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US Health Care Reform
Cost Containment and Improvement in Quality

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President Obama is the only sitting president of the United States in modern history to publish an article in *JAMA*.[1] That seems appropriate since he is also the only recent president to sign comprehensive health reform legislation, the Affordable Care Act (ACA). The president adopted a dual mandate for the ACA: it needed not only to expand coverage but also to contain costs (despite the additional utilization associated with the increased coverage) and improve quality.

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Numerous pundits on both the right and the left indicated that it was a mistake to tie these goals together, but other experts maintained that the president's approach was the only feasible one. In any case, it is difficult to argue with the results: fundamentally, the ACA is working. An estimated 20 million more people are insured because of the law, the increase in health care costs has declined sharply, and health care quality is improving following its enactment.

The Special Communication[1] by the president breaks some new ground; for example, by renewing a call for a public option on the exchanges created by the ACA. Mostly, though, the report is a compendium of the numerous positive outcomes related to the law to date and how the worst concerns (from creating massive job loss to substantial access problems) have proven almost entirely untrue. However, robust evidence demonstrating the actual health benefits of the coverage expansions is more tenuous than suggested,[2,3] and the article does not revisit medical malpractice reform (focused on safe harbors for evidence-based care).[4]

Rather than caviling over these minor points, however, this editorial will focus on what has proven surprising since the ACA was enacted and the path forward.

First, perhaps the most significant surprise since 2010 is the substantial deceleration in health care costs. The conventional wisdom at the time the ACA was enacted was that despite its ostensible dual mandate, the act largely addressed the coverage problem while doing almost nothing to address cost trends. That perspective was flawed and frustrating at the time, but even the most optimistic forecasts were conservative relative to what has since occurred.

Imagine, for example, if anyone had been bold enough to predict in 2010 that Medicare spending per beneficiary would *decline* on an inflation-adjusted basis through 2014. Yet, as the president points out, that is precisely what has happened, and recent data suggest that the slowdown in Medicare expenditures has continued.[5]

The deceleration in the growth in health care spending extends well beyond Medicare, although the drivers differ. A recent Robert Wood Johnson Foundation-Urban Institute analysis reported that national health expenditures are now expected to be $2.6 trillion (11%) lower from 2014 through 2019 than projected before the law was enacted.[6]

So why has this happened? For employer-sponsored insurance, the evidence points strongly to the economic downturn as the primary impetus.[7] That leaves little room for the much-discussed increases in cost sharing to play much role. Perhaps that is not as surprising as it may seem; as the president's article suggests, out-of-pocket spending has not increased as a share of total employer-sponsored insurance because the rise in deductibles has been offset by more protection against excessive out-of-pocket costs. There is more focus on the former because more people are affected by the upward pressure on deductibles, but given the extreme concentration of health spending, the latter matters just as much for the total dollars involved.

For Medicare, by contrast, the evidence shows little if any business cycle effect.[8,9] The Medicare trend thus provides the most suggestive structural evidence of "bending the cost curve." The combined effect of the various ACA cost initiatives, none of which were dominant in and of themselves, caused a crucial shift in thinking that fee-for-service payment was ending. That shift in perspective in turn changed behavior even before the payment reforms were fully implemented. After years of skepticism, even the otherwise conservative Medicare trustees are finally

"hopeful that U.S. health care practices are in the process of becoming more efficient as new payment models become more prevalent ...."[10]

The second surprise is the related improvement in quality. Hospital-acquired infection rates declined by 17% between 2010 and 2013, and 30-day readmission rates also declined.[11] The readmission declines underscore the expectation hypothesis. Although the ACA included a readmission rate penalty, avoiding hospital readmissions is still often contrary to a hospital's immediate financial interest. Hospitals are nonetheless working hard to reduce readmissions not only because it's the "right" thing to do but also because they recognize that in alternative payment models, their financial interest will be improved by avoiding readmissions.

The third surprise involves Medicare Advantage. When the ACA was enacted, the Congressional Budget Office and others anticipated that its payment reductions would cause a decline in Medicare Advantage enrollment.[12] Instead, Medicare Advantage has increased to roughly a third of all Medicare beneficiaries, and it seems plausible that its penetration rate will continue increasing.[13]

The fourth surprise has been that employer-sponsored plans have proven more resilient than expected. Such insurance has been stable since implementation of the ACA.[14] That is one of the challenges for the public exchanges: fewer than expected employers have discontinued their health insurance plans, so the public exchanges have lower enrollment.

So what is the path forward from here? On the exchanges, the administration has recently taken steps to restrict special enrollment periods and to limit nonexchange temporary coverage. Those are useful, as is the ongoing experience payers are gaining with the exchange populations. Ultimately, the exchanges require broad participation by both payers and beneficiaries. The movement toward private exchanges, which has also proceeded more sluggishly than some expected but could accelerate in the future, may ultimately provide a pathway toward more public exchange enrollment, as employers and employees become more comfortable with exchange-mediated insurance.

Continued progress on cost containment and value improvement requires correctly identifying the specific opportunities. In employer-sponsored insurance, the evidence shows substantial variation in prices,[15] and to date, transparency tools have proven relatively ineffective at reducing this variation.[16] Employers have to push for better pricing, and as the president notes in his Special Communication, the so-called Cadillac tax on high-cost employer plans should be reformed, not ended. That tax was useful in keeping pressure on employers to move toward a focus on value. The initial stage of that process often involved higher cost sharing for employees, but ultimately it would have required employers to become more active in helping to reduce total spending, rather than just shifting that spending between the firm and the employee.

For Medicare, by contrast, most variation involves utilization, not price. Care following acute episodes of disease accounts for almost three-quarters of that variation,[17] and preliminary results suggest that cost and quality are most negatively correlated with such care.[18] The postacute care sector thus looms large in the path forward to higher-value Medicare utilization patterns.

On Medicare policy, the administration has set a goal that 50% of traditional Medicare payments should be value based by 2018. To get there, reliance on purely voluntary measures will not be sufficient—and in any case, that would require the type of relatively weak incentives producing mediocre results to date with accountable care organizations.

As a group of health care experts recently wrote,[19] a better alternative is more mandatory bundled payments, similar to the joint replacement bundle that is being rolled out in almost 70 local areas. Such mandatory bundles should be expanded over more episodes until health care organizations and health care professionals gain sufficient experience and can handle the risks associated with moving to fully capitated payment structures. The most promising next mandatory bundles include episodes surrounding coronary artery bypass grafting, maternity care, other forms of orthopedic surgery, and certain types of oncology. Given the disproportionate role played by postacute care, all of these bundles should include 90-day postdischarge periods.

In sum, the US health care reform glass is more than half full. Despite ongoing and legitimate concerns about the public exchanges, the ACA has proven remarkably successful at boosting coverage and reforming the delivery system.

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