

Perspective

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## Cost Control after the ACA

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*This Perspective explains why implementation analysis of the cost control provisions within the Patient Protection and Affordable Care Act is not particularly useful. These provisions are either relatively straightforward or, more commonly, so flawed that successful implementation is highly unlikely. The analysis shows that effective and equitable cost control will require coordinating payers to create all-payer fee setting. This poses significant challenges but has been implemented relatively successfully in many countries. The balance of the article uses experience with all-payer systems in other countries and fee setting within Medicare to identify key choices within any all-payer system. It highlights the importance of simplifying considerations and focusing on outcomes—the incomes of providers and total spending—rather than engaging in a hopeless search for technocratic payment “accuracy.”*

The 2010 legislation known as the Patient Protection and Affordable Care Act (ACA) calls for many dozens of reforms that pose extensive implementation challenges (for just a small sample, see Jost 2013). Reform advocates, especially President Barack Obama, promised to “bend the cost curve” so that people who were already insured would not have to worry as much that their insurance would become unaffordable (Nather 2009; Wayne and Armstrong 2009). It appears reasonable, therefore, to consider implementation of cost control measures as part of this special issue on public administration challenges after health care reform.

Yet the extensive analyses posted on health policy billboards such as the *Health Affairs* blog give little consideration to measures to limit the cost of health care for the general population. Nor have such measures—other than nonexistent “death panels”—received much attention in broader politics. Public opinion data show little sense among respondents that the law will help control costs for most voters (Kaiser Family Foundation 2010a, 2010b). Mainline public opinion analyses do not even report on opinions about specific cost control measures (Brodie et al. 2010; Kaiser Family Foundation 2011a, 2011b).

This minimal public attention to spending control measures is easy to explain: the ACA includes few credible cost controls beyond its fee limits within Medicare. “Credible” here means “measures that traditional budget analysts who rely on evidence can project will work.” The Congressional Budget Office (CBO) expressed its skepticism about much of the proposed cost controls in the ACA before the legislative process began (CBO 2008) and then predicted hardly any savings outside of Medicare for the legislation as drafted and passed (CBO 2009, 2011).<sup>1</sup> Some eminent analysts have even argued that it was possible to pass legislation only by downgrading the goal of controlling costs (Altman and Shactman 2011).

### The Weak Cost Controls in the ACA

The ACA is a “patchwork” that seeks to mend the many holes in U.S. health insurance (Marmor and Oberlander 2011). It is a product of political compromises designed to win support from the most conservative Democrats. It also was shaped by years of discourse within the health policy community, which has promoted a view that cost control requires reorganization of how medical care is delivered. These views argue especially that geographic variations in medical practice show that care is unscientific, that it needs to be rationalized, and that rationalization would make the system more efficient (Berwick and Hackbarth 2012; *Health Affairs* 2012b; Skinner 2011; White 2011).

As a result, the legislation’s measures to “bend the cost curve” include a laundry list of pilot programs and attempts to induce more “rational” behavior. It promotes—but does not mandate—changes in how medical care providers are paid, how they are organized, and how care processes are validated. These ideas, such as “pay for performance,” “medical homes,” “comparative effectiveness research,” “health information technology,” and more “evidence-based medicine,” form an aspirational agenda that is shared throughout the health policy world in the United States and abroad. It is aspirational because, in spite of their popularity

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among experts, these approaches, with rare exceptions, have not been implemented anywhere to any significant extent.

Some eminent scholars believe that the ACA's call for pilots of many of these ideas will eventually rationalize the delivery of health care and save boatloads of money. Yet this create-test-succeed-expand process could not have significant effects outside of Medicare, even if the pilots succeed, before 2020. And, as the CBO and others have argued (e.g., Alliance for Health Reform 2008; Marmor, Oberlander, and White 2009; Oberlander 2010), the assumptions behind the reform theories can be very difficult to meet. Some presume measurements that do not exist and may never be agreed upon. Some rely on technical innovations that sound attractive but will become very controversial as soon as they are reduced to details.

Many of the obstacles to this aspirational delivery reform agenda can be illustrated through looking at one of the most prominent ideas, "accountable care organizations" (ACOs). ACOs are supposed to be created and show their worth in the Medicare Shared Savings Program, after which, if all goes well, they will come to dominate the private medical market. ACOs are meant to "manage care" but be more popular than health maintenance organizations (HMOs) because patients will not be forced to join them. Instead, organizations will be held responsible for the costs of care for patients who are deemed to be part of the ACO but are free to go to other providers.

