The Forest for the Trees: National Health Expenditures and Healthcare Reform

It is no secret that the United States spends more on health care than any other nation and yet, has poorer health outcomes compared to its peer countries.[i] Fixing the paradox of high costs and poor outcomes has been the impetus for health reform efforts for decades. From Diagnosis-Related Groups and health maintenance organizations to the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015, policymakers have made numerous attempts to rein in spending and improve quality. Rather than taking on the task of reducing absolute spending year-over-year, policymakers have focused on the less herculean – though still ambitious – goal of reducing the rate of cost growth (better known as "bending the cost curve"). While the concept of bending the cost curve appears simple enough, evaluating individual reform efforts and developing consensus on what success looks like has been far more elusive. We contend that recent trends in national health expenditures (NHE) show the cost curve is bending, that payment reform efforts are a likely contributing factor to this change, and that policymakers would benefit from incorporating broad indicators like NHE trends alongside granular evaluations of individual reform models when planning future reforms.

The Trees: Payment Models and Evaluation

Many of the nation's most recent payment reform efforts are a direct result of the ACA. Passed in 2010, the ACA dedicated funding to establish the Center for Medicare and Medicaid Innovation (CMMI), focused on testing reforms such as alternative payment models intended to reduce health spending and improve the quality of care, and the Medicare Shared Savings Program (MSSP), a voluntary nationwide program that allows providers to form Accountable Care Organizations. As of 2019, over 40 percent (~580,000) of Medicare providers have participated in either MSSP or a payment reform model operated by CMMI.[ii] While the pace and scope of these reform efforts is evident, determining their impact on spending has been a challenge, spurring much debate.

Evaluators have the unenviable job of navigating a health care market rife with overlapping reform efforts (and subsequent spillover effects) and numerous other confounding variables. Consequently, efforts to quantify the cost and quality impacts of individual models have yielded mixed results, causing some to reasonably question the efficacy of these reform efforts. Conversely, researchers have found evidence that these payment reform models can create positive spillover effects in the wider market. Researchers have also noted that, as a result

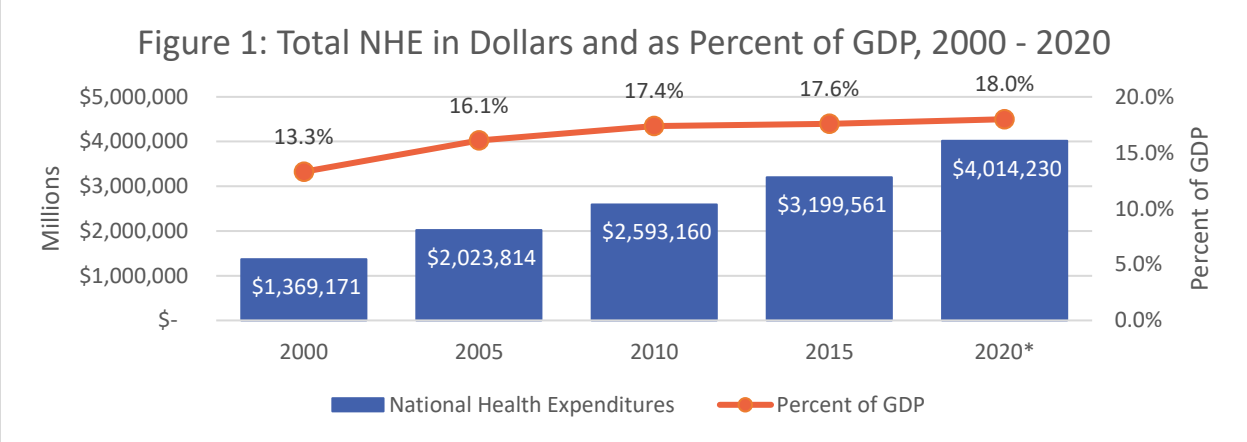
[i] R. Tikkanen, M.K. Abrams, U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?, The Commonwealth Fund, January 2020

[ii] MedPAC, Chapter 2: Streamlining CMS's Portfolio of Alternative Payment Models, Report to the Congress: Medicare and the Health Care Delivery System, June 2021

of these factors, evaluations likely underestimate the true benefits of these models.[iii,iv] While evaluating the impacts of individual models is essential, we believe that examining broader changes in national health expenditures offers a much-needed perspective on progress toward the larger policy goal of bending the cost curve.

