SOUNDING BOARD

Bending the Cost Curve through Market-Based Incentives

Joseph R. Antos, Ph.D., Mark V. Pauly, Ph.D., and Gail R. Wilensky, Ph.D.

The high and rising cost of U.S. health care is a growing burden on families and businesses and a threat to the fiscal stability of the government. This year, national health spending will total $2.8 trillion, or 17.9% of the gross domestic product (GDP).[1] By 2021, national health spending will account for nearly one fifth of our economy, reflecting major expansions in health insurance coverage under the Affordable Care Act (ACA) and increased numbers of people on Medicare resulting from the ongoing retirement of the baby-boom generation.

The ACA expands eligibility for Medicaid, creates new subsidies for coverage for large numbers of the uninsured, and changes the terms under which insurance can be sold to persons in the nongroup market. The new federal spending, amounting to $1.2 trillion through 2022, is offset primarily through reductions in Medicare provider payments.[2] The ACA also contains provisions that, it is hoped, will ultimately slow health care spending, including accountable care organizations, value-based purchasing programs, and bundled-payment pilot projects. However, the payment provisions and pilot projects fail to address a flawed financing system whose incentives promote more spending, not better spending.

In a market-based approach, open-ended subsidies to beneficiaries and price-controlled reimbursements to providers should be replaced with fixed dollar subsidies — effectively shifting Medicare from a defined-benefit to a defined-contribution approach. The business model would shift from one that is driven by the volume and intensity of services to one that rewards cost-effective and efficient care.

Under this approach, Medicare would adopt a premium-support model, which provides a fixed subsidy for each beneficiary's purchase of insurance. Health plans, including traditional Medicare, would compete with each other on equal terms. Beneficiaries could purchase more expensive coverage if they felt the extra cost was worth it to them.

Similarly, the principle of defined contribution should be applied to the currently unlimited tax subsidy for employer-sponsored insurance. Employer contributions to health insurance are not counted as part of the employees' taxable income. That subsidy encourages the purchase of health insurance, but it also provides an incentive to increase the amount of coverage, which helps fuel the growth of private health spending. Converting the current exclusion to a predetermined refundable credit would be a reform similar to premium support for Medicare. A less dramatic compromise would set a dollar limit on the tax exclusion that is indexed to grow more slowly than the trend in medical spending.

Well-functioning competitive markets are required for these types of decentralized approaches to work effectively. Objective, understandable information needs to be available so that consumers can make informed decisions about their choice of health plans. The plans need to be able to adjust their benefit offerings to respond to changes in consumer demand. This could be facilitated by public and private health insurance exchanges without limiting what plans can offer and what consumers may buy.

A defined-contribution approach to subsidies would help resolve the federal budget problem without limiting the way in which consumers are able to spend their own funds. Reliance on competitive markets rather than on regulatory controls provides strong incentives for more efficient delivery of the health care services that consumers truly value.

Health care can and should be delivered more efficiently, which would lower its unit cost. But the resulting level of health care spending (or its rate of growth) could be higher or lower than a budget-driven target. More efficient care that was more effective in treating disease might appropriately result in an increased level of aggregated health care spending — but for the right reasons. In other words, an increase in spending could reflect how individuals wish to spend their own money.

MARKET REFORMS FOR MEDICARE

The financial future of Medicare is perilous, but reforms based on premium support can set the program on a more sustainable fiscal path. And the impact of this change may extend well beyond the federal budget. Medicare is the largest purchaser of health services, and its leverage over the health system will only grow as members of the baby-boom generation enroll in the program. Efficiency-enhancing reforms in Medicare could shape the professional and financial climate for the rest of health care.

The uncapped entitlement and distorted fee-for-service structure of traditional Medicare are major causes of the rapid rise in program spending. Poorly targeted fee-for-service payments promote the use of more — and more expensive — services, delivered in a fragmented and uncoordinated environment. The result has been higher spending and poorer patient outcomes.

Premium support would fundamentally change the incentives in Medicare. Seniors would receive a uniform subsidy to purchase insurance from competing health plans (including traditional Medicare), with each offering at least a core set of benefits. The subsidy would be based on the low bids, with higher subsidies going to beneficiaries with greater financial and health needs but not varying according to the cost of the plan chosen. Beneficiaries could choose more expensive plans but would pay any extra premium with their own money. This would give seniors an incentive to select lower-cost plans and provide plans with an incentive to provide appropriate services in a cost-effective manner. More efficient health care delivery would be rewarded, rather than penalized, as is the case under the current system.

