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Bending the Cost Curve

A Critical Component of Health Care Reform

Stephen M. Shortell, PhD, MPH, MBA

THE ESTIMATED 10-YEAR COST (2010-2019) OF EXPANDING health insurance coverage is at least \$1 trillion. New revenue sources will not cover this cost. Thus, to make such coverage affordable, it is necessary to “bend the cost curve” in the rate of annual increases in health care spending, which in most years has significantly exceeded the overall rate of inflation. This will require addressing the underlying determinants: primarily the behavior of patients, hospitals, and physicians as they use available technologies and treatments.

Prevention, Patient Behavior, and the Community

Disease prevention initiatives aimed at improving nutrition, physical activity, tobacco use, and related lifestyle behaviors are likely to have the greatest effect on slowing the annual increase in health care costs. This is because they have the largest influence on reducing the future burden of disease, particularly in regard to obesity and the sequelae of diabetes, heart disease, and cancer.¹

Evidence suggests that investment in physical activity, nutrition, and smoking cessation yields a 5-fold greater return in cost savings² than that documented for most clinical preventive services, owing to the inability of identifying the specific high-risk populations likely to benefit from such interventions as opposed to across-the-board screening and testing.^{1,3} Current health reform proposals that would allocate \$10 billion for a Prevention and Wellness Fund targeted to promoting healthier lifestyles and communities represents a major step toward slowing the annual increase in health care spending over time, given the current evidence on return on investment.

Hospital and Physician Behavior

Key to changing hospital and physician behavior is changing the financial incentives and establishing accountability for both cost and quality of care through performance measurement and public reporting. Capitation, partial capitation for selected conditions, bundled payments, and episode-of-care–based payments create incentives for hospitals and physicians to work together. Provided that predetermined quality criteria are met, those who can provide care for less than the risk-adjusted established payment would share in

the savings. Current laws prohibiting gain-sharing will need to be modified to permit such savings.

Additional bonus payments to physicians willing to serve as care coordinators also could be made, particularly for those practices meeting the criteria of a patient-centered medical home (PCMH).⁴ The Medicare Payment Review Commission (MEDPAC) could also recalibrate the Relative Value Scale formulas to provide increased payment for more time-intensive patient interaction and primary disease prevention services.

Role of Accountable Care Organizations and Medical Homes. Hospitals and physicians should be offered choices in how they choose to respond to the new incentives. These choices can be described under the umbrella concept of accountable care organizations (ACOs)^{5,6}—organizational structures within which physicians, hospitals, and others can work together to improve cost and quality performance and be held accountable for the results produced. Options include existing integrated delivery systems, multispecialty group practices, physician hospital organizations, independent practice associations, and virtual physician organizations of smaller practices that group together to share resources for purposes of quality improvement, care coordination, performance measurement, and public reporting of data.

New payment incentives could be linked to the ACOs in the following manner. Based on current utilization data, Medicare beneficiaries could be assigned to a physician who in turn is a member of or associated with an ACO.⁶ The most recent 3 years of risk-adjusted utilization and cost data could be used to establish a spending target for the group of physicians and hospitals associated with the ACO. The physicians and hospitals associated with the ACO would then share in any savings from providing care that meets quality standards at a cost lower than that established by the spending target. Hospitals and physicians choosing not to participate in an ACO could still be eligible for quality bonuses and efficiency rewards for implementing electronic health records, pay for reporting, or pay for performance programs, but they would not receive rewards of the magnitude available to those who are a part of an ACO. In the long run, physicians not participating in such accountable in-

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centive payment systems might be subject to reductions or penalties in updates of the MEDPAC fee schedule.

Hospitals and physicians associated with ACOs should be free to choose how they wish to organize, but one promising approach is to establish PCMHs.⁴ A medical home can be a single primary care physician with support staff, a small group of primary care clinicians, or a large multispecialty practice. The advantage of establishing PCMHs is to provide the foundation of primary care to reap the advantages of prevention and provide a point of coordination for all care. PCMHs also provide a way for ACOs to fix internal accountability for performance at the unit of analysis closest to where care is provided and where quality and cost data are generated. ACOs could also be given bonuses for establishing medical homes.

Role of Comparative Effectiveness. A center for comparative effectiveness research is needed to provide hospitals and physicians with reliable and accessible data on the efficacy, effectiveness, and cost of new treatments, technologies, and interventions for disease prevention or health promotion.⁷ The center should emphasize those conditions that contribute the greatest amount to the nation's burden of disease and that are amenable to action. Particular emphasis should be given to public health interventions and related patient lifestyle behaviors, given their contribution to the burden of disease. Formation of ACOs and PCMHs, expanded use of electronic health records, and the new aligned financial incentives are likely to result in a much greater use of comparative effectiveness research and thus may yield greater long-run savings than the \$8 billion currently projected.⁸

Additional Steps

Two additional steps can help slow increases in spending—one that will have an immediate effect and the other that will increase over time. First, immediate cost savings can be achieved by reducing Medicare waste, fraud, and abuse. Examples include requiring compliance programs of clinicians and suppliers, targeting certain areas at elevated risk of fraud for increased oversight, and analyzing claims before they are paid to identify up-coding of procedures, duplicate billing, and billing for nonexistent patients.⁹

Second, patients and employers should be provided with incentives to select the highest-performing, most cost-effective clinicians and health plans. This can take the form of reduced co-payments, decreased deductibles, or both, for those selecting higher-value clinicians and plans. Further incentives in the form of premium rebates can be provided to individuals who make lifestyle disease prevention and health promotion changes. These changes are likely to have a slower but cumulative effect on health care spending over time.

Conclusions

If health care reform is to succeed this year, compromise is greatly needed to reach agreement on how to cover the increased cost of expanding health insurance for all US citizens. Taxing alcohol, tobacco, and related products; taxing high-income in-

dividuals and families; and capping the tax credit on employer-sponsored insurance and related revenue-generating proposals will, even if enacted, be insufficient to cover the estimated \$1 trillion cost of expanded insurance coverage over the next 10 years. Fundamental internal changes within the health care delivery system, combined with public health interventions and comparative effectiveness studies, must occur.

While it is difficult to “score” all savings over time from implementing these changes, they could amount to \$540 billion over the coming decade.⁹ Still another assessment places the potential cumulative financial savings at approximately \$2 trillion.¹⁰ However, it is certain that failure to act now to reform the health insurance and health care delivery system will keep the United States on the path of ever-escalating costs and increasing numbers of uninsured persons, while offering the poorest value for the money invested among nearly all nations in the world. Unlike previous efforts at health care reform, maintaining the status quo is much less in any stakeholder's best interest at this point. Some relative reduction and redistribution of revenue and net income must occur—that is what reducing the rate of increased spending or “bending the cost curve” means. Therefore, entities that generate those revenues, expenses, and net incomes—primarily hospitals, physicians, and patients—hold the keys to successful, sustainable reform. The delivery system reform package outlined above provides an opportunity for all to succeed in the short run and to improve over the long run.

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