Advocates assert that organizations such as Kaiser Permanente and Geisinger Health System (Dentzer 2010) show that ACOs can be created. These organizations, however, tend to have members who know they are members and/or are dominant providers in their communities—so there is likely to be little spillover to other providers. Moreover, decades of experience show that "a rare and fortuitous combination of circumstances" was "needed to incubate the kind of large multispecialty groups on which true HMOs are built" (Iglehart 2004, 35). ACO theorists believe that payment incentives will somehow overcome the market and organizational factors that inhibited wider development of true HMOs—and that having less control of the patients will not make it much more difficult to implement cost controls. These are not plausible assumptions. The evidence that ACO-like organizations will yield significant savings is therefore quite weak (Gold 2010; *Health Affairs* 2012a).

The process of drafting rules for the Medicare Shared Savings Program has not justified optimism. As one summary by ACO advocates put it, "perhaps the greatest concern with the initial rule was the requirement that all ACOs bear risk by year three." That means be accountable if they actually increased costs. "Under the final rule," instead, "participating providers can join a three-year, shared-savings-only, version." That is, they would not be responsible for extra costs (McClellan and Fisher 2011). This is good news if one wants to promote ACOs, but not so good if one expects them to save money.

Other cost control theories within the ACA also have little support from the literature.<sup>2</sup> More optimistic analysts respond basically with faith and anecdotes. As one example put it, "there is not much evidence in the published literature on policy reforms short of severe

constraints that save large amounts of money. And for every study that does show savings from baseline, there is another study that does not." Therefore, these authors concluded that "it is imperative to cast a wider net than traditional evidence standards" (Cutler, Davis, and Strembeckis 2009, 10).

Absent "traditional evidence," analysis of how to implement most of the supposed cost controls in the ACA seems like a waste of time. We can wish the Centers for Medicare and Medicaid Services (CMS) good luck and hope that some of the pilots are encouraging. However, we simply do not have information about how to administer intentionally imprecise ideas. The lack of attention in the blogs and public opinion fits the CBO's judgment (2008, 2009, 2011) that there is little "there" there.

CBO did, however, project savings from two kinds of cost controls within the ACA. The first consists of fee restrictions within Medicare. The second involves limiting the extent of insurance.

Some critics claim that the Medicare rate regulations will not happen. They cite the fact that presidents and Congress have continually prevented physician fee reductions that are required by the sustainable growth rate (SGR) mechanism legislated in 1997. "Sustainable" spending increases would be no more than the percentage increase in per capita gross domestic product (GDP); the SGR calls for physician fee cuts if increases in the volume of services would cause faster growth in Medicare's physician expenses (Holtz-Eakin and Ramlet 2010). Arguments emphasizing the SGR ignore the long history of other successful fee restrictions within Medicare (Horney and Van de Water 2009). Because of this better restraint of prices, Medicare spending has grown more slowly than costs paid by private insurance (Hurley, Strunk, and White 2004; MedPAC 2008; White 2007). The CBO projects that measures such as reducing payment updates for hospitals will work because there is a history of them working.

The exceptional case of the SGR does point to some lessons about how payment restrictions should be implemented. These issues, however, apply to rate regulation under any circumstances rather than only in Medicare. We will look at those issues later in this analysis.

The other cost controls for which the CBO gives credit would reduce spending by reducing insurance, either through not covering some services (delisting) or requiring patients to pay a larger portion of the charge for a service (cost sharing). If the government pays for less coverage, then government spending may be reduced even if total costs are not. There are exceptions—for example, if making prescription drugs less affordable causes patients to skip medications and therefore require hospitalization (Goldman, Joyce, and Zhang 2007). Increased cost sharing may also reduce necessary care and be especially harmful to sicker people with lower incomes.<sup>3</sup> Nevertheless, the CBO (2012) properly scored the budget savings from the major version of this approach in the ACA: the "Cadillac tax."

This is actually an excise tax of 40 percent on "high-premium insurance plans," scheduled to take effect in 2018. Its advocates within and outside the administration say the tax would discourage insurers

from offering supposedly luxurious (so-called Cadillac) benefits. If employers then cut the value of the plans they sponsor, that would reduce the value of the average tax preference for health insurance, which, in turn, would raise federal revenues. From a budgetary perspective, this does not depend on the effects of cost sharing on patients or even total spending, so long as the total value of insurance is lower.

Critics (including myself) have argued that when insurance plans are particularly expensive, that is explained mainly by their being in high-cost areas and serving groups with sicker members (Gabel et al. 2010). Therefore, the “Cadillac tax” is more like an “ambulance tax,” discriminating against those who need coverage most.<sup>4</sup> Similar objections from congressional Democrats led to scaling back of the original Senate proposal (Van de Water 2010).

