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No Cure for the Cancer of Health Costs

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Contrary to claims by some of its advocates, this year's health care reforms will not slow health cost inflation or retard the increasing share of GDP which health expenditures will consume in the decade ahead. This is the conclusion, not of the Cato Institute, but of government actuaries at the federal Centers for Medicare and Medicaid Services in a recent report.

As detailed in the journal, *Health Affairs*, the actuaries say health costs will rise at a 6.3 percent annual average over the next decade (as opposed to the 6.1 percent projected in February prior to the passage of the [Patient Protection and Affordable Care Act](#)). As has been true in the past, health cost inflation will be multiples of general inflation in the future.

The actuaries also project that national health expenditures in 2019 will be \$4.7 trillion and 19.6 percent of GDP, up from \$2.5 trillion and 17.3 percent of GDP in 2009 (and marginally higher than their February projections). This nation is on course to spend about 25 percent of GDP on health in 2025.

Policy wonks have bemoaned high health cost inflation and national health expenditures as an increasing percentage of GDP (they were 7 percent in 1975) for more than four decades.

But confirmation by the government actuaries that these trends will continue--that, after a convulsive legislative process, the new act will not, in fact, "bend the cost curve" for the next decade--confirms the fears of many advocates, not just opponents, of health care reform that the cancer of health costs will continue to be aggressive, threatening personal, business, state (!!!) and federal solvency, retarding economic growth and diverting scarce resources away from other pressing national needs.

The goals of health reform have always been: increase access, improve quality and control costs. More than a year ago, many who had experience with the health care system were unhappily predicting that the proposed health care reform would:

- increase government program and private insurance coverage (by 2019 92.7% of the U.S. population will have coverage, compared to 84% today);
- be "neutral" on quality for those already covered;
- and not address health cost inflation in a meaningful way. (I was one of that multitude, see "The Cancer of Health Costs" [written](#) at the end of last year.)

In broad summary, the Affordable Care Act continued the current system of a federal program (Medicare with increased drug benefits), a federal-state program (Medicaid with coverage for all individuals at a certain income level, not just poor families) and private insurance (with greatly expanded coverage through business and individual insurance mandates and subsidies for those needing help to pay the resulting insurance premiums as well as inclusion in parent plans of those under 26).

As many have noted, any greater discontinuity with the current system was politically impossible (and raised the spectre of the spectacular failure of the Clinton health plan prior to the 1994 Congressional elections). Like the Massachusetts plan, on which it was based, the health reform made a Faustian bargain that coverage (the carrot) could come first with real cost control (the stick) to follow.

Thus, many of the policy problems driving costs up remain--fee for service, imperfect limits on utilization, lack of patient ability to make choices based on cost, provider and insurer incentives to increase, not cut costs etc, etc.. To be sure, there are small, experimental reforms--pilot programs--in the legislation to address some of these problems such as a movement away from "fee for service" payment to a single thirty day fee for all inpatient and outpatient services relating to a certain procedure to give clinicians an incentive to work together to minimize complications and return visits. But, at least for now, the actuaries don't credit these pilot programs with much cost reducing impact. A broad systematic approach with meaningful targets---combining productivity, competition and budgeting---was not in the cards politically.

And, of course, the politics of both the left and the right which prevented meaningful cost control in the Affordable Care Act (and in the decades which preceded it) have only---if this is possible---worsened of late. The ever more conservative Republicans want to slash government programs (and the increased coverage) over the dead bodies of the Democrats. And the Democrats want to constrain insurance premiums and profit-maximizing in the private sector over the dead bodies of the Republicans. A bipartisan attempt to find the right combination of systemic productivity gains, meaningful competition and appropriate budgeting has receded far over the horizon.

It is not, in the oft-quoted line from Yeats, that "the center cannot not hold." There isn't any center.

Perhaps, after the Congressional elections, this issue will be addressed. "Perhaps" but almost surely not, as the polarizing election of 2010 elides into political posturing for 2012, and the fight is over rolling back 2010's health reforms, not extending them to the critical problem of systemic health cost control across both public and private sectors.

If President Obama is re-elected in 2012, he will confront a list of pressing national issues, not amenable to easy solutions, on which he can spend down all his remaining political capital to secure a place in history. The cancer of health cost increases, just underscored in the little-noticed actuarial report, will surely be at the top of the list.

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