The Forest: Trends in National Health Expenditures

In a recent paper, the Health Care Transformation Task Force (HCTTF or Task Force) explored the broader trends in health spending using NHE data produced by the Center for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) from 1960 to 2020.[v] The analysis focused on the actual and projected expenditures from 2000 to 2020 to identify trends in total spending, spending as a percentage of GDP (a measure of health care spending growth compared to the wider economy) and actual vs. forecasted spending (a measure of the relationship between the government's expectations for spending vs. real spending). The analysis found that while total national health expenditures have grown steadily, NHE growth as a percentage of GDP has leveled off in recent years (Figure 1). The annual NHE growth rate has also slowed over the last decade and currently sits at a historic low, 2 percentage points below the 2000-2010 average and over 8 percentage points below the historic peak from 1970-1980 (Figure 2). Finally, and perhaps most important to the discussion of bending the cost curve, actual expenditures over the last decade have consistently fallen below CMS projections, a notable departure from prior trends (figures 3 and 4).

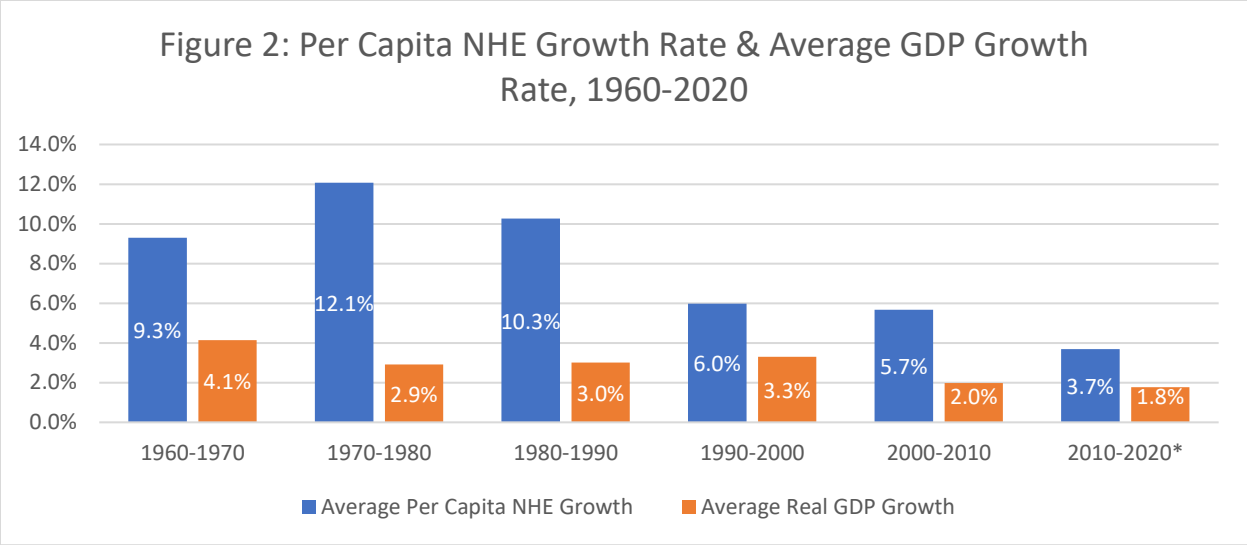


*Estimated based on 2019 NHE projections.

