

WHY CBO WON'T CREDIT CONGRESS FOR REDUCING HEALTH COSTS

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Again and again, health reformers believe they have identified ways to save money through more efficient delivery of care. So why can't we count on those savings to budget the coming expansion of health care for Americans or lower cost growth?

It is not as if various steps to contain health care costs won't yield positive results. Electronic health records and promoting comparative cost effectiveness are only two examples that could yield benefits. Providing rapid access to patient centered care, greater use of primary prevention, efforts to reduce re-admissions to hospitals soon after discharge, and better identification of low-quality and high-quality hospitals—all these are sensible steps.

But much to the chagrin of the members of Congress looking for ways to reduce costs, the Congressional Budget Office often "scores" these potential improvements in health care as generating moderate or no saving. That makes it harder for the President and the Congress to finance larger health subsidies or tackle our long-term deficit.

Having had charge over an office of government estimators at one time, I'd like to explain the dilemma of both the health and budget reformers.

Like any industry, the health care industry should, can, and does proceed on a path of improvement. New possibilities and ideas appear all the time. But when there are few cost constraints faced either by consumers or providers, there are reduced incentives to adopt those improvements. Even when adopted, they can easily be offset by higher demand or higher prices.

Consider three metaphors:

1. You propose to offer free gym memberships as a way to tackle the problem of obesity. Now getting more people to the gym may be a good idea. But if not backed up by a nutrition/exercise routine that reduces caloric intake relative to the rate of fat and glucose burn, the change in behavior is unlikely to have much effect.
2. You push on air in a balloon. Yes, you had an impact: a dent is made where you push. If the nozzle remains tied, the air simply gets shifted somewhere else.
3. You give your kid a credit card that he can use without limit. You then replace it with one that gives a discount on everything that he purchases. Yet your bill at the end of the month is just as high as ever.

Real World Examples

Now consider a few real world examples from the world of health care.

Increased use of generic drugs. Efforts to improve the efficiency of the health care marketplace are hardly new. One flavor du jour has been the speedier development of generic drug alternatives. Clearly, such efforts do reduce costs.

But now consider how drug companies react. Some merely reweight their research efforts toward specialty drugs less likely to receive competition down the road from generic alternatives. Others set higher initial prices for newly patented offerings. For instance, a company simply offers the new drug cocktail for the cancer patient at a cost of \$120,000 a year instead of \$100,000, offsetting lower profits from drugs going off patent. Would Medicare or insurance companies prevent this price adjustment? Probably not.

Better health and longer lives. Suppose that a proposal advances medical science in a way that extends life and improves its quality, especially at later ages. Surely the estimators would grant substantial cost saving to the lower prevalence of health problems at various ages?

Well, yes, but then they are likely to consider all the offsets. If longer lives merely delay the onset of the same conditions—e.g., we now live five years longer and get cancer at age 85 instead of 80—then some costs have only been deferred, not eliminated. The later cancer care is also likely to be a lot more expensive than if received a few years before. In addition, we now get Medicare (and Social Security) for several additional years, draining the federal budget further. Finally, if we don't work longer when we live longer, then there may be little or no increase in GDP, and costs relative to GDP rise even more.

Electronic health records. I served for several years on a government committee largely dealing with smoothing the path toward adoption of electronic health records (EHRs). Among other potential gains, EHRs offer great hope for preventing duplicative health care and unneeded prescriptions, improving a doctor's ability to diagnose, and, perhaps most importantly, providing data that can be used by researchers and the Centers for Disease Control to discover causes of disease and run early warning and monitoring systems. But EHRs may also lead to increased demand for health care, in the same way that information from Consumer Reports may lead us to purchase more or better cars but not spend less on them.

Comparative Effectiveness. Studies that compare effectiveness across regions and among providers may give us valuable information on the relationship between quality and price. An open issue is whether insurance companies and government would use the results to redirect spending, something not easy to estimate. But even if they did, one cannot assume that half of all hospitals or doctors will still not remain below median, or that, without other constraints, the half "found" to be above median won't begin to charge even more once labeled superior. We've known for a long time that Florida charges much more than Minnesota for health care with no measurable quality improvement. So far, that knowledge hasn't led to much, if anything, in the way of cost saving.

Conclusion

If you're interpreting these examples to mean that efficiency improvements shouldn't be sought, you've got it backwards: we need to reinforce them. But return to our metaphor of free gym memberships. Lowering the cost of exercise might be a good way to tackle obesity, but in isolation it's not likely to be very effective.

Open-ended budgets—which is largely how government spending and tax subsidies are designed in the health arena—are like an unrestricted diet of limitless calories. Budget constraints and innovative practices work to improve any industry, including health care, just like good nutrition and exercise work together to improve the quality of life. A virtuous cycle of true health reform requires both.