For each plan, the Internal Revenue Service (IRS) must determine total spending and the age distribution of the covered population in years that have already been completed, each of which employers can be required to provide and should know. Perhaps discretionary spending in 2018 will be so brutally restrained that the IRS is not able to do its job. Yet we cannot give any advice about that (other than generic advice against irresponsible discretionary spending cuts). Moreover, some of the effect of the excise tax will be nearly automatic and also sooner than in the estimates, as employers are already looking to reduce benefits so as to ensure that the tax does not apply to their coverage (Sammer 2012).

The excise tax might not be implemented because it is not at all popular (White 2011). Yet we should remember that conservative Democrats, Republicans, and most of the economic profession have supported this general approach, and budget constraints will inhibit repeal. So we cannot know how political conflict will shape the excise tax's future. Yet it seems fair to say that regardless of its policy merits, the excise tax poses normal administrative challenges—meaning that it is possible to imagine how it would be administered. Even the threat of implementing it can have some of the projected effect.

Unfortunately, the excise tax is even less likely than the aspirational agenda to accomplish what average citizens want: to make care more affordable. It is designed to make care less affordable, especially for people who most need help paying for care.

If the ACA's cost control measures are quite unlikely to accomplish what most citizens think cost control would mean, then the question of public administration challenges in the future should be rephrased. *If* political leaders decide to pursue cost controls that might work without contradicting the basic purpose of health insurance—namely, to ensure that people receive necessary medical care—what would be the public administration challenges? The answer must begin by identifying the right policies.

### The Need for Price Regulation

Health costs in the United States, as a share of the economy, are nearly half again larger than in all other countries. By one standard calculation, in 2010, the United States spent 17.6 percent of its GDP on health; second place went to the Netherlands at 12 percent (OECD 2012).

The Organisation for Economic Co-operation and Development and other researchers have established that other countries' systems are less expensive mainly because they spend less on administrative overhead and pay lower prices for services (Anderson et al. 2003; Angrisano et al. 2007; Ginsburg 2008; Pearson 2009). The more aggregated data about prices in some of these studies are supported by research on specific services, such as primary care office visits and physician services for hip replacement (Laugesen and Glied 2011).

Higher expenditures in the United States have little to do either with excess amounts of care or with social and individual failings that create extra need for care, such as the “obesity epidemic.” The United States does not have unusually high volumes of care per person, partly because it has particularly low levels of physician visits, hospitalizations, and lengths of stay (Angrisano et al. 2007). Nor does the disease burden argument hold up when put in comparative perspective. While need is increased by obesity in the United States, it is reduced, compared to other countries, by factors such as low rates of smoking and a younger population. The McKinsey Global Institute's analysis concluded that, for 2006, “U.S. disease prevalence does not explain any portion of the nation's \$650 billion in spending above expected” (Farrell et al. 2008, 88).

High prices help explain even the cases in which U.S. volume is unusually high. This includes some outpatient services, for which much higher capacity in the United States is believed to induce excess services. As Paul Ginsburg writes, “U.S. costs in outpatient settings are higher because of subscale operation of facilities. With prices very high, outpatient facilities in the United States can earn a profit despite underutilizing capacity” (2008, 10). When the Medicare program reduced fees for imaging done at outpatient facilities to the level paid to hospitals, the number of imaging centers declined, and with that, utilization growth slowed (Lee and Levy 2012).

Both prices and administrative costs are high because of *uncoordinated* payment by the thousands of insurance plans within the system. Uwe Reinhardt has extensively documented the variation that results:

[I]n New Jersey . . . I asked an insurer a very silly question—what do you pay for a colonoscopy. And he said what do you mean? You cannot answer that. It turns out the prices they pay to different hospitals vary by a factor of three. In California I asked the same thing. Give me some prices for an appendectomy. It ranged anywhere from \$800 to \$13,000. So I'm not sure what this market actually needs. There are no prices in this. It is whatever you can grab and negotiate. (Alliance for Health Reform 2008, 18)

This variation creates administrative costs for insurers (which must both negotiate and then keep track of all the different prices from all the different plans they manage for all the different providers) and for providers (which must maintain elaborate billing operations to deal with the insurers). At the same time, fragmented insurers, except in quite uncommon circumstances (White 2007), have not had the bargaining power to drive prices down toward the levels achieved by payers in other countries. If anything, recent years have

seen hospitals and specialty medical groups increasing their market power (Berenson et al. 2012; Reinhardt 2012).

From 1970 to 2006, Medicare spending per enrollee rose, on average, by about 1 percentage point less per year than spending for the privately insured (MedPAC 2008, 9). This was certainly not achieved by reducing volume or “managing” care; instead, it resulted from Medicare’s greater ability to restrain prices (Hurley, Strunk, and White 2004). Medicare’s advantage over private insurers is recognized by opponents of regulation who claim that hospitals and doctors “cost shift” to the private sector (Reinhardt 2011). Even the period when “managed care” was associated with relatively stable costs is explained by temporary success in restraining prices rather than by actually managing care (Gold 2010, 5–6; for an extensive discussion, see White 2007).

