



Statement of Paul B. Ginsburg, Ph.D.
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**Before the United States Senate
Committee on Finance**

**Hearing on “Rising Costs, Low Quality in Health Care:
The Necessity for Reform”**

June 3, 2008

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Chairman Baucus, Senator Grassley and members of the Committee, thank you for the invitation to testify about health care costs. My name is Paul B. Ginsburg, and I am an economist and president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded in part by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research, Inc.

HSC's main research tool is the Community Tracking Study, which consists of national surveys of households and physicians and intensive site visits to 12 nationally representative metropolitan communities. We also monitor secondary data and general health system trends. Our goal is to inform policymakers with objective and timely research on developments in health care markets and the impact on people. We do not make specific policy recommendations. Our various research and communication activities may be found on our Web site at www.hschange.org.

American health care—often lauded as the best in the world—is too expensive and growing more so every day. Too many Americans go without vital medical care because they are unable to afford health insurance.¹ At the same time, the overall quality of health care in the United States is uneven at best. How we finance health care and our pervasive unwillingness to confront the difficult trade-offs inherent in containing costs, improving quality and expanding coverage contribute to the seemingly intractable problem of stemming rising health care costs.

My testimony today will make three points:

- By any measure—per-capita spending and share of gross domestic product (GDP), for example—U.S. spending on health care is greater than other developed countries. In 2006, the United States spent \$2.1 trillion, or 16 percent of GDP, on health care, translating to \$7,026 per person annually.² But unlike other developed countries, which provide near-universal coverage, 47 million people in 2006, or 15.8 percent of the U.S. population, were uninsured.³
- The enormous amount of money spent on medical care in the United States does not appear to buy us outstanding health. Again, by almost any measure, ranging from infant mortality⁴ to preventable deaths,⁵ the United States does not measure up well against other developed nations.

¹ This testimony is in part based on previous work of the author. See Ginsburg, Paul B., and Len Nichols, “The Health Care Cost-Coverage Conundrum: The Care We Want vs. The Care We Can Afford,” Center for Studying Health System Change, Washington, D.C. (2003).

² Caitlin, Aaron, et al., “National Health Spending In 2006: A Year of Change For Prescription Drugs,” *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

³ U.S. Census Bureau, “Income, Poverty and Health Insurance Coverage in the United States: 2006” (August 2007).

⁴ Organisation for Economic Co-operation and Development (OECD), *OECD Health Data: Statistics and Indicators for 30 Countries* (July 2007).

⁵ Nolte, Ellen, and C. Martin McKee, “Measuring The Health Of Nations: Updating an Earlier Analysis,” *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

- Cost-containment and quality-improvement efforts are essential if Americans are to get better value for the tremendous amount of money spent on U.S. health care and to avoid an increasing proportion of our society lacking access to mainstream care.

Spending Beyond Our Means

After a significant respite in the mid-1990s during the zenith of tightly managed care, Americans are again struggling with health care costs rising substantially faster than incomes. According to data from the Kaiser Family Foundation-Health Research and Educational Trust Annual Employer Survey and the U.S. Department of Labor, premiums for employment-based private insurance increased 114 percent from 1999 to 2007, while average hourly earnings increased 27 percent, leaving a gap of 6.7 percentage points per year.

From 2007 to 2017, government economists expect U.S. health care spending to almost double from roughly \$2.2 trillion to \$4.3 trillion, while the share of GDP devoted to health care is expected to grow from 16.3 percent to 19.5 percent.⁶

Longer-range forecasts start with the premise that extrapolation of current trends will produce implausible results, such as more than the entire GDP going to health care, so they work from the other direction, considering how much health spending growth society will tolerate. This leads to conclusions that far more aggressive actions on the part of both the public and private sectors to control spending will be required than has been the experience to date. The Congressional Budget Office (CBO) recently published such a forecast, examining how rapidly health care spending could grow under the constraint that spending for goods and services other than health care does not decline in real terms from today's level. Under this scenario, health spending reaches 49 percent of GDP in 2082.⁷ The projection concludes that between 2018 and 2082, to meet this constraint, health spending could increase only 1 percentage point per year more rapidly than GDP on average (2.1 percentage points in 2018 declining to 0.4 percentage points by 2082), a much smaller gap than the historical experience.⁸

