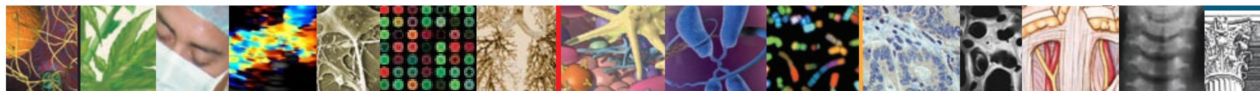

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Perspective

Systemwide Cost Control — The Missing Link in Health Care Reform

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Successful health care reform requires effective control of health care spending — without it, rising costs will continue to strain federal and state budgets, businesses, and families, jeopardizing gains in insurance coverage. The reform legislation now before Congress, however, cannot be relied on to control spending.

The Obama administration and others have emphasized the cost-saving potential of prevention, comparative-effectiveness research, disease management, and health information technology. But there is little evidence that these worthwhile measures would produce meaningful cost control over the next decade.[1] The Congressional Budget Office (CBO) has consequently forecast scant savings from these sources, fueling debate about the affordability of reform[2] and raising concerns among fiscally conservative Blue Dog Democrats, without whom health care legislation cannot pass.

In response, the administration has touted a proposal establishing an Independent Medicare Advisory Council (IMAC). The council would, along with the President, have broad authority to change Medicare rules in order to reduce program spending. Yet the scope of the savings that may be achieved through IMAC is impossible to know. And any savings would be limited to Medicare — a modest part of national health care spending.

Other cost-control proposals are more tangible. The Obama administration and Congress have proposed significant cuts in projected federal spending on Medicare over the next decade that largely involve reduced payments to hospitals and private Medicare Advantage plans. These savings, though, would be partially offset — at least in the House legislation — by the cost of canceling scheduled cuts in physician payments.

Moreover, there is a sharp distinction between restraining government spending on medical care and restraining systemwide spending. Slowing the growth of federal Medicare expenditures would not guarantee spending restraint outside Medicare. Indeed, to some extent, medical providers could respond to reduced Medicare income by shifting costs to private payers.

Nor would creating a new public insurance program guarantee that national health care spending will be restrained. With lower

administrative costs and greater purchasing power, such a plan could provide less expensive coverage than that offered by private insurers. This, in turn, could lead private plans to find ways to reduce premiums to stay competitive, potentially generating substantial savings.[3] But the public-plan proposal has been steadily weakened during the reform debate. Senate Finance Committee leaders have indicated that they intend to pass a bill with no public plan. And the strongest proposed public-plan model, in the House bill, would, according to the CBO, enroll only 10 million persons — about 3% of the population — in 2019. With such limited enrollment, such a plan would not make much of a dent in national health care spending.

The missing link in reform legislation, then, is any mechanism with the potential for systemwide control of medical spending. One straightforward way to achieve that goal would be to adopt a single-payer plan — but that would displace the private insurance industry and remains politically infeasible.

There is, however, another option that could control spending across both the public and private insurance pools. Other countries that have multiple insurers, such as Germany, Japan, and the Netherlands, use all-payer regulation to control costs. In these countries, insurers come together to negotiate, or the government takes the lead in setting, common payment rules for medical care. With a few exceptions, payments to all doctors in a given geographic area follow a standard fee schedule. Hospitals are also paid on comparable terms.

All-payer regulation has four major advantages.[4] First, prices are significantly lower in systems with such regulation — “all-payer systems” — than in the United States. Lower prices are, in fact, the main reason why other rich democracies spend much less on medical care than we do. U.S. health policy analysts often assume that we can control health care spending only if fee-for-service payment is jettisoned. Yet efforts to contain costs are much more effective in those fee-for-service systems that regulate fees. An all-payer system would allow us to establish systemwide, enforceable spending targets. If the volume of one service — for example, imaging — increased quickly, fees could be adjusted accordingly. And if policymakers decided to increase payments in pursuit of other goals — such as increasing the number of primary care doctors — then payments could be adjusted across the board to ensure maximum effect.

Second, all-payer regulation reduces concerns that costs will be shifted rather than reduced and would create a fairer payment system. Currently, employers may worry that better control of Medicare spending could lead providers to shift charges to private payers. But an all-payer system would put employers and government in the same boat, broadening the constituency for cost control. Moreover, a fully implemented all-payer system would reduce access problems associated with price discrimination. The goal would be to eliminate or substantially narrow the differences in what various insurers pay for medical services. The result would be a much fairer payment system for providers, who are now punished financially for seeing patients who have no insurance or who receive Medicaid. Given the current payment disparities among Medicare, Medicaid, and private insurance, there would have to be a transition period during which differences would be narrowed. Still, an all-payer system would immediately simplify health insurance by standardizing fee categories and reducing payment disparities among private insurers.

Third, setting standard rules would simplify billing and reduce the related confusion and expense. The staggering price variation in the U.S. health care system[5] would end, significantly reducing administrative expenses for providers who must now maintain costly billing systems and administrative staffs to cope with different insurers’ disparate rules. Standardization would also create more transparency for consumers, who could more easily determine what prices insurers were paying for services and thus their appropriate copayments.

Finally, a public insurance plan and private insurers could coexist. Concerns that the public plan would use its purchasing power to offer less expensive coverage and crowd out private insurers would be eased, since all insurers would pay similar rates. Many legislators have sought to protect the insurance industry by weakening the public plan. Instead, Congress should strengthen private insurers’ capacity to control costs alongside the public plan through all-payer regulatory reform.

An all-payer-regulation strategy should appeal to businesses, since it would help to slow rising premiums for employer-sponsored health insurance. It should similarly appeal to workers who worry about the growing costs of coverage. And it would provide fiscal conservatives with an effective cost-containment tool.

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The medical community should also find much to like in all-payer regulation. By limiting contracting and billing expenses, it can reduce physicians' administrative overhead. By insuring everyone and narrowing or eliminating gaps in payment, it can allow providers to treat all patients on the basis of their medical condition, not their finances. And by creating systemwide cost control, it would ensure that responsibility for controlling costs is shared by all, rather than concentrating the burden on providers who treat Medicare patients. In addition, all-payer regulation addresses important political constraints: the opposition of the President and most legislators to eliminating the private insurance industry, the urgency of cost control for many Americans, voters' preference for minimal disruption — if any — of their own coverage, and the fiscal crisis that renders cost control essential.

Health care reform cannot be financed by seeking savings only from Medicare. It cannot be made affordable through the overly optimistic agenda of delivery-system reform with which many advocates began this year's debate. It is time to turn to approaches for which the evidence is much stronger. An all-payer system offers the best hope for health care reform.

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1. Marmor T, Oberlander J, White J. The Obama administration's options for health care cost control: hope versus reality. Ann Intern Med 2009;150:485-9.

2. Congress of the United States. Budget options, volume 1: health care. Washington, DC: Congressional Budget Office, 2008. (Accessed August 25, 2009, at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.)

3. Hacker JS. The case for public plan choice in national health reform: key to cost control and quality coverage. Berkeley: University of California, Berkeley, School of Law, 2008.

4. White J. Cost control and health reform: the case for all-payer regulation. Washington, DC: Campaign for America's Future, 2009. (Accessed August 25, 2009, at http://www.ourfuture.org/healthcare/white.)

5. Reinhardt UE. The pricing of U.S. hospital services: chaos behind a veil of secrecy. Health Aff (Millwood) 2006;25:57-69.

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