Some analysts may believe that price restraint is not effective because providers will maintain incomes by increasing the volume and intensity of services. The CBO rebutted this claim, reporting that “a decline in the amount that a provider is paid would generally be expected to result in fewer services being delivered. That type of response has been observed in skilled nursing facilities and home health agencies, and there is some evidence that it occurs in hospitals” (2008, 109). Physicians’ own services are different, and in some cases, doctors induce further demand in an attempt to offset the effects of fee constraints. Those efforts, however, have only modest success. The behavioral response to physician fee cuts is estimated to offset only 25 percent to 30 percent of the savings (CBO 2008; Medicare Actuaries 1998; Technical Review Panel 2000).

Prices were not visibly on the agenda for system-level cost control during the 2009–10 debate, partly because the Obama administration expected that would turn the doctors, drug companies, and hospitals against reform. The only serious advocacy for cutting costs by limiting prices was indirect, in the arguments for a “public option” that would pay something resembling Medicare prices for non-Medicare enrollees (Holahan and Blumberg 2008).<sup>5</sup> The politics was also shaped, however, by belief among leaders of the administration, business leaders, and key Senate Democrats that costs could be reduced by 30 percent or more if unnecessary care were eliminated through the measures of the aspirational agenda (Skinner 2011; White 2011).

This view identified the basic problem as “fee-for-service” payment, on the grounds that paying per service induces extra services. The aspirational agenda was supposed to change these incentives. Advocacy for such measures helped build a groupthink that ignored an evident fact: the big difference between the United States and other countries is not that the United States uses fee for service, but that the fees per service are much higher in the United States.

In most countries, such as Australia, Canada, France, Germany and Japan, fee for service is the normal mode of paying physicians. Moreover, in spite of the good reasons to bundle payments, there has been some increase in reliance on “activity-based payment.” This is especially shown by a move from hospital budgets to payments per hospitalization (Busse et al. 2011). “Pay for performance” in England has made fees for individual services a larger part of general practitioners’ compensation (Doran and Roland 2010). Medicare’s

own success relative to U.S. private insurers further shows the importance of targeting the level, rather than the existence, of fees per service.

Since passage of the ACA, cracks have grown in the wall of groupthink against the evidence about prices. Studies by MedPAC and others have explained how the emphasis on volume is overstated (for sources, see White 2011). Recent overviews indicate that “overtreatment” is only a modest portion of supposed “waste” in the health care system (Berwick and Hackbarth 2012; *Health Affairs* 2012b). A group of leading health policy experts, including some with long histories of rejecting an emphasis on prices, called for “A Systemic Approach to Containing Health Care Spending” (Emanuel et al. 2012), beginning with better control of payment rates within overall spending targets. Desperation is beginning to encourage some leaders in the health policy community to consider measures they had long rejected. In a telling example, one of the leading health economists in the country, Joseph P. Newhouse, listed reasons to object to “any kind of regulatory control on medical spending” but then concluded that “[d]espite all of the substantive and political problems of price setting, some sort of all-payer regulatory regime may be the only feasible alternative” (2010, 1723). In March 2013, Steven Brill’s massive exposé of hospital pricing in *Time*—the longest cover article in the magazine’s history—further documented the sometimes obscene prices in the U.S. health care system.

What, then, is “all-payer” regulation, and what are the implementation issues? The balance of this article provides an overview of major concerns related to payment and cost control. Analysis of some other issues, such as how to limit cherry-picking and other socially unproductive aspects of competition among insurers, can be found elsewhere (White 2009a, 2009b).

### **Coordinating Payment through All-Payer Rate Setting**

Other advanced industrial countries coordinate payment: even if there are multiple insurers, as in France or Germany or Japan or the Netherlands or Switzerland, there are standard fee schedules by which hospitals, physicians, or pharmaceutical companies bill the insurers.

In Canada, provincial governments set the rates amid a process of political negotiations (often contentious) with the various types of providers. In countries with multiple payers, there are two main methods. In some, a government body (e.g., the Ministry of Health and Welfare in Japan) works out the fees (again, with some form of consultation with providers). In others, such as Germany, the government encourages (or organizes) the payers into bargaining cartels that then negotiate with organizations of providers. Either way, bargaining power on the payer side is much more concentrated than in the United States (Reinhardt 2012).

