

**Testimony of Peter R. Orszag,
Director of the Office of Management and Budget
Before the Committee on Finance, U.S. Senate
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Chairman Baucus and Ranking Member Grassley, thank you not only for your extraordinary leadership on health care reform, but also for your participation and contributions during the White House Forum on Health Reform. I look forward to continuing to work with you, other members of this Committee, and other policymakers to get health reform enacted this year.

I come before the Committee at a time of great peril for our economy and for our nation's fiscal future. The Administration has inherited an economic crisis unlike any we have seen in our lifetimes. Our economy is in a deep recession, which threatens to be more severe than any since the Great Depression.

The result of this bleak economic picture, as well as the misplaced policy priorities of previous years, is a pair of twin deficits, each in the range of \$1 trillion per year. The first trillion dollar deficit is the gap between how much the economy has the potential to produce and how much it is actually producing each year. This output gap of roughly \$1 trillion in 2009 would represent nearly 7 percent of the estimated potential output of the economy. The Recovery Act that Congress passed a few weeks ago was a bold and important first step toward filling this hole and jumpstarting the economy through fiscal stimulus that increases short-term demand for goods and services.

The second trillion dollar deficit that the new Administration is inheriting is the budget deficit. Under current policies, we face fiscal deficits of almost \$1 trillion a year on average over the coming decade. OMB projects that the baseline deficit for FY 2009 will be about \$1.5 trillion, or 10.6 percent of GDP. Over the ten-year budget window, from FY 2010 to FY 2019, aggregate baseline budget deficits will total nearly \$9.0 trillion and average almost 5 percent of GDP. Over longer periods of time, the deficit reaches even higher shares of GDP primarily because of rising health care costs.

Over the medium to long term, the nation is thus on an unsustainable fiscal course. We need to act, and since the key to our fiscal future is health care, it makes sense to begin the process of putting the nation on a sounder fiscal path by tackling health reform. I will spend the remainder of my time today focusing primarily on proposals in the President's Budget for dealing with rising health care costs and the need to provide all Americans with affordable, high-quality health care, along with a few other key health care investments in the Budget.

Containment of Health Care Costs

Controlling health care cost growth is the key to our long-term fiscal future. Total national health spending has increased from about six percent of GDP in 1965 to more than 16 percent in 2007. This rise in health care as a share of the economy is expected to

continue in the future; between 2008 and 2018, average annual health spending growth is anticipated to outpace average annual growth in the overall economy by 2.1 percentage points per year. As a result, by 2018, national health spending is expected to account for just over one-fifth (20.3 percent) of GDP.^[1]

These projected increases in overall health costs drive the cost trends in our public insurance programs – which are themselves the primary driver of our long-term fiscal gap. For example, if costs per enrollee in Medicare and Medicaid grow at the same rate over the next four decades as they did over the past four decades, those two programs will increase from about five percent of GDP today to about 20 percent by 2050.^[2] As the Centers for Medicare and Medicaid Services (CMS) actuaries, the Congressional Budget Office (CBO), and others have noted, there are reasons to expect cost growth to slow in the future relative to the past even in the absence of policy changes.^[3] But the point remains that reasonable projections of health care cost growth under current policies shows that they are the principal driver of the nation’s long-term fiscal imbalance.

The large projected increases in cost in Medicare and Medicaid, in turn, are mostly a reflection of rising costs per beneficiary, not the effects of demographics. In other words, costs increase mostly because each beneficiary is expected to cost significantly more in the future than today – and only partially because we will have more (and older) beneficiaries in the future.

These observations lead to an emphasis on reducing costs per beneficiary over time – not only in Medicare and Medicaid, but also in the overall health care system. The effects of rising health care costs are not limited to public programs. Health care cost growth can impede the growth of cash earnings for workers with employer-based coverage. While employers may appear to cover much of the cost of health insurance for employees, economists generally agree that workers ultimately bear most of those costs through wages and other forms of compensation that are lower than they otherwise would be. Also, as the costs of medical care increase, employers may find it difficult to offset their health insurance costs through reduced wages, and may instead reduce benefits or increase the costs (e.g., deductibles, premiums) paid directly by workers, which would result in more workers forgoing employer-based health insurance. Rising health care costs also make individual private coverage prohibitively expensive for more individuals. As health costs and premiums rise, so too does the number of uninsured Americans.

