



# Controlling Health Care Spending: Can Consensus Drive Policy?

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## Abstract

Sensing that 2013 would be the year for federal entitlement and tax reform, at least 10 organizations or coalitions developed comprehensive strategies to contain health care costs. The consistent vision among these diverse stakeholders was striking, especially the emphasis on reengineering the delivery of health services through a diminished role for fee-for-service provider payment. While the consistent vision provides an opportunity for policy development, there are important obstacles, including the nascent state of reformed payment approaches and lack of provider readiness to increase clinical integration and improve care coordination. Likewise, unresolved political issues related to the scope of entitlement and tax reforms pose a significant barrier to pursuing important cost-containment initiatives.

Although economists agree that the recent slowing of health care spending trends has been substantial, they disagree about how much is due to the financial crisis and recession and how much is structural and thus might continue. But most perceive a real need to take additional steps to control spending and to initiate them sooner rather than later. When health care spending grows significantly faster than people's income and the

overall economy, both consumers and government forgo opportunities to invest in other priorities.

The need for new tools and workable approaches has led a diverse cadre of stakeholders and policy experts to develop broad cost-containment strategies. Indeed, over the last year, at least 10 relatively comprehensive plans to contain health care costs were released, with seven funded by the Robert Wood Johnson Foundation (RWJF). The projects as a group show both a high degree of creative thinking and striking consistencies in vision concerning how to proceed to contain costs—something that would have been unlikely five or 10 years ago. While these projects outline impressive goals for implementing their visions, many stop short of providing concrete and detailed steps to achieve them. The lack of specifics is not unexpected given the broad array of stakeholders, and more details will emerge in the context of the legislative process.

This article reviews the cost-containment approaches developed by the 10 organizations or coalitions, identifies barriers to effective cost-containment strategies, and points to the most promising ways forward (see Exhibit 1 for a brief description of the reports).

## Policy and Political Context for Reports

With periodic discussion of a “grand bargain” to address federal fiscal issues, especially broad entitlement reform, many perceived that 2013 would be the year for substantial Medicare policy changes. Many also perceived that Congress once and for all would address the formula—known as the sustainable growth rate (SGR)—that adjusts Medicare physician payment rates each year, creating an opportunity to couple an SGR

fix with concrete steps toward broad cost containment, especially Medicare provider payment reform.

Some projects and reports were designed to bridge diverse points of view, ranging from health policy experts with different policy perspectives (Brookings Institution, Commonwealth Fund, and National Center for Public Policy Research) to explicitly bipartisan efforts (Bipartisan Policy Center and Simpson-Bowles) to various industry and consumer stakeholder initiatives (Partnership for Sustainable Health Care and National

## Exhibit 1. Cost Containment Strategies Reviewed

**Pacific Business Group on Health (PBGH).** PBGH convened an employer “kitchen cabinet” to stimulate and elevate large employers in discussions to reduce health care spending.

**Partnership for Sustainable Health Care.** The Partnership for Sustainable Health Care brought together five distinct stakeholders—America’s Health Insurance Plans, Ascension Health, Families USA, the National Coalition for Health Care and the Pacific Business Group on Health—to craft a consensus agenda for health system reform.

**Bipartisan Policy Center (BPC).** BPC developed a system-wide approach to cost containment emphasizing the potential for bipartisan support and political feasibility. The project was led by the organization’s Republican and Democratic leaders in health policy and economic policy.

**National Coalition on Health Care (NCHC).** NCHC developed a plan through a series of off-the-record discussions with health experts and a diverse range of member stakeholder groups, including providers, consumer advocates, health plans, and employers.

**Brookings Institution.** Updating earlier reports in the Bending the Curve series, Brookings brought together experts from a range of political perspectives to develop delivery system reforms to slow the rate of spending growth.

**State Health Care Cost Containment Commission (SHCC).** The University of Virginia’s Miller Center organized a commission led by two former governors that included representatives from key sectors of the health care industry to outline an agenda for state governments to control health care costs.

**National Commission on Physician Payment Reform (NCPPR).** Organized by the Society of General Internal Medicine, the commission included a diverse range of health care leaders and thinkers and developed recommendations to reform physician payment to restrain health care costs and improve patient outcomes.

**Center for American Progress (CAP).** Developed by CAP staff, the Senior Protection Plan seeks to reduce federal health care spending through efficiencies rather than shifting costs or rationing care.

**Commonwealth Commission on a High Performance Health Care System.** The Commonwealth Fund convened and staffed a commission of health care leaders to develop a plan to stabilize U.S. health spending while moving to a better performing health care system.

