

No Free Lunch: The Misaligned Incentives of the American Health Care System

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AS HEALTH CARE COSTS SOAR seemingly inexorably, taking up a larger and larger portion of national spending, policy makers continuously look for ways to tame cost growth in the health care system. For example, CMS has emphasized a number of alternative payment models (APMs) that have the goal of transforming

care and reducing costs.¹ But, for the most part, these models have had only modest impacts on costs.²

One major difficulty with the goal of savings in the health care system is that, in a budget neutrality sense, any savings are inevitably some entity's loss of income. As Shashikumar et al showed, there may be financial incentives for reducing medical spending but the declines often do not offset these bonuses.² In other words, in practice, savings do not appear to materialize. So there has not been a loss of income, and there have been no overall savings to Medicare. Whereas the key to *savings* means a loss of income, here I talk about 3 reasons why this is a major impediment to major changes in the health care system. The first is that, unlike other markets, most technological advances in health care have historically not ended up leading to cost savings; second, because of the complexity of the health care system, many of the potential policies are gameable by key players; and third, many of the key players in the health care system have powerful political arms.

In many other areas of the economy, technological change helps to make products both higher quality and less expensive to produce.^{3,4} However, health care is an especially labor-intensive industry,⁵ where much of the technology gains are complementary to physicians' and other providers' services rather than substitutes.^{6,7} For example, advanced surgical techniques such as robotic surgery or advanced imaging do not replace the provider so much as augment their skills. Although future technological applications, such as artificial intelligence, may be touted as possibly substituting for labor, history suggests this may be difficult and these tools may be used for improving the productivity of providers rather than replacing them, especially if policy makers mandate keeping providers in the loop.

The one area that might be an exception is prescription drugs that prevent the need for medical care.⁸ However,

prescription drugs make up only 9% of health care expenditures,⁹ and given the high and growing cost of prescription drugs,⁹ it often requires years for prescription drugs to become generic and lead to potential cost savings.⁸ Thus, a major impediment is the labor intensity of health care—specifically, attracting and retaining high-quality providers means having to pay more each year even if there is not a huge gain in productivity, often referred to as Baumol's cost disease (eg, a 15-minute office visit is still a 15-minute office visit).^{10,11}

These solutions will not be a silver bullet, but a number of health economists have identified a range of smaller and wide-ranging fixes that together may help move the needle on costs... Although these fixes may not be as alluring as one-size-fits-all solutions, hopefully, policy makers can commit to making real, evidence-based changes to reduce health care costs.

A second major impediment to achieving significant cost savings in the health care setting is that no policy maker just wants cost savings on their own—rather, they want cost savings without compromising health care quality.¹² As such, nearly all APMs that aim to reduce costs also have a variety of quality metrics built in to ensure that providers are maintaining, if not improving, the quality of care.¹³ However, quality of care is very difficult to measure, especially in claims data, which are used to evaluate most


APMs.^{1,14,15} Thus, there is a strong incentive to try to game the measures that are intended to reduce health care costs.¹⁴

For example, there has been considerable attention paid to the issue of upcoding, or “billing for services at higher level of complexity than the service actually provided or documented,”¹⁶ especially in the Medicare Advantage program.^{17,18} Because programs to generate cost savings are ultimately losses to health care providers and systems and risk adjustment is difficult,^{14,15} there is an inherent problem in that health systems have a strong incentive to upcode. And because upcoding is difficult to definitively detect,¹⁶ health systems are able to maintain revenue. Another area of concern is the wave of consolidation over the past 10 to 15 years. Greater provider market power has been shown to correlate with higher prices with limited impact on costs,¹⁹ which only further blunts efforts to rein in costs.

An important third factor is the political and lobbying power of the health care industry. Because cost savings have the potential to reduce revenue for hospitals and other providers and approximately half of all medical spending is from federal and state governments,⁹ the return for successful lobbying can be substantial. We saw examples of this with the battle against surprise billing legislation. Despite widespread support of policies to restrict surprise billing,²⁰ a number of groups (eg, those representing air ambulances,²¹ emergency department physicians, anesthesiologists²²) engaged in substantial lobbying to protect their interests. Further, the American Medical Association has long lobbied against rate cuts or other policies that may impact physician incomes (eg, opposing expanding the roles of nonphysician providers and historically opposing increases in medical residency slots).²³ Although some of these efforts may be changing (eg, supporting increased residency slots), there remains opposition to policies such as expanding scope-of-practice laws for nurse practitioners; these laws are a threat to physicians’ incomes.²⁴

These points highlight an important set of reasons that we have not seen substantial cost savings in the health care industry and why future efforts are likely to continue to see forceful pushback. However, the inevitable question is *what to do*. Unfortunately, there are no simple answers, no free lunches. Given the labor intensity of medicine, efforts to significantly reduce costs are likely to mean losses to key stakeholders. As such, policy makers need to decide if large cost reductions are a key policy goal. If so, they will have to push against what will inevitably be a large counter-lobbying effort. In addition, they will also have to acknowledge an inevitable trade-off with quality, as both hospitals and pharmaceutical companies make decisions about investments in quality based on expected returns. If large cost reductions are the key goal, then large transformations such as public options or major involvement by the government in setting prices might be policy goals. However, again, they are likely to have trade-offs.

However, there are more modest, incremental options as well. These solutions will not be a silver bullet, but a number of health

economists have identified a range of smaller and wide-ranging fixes that together may help move the needle on costs.²⁵ These could include increasing antitrust scrutiny of hospital mergers and hospital ownership of physician practices, reforming reimbursement for long-term care hospitals, and instituting a variety of tweaks to the pharmaceutical industry. As might be expected, many of these incorporate ideas from some of the other pieces in this issue. The other advantage of a portfolio approach is that savings are spread across numerous stakeholders. Although these fixes may not be as alluring as one-size-fits-all solutions, hopefully, policy makers can commit to making real, evidence-based changes to begin to reduce health care costs. 

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