Substantial opportunities appear to exist to reduce health care costs without impairing quality of care or outcomes. In particular, evidence suggests that a significant share of

^[1] CMS. National Health Expenditures Data.

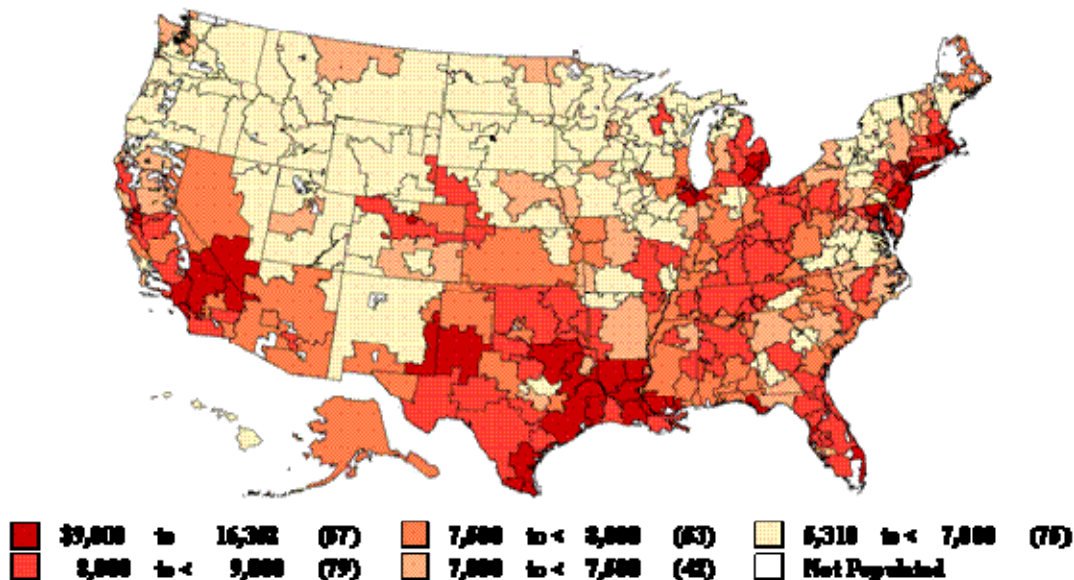
http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

^[2] Letter from CBO Director Orszag to Senator Judd Gregg. “Financing Projected Spending in the Long Run.” July 9, 2007.

^[3] CMS Office of the Actuary. Memo on “The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures.” March 25, 2008.

current health care spending contributes little if anything to the overall health of the nation. Perhaps the most compelling evidence of this opportunity is that spending varies substantially across the United States, mostly because of variation in the volume and intensity of services provided. The Dartmouth Atlas project found that Medicare spending in 2006 varied more than threefold across U.S. hospital referral regions.^[4] However, Medicare enrollees in areas with higher spending do not appear to have better health outcomes on average than those in areas with lower spending.

Medicare Spending Per Capita by Hospital Referral Region, 2006



Source: www.dartmouthatlas.org

Variations in spending appear to be driven in large part by different professional norms across our nation – and the higher-cost norms in some parts of the country are not more effective (and may be less effective) than the lower-cost norms in other parts of the country. Research indicates that discretionary decisions by physicians regarding referrals to specialists, diagnostic tests, and hospital admissions contribute to higher costs.^[5]

Differences in supply are also important; supply appears to generate its own demand.^[6] Some researchers believe health care costs could be reduced by a stunning 30 percent—

^[4] Dartmouth Institute for Health Policy and Clinical Practice. “Health Care Spending, Quality, and Outcomes, More Isn’t Always Better. February 27, 2009.

^[5] Dartmouth Institute for Health Policy and Clinical Practice. “The Policy Implications of Variations in Medicare Spending Growth.” February 27, 2009.

^[6] Dartmouth Institute for Health Policy and Clinical Practice. “Health Care Spending, Quality, and Outcomes, More Isn’t Always Better. February 27, 2009.

or about \$700 billion a year—without harming quality if we moved as a nation toward the proven and successful practices adopted by lower-cost areas and hospitals.^[7]

Slowing Health Spending Growth While Expanding Coverage

Moving toward a more efficient and high-quality health care system would make better use of existing Federal spending and help to expand health insurance coverage. Our current system of providing health care for the uninsured is composed of a patchwork of government subsidies, safety net programs, and charity care from many sources. Such a system has serious gaps; in most States there are few to no affordable options for poor adults without children. It is also poorly designed to provide quality and cost-effective care. Research has found that the uninsured are less likely than the insured to have regular outpatient care and are more likely to be hospitalized for avoidable health problems.^[8] The uninsured are also less likely to receive preventive care that may help avoid more serious and costly illnesses.