**Simpson-Bowles.** The Moment of Truth Project, led by Democrat Erskine Bowles and Republican Alan Simpson updated its 2010 comprehensive deficit reduction plan.

Coalition on Health Care). SHCC incorporated both the bipartisan approach and diverse stakeholders. Others were drafted by those who share a common vision, such as large employers (Pacific Business Group on Health) or progressive political philosophy (Center for American Progress).

## The Vision: Moving from Volume to Value

Overall, the 10 reports reflect a striking consistency in approaches to containing health care costs. All want to diminish the role of fee-for-service (FFS) payment by moving to payment methods that will foster delivery system reform focused on improving population health through greater clinical integration and care coordination. New payment approaches include accountable care organizations (ACOs) and similar approaches to global payment, bundled payment for episodes of care, and patient-centered medical homes. The reports envision savings from reducing services that contribute little to patient outcomes and better quality of care through improved care coordination and chronic disease management.

## Strategy

As the most powerful lever over federal health care spending and a major driver of health care delivery change, Medicare payment policy is at the heart of almost all of the cost-containment proposals. Medicare changes can have broader influence on providers, particularly hospitals and post-acute care providers. Indeed, Medicare payment reforms are designed to stimulate changes in delivery, which would affect all patients. SHCC, with a mission to focus on state cost-control opportunities, identifies Medicaid, state employee health plans, and state health insurance exchanges, along with state regulatory authority in other health areas, such as malpractice, scope of practice and price and quality transparency, as key levers for state government.

These proposals are distinct from past federal cost-containment efforts that have focused on administered Medicare prices for services. All of the reports identify increased productivity—fewer resources to deliver care of comparable or better quality—as the only way to reduce federal spending in the long run. And, almost all of the reports explicitly avoid policies that reduce federal

outlays mostly at the expense of other payers, providers, or patients.

But some important exceptions exist. Many of the reports identify specific types of services that are commonly perceived as overpaid by Medicare and recommend either direct payment rate cuts or competitive mechanisms designed to lead to lower prices. For example, the BPC, CAP, and NCHC proposals call for expanded competitive bidding in Medicare for durable-medical equipment (DME), noting that experience to date shows large price reductions are possible without limiting beneficiary access. Additionally, many of the reports focus on other aspects of Medicare, including benefit design, premiums, and eligibility.

Most of the reports also go beyond Medicare, stressing that without changes in the health system as a whole, large Medicare savings over the long term cannot be achieved. Brookings, CAP, and BPC recommend changes in the tax treatment of employer-sponsored health insurance, which would increase federal revenues and influence the delivery system by diminishing the prevalence of overly comprehensive health benefits that work at cross purposes with cost-control efforts. SHCC is quite distinct in calling for a state-led approach to establish regular data collection on aggregate state-level spending and quality, setting goals for trends over time and responding with corrective policies should performance fall short. Some reports outline changes in antitrust and other policies to increase provider competition in quest of lower prices.

To maintain broad stakeholder coalitions, especially bipartisan approaches, no group considered changes in the controversial core of the Affordable Care Act (ACA)—the Medicaid expansion and tax subsidies to purchase private coverage. In contrast, some reports did focus on less-controversial ACA aspects, for example, by seeking to amplify the effects of ACA Medicare payment innovations on the delivery system.

### **Medicare Provider Payment Reform**

The various groups generally agree about the importance of reducing the role of FFS payment in Medicare but diverge on how to accomplish this. Indeed, many provide no explicit policies to reduce the FFS role in

Medicare and simply set ambitious goals. For example, PBGH sets a target of 75 percent of Medicare payments through non-FFS arrangements by 2020. CAP has a similar goal of 75 percent of hospital payments within 10 years. NCPPR recommends a five-year transition to eliminate FFS payment. Advocating a diminished FFS role is certainly meaningful and represents a change in thinking in recent years, but specifying targets without concrete steps limits the potential influence on policy.

In contrast, some of the reports have specific proposals to shift payment away from FFS. BPC and Brookings link provider payment rate updates to participation in reformed-payment approaches. NCPPR makes the important point, as do some other reports, that even with a major shift away from FFS payment, addressing the shortcomings of the Medicare physician fee schedule, such as overly low payment rates for evaluation and management services in relation to rates for procedures, remains very important.