All-payer rate setting can include some variation. The Japanese system has a standard fee schedule, but cost sharing is lower for the elderly. In Germany, about 10 percent of the population is covered by private insurers that pay higher fees (in return for what their enrollees expect will be preferential service). In both France and Australia, some physicians can “extra bill” above the standard fees. There is much less variation for any one payer to manage, however, and even less for any provider to manage. Standardized rates

change the politics of cost control. In the United States, in spite of the academic arguments against the theory of “cost shifting,” many business representatives have worried that controlling costs for Medicare increases costs for them. Limiting prices for all payers therefore would unify the payers politically as well as for bargaining purposes.<sup>6</sup>

Compared to the United States, any all-payer system dramatically increases payer power, must substantially reduce billing expenses, and should improve the political support for cost control. Systems vary substantially, however, so we turn now to some of the important choices in implementing all-payer fee setting.

First is the unit of payment. Hospitals, for example, could be paid for each individual service (including aspirin or saline solution). They could be paid a set rate per inpatient day (the major method for many U.S. private insurers), or a set fee according to the patient’s diagnosis (as in Medicare’s Prospective Payment System), or given a budget for the year. The fee schedule for doctors could be quite detailed, as in the United States, or relatively vague and uninformative, as in France.

In the United States, the simplest approach to defining units would be easiest to implement because it would build on systems that are already accepted: pay hospitals according to the Medicare diagnosis-related prospective payment categories, and physician and other ambulatory services by adapting the current Medicare fee schedule. Each schedule might require some adjustment because certain services (e.g., pediatrics, obstetrics) are not common for the Medicare population. Medicare’s physician fee categories, however, are already the basis for many private insurers’ payments.

### Relative Values, Conversion Factors, and Volume Adjustments

Any fee schedule, then, involves two further dimensions. One is the *relative values* of different items. Intentionally or not, any system says what an arthroscopy is “worth” compared to a primary care office visit. The second dimension is the desired level of spending for the total of services in the system. Any set of relative values can be conceived as a point scale, so all services combined add up to a point total. Spending, then, depends on the explicit or implicit *conversion factor*: how much is paid for each point.

The spending goal may be a *target* (the basis for setting a conversion factor but without particular enforcement), a *cap* (so somehow enforced), or something in between (with enforcement measures that are weak or uncertain). Budget projections presume a volume and mix of services, so enforcement requires some sort of *volume adjustment*: if there are more services than expected, then, in some way, prices must be further reduced (or, if fewer services, raised). Germany over many years provided the model for a hard cap: physicians billed according to the points of the relative value scale, and at the end of each quarter, the points were added up, divided into a negotiated budget for the geographic area, and the conversion factor calculated retrospectively to fit the budget.

How, then, will relative values and conversion factors be established? Who will set the categories, how often will the categories and their relative values be changed, and by whom?

The default in most systems has been for the political authorities and/or insurers to focus on the conversion factors and leave more influence over relative values to physicians. This makes sense because the payers care more about the totals and less about physicians’ relative incomes. This norm, however, has distinct disadvantages.

Developments in technology can reduce the cost of delivering some services. Technology or other factors can increase demand for some services (e.g., scans) more than others (e.g., primary care visits). Volume increases, whether caused by greater productivity for a service or simply greater demand, should be associated with lower costs per service as fixed resources are used more intensively. Changing only the conversion factor, then, cuts some providers (e.g., general practitioners) because others (e.g., radiologists) are earning more. Hence, reducing the relative value for such services is normally better policy.

Policy makers will want to involve providers in setting and adjusting the relative values, both because the latter have some expertise and because it is better to implicate some of them in the results than to allow all providers to unite against the regulations. Any such processes will favor some providers over others. In 1961, the French increased general practitioners’ representation because of concerns that specialists had been favored (Glaser 1970). In Japan, doctors who practice outside hospitals are represented, and hospital physicians basically are not. This leads to fees that favor doctors in private practice (Campbell and Ikegami 2008). The Medicare physician fee-adjustment process is led by the American Medical Association’s Relative Value Update Committee; specialists greatly outnumber generalists, and critics argue that as a result, annual updates favor specialists and do not sufficiently recognize developments that would justify relative fee reductions (Eaton 2010; Hackbarth 2007; Laugesen, Wada, and Chen 2012; Mathews and McGinty 2010). Therefore, policy makers must structure the consultation process so as to encourage the results that best fit policy goals. As in any situation that involves interests in administrative policy making, the potential gain in legitimacy or acceptance risks loss of authority and effectiveness.

A related question is equally fundamental, though less recognized, in the U.S. debate. What standards will guide decisions? In the United States, the discussion is continually framed in terms of “accuracy,” that is, determining prices that fairly reflect costs (e.g., Hayes, Pettengill, and Stensland 2007). As David Frankford writes, American policy makers have assumed that “health care can be rationally allocated if it can be measured through appropriate technologies” (1994, 647), and both the diagnosis-related and resource-based relative value scale (RBRVS) systems set prices through such measurement of input costs. Unfortunately, such measurements are flawed, for at least four reasons (for more extensive discussion, see Rosenbaum et al. 2012, chap. 12).