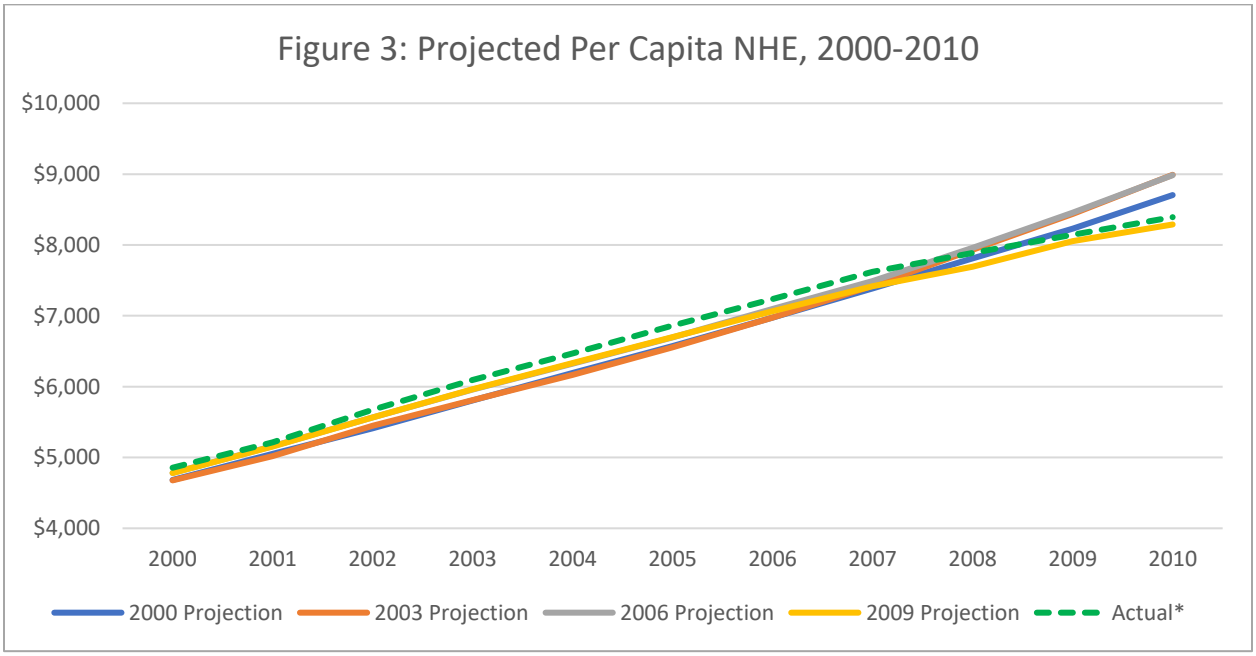
[iii] L. Einav et. al. Randomized trial shows healthcare payment reform has equal-sized spillover effects on patients not targeted by reform, PNAS, August 2020

[iv] A.S. Navathe et. al., Alternative Payment Models—Victims of Their Own Success?, JAMA, June 2020

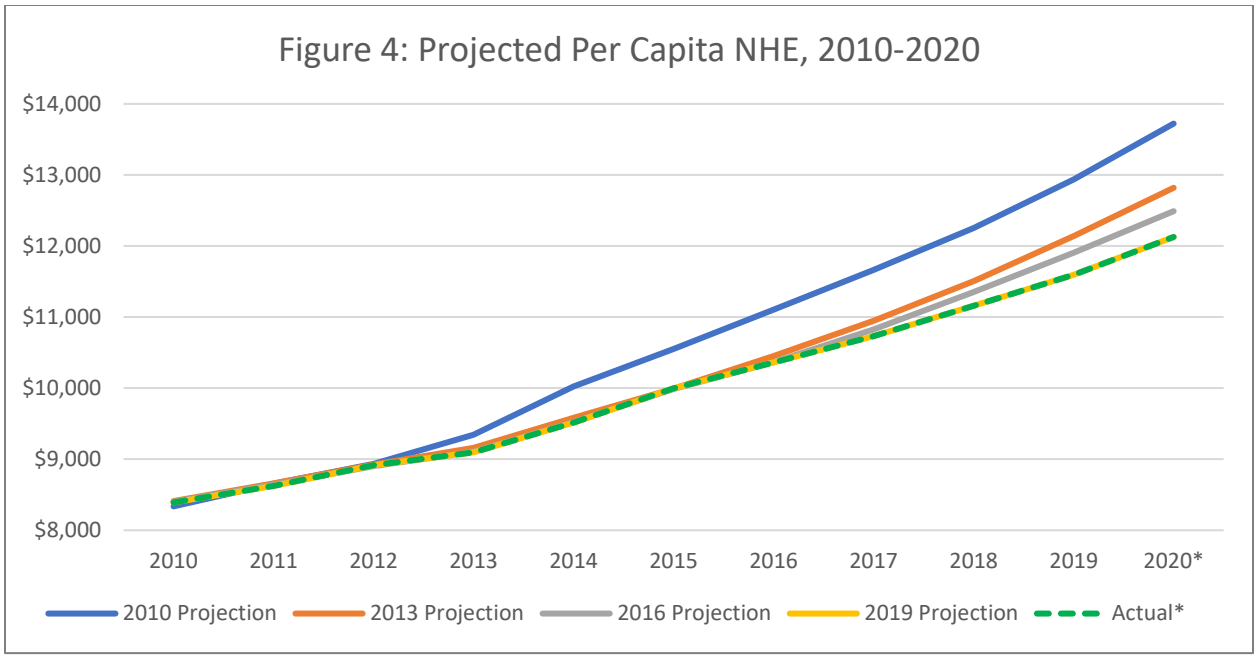
[v] The Health Care Transformation Task Force, Getting Warmer: Health Expenditure Trends and Health System Reform, August 2021



*Estimated based on 2019 NHE projections.