Even though other industrialized countries devote smaller percentages of GDP to health spending, their health care costs per capita also have grown faster than their GDPs. But recent analysis suggests that since the mid-1980s, other countries have had been more successful at limiting the gap between their health spending trends and GDP.⁹

⁶ Keehan, Sean, et al., Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare," *Health Affairs*, Web exclusive (Feb. 26, 2008).

⁷ Congressional Budget Office, "The Long-Term Outlook for Health Care Spending," No. 3085 (November 2007).

⁸ Personal communication with CBO staff.

⁹ White, Chapin, "Health Care Spending Growth: How Different Is The United States From The Rest Of The OECD?" *Health Affairs*, Vol. 26, No. 1 (January/February 2007).

Interestingly, the magnitude of difference between U.S. health spending growth and income growth has not been constant. On a number of occasions in past decades, public or private initiatives have slowed the rate of cost growth substantially, only to be followed by periods of particularly rapid growth.¹⁰ These findings suggest that initiatives to slow cost growth were effective but could not be sustained. This was certainly the case with restrictive models of managed care, which created an intense backlash.

Why Health Care Costs Are High

A combination of factors contributes to high health care costs, including the way most health care is financed. Since much of the need for health care is unpredictable, insurance pools are necessary to provide the wherewithal to pay for expensive services needed by the relatively few who are seriously ill at any particular time. Unlike most other forms of insurance, such as life or fire, the benefits of health insurance are not predetermined or defined in terms of a set payment for a distinct event, such as death or your house burning down. Instead, health insurers' financial obligations are defined in terms of spending on treatments that physicians and patients decide to pursue—providing an environment where treatment decisions can be made with little regard for costs. This provides great comfort for those who are ill, but the downside is that when someone else pays—the health insurer—patients and their physicians have little incentive to economize and make sure the expenditure is commensurate with the clinical value of the service.

The impact of reduced patient out-of-pocket costs is probably magnified by uncertainty about the effectiveness of many medical tests and procedures. Little information on comparative effectiveness of medical goods and services is produced by the private market because of limited ability to charge the millions of users of the research. But limited public funding for effectiveness research is puzzling, given the clear interests of those—public and private—who pay the costs of health insurance—not to mention taxpayers. To date, providers and developers of medical technology have been more effective politically than the much broader array of interests who would benefit from increased comparative effectiveness research. But pressures on government to address health care costs are changing this dynamic.

Why Health Care Costs Are Rising Rapidly

Health care costs are not just high; they are rising rapidly as well. We know that much of the long-term trend toward greater per-capita spending is driven by technological change—new diagnostic tests and treatments and new applications of older technologies.¹¹ Much of this is highly valuable, but the benefits are diminished when the technology is applied beyond those patients most likely to benefit from it. But rapid technology diffusion would not be possible

¹⁰ Altman, Drew E., and Larry Levitt, "The Sad History of Health Care Cost Containment as Told in One Chart," *Health Affairs*, Web exclusive (Jan. 23, 2002).

¹¹ Congressional Budget Office, "Technological Change and the Growth of Health Care Spending," No. 2764, (January 2008).

without a financing system that pays most of the cost of all services and institutionalizes few mechanisms to screen new techniques and devices for clinical effectiveness prior to coverage. And a major downside to the status quo is that a significant proportion of Americans—the almost 16 percent without health insurance—have limited access to the wonders of modern medicine.

Following the collapse of tightly managed care, hospitals and physicians made the most of the reprieve from aggressive cost-containment tactics. Providers focused primarily on two strategies to bolster their financial position—pressing health plans for better payment rates and contract terms and expanding capacity to provide select services and technology that are particularly well compensated. Many medical groups opened ambulatory surgery and diagnostic centers and added capacity to deliver radiology, laboratory and imaging services in their practices.

