Eur J Health Econ (2014) 15:113–116
DOI 10.1007/s10198-013-0548-2

EDITORIAL

Is the US "leading from behind" on health policy?

Peter J. Neumann · Cayla J. Saret

Received: 31 October 2013 / Accepted: 21 November 2013 / Published online: 10 December 2013

Introduction

There is a common and perhaps understandable perception that the US is an international laggard when it comes to health policy. The US famously spends far more per capita than other countries, despite middling performance on key population health metrics. The country's political system and cultural traditions make it challenging at the national level to advance sweeping social policy of any kind, including health policy. The US was the last industrialized nation to enact a comprehensive health insurance plan for its citizens, for example, and implementation of that law, the 2010 Affordable Care Act (ACA), continues to be deeply controversial. The American health care system has historically been decentralized and fragmented and heavily influenced by interest groups.

Yet it would be a misconception to infer that the US is lagging in health policy innovation. Indeed, a quiet transformation is occurring in the country in terms of new organizational arrangements, incentive-based programs, and an orientation in research towards "patient-centeredness." As in foreign policy, where the US has been characterized as "leading from behind" on flashpoints from Libya to Syria, one might conceive of US health policy in somewhat similar fashion.

P. J. Neumann (✉) · C. J. Saret
Center for the Evaluation of Value and Risk in Health,
Institute for Clinical Research and Health Policy Studies,
Tufts Medical Center, 800 Washington Street,
Box #063, Boston, MA 02111, USA
e-mail: pneumann@tuftsmedicalcenter.org

The US as a laggard in health policy

Much has been written about "American exceptionalism," the idea that the country, because of its unique history, retains its commitment to personal liberties and free markets, as well as a streak of anti-authoritarianism [1]. As the scholar James Q. Wilson has written, the nation was founded by a people who had no experience with a hereditary aristocracy or king, and the European settlers who reached America came to occupy a vast and isolated continent [2]. This has translated through the ages to more culturally conservative voters, domestic policies ranging from maintenance of capital punishment to the right to bear arms, and a foreign policy committed to spreading American-style democracy across the globe.

The absence of national health insurance has long been discussed as part of the peculiar arc of American social policy. The cultural heritage as well as the US system of government, with its checks and balances system ensuring that no branch can become too powerful, has impeded the adoption of large-scale health reforms. Moreover, a tradition of federalism has meant a distribution of power between central authorities and states and locally elected officials.

Americans' trepidation about relinquishing too much power to central health authorities can be seen in various policies. National efforts to establish health technology assessment bodies have faltered [3]. The Medicare program, which provides health insurance to some 40 million, mostly older Americans, does not consider costs and cost-effectiveness when deciding whether to cover a new technology. The ACA created an Independent Payment Advisory Board to recommend spending reductions for Medicare but is prohibited from "rationing care." The law

also created a Patient-Centered Outcomes Research Institute (PCORI) to conduct comparative effectiveness research, but forbids it from using cost per quality-adjusted life year thresholds [4].

The US as "leading from behind"

The US health system attempts to cobble together, through a series of public programs, employment-based insurance, taxes, mandates, and subsidies, a piecemeal arrangement that by default and design encourages states and the private sector to fill in the gaps. The innovation in health policy underway is sparked in part by the ACA, but it is also the consequence of states and private businesses taking matters into their own hands.

Payment and delivery reforms

Gradually but unmistakably, the country is adopting new approaches to paying for and delivering health care. While details differ across payers and delivery networks, the new systems attempt to pay for value rather than volume by putting hospitals and physicians at some financial risk for the patient care delivered, while simultaneously monitoring the quality of care provided.