All of the proposals would end the SGR approach to Medicare physician payment rates, with many tying higher annual rate updates to physician participation in reformed payment approaches. Brookings would link physician payment rate increases to comparisons of spending growth in fee-for-service payment and alternative payment approaches versus a spending-trend goal. NCPPR also would incorporate into an SGR fix a substantial shift in payment rates from procedures to evaluation and management services.

In contrast to BPC and Brookings, which focus on provider organizations, the NCHC focuses on performance of individual practices. This distinction between incentives for provider organizations and individual practices is important; Medicare is currently pursuing policies emphasizing both the former (ACOs and bundled payment) and the latter (physician value-based modifiers). The former approach would delegate the challenging task of motivating and supporting physicians to practice differently to organizations that they form. The latter involves measuring efficiency and quality at the individual physician level and may not be technically feasible yet.

A key accompaniment to payment reform in a number of the reports is giving Medicare beneficiaries a stake in cost-containment efforts. For example, the BPC would

reduce Medicare Part B premiums for beneficiaries enrolling in Medicare Networks—the group’s proposed second-generation ACO—and offer reduced patient cost-sharing to beneficiaries that choose providers in the Medicare Network. Likewise, Brookings calls for beneficiary enrollment in Medicare Comprehensive Care Organizations—its proposed second-generation ACO—with lower premiums or cost-sharing offered as an incentive. In both of these proposals, enrolling beneficiaries would address the beneficiary attribution challenge that some Medicare ACOs are finding problematic.

### **Revamping the Medicare Benefit Structure**

Although influenced by private health insurance at the time of its inception, Medicare has adopted few private-sector benefit-design innovations. The only major change was the addition of prescription drug benefits in 2006—about three decades after this happened in private insurance. Many Medicare cost-containment proposals include major benefit design overhauls to both improve financial protection and also make beneficiaries more conscious of costs.

The two most important changes are creating a unified benefit structure and protection against catastrophic expenses. Many proposals would replace the separate deductibles for Part A and Part B services with a single deductible. The unified structure would also include an annual limit on out-of-pocket expenses, a long-common feature in private plans and required in Medicare Advantage and now (per the ACA) in private plans. Although changing the distinct financing of Parts A and B is still seen as an impossible political task, advocates for a unified structure believe that actuarial calculations to assign payments to the correct trust fund can permit continuation of the existing financing distinctions.

Some reports recommend restrictions on private coverage to supplement Medicare—so-called Medigap coverage. This is another aspect of bringing the Medicare benefit design up to date; few with commercial coverage have zero patient cost-sharing at the point of service, which is what happens when a supplemental policy pays all of Medicare’s cost-sharing. Another motivation is to generate budget savings—the presence of supplemental coverage raises Medicare spending through

additional service use. For those envisioning second-generation ACO models that engage beneficiaries, existing supplemental coverage would be an obstacle to meaningful incentives to guide patients to in-network providers.

Although the degree to which supplemental coverage increases Medicare spending might justify a tax or fee on supplemental coverage, the proposals instead emphasize restrictions on the comprehensiveness of coverage in supplemental plans. Brookings would require that overall patient cost-sharing be at least 10 percent on an actuarial basis. CAP would prohibit first-dollar coverage for the first \$500 of costs for higher-income beneficiaries but exclude primary care costs from the limit. BPC would limit supplemental coverage to 50 percent of applicable Medicare patient cost-sharing.

Some proposals would increase support for low-income beneficiaries, moving in the direction of the ACA approach for the nonelderly. Simpson-Bowles would decrease deductibles and the out-of-pocket maximum for low-income beneficiaries. Likewise, BPC would expand existing cost-sharing assistance on a sliding scale to beneficiaries with incomes up to 150 percent of poverty. A number of proposals would increase Medicare Part B and Part D premiums for higher-income beneficiaries. Some would lower the income threshold for higher premiums (BPC), while others would raise premiums for higher-income beneficiaries without changing the thresholds (Simpson-Bowles and CAP).

Only Simpson-Bowles recommends increasing the Medicare eligibility age from 65 to 67. The lack of interest by others might be attributed to their orientation toward systemic change in health care delivery, while the eligibility age is a broader federal fiscal issue—how much can the nation afford—rather than a health policy issue. Expansion of the ACA to this age group or permitting them to buy into Medicare would transform the Medicare age of eligibility from a coverage issue to a financing issue.