The intense competition for niche specialty services—and avoidance of other less profitable services—is a strong sign that public and private payers are inadvertently overpaying for some services while underpaying for others. As HSC research has shown, marked disparities in the relative profitability of services under both Medicare and private plan payment policies appear to be a key force driving hospital and physician competition for certain specialty services.¹² Recently, Medicare has changed hospital and physician payment systems to better reflect relative costs of different services to reduce inadvertent incentives for providers to favor certain services at the expense of others. But market responses to these policy changes are not yet apparent, with some market observers indicating that the changes have not been substantial enough to alter provider behavior.¹³

Another factor behind rapidly rising costs is the likelihood that productivity increases in health care delivery have been small. Productivity in health care is extremely difficult to measure because product changes are important but difficult to adjust for. In much of the rest of the economy, price increases are held down by large increases in productivity over time. But productivity improvement is much less likely when each provider is paid on the basis of services it produces rather than on what is done by all providers to address a patient's medical condition. So providers have incentives to be efficient in their provision of each service but not to be concerned with the number of services or the cost of services of other providers involved in that patient's care.

Business Cycle Drives Employer Responses to Rising Costs

Employers' willingness to tackle cost control ebbs and flows with the business cycle. When health care costs are rising rapidly, profits are low and labor markets are loose, employers have

¹² Ginsburg, Paul B., and Joy Grossman, "When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care," *Health Affairs*, Web exclusive (Aug. 9, 2005).

¹³ Draper, Debra A., and Paul B. Ginsburg, "Health Care Cost and Access Challenges Persist: Initial Findings from HSC's 2007 Site Visits," Issue Brief No. 114, Center for Studying Health System Change, Washington, D.C., (October 2007).

taken strong actions to control costs, only to abandon their efforts when the cycle turns. As an example, in the early 1990s, employers responded to depressed profitability and extensive unemployment by incorporating restrictive models of managed care into their health benefit structures. In effect, they engaged private insurers to slow cost growth by imposing administrative controls on access to care and restricting provider choice to obtain larger discounts. But during the late-'90s' economic boom, when recruiting and retaining workers was perceived as a more significant challenge than containing health-benefit outlays, employers retreated in the face of worker complaints about restrictions on provider choice and access to care.

Following the 2001 recession, when premium trends spiked again, employers responded by buying down the benefit structure of their plans by increasing patient cost sharing through higher deductibles, coinsurance and copayments—a strategy that has mitigated somewhat in recent years. While employers don't appear to be interested in revisiting restrictive managed care models, they also are not optimistic that higher cost sharing alone is the long-term answer. Why employers opted for higher cost sharing rather than a return to restrictive managed care probably reflects the intensity of at least some employees' dislike of managed care restrictions, perhaps abetted by the lack of visibility of costs to them.

Once again, as the economy slows and costs and premiums continue to increase at higher rates than workers' earnings, employers are seeking solutions to rising costs. Employers now are looking to consumers to take more responsibility for medical costs, lifestyle choices and treatment decisions. While consumer-directed health plans have not gained widespread adoption, other developments—including a heightened emphasis on prevention and wellness, along with nascent provider cost and quality information—are advancing health care consumerism. However, concerns exist about whether these efforts will slow cost growth enough to keep care affordable or whether the growing problem of affordability will derail efforts to decrease the rising number of uninsured Americans and stymie meaningful health care reform.¹⁴

Government Responses to Rising Costs

State and federal governments deal with costs through two distinct roles—as managers of public insurance programs and as regulators of the health care system. Medicare and Medicaid have aggressively controlled spending when imperatives to cut budgets were greatest. The most heavily used tool has been to reduce provider payment rates. But rate reductions have been constrained by concerns about beneficiaries' access to physicians and concerns about hospitals and other providers' financial viability. After all, Medicare and Medicaid beneficiaries get their care from the same delivery system that others do, so there are limits to how much these programs can cut their outlays without addressing system-wide issues.

