Act will succeed in bending the cost curve. Health care spending growth slowed in 2009 and 2010 to its lowest rate in the 51-year *history of the National Health Expenditure Accounts.²⁷ Does this moderating of health care costs signal a long-term trend which the Affordable Care Act will reinforce and strengthen? Or was it a function of the deep recession of 2008-2009 which depressed GDP growth? If so, will health care spending revert to its long term pattern outpacing GDP growth because of the demographic patterns and long-established patterns of behavior by patients, providers, payers, and producers of pharmaceuticals and medical devices described in this paper?

Several economists think the second scenario is more realistic. Richard Nathan, for example, asserts that “modest reform [under the Affordable Care Act] will not be enough. America has a health care cost crisis that will take at least one more round of health reform to fix it.”²⁸ Uwe Reinhardt declares that “nothing in the history of health spending in the United States suggests that this is the time to break out the champagne to celebrate that victory.”²⁹

What difference will the reforms in the Affordable Care Act make in containing the growth of health care costs? That is a key consideration as the nation moves toward full implementation of the Act in 2014. It is a question that bears close watching not only at national and state levels, but also in communities where health care is delivered and most costs are incurred.

Notes

¹ U.S. Office of Management and Budget, *President's Message: a New Responsibility*, February www.whitehouse.gov/sites/default/files/omb/assets/budgets/03_Presidents_Message.

² David Cutler, "How Health Care Reform Must Bend the Cost Curve," *Health Affairs* 29, no. 6 (2010): 1131. Cutler, Professor of Applied Economics, Harvard University, was an advisor to the Obama Administration during development of the Affordable Care Act legislation.

³ Cutler, "How Health Care Reform," 1131.

⁴ Health Care Costs: A Primer, May 2012, 7. <http://www.kff.org>.

⁵ Health Care Costs, 2. <http://www.kff.org>.

⁶ For elaboration of points in this section, see Sarah F. Liebschutz, *Communities and Health Care: The Rochester, NY, Experiment* (Rochester, University of Rochester Press, 2011), chap. 1.

⁷ Paul B. Ginsburg and Cara S. Lesser, "A Decade of Tracking Health Systems Change," *Commentary* 2 (March 2006): 4.

⁸ See Liebschutz, 13-16.

⁹ Health Care Costs, 3. <http://www.kff.org>.

¹⁰ Institute of Medicine Report Brief, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, September 2012, 1.

¹¹ Julie Appleby and. Kaiser Health News, "Seven Factors Driving Up you Health Care Costs," October 14, 2012

¹² Clark Havighurst quoted in Holman W. Jenkins, Jr., "Yes, Hospital Pricing is Insane, But Why?" *Wall Street Journal*, March 2-3, 2013.

¹³ See Steven Brill, "Bitter Pill: How Outrageous Pricing and Egregious Profits are Destroying our Health Care," *Time* (March 4, 2013). Brill cites a McKinsey survey that found that 54 percent of physician practices were owned by hospitals in 2012, up from 22 percent ten years before. Brill, p. 40.

¹⁴ Atul Gawande, "The Cost Conundrum," *The New Yorker*, June 1, 2009 and various publications of Dartmouth Institute for Health Policy and Clinical Practice. <http://www.dartmouthatlas.org>.

¹⁵ Appleby, Seven Factors. See also "Salaried Physicians: Barriers and Benefits," *Las Vegas Sun*, 20 November 2009. <http://www.lasvegassun.com/new/2009/Nov> 20.

¹⁶ Appleby, Seven Factors.

¹⁷ Ezra Klein, "Administrative Costs in Health Care: A Primer," www.washingtonpost.com/2009.

¹⁸ George Lundberg, "Eight Reasons Why Healthcare Costs are Rising," *MedPage Today*.

¹⁹ Ezra Klein, "Administrative Costs"

²⁰ Health Care Costs, 29. <http://www.kff.org>.

²¹ Health Care Costs, 29. <http://www.kff.org>.

²² Rose Chu and Richard Kronick, "ASPE Research Brief. "Health Insurance Premium Increases in the Individual Market Since the Passage of The Affordable Care Act, DHHS, 22 February 2013. <http://aspe.hhs.gov>

²³ Chu and Kronick, *ASPE Brief*.

²⁴ Atul Gawande, "Now What?" *The New Yorker*, April 5, 2000, 22.

²⁵ For more details, see information prepared by Lillian Zhu, 2/12/2013.

²⁶ Health Care Costs, 30. <http://www.kff.org>.

²⁷ Uwe Reinhardt, "Is U.S. Health Spending Finally Under Control?" <http://economix.blogs.nytimes.com>, 1/20/2012. Reinhardt is Professor of Economics at Princeton University.

²⁸ Richard Nathan, "America's Health Care Cost Crisis and What to Do About It." <http://www.rockinstit.org> March 2013. Nathan, a political economist, is the past director of the Rockefeller Institute, University at Albany, State University of New York.

²⁹ Uwe Reinhardt. <http://economix.blogs.nytimes.com>.