First, even if one can observe input costs, that does not reveal whether those costs are appropriate. Second, costs are very difficult to observe, and the people delegated to provide data may use inappropriate methods. This appears to have been a particular problem in the United States, where data gathering has tended to be delegated to specialty societies (Braun and McCall 2011). Third, in hospitals especially, there is a huge amount of overhead for which there is no agreed allocation formula (this is how hospitals have

justified claiming costs of \$100 or more for giving a patient saline solution). Finally, for any service, but especially for physicians, one of the core inputs is reimbursement of personnel, and there is no objective standard for that. One may operate with some notion of how physicians' average incomes should compare to the national distribution, such as being at the 95th percentile (Feldstein 1970). If medical care is financed collectively, however, this is inherently a social choice: how much of everyone else's income to allocate to the health care industry.<sup>7</sup>

Current Medicare rate setting subordinates both the real policy goals and actual political concerns to a technocratic rationalization. For example, the CMS developed practice expense differentials "to more accurately compensate physicians when they furnish procedures in their offices versus in other ambulatory settings." So CMS paid doctors more for services provided in their offices (Maxwell and Zuckerman 2007–8). It would make more sense to pay all services at the price associated with the most efficient site, thereby discouraging less efficient delivery.

It is simply a mistake to think of fees as "reimbursement" rather than, more simply, "payment" (Reinhardt 2012). As the chair of MedPAC testified, instead of basing fees on "input costs," Medicare physician payments might instead consider the "value of the service and the price needed to ensure an adequate supply" (Hackbarth 2007). "If the United States wishes to contain health care spending," two close observers of international practice advise, "it should rethink the basic assumption that providers should be compensated for their costs. Instead, payments should reflect the relative income of different groups of providers and what the country can afford" (Ikegami and Anderson 2012, 1055).

Policy makers should consider the physicians' incomes when shaping relative values for physician fees. For hospitals, the indicators that should guide policy are a bit different. If some services are more profitable than others, that might result in increased volume but will also be revealed by capital investment in those services and increasingly generous contracts with the relevant specialist physicians—as has been especially common for cardiac procedures (Ginsburg and Grossman 2005; Hayes, Petengill, and Stensland 2007). Rising sales of any drug inherently justify lower prices, as the development costs are spread over more units.

Updates should be frequent, both to deal with "unexplained increases in certain procedures" (Busse et al. 2011, 159) and to manage innovation. This will involve both creating new payments when it seems appropriate to encourage an innovation and then lowering payments as the innovation is diffused. A reasonable approach would be to have an expert technical organization make proposals and final decisions, with a formal process for provider organizations to provide evidence for alternatives—a more constrained version of notice and comment rulemaking. The Independent Payment Advisory Board created by the ACA could play this role. The current Relative Value Update Committee could be a model for formalizing providers' response—as opposed to its current much more powerful role.

These observations fit the challenge of updating within a category of services. If spending targets or caps are meant to be global, however, a

further issue is how to relate categories of expense—such as pharmaceuticals, medical devices, physicians, and inpatient care. This is clearly a political call that will depend on the strength of each interest. The Japanese provide an interesting model: after setting a spending increase target, they normally set lower targets for drugs, adjusting prices accordingly, so as to allow less restraint of physician fees.

Both priorities among service categories and how tightly to enforce caps are political decisions. Yet whether caps are as tight as in Germany or adjustments are made less strictly and with a lag, it is vital that they address relative values in a timely manner.

## Variations and Exceptions

Other choices involve what variations to allow.

States or other geographic units vary in both input costs for services and the volume of services, which, in turn, are attributable to differences in capacity, health burden, and local practice styles. For both reasons, spending per capita is much lower in North Dakota than in south Florida.

Although it may seem fair to adjust for input costs that are relatively uncontrollable, such as differences in rent levels, policy makers could have reasons not to do so. Such inputs tend to be more expensive in urban than in rural areas. Hence, standard national fees could provide higher net incomes in rural areas and help attract physicians to those areas. Geographic adjustments can also lead to arguments that lines are drawn unfairly (e.g., that the labor market for a hospital in one county may include another county). On balance, adjustments for factors such as rent and wage levels make more sense for hospitals than for physicians, and any adjustment for physicians should consider whether doctors are choosing to live somewhere in spite of higher expenses.