Benefit reductions have not been common, and governments have been less inclined to control utilization of services through administrative controls, partly due to statutory prohibitions against

¹⁴ Ibid.

“affecting the practice of medicine.” Medicaid programs have successfully outsourced some utilization management to managed care companies, but the Medicare program has faced intense opposition to mandating, or even favoring, tightly managed care.

Except for the 1970s, governments as regulators have not been very active in attempts to contain costs system wide. Hospital rate regulation, adopted by a number of states in the 1970s and unsuccessfully proposed at the federal level by President Jimmy Carter, was one exception. These programs had some success, but most were abandoned in the 1990s as the nation turned away from regulation in general, and because the combination of Medicare prospective payment and managed care contracting were perceived as adequate constraints on hospital costs.

Certificate-of-need (CON) legislation—which limited major capital expenditures by hospitals and some other facilities based on the belief that unneeded facilities increased costs, either by creation of excess capacity or by inducing additional use of services—was more widespread and continues to this day in many states. But most research shows that CON programs had little impact on capital spending in the aggregate, although they did have substantial impact on which institutions expanded facilities.¹⁵ This tool has been revitalized in some states as general hospitals have advocated its use to block construction of physician-owned specialty hospitals and outpatient facilities that are perceived as competitive threats.

Other Approaches

In contrast to the United States, OECD countries use a wider array of tools to limit resource use and expenditure growth. Until recently, patient cost sharing has not been used extensively in these countries. Direct regulation of prices, involving unabashed use of government’s sole-buyer purchasing power, and administrative limits on the acquisition and use of expensive technology are used in place of substantial patient cost sharing in these systems. Although a number of studies have focused on higher prices paid for services in the United States than in OECD countries, recent work by McKinsey has taken this further by documenting how this drives large differences in efficiency of delivery of services.¹⁶

Initiatives to collect and distribute more information on medical effectiveness, to reduce medical errors and improve quality, and to screen the development of new technologies all presume a rich lode of services being delivered today that will turn out to have little medical benefit to patients. There is compelling evidence from researchers analyzing Medicare data that suggests the higher-

¹⁵ Sloan, Frank A., “Controlling Health Expenditures: Lessons Learned from Certificate of Need Programs,” in *Cost, Quality, and Access in Health Care*, ed. F. Sloan, J. Blumstein, and J. Perrin, San Francisco, Calif., Jossey-Bass (1988).

¹⁶ Anderson, Gerard F., et al., “It’s The Prices, Stupid: Why The United States Is So Different From Other Countries,” *Health Affairs*, Vol. 22, No. 3 (May/June 2003); Anderson, Gerard F., et al., “Health Spending In The United States And The Rest Of The Industrialized World,” *Health Affairs*, Vol. 24, No. 4 (July/August 2005); and McKinsey Global Institute, “Accounting for the Cost of Health Care in the United States,” (January 2007).

than-average spending—as much as 30 percent—in many areas of the country does not buy better outcomes; in fact, much of the spending variation comes from services where guidelines based on effectiveness research do not exist.¹⁷ But other research has pointed out that many quality problems in U.S. medicine are associated with underprovision of services that are known to be effective for specific types of patients.¹⁸ Thus, while more widespread application of evidence-based practice would surely improve the quality of care, it may add to, not subtract from, health care use and cost.

Implications of Rapidly Rising Health Care Costs

When spending rises for most goods and services, policymakers' attitude toward it is neutral because of a shared belief in consumer sovereignty. But health care is quite different because most health care is financed through health insurance. This reliance on third-party payment blunts consumer incentives to economize on the use of care and to signal by their behavior the value they place on services. And rising premiums cause problems for the employers, employees and governments that pay for health insurance. So, policymakers have good reason to be concerned about rising health care costs.

Unlike a housing purchase, for example, where a consumer can tailor the purchase to what they are willing to spend and can afford, consumers have much less ability to adjust their health spending to their ability to pay. For the most part, we have a single medical standard of what should be done for people who have various illnesses. This means that purchasing most types of health insurance buys into that standard. Those without the means to afford a typical insurance policy cannot simply go to a less expensive version in the way they would opt for a smaller or less well-located house. So if we want people with lower incomes to have access to care, they need to be subsidized, either through pools that employers establish (where the employer makes the same contribution regardless of the worker's earnings) or through government programs.

