Rising Medical Costs Mean More Rough Times Ahead

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Medical costs are rising again, after recent years of historic lows. As the figure shows, growth rates of real per person medical spending in the past 3 years have averaged 3.4% annually, up from 0.9% in 2011 to 2013. Although the current growth rate is low in a historical context, it exceeds the economy’s growth as a whole. Thus, health costs are expected to reappear on the radar screen of governments, businesses, and households.

The issue of health care costs plays differently in the political arena than the issue of coverage. Politicians bicker endlessly about who should be covered and how generously, as the never-ending debate about the Affordable Care Act has demonstrated. In contrast, there is bipartisan agreement that policy action is needed to address rising medical costs.

That said, addressing costs in a meaningful way is difficult. The central difficulty is that medical spending increases apply to a mix of valuable services and less valuable ones. Spending more for drugs or surgeries that cure disease is worthwhile. But paying more for a medication because a pharmaceutical company has decided that the market will bear the cost is not.

The political arena is hunting for the equivalent of the perfect surgeon, one who can take out the diseased tissue without harming the intertwined vital organ. Sadly, no such policy exists.

The closest we come to the ideal policy is prevention. Disease prevented is both healthier for the individual and less expensive for the system. There have been major successes in prevention, such as new medications for hypertension and high cholesterol that have materially reduced the incidence of chronic cardiovascular disease in the past few decades. There is more to be done here, but prevention has its limits. Obesity accounts for a greater part of medical spending over time, and there are no widespread prevention strategies shown to reduce excessive weight. Furthermore, the risk factors for many high-cost conditions, such as Alzheimer disease and other forms of dementia, are not well understood.

As a result, when attention turns to action, the steps taken will necessarily involve difficult trade-offs. Three approaches that policy makers might take are cutting prices, charging people more in the form of cost sharing, or bundling payments.
Cutting Prices
The time-honored way to reduce spending is to limit what is paid for each service. Both Medicare and Medicaid have responded to periodic budget crises by cutting prices paid.

The most obvious target for price-cutting is pharmaceuticals. Prices for pharmaceuticals vastly exceed production costs, as well as prices charged in other countries, so prices could be lowered without fear that existing drugs would become unprofitable. How lowering prices might affect pharmaceutical research and development is debated, which may limit action here.

But make no mistake: cost concerns will not be limited to pharmaceuticals. Physician and hospital prices are rising as well, and are also prominent targets for price cutting. The steps to lower prices are starting already. The Republican health care bill (the American Health Care Act, or AHCA), combined with President Trump’s budget, proposes a 50% reduction in federal contributions to Medicaid. That would surely result in massive reductions in prices paid by Medicaid programs.

Charging People More
The strategy used by most businesses to address rising medical costs is to increase the amount that people have to pay to access care. Between 2006 and 2016, the proportion of people enrolled in a high-deductible health plan (a plan with a deductible higher than $1000 for an individual or $2000 for a family) rose from 4% to 29%.

People enrolled in high-deductible health plans use less care than people enrolled in plans with more modest cost sharing; savings are on the order of 10% to 15%. The difficulty is that the savings come from reductions in both more and less valuable care. People cut back on less-appropriate imaging but also on chronic medications for high cholesterol, diabetes, and hypertension. Unfortunately, even providing information about the cost and value of different therapies does not limit the damage from higher costs.

For physicians, there are other detrimental aspects of increased enrollment in plans with high cost sharing. When cost sharing is high, physician offices become bill collectors along with care providers. This complicates the doctor-patient relationship. Collecting all the money also adds to administrative expense. Nevertheless, businesses show no signs of wanting to slow down the push to high-deductible policies, so this conundrum is likely to get even bigger.

Bundled payments
Increasing cost sharing is more feasible in the private sector than in the public sector, where many people have lower incomes. The more common strategy in the public sector is to change the way that medical care is paid for, moving from volume-based payment to value-based payment. The Affordable Care Act created many such payment models, as did the Medicare Access and CHIP Reauthorization Act of 2015.

In practice, value-based payment often involves paying one amount for services that used to be reimbursed separately. Rather than pay separately for a hospitalization, the surgeon, and any postacute care, there might be a bundled payment for the entire surgical episode. At a higher level, there might be a single payment for all care provided in an entire year, as in Medicare’s accountable care organization program.

Theoretically, the shift to value-based payments may be either good or bad. It gives incentives for physicians to monitor care carefully because money not spent on medical care can be used for other purposes or added to take-home pay. But it also gives incentives to skimp on care or to select patients who are expected to cost less than the bundled payment.

Value-based payments are more recent than higher cost sharing, so information about the effects of such payments on care quality is much less developed. Generally, the literature shows some savings associated with value-based payments, but the savings are not enormous—5% or less—depending on the program. To date, there has been no evidence of adverse consequences. Indeed, many measures of quality are used to determine compensation, and by those metrics, quality seems to have improved.

The literature thus supports an expansion of value-based payments, but with a caveat: we have not yet figured out how to use bundled payments to save significant money.

It is difficult to predict how policy debates will evolve. But physicians should be aware that the difficult practice environment that they already face could become even more challenging as health care costs increase at faster rate.

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