Given the serious fiscal challenges facing the country, a realistic limit on the growth of Medicare spending is needed. Recent proposals for Medicare reform include a statutory limit on the subsidy growth, such as GDP plus 0.5%.[3] Such spending limits ensure a favorable budget score from the Congressional Budget Office and may even impose temporary fiscal discipline on what has become an unruly political process. However, if unduly restrictive limits were enforced, they could threaten access to beneficial care and impede medical progress.

That is a problem common to all formula-driven spending controls, including the limits to be enforced by the Independent Payment Advisory Board (IPAB). Recent experience with the sustainable growth rate formula for physician payment suggests that Congress may not try to enforce what it regards as unreasonable, although the ACA does not allow Congress to override IPAB decisions by enacting severe payment reductions.

A limit that is tied in part to the cost of efficiently provided care might provide enough fiscal stringency without unduly reducing care. But the fundamental issue is how effective premium support would be in changing the way that care is delivered. Better incentives, not fiscal targets, are the source of appropriate reductions in the cost of health care. If competition can keep Medicare spending within the bounds set by the targets, then the targets are unnecessary. If not, price controls will do no better.

Because we believe that a politically viable premium-support program will need to include traditional Medicare as an option, it is important that the program become a more effective competitor than it is today. One long-standing proposal would simplify the benefit structure by combining the deductibles for Part A and Part B into a single deductible and using a standard coinsurance rate for all Part A and Part B services.[4]

Better payment methods in traditional Medicare would help reduce inappropriate fee-for-service incentives that result in fragmented care and an increased use of services and thus would allow traditional Medicare to remain competitive. Expanding the hospital payment bundle to include physician services provided during an inpatient stay or paying a single rate for inpatient and outpatient services may lead to new efficiencies in care delivery. Similarly, physician payments could be redefined so that a physician might receive a single payment for an array of related services rather than separate payments for each individual service. Expanded use of competitive bidding for medical products can also reduce the costs of traditional Medicare.

Other changes to traditional Medicare may be more controversial. In addition to standard benefits, a high-option plan — one that includes coverage for catastrophic health costs — could be offered. This might limit the demand for Medigap, which most economists believe drives up the cost of traditional Medicare by eliminating the need for patients to pay out of pocket when ser-

vices are used. Alternatively, limits could be imposed on Medigap coverage and beneficiaries could be given better information about the full cost of their plan options, including the cost of supplemental insurance to traditional Medicare.

Such reforms are important, but they do not make traditional Medicare more responsive to changes in its own environment. If we want greater potential for success, we must open the program to greater entrepreneurship.

This is especially important for beneficiaries — such as those living in small cities and rural markets dominated by a few health care providers — who may not have many options other than traditional Medicare. Lack of competition among providers in such areas gives less room to private plans to negotiate lower costs than traditional Medicare or offer better deals to beneficiaries. According to one estimate, about half of Medicare beneficiaries would have faced lower premiums in traditional Medicare than in private plans if full competitive bidding (with the amount set at the 25th percentile) had been in use in 2009 (Feldman R: personal communication).

Allowing for greater entrepreneurship requires restructuring traditional Medicare so that it can operate with greater autonomy. Subdividing the program into regional fee-for-service plans would make it easier to develop and implement innovations that can reduce costs or improve value. Such regional plans could begin to operate as businesses capable of responding in a timely fashion to developments in the local market. High-level policy would continue to be set in Washington, but the chief executive officers (CEOs) of regional plans would have greater autonomy and be held to greater accountability for performance. And unlike the members of the IPAB, who are not subject to recall, regional CEOs could be fired if they fail to make significant improvements in the operation of their plans.

These proposals would give Medicare greater flexibility to meet the demands of beneficiaries, provide incentives to promote efficient health care delivery, and allow private plans and the restructured traditional Medicare plan to compete effectively. The final choice of plans — which might or might not result in a large share of enrollment for the traditional plan over the long run — would reflect the preference of the beneficiary, as it should in a market-reformed Medicare world.

MARKET REFORMS FOR PRIVATE INSURANCE

A reform parallel to premium support for Medicare is needed to limit the open-ended tax subsidy associated with employment-related health insurance. That coverage accounts for more than 90% of all private health insurance sold to people younger than 65 years of age. One approach would provide increased financial support to low-income persons while correcting the perverse incentives of the current subsidy.