More intensive practice patterns in some areas will lead to higher spending than in others. Moreover, the distribution of services varies: for example, some areas have relatively more interventional cardiac care, and some have more medical management. Some have more hip replacements and some more knee replacements. These practice variations suggest that both conversion factors and relative values need to be adjusted at subnational levels.

The sheer size of the United States also suggests that fee setting or negotiation should be conducted at the subnational level—as is also true in Germany. Logically, it should follow the boundaries of the new health insurance exchanges. If all the funds for care in one area were raised in that area, we could say that both specific fees and total spending should be decided in that area. In areas with higher volume, payers could choose between raising more money than is spent in other areas and ratcheting down fees more strictly. Because much of the funding in any region will come from the federal government, however, it must influence regional spending targets.

Should there be any variation in payments according to whom is paying—as in Germany, with private insurers paying more than the public law sickness funds, or in the United States, where Medicaid on average pays less than Medicare, which pays less than private insurers? In Germany, the privately insured pay more for what they hope is more attentive service. Although not ideal, this could be

viewed as an “escape valve” that reduces pressure for higher overall fees or other forms of inequality among patients. Yet paying a bit more for small numbers of people is more defensible than paying a lot less for large numbers. Because Medicaid fees are much lower than other fees in the United States, many physicians reject new Medicaid patients, and so the difference in the United States punches holes in the safety net (Kaiser Commission 2012).

Neither the sources of payment (public versus private) nor enrollee characteristics give good reason for some payers paying more than others. Yet once this exists, it is very difficult to fix. As Ginsburg and Thorpe wrote two decades ago, “With Medicare and Medicaid paying substantially less than private payers now an equal payment rate that allowed the same revenue to go to providers would require a substantial increase in public outlays” (1992, 82). Therefore, any all-payer regulation in the United States would have to begin by limiting private insurance fees to Medicare plus some percentage while perhaps raising Medicaid fees. There would have to be a phase-in toward equality, and it may never be achieved.

There are three further arguments for paying some providers within a region more than others. First, some providers may perform extra functions, such as medical education, that require extra compensation. This is not a good reason to vary fees. If the government wants to pay for medical education, it should pay directly. If it wants insurers to contribute, it should levy a charge on insurers, then pay directly.

Second, some providers believe they are “higher quality” so should be paid more. In the United States, reputation is rewarded in market bargaining between insurers and hospitals. In France, certain doctors in “Sector 2” are allowed to extra-bill while other doctors are not, so the former receive higher fees. The rationale is that higher fees provide an incentive for higher quality. One version of this argument says that equal fees provide no incentive for quality. Such a claim is absurd. A better reputation should be rewarded with more business, so higher income. Moreover, there are other motivations (such as pride) that cause people to seek good reputations. It is also very hard to measure quality, which is one reason “pay for performance” is so hard to achieve. On balance, “quality” differentials should be extremely limited and require strong evidence.

Third, some providers face different cost structures than others. Their patient population may be particularly difficult (e.g., they may have language barriers that require translators or behavioral patterns that require extra intervention to increase treatment adherence). Hospitals might simply have different built-in costs because of the nature of their physical plants or previous practices. Such factors have long been recognized implicitly, if not explicitly, in systems that paid hospitals through overall budgets. Sociological factors are legitimate reasons for higher (or lower) payments into the future, while, at a minimum, historical cost structures may require temporarily higher payments and some phase-down toward the norm. These factors are more likely to be significant at the hospital level than for ambulatory care, and so even if hospitals are paid by activity, there is a case for some variation in the conversion factors.

There is no international norm about how to handle these legitimate cost differences. On balance, it is best to limit adjustments and the

allowed reasons for adjustments—in part to avoid abuse, in part to provide incentives for efficiency, and in part to limit complexity. If a hospital’s patient population requires specific extra services, those should be covered by separate payments. Higher fees resulting from high base-year costs should be cut over time. That, however, is more easily said than done.

Of the many other issues, one in particular deserves consideration. If there is a standard fee schedule, how would that accommodate insurers and providers that wish to contract on a different basis—for example, to set up accountable care organizations with some form of capitated payments or to bundle fees for care of a chronic illness? In principle, there is no problem. Alternative payment mechanisms are supposed to allow better care with fewer or different services. Then providers should make more money for a given amount of effort, and patients should enjoy better results. If this is true, all involved will have an incentive to contract. If alternative contracts cannot outperform the value proposition from coordinated fee-for-service payment, then nothing is lost by not having them.

All-payer rate setting by itself cannot address the most basic problem with having competing, profit-seeking insurers. Competing health plans can also seek profit from recruiting a healthier pool of enrollees. This has happened with Medicare Advantage plans as they compete with fee-for-service Medicare, increasing federal spending beyond what it would have been without the competition (MedPAC 2011, 293–94). Coordinated payment, however, can also improve oversight of insurers’ total costs and risk-profiles and so help with implementing any system of risk adjustment.