Rising health costs affect people's ability to afford health insurance. When insurance premiums rise faster than workers' wages, fewer people obtain employment-based health insurance. This happens through small employers deciding not to provide coverage to their employees and employees deciding not to take up employer coverage because the employee contribution is too high. If health care cost trends continue to exceed increases in wage rates by a large margin, this could result in substantial loss of employer-based health insurance.

While there is policy interest in shifting from a system based on employer-sponsored health insurance to individual coverage, caution is in order before jettisoning the employer system because today's individual insurance market is not an attractive alternative. The presence of underwriting in the individual insurance market based on medical history and age would make

¹⁷ Fisher, Elliott S., et al., "The Implications of Regional Variations in Medicare Spending," *Annals of Internal Medicine*, Vol. 138, No. 4 (Feb. 18, 2003).

¹⁸ McGlynn, Elizabeth A., et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26 (June 26, 2003).

insurance unaffordable for many who now obtain coverage through employment.¹⁹ The concept of regional health insurance exchanges to create pooling mechanisms that include both healthy and sick people is promising but largely untested. Rather than a wholesale abandonment of the employer-based system, it might be more prudent to test the concept with the millions of Americans who lack access to employer-based coverage than with the entire privately insured population.

Rising health care costs and stagnant incomes also are increasing the financial burden of health care for American families.²⁰ More than one in six Americans in 2004—or 17.7 percent of the nonelderly population—lived in families spending more than 10 percent of after-tax income on health care, including health insurance premium payments and direct spending on services, up from 15.9 percent in 2001. Despite the overall increase in financial burden, the share of total health spending paid for out of pocket actually decreased slightly from 34.8 percent in 2001 to 33.6 percent in 2004, meaning that much of the increased burden was a result of health spending growing more rapidly than income.

Finally, rising health care costs also pose a problem for the federal and state governments, which finance 40 percent of national health expenditures, mostly through Medicare and Medicaid.²¹ With public revenues staying at a relatively constant percentage of national income, growth in outlays for these programs in excess of growth in income that is taxed poses particular strains on public budgets. As the economy slows, states are facing these strains now in an acute manner, as Medicaid outlay growth exceeds the trend in state revenues by a large margin. The strain will become acute for the federal government as concerns about rising deficits increase and when the baby boom generation begins to become eligible for Medicare.

While I have touched on a number of the drivers of rapidly rising costs, I want to emphasize one core factor that is behind much of the cost problem. In the United States, our culture emphasizes that insured people should get all the medical care they want, regardless of cost. This works against attempts to discourage the development of treatments in which the benefits are uncertain or known to be small. Until the public becomes more aware of what is involved in truly containing costs, rising health care costs will continue to strain the resources of government purchasers, employers and consumers.

The Need for Leadership

The next few years are likely to be a period of particularly intense concern about costs. A combination of higher insurance premiums and increased patient cost sharing has already

¹⁹ Ginsburg, Paul B., “Employment-Based Health Benefits Under Universal Coverage,” *Health Affairs*, Vol. 27, No. 23 (May/June 2008).

²⁰ Bantlin, Jessica S, Peter Cunningham and Didem M. Bernard, “Financial Burden of Health Care, 2001-2004,” *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

²¹ Caitlin, Aaron, et al., “National Health Spending In 2006: A Year of Change For Prescription Drugs,” *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

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convinced the public there is a cost problem,²² though they appear to be focused more on who pays what share rather than on how much we all pay. Government budgets probably will be tight for some time, and policymakers will find growing outlays for Medicare and Medicaid increasingly threatening. Private insurers and employers will complain more loudly about provider reimbursement cuts by public programs being shifted onto them and further eroding the affordability of private coverage. More employers and employees are finding themselves priced out of the comprehensive health insurance market. Some will take cold comfort in plans with increasingly high deductibles, and others, faced with the choice of expensive comprehensive insurance for broad provider networks or being uninsured, will opt to take the risk and depend on the safety net in the event of serious illness. Hospitals already are alarmed by the increasing diversion of resources to providing uncompensated care to the uninsured and to bad debts owed by those who are insured.