Health care for the uninsured is currently funded directly or indirectly through a variety of sources, including the government and private insurers. One study estimated that individuals who were uninsured for any part of 2008 spent about \$30 billion out of pocket and received approximately \$56 billion in uncompensated care while uninsured, and that government programs finance about 75 percent of uncompensated care.^[9] Examples of Federal sources of funding that help subsidize uncompensated care include roughly \$20 billion in estimated disproportionate share hospital (DSH) payments made through Medicare and Medicaid in 2009. The Federal government also provides funds to support community health centers and other programs that provide health care for the uninsured. Recent estimates indicate that hospitals provided about \$35 billion in uncompensated care in 2008, and that perhaps as much as half of those costs were shifted to private insurers, which would then raise premiums for the insured.^[10] Both this hidden tax and Federal spending through various programs could be reduced if health care reform that covered all Americans were enacted.

The Administration believes that it would be irresponsible to expand coverage without accompanying changes to reduce health costs, and that it would be short-sighted to reduce costs without expanding coverage to Americans who need it. The savings from reducing health care cost growth compound over time and the power of compound interest is so strong that such savings will ultimately more than offset the costs of providing essential health insurance to more Americans. As the President said at the White House Forum on Health Reform, he developed a strong plan during the campaign that would make up-front investments to expand coverage and reduce costs. He also

^[7] CBO Testimony. Increasing the Value of Federal Spending on Health Care. Before the House Committee on the Budget. July 16, 2008. <http://www.cbo.gov/ftpdocs/95xx/doc9563/07-16-HealthReform.1.2.shtml>

^[8] Kaiser Family Foundation. The Uninsured, A Primer. Key Facts about Americans Without Health Insurance. October 2008.

^[9] Hadley, Jack; John Holahan; Teresa Coughlin, and Dawn Miller. Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs. Health Affairs. Web Exclusive. 2008.

^[10] Ibid. Also, CBO. “Key Issues in Analyzing Major Health Insurance Proposals. December 2008.

underscored that he has no monopoly on good ideas and will consider all serious ideas that, in a fiscally responsible manner, ensure quality, affordable coverage for all Americans.

Administration Actions

The Administration is moving aggressively to reduce costs, improve quality, and expand coverage. The key steps to reduce costs over time and “bend the curve” involve:

- Investing in information technology, a step that is necessary for a high-performing health care system;
- Conducting comparative effectiveness research, to examine what works and what doesn’t so doctors have better information on appropriate treatments;
- Modernizing public program payment systems, so that we reward better care rather than simply paying for more care; and
- Promoting prevention and wellness, so that Americans are healthier.

In addition to expanding coverage, the Administration is moving aggressively on all four of these steps to improve the efficiency of the health system.

Reauthorization of the Children’s Health Insurance Program (CHIP)

In one of his first official acts, the President signed into law the reauthorization of CHIP, extending the program through 2013 and providing coverage to the seven million children it currently insured and an additional four million uninsured children on average. This bill was a first step toward fulfilling the Administration’s goal of providing health insurance coverage for all Americans. The President is committed to implementing this Act as quickly as possible to help children in families affected by this economic downturn. The CHIP legislation was one component of the Administration’s efforts to modernize health care in America, and was shortly followed by the American Recovery and Reinvestment Act of 2009.

The American Recovery and Reinvestment Act of 2009

The Recovery Act makes important investments in reinforcing Federal assistance to States through the Medicaid program; continuing health care coverage and services for low-income individuals; computerizing America’s health records; developing and disseminating information on the most effective medical interventions; and prevention and wellness interventions.

- Reinforce Federal Assistance to States. The Recovery Act provides States with a temporary increase in the Federal medical assistance percentage (FMAP), the Federal share of spending in the Medicaid program. This assistance is provided via three pillars of support: (1) temporary suspension of FMAP decreases via a hold-harmless provision; (2) a general 6.2 percentage point increase in the Federal share of Medicaid; and (3) a sliding-scale decrease in the State Medicaid share for

those States that experience high increases in their unemployment rates. The Act requires maintenance of effort for eligibility and requires compliance with statutory prompt pay requirements, including to nursing facilities and hospitals.