## Conclusion

This article has argued that if the aftermath of the ACA leads to better control of spending, that will result from choices to go beyond the ACA’s specific provisions. We should not be so optimistic as to expect that development. Yet cost control measures become more likely as the federal government’s budgetary stakes increase. President Jimmy Carter failed to enact hospital cost controls when he targeted the whole system, but President Ronald Reagan supported, and Congress then enacted, regulatory controls for Medicare’s hospital costs. As the ACA puts a larger share of spending on the government’s budget, decision makers are likely to become more willing to take the political heat for more successful cost control (Oberlander 2011). Moreover, the menu of policy alternatives shows signs of expanding. As described earlier, health policy experts with records of opposing regulation are beginning to show more interest in the methods that help other countries control spending better than the United States does and to help Medicare control spending more successfully than U.S. private insurers.

The latter standard is not hard to meet because the uncoordinated payment in the United States maximizes the power of the providers vis-à-vis the payers. Coordinated payment through some sort of all-payer regulation or bargaining is necessary.

This article has reviewed some of the choices involved in implementing such an approach in the United States. Most of the foregoing judgments share a common theme: simpler is better. Extra functions should be paid outside the fee schedule. Policy makers should not try to “reimburse” a huge array of costs. Instead, they

should focus on the outcomes that matter: total spending, relative incomes of providers, and whether fees are causing supply shortages. Exceptions should be limited absent quite compelling evidence. The major exception to this emphasis on simplicity involves updating relative values. Updates should be more frequent and extensive than has been common within Medicare.

The suggestions here share a common view of the allocation of authority. Physicians especially, and other providers as well, should have a formal role in the rate-setting or rate-negotiation processes. The United States does not, however, have Germany's tradition of corporate governance and responsibility. Governments are also direct payers to a much greater extent than in Germany. Therefore, governments should play a role more like in Japan (where the Ministry of Health and Welfare leads fee setting) than in Germany. Yet there should be procedures that involve (and implicate) the private insurance industry and employer representatives in the rate structure as well. It is especially important that employers believe that the system serves their interests—and that providers realize it is not just the government that wants to restrain spending.

All-payer regulation would help nongovernment payers but also would be good for the federal budget. Lower payments by private insurers would reduce the tax preference for employer-sponsored insurance and the subsidies for insurance within the exchanges. Medicare's managers would no longer have to worry that Medicare fee controls will lead providers to abandon Medicare patients because of much higher payments for the privately insured (Newhouse 2010). There should be an offset from higher Medicaid fees, but those can be (and if states have any voice, will be) increased more slowly than other savings are realized. The simplified billing from coordinated payment would even reduce expenses for doctors and hospitals.

Over the past half century, the United States became the great exception in health care finance. It became both the only advanced industrial country that did not attempt to guarantee health care coverage to all citizens and the nation that spends by far the largest share of its income on health care. The ACA could eliminate some, but not all, of the distinctive lack of coverage. It is highly unlikely to alter the exceptionally high costs. Better cost control requires measures that have been used by other countries but are not part of the ACA. The political prospects for such measures remain uncertain at best, though perhaps better than they have been in the past. From a policy perspective, however, it is time for U.S. health care finance to take the great leap into the late twentieth century.

## Notes

1. In spite of concerns cited later, the budget estimates for the ACA are reasonable. They largely involve the extra revenues in the ACA and savings from direct reductions in Medicare fees. My topic here is effects on the rest of health expenditure.
2. The best summary analysis is provided by the CBO (2008). Among other sources, see Cohen, Neumann, and Weinstein (2008) on preventive care; Keller (2013) on "pay for performance"; and Vladeck (1999) on the health policy world's penchant for believing in "policy unicorns"—beautiful concepts that have not been seen in nature.
3. See Remler and Greene (2009) for a comprehensive overview. Jost and White (2010, 5–10) provide further sources and argument.

4. For examples of the two views, see Van de Water (2010) and Jost and White (2010).
5. Policy makers showed a strange schizophrenia about lower prices, however. While they barely considered using them to reduce costs for private insurance, they relied on them for budgetary savings in Medicare. Expanding coverage through expanding Medicaid was also attractive in part because Medicaid's lower fees give it lower costs—at a price of uncertain access in some cases.
6. Business organizations that opposed the public option during the ACA debate feared cost shifting from that plan to large employer plans as well. Allowing all payers to pay the same fees as the public option plan would have "leveled the playing field," but this was rarely suggested (White 2009a, 2009b).
7. For this reason, it might be useful to inform physicians of how well they are doing compared to the average person (Glaser 1970).

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