



Addressing Rising Health Care Costs — A View from the Congressional Budget Office

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The long-term fiscal balance of the United States will be determined primarily by the future rate of growth of health care costs, as we have recently noted.¹ If costs per enrollee in Medicare

and Medicaid continued to grow at the same rate as they have over the past four decades, federal spending on those two programs alone would increase from about 5% of the gross domestic product today to about 20% by 2050 — roughly the share of the economy now accounted for by the entire federal budget. Compounding the challenge for policymakers is the difficulty of controlling federal spending over the long term without addressing the underlying forces behind the increase in both private and public health care costs.

A variety of evidence, however, suggests that there are opportunities to constrain health care costs without incurring adverse health

consequences. One approach that could reduce total health care spending (rather than simply reallocating it among different sectors of the economy) involves generating more information about the relative effectiveness of medical treatments and enhancing the incentives for providers to supply, and consumers to demand, effective care.

Such an approach would address two shortcomings of the current U.S. health care system. First, relatively little rigorous evidence is available about which treatments work best for which patients or whether the benefits of more expensive therapies warrant their additional costs. As a result, treatment choices often de-

pend on the experience and judgment of the physicians involved, as well as on anecdotal evidence and local practice norms. At least in some cases, this decision-making method does not yield the most effective treatment. Although estimates vary, some experts believe that less than half of all medical care in the United States is based on or supported by firm evidence of effectiveness.

Second, the financial incentives for both providers and patients tend to encourage the adoption of more expensive treatments and procedures, even if evidence of their relative effectiveness is limited. For doctors and hospitals, these incentives stem from fee-for-service reimbursement, which encourages providers to deliver a given service efficiently but also creates an incentive to supply additional or more expensive services — as long as the payment exceeds the costs. Insured patients,

for their part, generally pay only a portion of the costs of their care and, consequently, have only limited financial incentives to seek lower-cost treatments; this is a trade-off inherent in having insurance protection. Private health insurers have incentives to limit the use of ineffective care but lack information about what treatments work best for which patients. The Medicare program lacks clear legal authority to take costs into account in determining which services are covered and has made only limited use of the available data on relative effectiveness in setting payment amounts.

The expansion of research on comparative effectiveness could help to correct these problems, especially the addition of analyses that both examine the relative medical benefits and risks of each treatment option (for all patients or some subgroup thereof) and weigh the benefits against the costs.² To affect medical treatment and reduce health care spending, the results of that research would have to change the behavior of doctors and patients — that is, get them to use fewer services or less intensive and less expensive services than they would otherwise choose. Bringing about substantial changes would probably require public and private insurers to modify their coverage or payment policies, altering the incentives facing doctors and patients. For example, insurers could choose not to cover drugs, devices, or procedures that were found to be less effective or less cost-effective, or they could take more modest steps to adjust doctors' and hospitals' payments to encourage the use of more effective services.

Alternatively, or in addition, insurers could require enrollees to pay at least a portion of the addi-

tional costs of more expensive treatments that are shown to be less effective or less cost-effective (in which case enrollees would have to decide whether the added benefits were worth the added costs). Whereas insurance plans generally vary the share of costs paid by enrollees according to the type of service provided — with

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lower coinsurance rates for hospital care and higher rates for outpatient services — the new approach, sometimes called a value-based insurance design, would be tailored to the patient's condition and treatment. To inform such designs, the results of effectiveness studies would have to be sufficiently robust to ensure that subgroups of patients who could benefit greatly from a treatment are not overlooked. Even then, some patients and providers might object to such arrangements or to the manner in which they were established, and keeping pace with new treatments and procedures would be an ongoing challenge.

Even without more information about the comparative effectiveness of various treatments, changes in incentives could help to control costs, but the health gains obtained for a given level of spend-

ing would probably be greater if more information were available. On the provider side, the increased bundling of insurers' payments to cover all services associated with a treatment, disease, or patient could reduce or eliminate incentives to provide additional services that might be of low value. Such approaches, however, raise concerns: first, that providers may face financial risk for costs they may not be able to control and, second, that incentives may be created for them to provide too little care. On the consumer side, higher deductibles would encourage patients to be more prudent in their use of services, but they also raise concerns about the financial burden on persons with major health problems. Furthermore, the concentration of health care spending among a relatively small percentage of the population with very high costs limits the effect on total spending of increased cost sharing for initial charges.

Clearly, the option of generating more information about relative treatment effectiveness and then aligning incentives with it is not the only cost-reduction proposal that has been advanced. Some analysts have advocated substantial expansions of structured disease-management programs and care coordination as mechanisms for reducing costs — proposals that reflect the increasing prevalence of many chronic conditions, the large share of health care spending that is incurred by persons with those conditions, and the lack of care coordination systems in many insurance plans. However, the evidence to date — including the findings of several demonstration projects conducted under Medicare — suggests that these approaches may improve the

quality of care but do not substantially reduce costs among a broad array of patients.³⁻⁵ As more empirical evidence comes in, it may become easier to identify specific ways to reduce costs; for now, the possibility and scope of the savings remain unclear.

One approach that might improve the cost-effectiveness of disease-management and care-coordination strategies involves more accurately targeting these efforts toward the patients who would benefit the most. Indeed, the concept of better targeting is inherent in all the options considered here, from enhanced research on treatments to the designing of fi-

nancial incentives. As medicine moves toward increasingly targeted therapies, the options for shifting insurance designs in the same direction merit consideration as policymakers grapple with the serious financial challenges faced by our public and private health insurance programs.

An interview with Dr. Orszag can be heard at www.nejm.org.

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Climbing through Medicine's Glass Ceiling

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Earlier this year, I was named the first female dean of the Duke University School of Medicine, an event that National Public Radio summed up in the headline: "Andrews Makes History at Duke Med School." Why should the appointment of a woman dean still be big news in 2007? Perhaps because, with a few localized exceptions, there has been little change since the 1970s in the barriers to women's full participation in academic medicine.

I happen to believe strongly that diversifying all levels of academic medicine is not only politically correct, it is also the way to make our institutions better. The history of Harvard University, for example, where I spent many years before moving to Duke, is one of gradually increasing diversity, which I see as a necessary ingredient of an outstanding in-

stitution. When the university was young, 300 or so years ago, its faculty and students were Puritan men from good local families. Over the centuries, the Harvard community gradually became diversified in terms of geographic origin, religion, socioeconomic background, sex, race, nationality, and other personal characteristics. It has always seemed to me that it was only by choosing to recruit the individual scholars whom it viewed as the best, regardless of such characteristics, rather than limiting itself to a narrow circle of candidates, that Harvard was able to build a world-class faculty and student body worthy of the reputation it now enjoys. After all, brilliance and ability are not restricted to certain groups, so it seems logical that if they draw from the widest possible talent pool, the very best institutions will

naturally have diversity at all levels.

And yet most do not, despite efforts to begin with a diverse population of students. Given that the proportions of men and women in medical school classes have been similar for some time, it seems puzzling that there are not more women in leadership positions in academic medicine. I suspect that some of the reasons for this disparity are the same as those that apply at the entry level for physician-scientists — concerns about balancing work and family, perceptions that women need to be better than men at their professions in order to be considered equal, and a dearth of female role models.¹ But I also believe that if we are to have more female deans, we must be able to envisage female deans.

There was a riddle that was