Hospitals and integrated delivery systems in the private sector are, for example, creating accountable care organizations (ACOs) to achieve these goals. The number of private ACOs increased from 164 in September 2011 [5] to 235 in July 2013 [6], with more to follow [7–9]. Additionally, the ACA established different public ACO models under the Medicare program (e.g., under a "high-risk" model, providers can earn higher rewards for delivering care under prescribed budgets but incur penalties for exceeding thresholds) [10]. ACOs are innovating in various ways, such as using improved analytics to identify patients at high risk of hospitalization [11]; shifting resources towards prevention, mental health, chronic disease management, and telehealth technologies; and adding incentives to steer patients to more efficient providers and services [12–15]. A recent study found that in the state of Massachusetts, a sample of ACOs achieved average savings of 2.8 % over the first 2 years of the program, along with improvements in the quality of care provided [16].

Private employers are themselves experimenting with various initiatives. As of 2012, 94 % of large employers (those with over 200 employees) offered wellness programs, for example, tying employee premiums or other rewards or penalties to behaviors such as participation in smoking cessation programs or outcomes such as weight loss [17]. At least some studies suggest a positive return on investment and reductions in terms of sick leave and workers' compensation, though more research is needed [18]. Employers are also exploring initiatives such as offering no-cost hip and knee replacement surgeries, along with travel expenses to the appropriate health care centers, to employees who utilize high-value providers.

Individual states serve as laboratories for reforms. The state of Vermont, for example, is creating its own single payer system [19]. In Oregon, the governor likes to tell the story of a hypothetical elderly woman with congestive heart failure in an apartment without air conditioning. The governor is restructuring Medicaid, the state's public insurance program for low-income residents, so that it would be able to pay for a $200 air conditioner, a cost not traditionally covered, in order to prevent the woman from suffering a heart attack and avoid the subsequent $50,000 bill for medical care [20]. Oregon has also created coordinated care organizations, accountable for not only the health of their members (as with an ACO), but also for the health of the community (e.g., they can allocate resources for preventive care or public services). Elsewhere, the state of Washington has created its own health technology assessment program (and considers cost-effectiveness among other factors) [21]. Massachusetts, which implemented health reforms that served as a model for the ACA, enacted a law that established annual health cost growth targets for the state (albeit with limited enforcement mechanisms) as well as an agency to oversee the system [22].

Value-based cost sharing

Research suggests that patient cost-sharing in health care (via co-payments, deductibles, and co-insurance) is more widespread in the US than in Europe [23–25]. While the practice has traditionally been applied rather crudely, i.e., without linking cost sharing to evidence of value, the US is pioneering new incentive structures for patients and providers, relying in part on principles of behavioral economics [26].

For example, plans are using tiered provider networks to encourage patients to shift to high quality, cost-effective hospitals [27]. More are adopting value-based insurance design, which incorporates incentives for patients to use pharmaceuticals and other services in accordance with evidence of value [28, 29]. Studies report increases in adherence rates from 3 to 6 % from such adjustments [30–35]. Similarly, some plans are requiring higher copayments for the use of low-value diagnostic imaging services to discourage overdiagnosis [36]. Some wellness programs offer incentives to employees to change health behaviors in order to decrease absenteeism and employer costs, targeting smoking and obesity as key conditions. The ACA requires that health insurers provide full coverage of high value preventive care—those services rated "A" or "B" by the United States Preventive Services Task Force—and permits greater use of incentives in workplace wellness programs.

Patient-centered research

Adding the words "patient-centeredness" to the name of a new institute intended to conduct comparative effectiveness research was an eleventh-hour compromise during the ACA debate in order to mollify political opposition that feared the new institute would simply serve interest groups rather than improve patient care. It remains to be seen whether and how the fledgling Patient-Centered Outcomes Research Institute (PCORI) will actually change the research landscape. Moreover, the trend toward emphasizing patients is not limited to the US; for example, the European Patients' Academy on Therapeutic Innovation, founded in 2012, seeks to empower patients to engage with research and development of medicines [37].