Unlike with cash wages and other forms of compensation, most workers do not pay taxes on the amount that they and their employers pay for health insurance. Under this tax exclusion, the employer's "contribution" to the premium does not increase the worker's income-tax or payroll-tax liability. The employee's share of the premium is typically paid with pretax dollars. Consequently, the employee receives the full benefit of the insurance but shares the cost of the plan with the U.S. Treasury.

The subsidy is structured in a particularly unfair way. All workers, including low-income employees, gain from not having to pay Social Security taxes on the premiums, but shielding premium payments from income taxes is worth more to employees in higher income-tax brackets. Moreover, the exclusion is worth more to employees who can choose more costly plans than those (typically lower-income workers) who are more frugal. In contrast, most income-related subsidies favor the poor.

Predictably, employees choose more generous coverage than they would if they paid the full cost of the insurance. Because health insurance combines prepayment for routine care with coverage for unexpected and unaffordable treatment for serious disease, more generous health coverage encourages the use of more health services. In contrast, greater coverage for fire insurance does not create an incentive for more house fires. Not only does the resulting increase in health insurance mean that spending is higher at any point in time, but increases in medical spending — from new technologies or higher wages to medical providers — are also higher than they would be without the added insurance encouraged by the current tax exclusion.

The tax exclusion provides about $250 billion in annual subsidies for employment-based insur-

ance.[5,6] Proposals have been advanced to convert the exclusion to a predetermined tax credit.[7] That would make the subsidy available to anyone purchasing insurance, whether through an employer or on the individual market. The credit could be made refundable, and the amount of the credit could be graduated to provide greater help to those with lower incomes. Moreover, a credit is a fixed subsidy that would not increase if a person chose a more expensive health plan. That eliminates the bias of the tax exclusion toward more coverage and higher spending.

Although the problems inherent in the tax exclusion are widely recognized, tax-credit proposals have not enjoyed much political support. A less comprehensive reform would cap the tax exclusion without broadening its availability to coverage purchased outside the workplace. Any employer contribution above the cap would be subject to taxation. The amount of the cap could be indexed to inflation or some other measure that grows less rapidly than the trend in health spending.

The ACA creates a "Cadillac tax" on employer-sponsored health coverage that would be far less effective than a cap on the exclusion in reducing the incentive to buy expensive insurance. Starting in 2018, an excise tax on high-cost plans will be imposed on the insurer, who would pass the additional cost along to the purchaser in the form of higher premiums or reduced benefits. Because the tax exclusion was not modified in the ACA, employees would continue to avoid taxation on employer contributions and their own premium payments for plans that are now even more expensive. Although higher prices would eventually reduce the demand for high-cost plans, a reform of the exclusion would create much clearer incentives to change consumer behavior.

Other changes in the private sector could also contribute considerably to a more efficient health system. Health insurance exchanges promote competition and informed consumer choice but need not have the heavy regulation imposed by the ACA that limits the types of health plans that are made available. Consumers should have the right to buy less and pay less, if they choose to do so. State regulations, including benefit mandates and limitations on the scope of medical practice, also artificially raise the cost of health care. Reforming the medical liability system could also reduce the use of services and lower spending somewhat, but the distorted economic incentives of fee-for-service payments will still dominate.

CONCLUSIONS

Policies that attempt to reengineer the health system without changing the underlying financial incentives that drive health spending will ultimately fail. The adoption of a defined-benefit approach to federal health subsidies can improve the understanding of both consumers and providers that resources are limited and choices must be made, but those decisions should not be dictated from Washington through regulatory controls. A market-based approach that relies on competition and financial incentives can promote efficient health care delivery, reduce the unit cost of care, and thus help resolve the federal budget problem without placing limits on how individuals choose to spend their own money. Consumers will decide for themselves whether more costly coverage buys them access to better care and more effective medical technology, and those decisions will ultimately determine the pace of health spending growth. Budget-driven fiscal targets that are inconsistent with public wishes and the capacity of the health system to deliver are not sustainable.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the American Enterprise Institute, Washington, DC (J.R.A.); the Wharton School, University of Pennsylvania, Philadelphia (M.V.P.); and Project Hope, Millwood, VA (G.R.W.).

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