### **Medicare Premium Support Not on the Table**

None of the proposals call for Medicare premium support, a topic that was discussed extensively from 2010 to 2012 and recently raised again by Congressman Paul Ryan (R-WI). Although some organizations

involved in the reports have long opposed premium support, others apparently decided not to put it forward out of concern that the 2012 presidential campaign made the approach politically toxic. BPC would set the benchmark payment for Medicare Advantage through competitive bidding, but this differs from premium support because the process would not affect the amount that beneficiaries pay for traditional Medicare.

### Medicaid Reform

Many of the reforms suggested for Medicaid focus on managed care for people dually-eligible for Medicare and Medicaid. With a large-scale demonstration of this approach just getting underway, the reports were limited by the uncertainty about how successful the initiatives will turn out to be. Brookings emphasizes developing an improved data infrastructure to more easily assess savings and quality of care, along with offering shared savings to states. BPC also advocates greater opportunities for states to share in savings under these demonstrations.

Brookings proposes broadly revamping the process for state Medicaid waivers. For some time, much of the innovation in Medicaid, including managed care, has proceeded through specific waivers. Brookings would replace this approach by giving states more authority to innovate and use global spending projections where states take “two-sided” risk from changes in spending associated with their innovations. Simpson-Bowles takes a more cautious but generally similar approach to reforming the waiver process by fast tracking waivers that are promising and enabling states to share in savings. These recommendations appear broadly consistent with SHCC’s view of Medicaid as a key lever for pursuing coordinated care through state targets for spending and quality.

### Tax Policy for Health Insurance

One area outside of Medicare and Medicaid with potentially profound implications for cost containment is the tax treatment of employer-sponsored health insurance. With employer premium contributions—and most employee contributions—not taxable to the employee, there is a powerful incentive for employers to provide more comprehensive health insurance than they would if tax policies were neutral between health insurance and cash wages. The result has been health

insurance with minimal patient cost-sharing and broad choice of providers—characteristics that lead to high and rising health care spending. For many years, economists across broad political perspectives have recommended limiting the amount of contributions to health insurance that would be tax-free to employees. The ACA took an important step in this direction by taxing insurers and self-insured employers that provide coverage with premiums exceeding specified thresholds for single and family coverage—the so-called Cadillac tax that takes effect in 2018.

Many perceive the Cadillac tax as an awkward way to address the problem. BPC believes that the inability of insurers to deduct Cadillac tax payments as a business expense will result in a de facto cap on insurance premiums rather than just a limit on tax benefits. Both BPC and Brookings recommend replacing the Cadillac tax with a cap on the income tax exclusion of employer health benefits. A BPC simulation of its specific proposal concluded that it would be more progressive than the Cadillac tax. Both BPC and Brookings view their ideas as improvements on the Cadillac tax, but if these improvements cannot be made, both strongly prefer retaining the Cadillac tax over repealing it.

The other groups—except for CAP, which advocates an exclusion cap limited to high-income persons—do not venture into the tax treatment of employer health benefits—likely reflecting the longstanding opposition of both unions and employers to the idea and lack of support by providers, who want patients to have more comprehensive insurance. Nevertheless, it is instructive that none of the reports advocate repealing the Cadillac tax, which is now the baseline for budgeting. Indeed, many large employers are reportedly changing their health plans to prepare for the Cadillac tax.

### Spending Targets

Many of the reports include setting spending-growth targets based on GDP growth. Some of the reports focus on Medicare targets, where current law tasks the Independent Payment Advisory Board (IPAB), not yet appointed, with preventing the Medicare spending trend from exceeding GDP plus one percentage point. BPC and Brookings advocate tighter limits for Medicare and applying the limits separately to the traditional program and to Medicare Advantage, which would be

enforced through lower provider payment rate updates. Generally, the targets are perceived as back-ups to other mechanisms designed to slow spending, such as provider payment reforms.

The Partnership for Sustainable Health Care recommends state spending growth targets, with the federal government rewarding states that meet the targets—for example, through higher Medicaid matching rates—but not penalties for exceeding them. SHCC’s strategies are consistent with this. Like the BPC and Brookings proposals for Medicare, these state approaches are seen as motivating states to pursue a range of policies to meet spending targets. Many point to the SGR experience to conclude that either growth targets should only be used as a back up to policies to contain costs or should trigger a broad policy process rather than use a rigid formula.

### **Increasing Competition in Health Care Markets**

For Medicare and Medicaid, most cost-containment strategies generally look beyond the traditional tools of cutting prices and instead focus on encouraging more efficient delivery. In contrast, for private payers, high provider prices are a big issue. In recent years, price increases have accounted for a large part of increased private health care spending for a variety of reasons, including less service utilization in response to the economic downturn, increased patient cost-sharing, additional utilization management and, apparently, a slowing of expensive new technologies entering use.