Still, in a discussion of innovation in US health policy, the PCORI bears notice. The idea of patient sovereignty and patient-centered outcomes resonates with policy makers and even harkens back to American traditions of individual liberties. With a mandate to increase the involvement of patients at all phases of clinical research, including topic selection, methodology, investigation, and communication of findings, the PCORI seeks to focus on outcomes important to patients that have not traditionally been emphasized, such as quality of life.

Conclusion

Drawing conclusions about the trajectory of the US health care system is a fraught exercise, given the system's complexity and the stormy political climate. The system is far from perfect, with inefficiencies enduring at all levels. Still, behind the scenes, organizations are innovating and the landscape is changing. The causes of the recent slowdown in US health care growth have been much debated, but the trend seems in part driven by the kinds of structural changes such as payment reforms and cost sharing noted above [38]. The idea of America "leading from behind" in health policy seems apt. Of course, Europe has experienced its own moderation in health costs and has seen its own structural changes. However, US experiences are worth noting and might even serve as models for European experimentation, particularly in delivery reforms, the use of incentives to encourage cost-effective care and the move to patient-centeredness [39].

References

1. Neumann, P.J.: American exceptionalism and American health care: implications for the US debate on cost-effectiveness analysis. Office of Health Economics 47 (2009)
2. Wilson, J.: American exceptionalism. American Enterprise Institute for Public Policy Research, Washington, DC. On the Issues (2006)
3. Luce, B., Cohen, R.S.: Health technology assessment in the United States. Int. J. Technol. Assess. Health Care. **25**(Suppl 1):33–41 (2009)
4. Neumann PJ, Weinstein MC.: Legislating against use of cost-effectiveness information. N. Engl. J. Med. **363**(16), 1495–1497 (2010)
5. Muhlestein, D., Croshaw, A., Merrill, T., Peña, C.: Growth and dispersion of accountable care organizations. Leavitt Partners, Center for ACO Intelligence (2011)
6. Petersen, M., Muhlestein, D., Gardner, P.: Growth and dispersion of accountable care organizations. Leavitt Partners, Center for Accountable Care Intelligence (2013)
7. Beyond Medicare: Private payers embrace ACOs by the hundreds. The Advisory Board Company (2013)
8. Muhlestein, D.: Continued growth of public and private accountable care organizations. Health Aff. Blog. (2013)
9. Muhlestein, D., Croshaw, A., Merrill, T., Peña, C.: Growth and dispersion of accountable care organizations. Leavitt Partners, Center for Accountable Care Intelligence (2012)
10. Landon, B.E.: Keeping score under a global payment system. N. Engl. J. Med. **366**(5), 393–395 (2012)
11. Zigmond, J.: Why one Medicare pioneer ACO succeeded in saving money. Modern Healthcare Magazine. 7-16-2013
12. Bartolini, E.: Accountable care organizations and innovation: a changing landscape. Health Aff. (2013). http://healthaffairs.org/blog/2013/06/28/accountable-care-organizations-and-innovation-a-changing-landscape/
13. Partnership for Sustainable Health Care: strengthening affordability and quality in America's health care system. Robert Wood Johnson Foundation (2013)
14. Evans, M.: Embracing ACOs. Modern Healthcare Magazine. 8-10-2013
15. Chernew, M.E., Mechanic, R.E., Landon, B.E., Safran, D.G.: Private-payer innovation in Massachusetts: the 'alternative quality contract'. Health Aff. **30**(1), 51–61 (2011)
16. Song, Z., Safran, D.G., Landon, B.E., Landrum, M.B., He, Y., Mechanic, R.E., et al.: The 'alternative quality contract', based on a global budget, lowered medical spending and improved quality. Health Aff. **31**(8), 1885–1894 (2012)
17. Cawley, J., Price, J.A.: A case study of a workplace wellness program that offers financial incentives for weight loss. J. Health Econ. **32**(5), 794–803 (2013)
18. James, J.: Health policy brief: workplace wellness programs. Health Affairs (2013)
19. Hsiao, W.C., Knight, A.G., Kappel, S., Done, N.: What other states can learn from Vermont's bold experiment: embracing a single-payer health care financing system. Health Aff. **30**(7), 1232–1241 (2011)
20. Klein, E.: Is the future of American health care in Oregon? 5-20-2013. The Washington Post, Wonkblog
21. Blackmore, C.C.: Using evidence to inform coverage decisions: the Washington State experience. Acad. Radiol. **19**(9), 1055–1059 (2012)
22. Mechanic, R.E., Altman, S.H., McDonough, J.E.: The new era of payment reform, spending targets, and cost containment in Massachusetts: early lessons for the nation. Health Aff. **31**(10), 2334–2342 (2012)
23. Garattini, L., van de Vooren, K.: Could co-payments on drugs help to make EU health care systems less open to political influence? Eur. J. Health Econ. **14**(5), 709–713 (2013)
24. Drummond, M., Towse, A.: Is it time to reconsider the role of patient co-payments for pharmaceuticals in Europe? Eur. J. Health Econ. **13**(1), 1–5 (2012)

