



Healthcare Reform Legislation Distracts From the Real Problem: Costs

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The political circus that is healthcare reform is entertaining, but distracts our attention from one important fact: Healthcare reform, as proposed in the Senate and House bills and as enacted in Massachusetts, is primarily about increasing access to healthcare insurance, and only incidentally about controlling healthcare costs.

Let us state the obvious. One cannot control healthcare costs without imposing controls of some kind. We know this because we have done it before. In the mid-1990s, managed care plans, through prior approval requirements and the shifting of some cost-of-care risk to providers, significantly reduced increases in health insurance premium costs for a time.

The Clinton administration contributed to this cost control effort with legislation that sharply reduced increases in Medicare spending, although some components of this legislation were subsequently modified or indefinitely delayed. However, this cost-cutting initiative effectively shifted costs to the non-governmental health insurers, as providers negotiated for higher rates from such insurers to make up for lost Medicare revenues. This experiment in healthcare cost control led to sporadic, sometimes ill-considered, and sometimes subsequently undone, provider consolidations (i.e., hospital to hospital, and hospital to physicians) and a powerful, and ongoing, wave of health insurer consolidations.

The experiment was abandoned in the face of complaints from providers, who didn't have the information systems and other tools to manage the cost-of-care risks that they had agreed to accept, and patients who objected to any restrictions to their access to care (see, for example, the Helen Hunt character's obscenity-laced rant about HMOs in the movie "As Good as it Gets"). Resistance also showed up in opposition to restricted access networks and tiered-pricing arrangements. This brief experiment in cost control, and the reaction to it, created the healthcare financing and delivery system that is now devouring our economy. It led to:

- Years of double-digit increases in health insurance premiums (and associated increases in patient co-pays and deductibles, and in the employees' share of premium costs), absorbing most real dollar increases in wages for low and middle income workers;
- A significant consolidation in many health insurance markets and some consolidation of provider systems in certain markets; and
- A huge increase in the numbers of uninsured Americans, now at 46 million or more.

Overall, our healthcare delivery and financing system, which absorbs 17% or more of our GDP through overtreatment of the insured and undertreatment of the uninsured, produces mediocre outcomes at high cost when compared to the healthcare systems of other industrialized countries (e.g., in a 2008 Commonwealth Fund report, the U.S. ranked last of 19 countries on quality of care measures). As with the recent unpleasantness in the financial services sector, the "invisible hand of the market" (i.e., the rational, self-interested acts of market participants) has produced a financially unsustainable and clinically suboptimal result

that is as dangerous to our physical and fiscal health as the other was to our fiscal health alone.

In the 1990s, the prospect, or fear, of healthcare reform was an impetus for a consolidation of providers and health insurers that long outlasted the Clintons' healthcare reform efforts. Today, the specter of Obama Care, has stimulated further provider and insurer consolidation. Like Bill Murray in "Groundhog Day," we are destined to repeat this until we get it right.

In the 1990s, the Clinton Administration's Medicare cost reductions and the non-governmental health insurers' cost control initiatives, to use today's jargon, did "bend the cost curve" significantly for a time. While these cost control efforts were crude, not backed by adequate information systems, and not often linked to appropriate quality, safety and clinical effectiveness, or outcomes, goals, they were nonetheless effective to some extent.

Can we do better this time? The 1990s failure at healthcare reform in general, and cost control in particular, has made us less competitive as a nation, due to rising direct and indirect (for example, lost productivity due to undertreatment of the uninsured) healthcare costs.

Providers and health insurers will continue to consolidate to enable themselves to operate more efficiently in a fee-for-service world. However, some nongovernmental health insurers (e.g., Blue Cross in Massachusetts, with its Alternative Quality Contract) are working with some of these consolidated provider systems (e.g., Atrius Health, Caritas Christi) to create financial incentives for higher quality and more cost-effective care. There are other efforts planned, or under way, by governmental and non-governmental health insurers, to control the cost, and improve the quality, of healthcare services, such as pay-for-performance standards, bundled payments, and capitation.

These are important experiments that could use the resources and economies of scale of large provider systems to transform the delivery, and financing, of healthcare, and, ultimately, to make access to health insurance for the uninsured more affordable. The consolidated provider systems have the capacity, and a wary willingness, to be partners in these efforts.

The federal government could powerfully support these efforts by subsidizing access to healthcare insurance for the poor, and authorizing Medicare and Medicaid payment reform efforts that reward providers based on the quality and cost-effectiveness of care provided to patients. Or the federal government could, as it did in the 1990s, stand aside (other than ultimately imposing draconian, deficit-driven Medicare and Medicaid rate cuts), and let the fee-for-service arms race continue, leading to the continuation of spiraling healthcare costs with no significant improvements in quality or access. We hope for the former, while fearing the latter.

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