HealthAffairs Blog

Bending The Cost Curve

October 1st, 2010

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In the national debate leading up to the passage of the Patient Protection and Affordable Care Act (PPACA), President Obama said on several occasions that he would veto any bill that did not lower the growth rate of health care spending. So now that the Act is law, you would expect to find a lot of people focused on how that is going to work.

Yet an informal scan of news stories, opinion pieces, journal articles and even conference agendas reveals that "cost control" is probably the least talked about feature of the new law. An exception is a study published in *Health Affairs* by analysts at the Office of the Medicare Actuary — concluding that costs will go up, not down, as a result of the new legislation. Other exceptions are all the members of Congress who voted for PPACA who are now campaigning for reelection by claiming, "If we had not passed this law, health care costs would have…"

Okay, so how does the new law promise to control costs? I'm going to skip over efforts to control fraud, waste and abuse, electronic medical records, managed care, coordinated care, teamwork care, medical home care, cost effectiveness research, etc., as ideas that, however meritorious, have not been shown to control costs and probably won't control costs. That leaves us with three cost-control initiatives that are new, unique to PPACA and worth discussing.

Refusing to Fund the Supply Needed to Meet the Demand. This is a little-noticed feature of the new law that has been almost completely ignored by everyone other than yours truly. The demand for care will almost certainly soar. Start with 32 million to 34 million newly insured people, who will try to double their consumption of care — if economic studies are to be believed. Add to that another 70 million or so who will have much more generous insurance than they currently have. Almost everybody else is promised an array of preventive care services, with no copayment or deductible.

How can you have all this newly created demand for care without an enormous increase in health care spending? PPACA's answer: make sure there is no new supply to meet the demand. Although early versions of the bill contained subsidies to increase the number of doctors, nurses and paramedical personnel, these items were all zeroed out before final passage.

But will this work? In a normal market, when demand exceeds supply, prices rise. If supply is prevented from increasing, prices will rise even more. If the demand is relatively insensitive to price, total spending will rise. This is Economics 101. In terms of the nuts and bolts, the ability of third-party payers to use their bargaining power will be severely undermined. As demand explodes, the third-party payers' threat to withhold their contracts will become an increasingly weak bargaining ploy.

Bottom line: this control device is not only unlikely to work, it may make things worse than they otherwise would have been.

Squeezing Medicare Providers. Once you get past the rhetoric about doctors becoming more "productive," you will discover that the new law's mechanism to control Medicare spending is to ratchet down payments to doctors and hospitals. The only person (in the federal government) to have really explained this is the Office of the Medicare Actuary, which actually produced a chart showing how bad things are going to be. Medicare payment rates will fall below Medicaid rates in 2019 and fall increasingly behind Medicaid in future years.

Were there the political will to do this, Medicare enrollees would be getting Medicaid-like services in just a few years and, beyond that, the elderly and the disabled would be in a completely different (and inferior) health care system. The problem is, there is not a smidgen of evidence that the political will is there.

Experimenting with Pilot Programs. The third major weapon is the funding of pilot programs to try out different ways of reducing costs and improving quality. But how can pilot programs be valuable? They can't, unless there is a way to "copy and paste" anything we discover that we like. The problem is that we already have a slew of "natural" pilot programs — islands of excellence that have sprouted up here and there throughout the health care system. And although many of these have been studied, no one has found a way to replicate them.

So here's the bottom line: The new health reform law does have three notable cost-control mechanisms — two of which are very aggressive. None of the three, however, are likely to achieve their objective.