Policymakers are pursuing ideas that promise to reduce costs, including federal support for an information technology infrastructure for hospitals and medical practices and an expanded role for disease management in Medicare and Medicaid. Many of these initiatives have merit because they have the potential to improve the quality of care, but skepticism is in order about the magnitude of cost reductions that might result.^{23 24} While there certainly will be instances where quality improvement will contain costs at the same time, it's questionable whether the net impact on costs will be commensurate with the magnitude of the cost problem.

Though some deny it, we ration care today. The uninsured get much less care than the insured and suffer worse health outcomes because of it,²⁵ and the insured with ample means get more care than do the lower-income insured, although without clear differences in outcomes. The challenge is to ration in a way that is more efficient and more equitable.

Once the clinical rationing imperative is widely acknowledged, a broader and complementary array of cost-containment tools can be brought to bear in the United States. These cannot and need not extend to the kinds of absolute limits on specific resources and consumer choices used by the centralized systems of most OECD countries. Rather, evidence-based practice guidelines and institutionalized technology assessment can help to inform benefit package design and differential cost-sharing requirements. In contrast to systems that decide for the patient what services are unavailable because of limited clinical value, a system more compatible with American values would continue to allow broad patient and provider choices, coupled with extensive information about likely clinical value and higher cost sharing when the values are small.

²² Kaiser Family Foundation, "Kaiser Health Tracking Poll: Election 2008," (April 2008).

²³ Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," No. 2976 (May 2008).

²⁴ Mattke, Soeren, Michael Seid and Sai Ma, "Evidence for the Effect of Disease Management: Is \$1 Billion a Year a Good Investment?" *American Journal of Managed Care*, Vol. 13, No. 12 (December 2007).

²⁵ Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, National Academy Press, Washington, D.C. (2002).

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Acknowledging that relying on cost sharing alone will ultimately increase segmentation of insured risk pools by socioeconomic class over time, one should also be mindful of the dynamic that is driving increasing fractions of lower-wage workers to lose coverage over time.²⁶ Today, many lower-wage workers are essentially being denied the opportunity to opt for lower cost and more tightly managed care products, such as health maintenance organizations (HMOs) because higher-income people have objected to restrictions, especially on their choice of provider.

Some restrictive provider networks are capable of delivering high-quality care; indeed, systematic evaluations of the relative quality of HMOs and fee-for-service medicine have always concluded that average quality was about the same.²⁷ Results from HSC's Community Tracking Study surveys have shown consistently over time that the public is divided in its willingness to have more restricted provider choice in return for lower costs, with low-income people much more willing to make that trade-off.²⁸ Purchasing vehicles and subsidies can be created to permit low-income workers to exercise this choice, while providing time to develop the more sophisticated mechanisms needed to vary cost sharing based on the clinical value of services.

There is much we do not know about how to do effective clinical value rationing at the moment. Estimates of the fraction of physicians' care decisions that are supported by unambiguous clinical trial evidence range from 11 percent to 65 percent, depending on specialty and care setting.²⁹

Actions to address costs can be taken by both the private and public sectors, with each feeling distinct pressures to act and having different tools available to them. There is no single, silver bullet to control spending growth, but the range of possible steps is large. Indeed, the main problem with focusing on a single approach is the risk that it will not be as successful as promised and valuable time will be lost in pursuing other approaches.

One way to view many of the options is to classify them into demand-side and supply-side approaches. A key demand-side approach, which has been pursued broadly by the private sector—but not the public sector—is increased patient cost sharing at the point of service. Although consumer-directed health plans and their large deductibles and savings accounts have received the most attention, most people with employer-sponsored coverage are enrolled in preferred provider organizations (PPOs) (57%) and HMOs (21%).³⁰ So the changing benefit

²⁶ Holahan, John, and Allison Cook, "The U.S. Economy And Changes in Health Insurance Coverage, 2000-2006," *Health Affairs*, Web exclusive (Feb. 20, 2008).