A number of reports include proposals to use antitrust policy to increase competition. For example, Brookings recommends tightening a Federal Trade Commission (FTC) practice of allowing physician organizations, such as independent practice associations, that can demonstrate clinical integration to negotiate prices for member physicians without bearing financial risk for patient care. Brookings would make such permission contingent on physician organizations’ reporting data to allow the FTC to assess whether, in fact, they are saving money for purchasers and increasing quality. Permission to negotiate contracts would be withdrawn in situations where consumers do not benefit.

BPC, PBGH, and NCHC recommend prohibiting provider-contracting practices that suppress competition,

including hospitals insisting on placement in the preferred tier under tiered-benefit designs as a condition of contracting; so-called “most-favored nation” clauses where a hospital commits to an insurer getting the lowest price; and hospital systems insisting that insurers contract with all units in the system.

### **Price and Quality Transparency**

The reports broadly support greater price and quality transparency but offer more in the way of goals than specific approaches, such as the SHCC recommendation that states should gather price (and quality) information to help inform consumer choices. CAP, PBGH, Brookings and Simpson-Bowles would prohibit “gag clauses” in contracts between health plans and providers that prohibit disclosure of negotiated prices. CAP wants insurers to release claims data, while BPC stresses information for enrollees with high-deductible health plans to make cost-conscious choices. Brookings notes the potential pitfall of price transparency discouraging providers or plans from offering discounts and suggests that transparency focus on prices for large units of care, such as an entire episode, to preclude this problem.

The reports suggest various ways to expand and improve the quality data available to consumers and others. Brookings calls for the development and adoption of consistent methods for measuring quality across providers. As a condition of participation in insurance marketplaces, plans would publish provider-level information on utilization and quality, permitting aggregation of this information across all public and private payers so that comprehensive and reliable information on provider performance is publicly available.

### **Medical Liability Reform**

Virtually all of the reports address medical malpractice liability reform, with most proposing approaches that go beyond capping damages—an issue long in gridlock at the federal level but adopted by many states over time. Simpson-Bowles recommends caps and augmenting them with shorter statutes of limitation, so-called “fair-share” rules allocating responsibility to the various defendants, sliding-scale limits on lawyers’ contingency fees, consideration of collateral source income in deciding damages and applying a health court model for malpractice claims.

Many of the reports call for safe harbors for providers following evidence-based clinical guidelines. It is striking how quickly this approach has gained support over a relatively short period of time. A number of reports call for additional demonstration activity, particularly at the state level, including federal funding and technical assistance for states.

### **Barriers to Advanced Practice Nurses and Other Professionals**

Efficiency in health care delivery is impeded by state scope-of-practice laws that prevent advanced practice nurses and other non-physician professionals from practicing to the extent of their capabilities. All of the reports that took up this issue seek to expand the role of advanced practice nurses. BPC supports the National Council of State Boards of Nursing Model Nursing Practice Act, which to date has been adopted by 17 states. CAP would have the federal government provide bonus payments to states that allow non-physician providers to practice to the extent of their training.

But scope-of-practice laws are only one barrier to advanced practice nurses, with payer rules possibly posing an even greater obstacle.<sup>1</sup> For example, Medicare requires a collaborative relationship with a physician for nurse practitioner services to be reimbursed and does not permit nurse practitioners to order home health services or durable medical equipment. CAP, BPC, PBGH, and PSHC all call for the elimination of these barriers.

### **Greater Role for States**

SHCC and many of the others recognize that state initiatives to control spending will be critical. SHCC emphasizes that states have an advantage as the control strategies have to be tailored to the unique health care markets and cultures of individual states. Most reports generally do not call for federal mandates to states but instead advocate federal financial incentives to states and technical support.

The SHCC approach of state targets for spending and quality would likely reinforce this as another motivator to adopt promising policies in these areas. The federal government could still encourage specific policies, but if most of the reward is based on overall performance on

spending and quality, this could shift the state calculus from checking boxes to choosing effective policies.

### **Wellness and Prevention**

While many of the reports discuss wellness and prevention as being critical to long-term slowing of cost trends, there is recognition of the lack of evidence about economic impact of interventions to promote wellness. BPC recommends a large federal program of research and development.