*Based on 2019 NHE data



*Based on 2019 NHE data.

Factors Bending the Curve?

The key questions for policymakers are: 1) what is driving the deceleration in cost growth, and 2) is there anything that can be done to further slow growth while improving access and outcomes. Initially, this slowdown was largely assumed to be a consequence of the Great Recession, with health spending growth expected to return to pre-recession levels as the economy recovered. Yet, growth rates remained near historic lows throughout the economic recovery and the period of full employment leading to the COVID-19 pandemic. So, if the economic impact of the Great Recession does not explain the enduring slowdown in spending growth, what other factors may be at play?

Myriad variables influence spending and create differences between projected and actual NHE. In 2020, OACT issued a report categorizing the main factors impacting NHE projections: exogenous and endogenous assumptions (factors outside and inside the health care system, respectively), changes in law, historical data revisions, and unforeseen developments in the health care industry.[vi]

Exogenous and endogenous assumptions impact NHE projections by altering the expected pricing and utilization of services. The forecast of real disposable personal income is a primary variable for NHE forecasts and economic shocks (*e.g.*, the 2008 Great Recession) can significantly alter actual health care spending compared to projections. Changes in law also impact expectations for health spending and service utilization (*e.g.*, the ACA caused projected expenditures to rise in Medicaid, Medicare, and Private Health Insurance). OACT periodically revises data sets to incorporate new and better information (*e.g.*, a 2019 methodology change accounted for higher prescription drug rebates, decreasing historical drug spending estimates).

The most interesting category of factors for policymaker consideration is that of "unforeseen developments" in the health care industry. This category captures variables including unexpected market responses to legislation and changes in standards of care that impact spending and utilization. The OACT report notes two unforeseen developments which we believe are directly connected to the last decade of payment reform efforts. First, hospital care experienced lower than expected growth in the volume and intensity of inpatient services (especially for Medicare beneficiaries), a drop in readmission rates, and increased use of outpatient services. Second, physician and clinical services saw slower than forecasted price growth likely driven by changes in practice patterns and shifts in workforce, specifically the use of more coordinated care teams.

While we believe there is a credible argument for attributing some portion of the slowing NHE growth to

Notable Events Impacting NHE

December 2003 The Medicare Prescription Drug, Improvement, and Modernization Act is passed creating Medicare Part D

January 2006 Medicare Part D goes into effect

December 2007 – June 2009 the Great Recession

March 2010 The Patient Protection and Affordable Care Act (ACA) is passed

June 2012 The U.S. Supreme Court finds the ACA's Medicaid expansion coercive of states, making Medicaid expansion optional

January 2014 The ACA is fully implemented

April 2015 The Medicare Access and CHIP Reauthorization Act (MACRA) is passed, repealing the Sustainable Growth Rate formula, and creating the Quality Payment Program

January 2017 MACRA goes into effect

December 2017 Repeal of ACA's individual mandate penalty

January 2019 Repeal of ACA's individual mandate penalty goes into effect

[vi] Centers for Medicare and Medicaid Services: Office of the Actuary, Analysis of National Health Expenditure Projections Accuracy, November 2020

payment reform efforts, we acknowledge that quantifying the magnitude of these impacts is challenging and requires further study.

Lessons for the Policy Road Ahead

Controlling health spending is a prerequisite for attaining an affordable, efficient, equitable, and high-quality health care system. While health expenditures in the U.S. continue to outpace other high-income peer nations, the slowdown in average NHE growth offers reason for optimism. Despite this progress, more work needs to be done. Employer and employee spending on health care continues to increase faster than GDP and wages. Bending the cost curve must translate to affordable care for consumers. To achieve this, health care reform efforts must transition from slowing spending growth to actually decreasing spending. The most obvious targets for such an effort are reducing the utilization of low-value care and lowering the unit price of services; two areas that alternative payment models are particularly well suited to impact.

While it may not be feasible to measure all the factors influencing NHE with certainty, it is noteworthy that the deceleration in spending growth coincides with the decade long effort by both the public and private sectors to reform the health care delivery system. We believe that reform efforts like the CMS Hospital Readmission Reduction Program, and alternative payment models like the Medicare Shared Savings Program and models launched by CMMI and several private payers are all likely contributing to the pattern of actual spending consistently falling below projections. In short, while model-specific evaluations are invaluable for refining model concepts, monitoring overall NHE may be a more useful indicator of the cumulative impact of health reform efforts on bending the cost curve. We should not lose sight of the forest for the trees.