25. Cohen, J., Cairns, C., Paquette, C., Faden, L.: Comparing patient access to pharmaceuticals in the UK and US. Appl. Health Econ. Health Policy **5**(3), 177–187 (2006)
26. Brooks, D.: The unexamined society. New York Times 2011 Jul 7; Sect. Op-ed
27. Sinaiko, A.D., Rosenthal, M.B.: Consumer experience with a tiered physician network: early evidence. Am. J. Manag. Care **16**(2), 123–130 (2010)
28. Shrank, W.H.: Effect of incentive-based formularies on drug utilization and spending. N. Engl. J. Med. **350**(10), 1057 (2004)
29. Landon, B.E., Rosenthal, M.B., Normand, S.L., Spettell, C., Lessler, A., Underwood, H.R., et al.: Incentive formularies and changes in prescription drug spending. Am. J. Manag. Care **13**(6 Pt 2), 360–369 (2007)
30. Choudhry, N.K., Avorn, J., Glynn, R.J., Antman, E.M., Schneeweiss, S., Toscano, M., et al.: Full coverage for preventive medications after myocardial infarction. N. Engl. J. Med. **365**(22), 2088–2097 (2011)
31. Loewenstein, G., Asch, D.A., Volpp, K.G.: Behavioral economics holds potential to deliver better results for patients, insurers, and employers. Health Aff. **32**(7), 1244–1250 (2013)
32. Fendrick, A.M., Chernew, M.E.: Value-based insurance design: aligning incentives to bridge the divide between quality improvement and cost containment. Am. J. Manag. Care. (2006); 12 Spec no. SP5-SP10.:SP5-SP10
33. Chandra, A., Gruber, J., McKnight, R.: Patient cost-sharing, hospitalization offsets, and the design of optimal health insurance for the elderly. NBER working paper no 12972 (2007)
34. Chernew, M.E., Rosen, A.B., Fendrick, A.M.: Value-based insurance design. Health Aff (Millwood) **26**(2), w195–w203 (2007)
35. Chernew, M.E., Juster, I.A., Shah, M., Wegh, A., Rosenberg, S., Rosen, A.B., et al.: Evidence that value-based insurance can be effective. Health Aff. **29**(3), 530–536 (2010)
36. Lee, D.W., Levy, F.: The sharp slowdown in growth of medical imaging: an early analysis suggests combination of policies was the cause. Health Aff. **31**(8), 1876–1884 (2012)
37. About EUPATI. European Patients' Academy on Therapeutic Innovation (2013)
38. Cutler, D.M., Sahni, N.R.: If slow rate of health care spending growth persists, projections may be off by $770 billion. Health Aff. **32**(5), 841–850 (2013)
39. Ryu, A.J., Gibson, T.B., McKellar, M.R., Chernew, M.E.: The slowdown in health care spending in 2009–11 reflected factors other than the weak economy and thus may persist. Health Aff. **32**(5), 835–840 (2013)