A number of reports recommend increased taxation of tobacco, alcohol, and sweetened beverages. For tobacco, this includes both raising the federal excise tax (NCHC would increase it by \$1 per pack) and closing loopholes in the tobacco tax (CAP). NCHC calls for a penny per ounce federal excise tax on sweetened beverages as well as equalizing taxation of beer, wine and liquor and updating the taxes for inflation. In contrast to wellness activities, the connection between these tax initiatives and reductions in health spending is well established.

### **Opportunities and Obstacles**

Reflecting on these reports, some key policy opportunities and obstacles are apparent. The consistent vision among payers, purchasers, and providers of using provider payment reform to reshape care delivery offers an important opportunity. The Medicare provider payment cuts in the ACA have bolstered this opportunity, since broader payment units expand provider options to increase productivity and deliver the savings demanded by Medicare. The consensus about the need for an SGR fix also provides a policy opportunity to advance payment reform.

But two key obstacles to provider payment reform are not addressed by the reports. One is that innovative payment and contracting approaches are rudimentary at this point and to date offer little information about impact. While Brookings and BPC each outlined “second-generation” models of ACOs and BPC offered a mandatory version of bundled payments, there is little evidence on the ground of the effectiveness of first-generation ACOs. The consensus around diminishing the role of fee-for-service is sufficiently strong that attractive second generation models might be pursued without waiting for the evaluation results of the initial approaches. Looking at these approaches

from the provider side, it is clear that the capacity to manage population health, coordinate care across many settings, and to draw on newly available performance information will take substantial time and resources to develop.

The other key obstacle to payment reform is the importance of various payers using consistent approaches. Lower hospital admission rates achieved through changes in care delivery lead to gains under ACO contracts but losses under traditional payment. Development and implementation of new payment models across the public and private sectors is critical to mustering sufficient critical mass in local health care markets to advance care delivery improvements.

Demand-side approaches to cost containment, long perceived in the health care community as a barrier to needed care, have become much more important as a result of both actions by employers providing coverage—principally higher deductibles—and ACA policy changes. Some large employers are embracing defined contributions and private exchanges, prompted in part by the Cadillac tax. Public exchanges appear to be leading a sharp shift toward limited-provider networks, a response to the highly competitive environment created through web sites, standardized actuarial values and the absence of medical underwriting.

The movement toward demand-side approaches to date has bypassed the Medicare program. With extensive supplemental coverage, most beneficiaries in the traditional program face no cost-sharing at the point of service. The ACA's design of ACOs and other approaches to motivate providers to reduce costs and increase quality purposefully do not engage beneficiaries and eschew any restrictions on beneficiary choice. Indeed, the potential of provider payment reforms to contain costs will be compromised without involving beneficiaries and risks tension between provider efforts to respond to incentives and beneficiary resistance to change.

Another opportunity is to move to new approaches to federalism. Although the notion of Medicaid block

grants has gone nowhere for decades, proposals by SHCC and others to move from waivers toward greater state autonomy coupled with incentives for improved cost and quality performance for either Medicaid or all health care spending in the state could be a productive path forward.

The fact that many of the reports, particularly those from stakeholders, are short on specifics may cause some to doubt the potential for progress on the broader consensus about needed cost-containment strategies. Stakeholders that will negotiate specifics during the legislative process cannot be expected to “tip their hand” in advance. But their work together to develop a shared vision for cost-containment efforts—even if it is at 30,000 feet—will be valuable to the subsequent policy process to develop the concrete steps.

Clearly, the political polarization at the federal level will complicate meaningful efforts to slow health care spending growth to a sustainable level. The most significant obstacle is the absence to date of the broad decisions about taxes and how much savings to seek through entitlement reform. Targets for revenues and Medicare savings create the environment for meaningful policy to contain costs.

And, much work needs to be done to shift Americans' views about what constitutes high-quality care. Shifting the current paradigm from one of more care is better and that more expensive care is even better will be difficult at best and impossible at worst if the public perceives delivery system reforms are all about cost containment at the expense of quality.

While delivery system reforms can accomplish a lot, the scope of cost containment policy will eventually have to expand into health promotion. Although health providers can certainly contribute to health promotion and should be motivated and supported to do so, government also has a role to improve health through policies that discourage tobacco and drug use and encourage better nutrition and more exercise.

*Note: The author was the president of the Center for Studying Health System Change when this paper was written.*

## Endnotes

- 1 Tracy Yee, Ellyn R. Boukus, Dori Cross and Divya R. Samuel, *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, National Institute for Health Care Reform, Research Brief No. 13, February 2013. <http://www.nihcr.org/PCP-Workforce-NPs>.