²⁷ Miller, Robert H., and Harold L. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997-2001," *Health Affairs*, Vol. 21, No. 4 (July/August 2002).

²⁸ Tu, Ha T., "More Americans Willing to Limit Physician-Hospital Choice for Lower Medical Costs," Issue Brief No. 94, Center for Studying Health System Change, Washington, D.C. (March 2005).

²⁹ "What Proportion of Healthcare is Evidence Based? Resource Guide," www.shcf.ac.uk/~scharr/ir/percent.html, accessed May 28, 2008.

³⁰ Kaiser Family Foundation-Health Research & Educational Trust, "Employer Health Benefits: 2007 Annual Survey" (2007).

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structures of PPOs and HMOs toward higher patient cost sharing is a more significant development. Although these steps clearly lead to reduced spending, the question is how much of a reduction can be achieved without major sacrifices in other societal goals, such as access to care and protection from financial hardship.

Should policymakers want to push the demand-side approach further, the most powerful tool would be changes in the tax treatment of health insurance, a step that President Bush and Republican presidential candidate John McCain have advocated; Democratic presidential candidate Hillary Clinton also has a more modest proposal to change the tax treatment of health insurance. Government can also contribute to this approach by continuing to expand provider quality reporting to Medicare and making data and information from Medicare claims files available to the public.

Supply-side approaches include reforming provider-payment mechanisms and administrative controls on service use. Because private insurers and Medicaid programs now follow Medicare provider payment mechanisms extensively, this presents an opportunity for federal policymakers to influence the entire delivery system. There is ample evidence that Medicare payment structures for physicians do not reflect relative costs and are providing inadvertent incentives to specialize in more profitable services, such as imaging and minor procedures.³¹ Revising Medicare payment structures to better reflect relative costs could make an important contribution to controlling costs.

Building on revised Medicare payment structures, payment mechanisms that depart from fee for service have the potential to increase provider efficiency. This includes paying for major procedures on a per-episode basis that includes all providers involved in the episode of care and paying for the management of chronic disease, including care coordination, on a capitated basis. High-performance networks and newer forms of pay for performance are examples of initial steps in this direction. But with the fragmented payment system limiting the effectiveness of these approaches, Medicare leadership can potentially have a large impact.

Research on spending trends has highlighted the opportunity to contain costs—for at least the intermediate term—if wellness can be successfully promoted.³² Both employers and the public sector can support efforts of individuals to reduce high-risk behavior. But these wellness and prevention initiatives are at an early stage, without particular approaches demonstrating effectiveness. Many are intrigued with the notion of promoting wellness, but we are not yet at the point of having tools with proven effectiveness.

³¹ Ginsburg, Paul B., and Robert A. Berenson, “Revising Medicare’s Physician Fee Schedule—Much Activity, Little Change,” *New England Journal of Medicine*, Vol. 356, No. 12 (March 22, 2007); and Medicare Payment Advisory Commission, “Report to the Congress, Promoting Greater Efficiency in Medicare,” (June 2007).

³² Thorpe, Kenneth E., et al., “Trends: The Impact Of Obesity On Rising Medical Spending,” *Health Affairs*, Web exclusive (Oct. 20, 2004).

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Reflecting on the U.S. experience with health care cost containment, what is striking is the consistency with which leaders in both the public and private sectors have avoided the idea that real cost containment involves real sacrifice—patients going without services that may provide some benefit, or physicians, hospitals and insurers settling for smaller incomes or profits. After all, all medical care spending is somebody's income. Often what we hear from leaders is more wishes about directions that the health care system should take than concrete policy options to lead it to happen. More effective ways to cope with limited resources will depend on political, professional, corporate, labor and opinion leaders articulating the need to confront trade-offs among clinical effectiveness, costs and equity.