- Extend COBRA Coverage. The Recovery Act provides a 65 percent reduction in COBRA premiums for certain assistance eligible individuals to help make health care affordable. This provision will help seven million Americans keep their health care.
- Continue Health Care Supports for Low-Income Individuals. The Recovery Act extends both Transitional Medical Assistance (TMA) and the Qualified Individuals (QI) program through December 31, 2010. TMA provides access to Medicaid coverage for low income families with children who are transitioning into the workforce, and the QI program provides Medicare Part B premium assistance for eligible low-income beneficiaries.
- Computerize America's Health Records in Five Years. The current, paper-based medical records system that relies on patients' memory and reporting of their medical history is prone to error, time-consuming, costly, and wasteful. At present, perhaps only 17 percent of U.S. physicians and 8 to 11 percent of U.S. hospitals have at least a basic electronic record system. Far fewer have and routinely use the types of comprehensive systems that would allow them to fully realize the potential of the technology. With rigorous privacy standards in place to protect sensitive medical records, we are embarking on an effort to computerize America's health records in five years. This effort will help prevent medical errors and improve health care quality, and is a necessary step in starting to modernize the American health care system and reduce unnecessary health care costs.
- Develop and Disseminate Information on the Relative Effectiveness of Medical Interventions. Medicine is changing so rapidly that it is almost impossible for any individual physician to keep abreast of all the latest research studies. Each month nearly 500 articles are published on breast cancer alone. Despite this profusion of research, there are often gaps, especially in studies that compare how well different diagnostic tests and treatments work for the very same conditions and diseases. Without the most recent information on the effectiveness of alternative treatments, it is difficult for doctors to give each patient the type of treatment he or she deserves. To help patients and providers get the information they need for the highest quality care, the Recovery Act devotes \$1.1 billion to comparative effectiveness research—studies on the relative advantages and disadvantages of competing medical interventions. The information from this research should help improve the performance of the U.S. health care system.
- Invest in Prevention and Wellness. Over a third of all illness is the result of poor diet, lack of exercise, and smoking. Indeed, obesity alone leads to many expensive, chronic conditions including high blood pressure, heart disease,

diabetes, even cancer. Furthermore, there are important vaccines that can prevent disease and screening tests that can detect cancer and other diseases at an early stage when they are more curable. Yet many Americans are not getting these effective treatments. For instance, according to the CDC, fewer than 75 percent of women recommended to do so get mammograms and fewer than 50 percent of Americans recommended to do so receive any type of colon cancer screening. The Recovery Act devotes an unprecedented \$1 billion for prevention and wellness interventions. This will dramatically expand funding for immunizations, healthcare acquired infections, and community-based interventions proven to reduce chronic diseases.

- Strengthen the Health Workforce. The President believes that a strong health workforce, including doctors, nurses, community health workers and public health practitioners, are the lynchpin to an effective health care system. The law provides \$500 million to support programs like the National Health Services Corps, which place providers in underserved communities. Further, it will fund existing workforce programs (Title VII and VIII) which are critical for the education and training of the next generation of doctors and nurses.

Health Care Reserve Fund

As the President said at the White House Forum on Health Reform this past Thursday, health care reform is no longer just a moral imperative, it is a fiscal imperative. The President's Budget sets aside a reserve fund of more than \$630 billion over ten years dedicated to financing reforms to the American health care system that will lower costs, put us on a clear path to cover all Americans and improve quality. The reserve fund is financed roughly 50-50 between a combination of re-balancing the tax code so that the wealthiest pay more and specific health care savings in three areas: promoting efficiency and accountability, aligning incentives toward quality, and encouraging shared responsibility.

The Budget includes a proposal to limit the tax rate at which high-income taxpayers can take itemized deductions to 28 percent. This policy limits, but does not eliminate, the tax break for families with income above \$250,000. The initial reserve fund would be about half funded through this progressive provision, which would raise \$318 billion over ten years. In the health reform policy discussions that have taken place over the past few years, a wide range of other revenue options have been discussed—and these options are all worthy of serious discussion as the Administration works with Congress to enact health care reform.

On the savings side, the Budget proposes improvements to Medicare and Medicaid, which are discussed in detail later in my testimony and would achieve \$316 billion in savings over ten years. These proposals would simultaneously help to improve the quality and efficiency of health care without negatively affecting the care Americans receive.

Although the reserve fund represents a major commitment to reform, the Administration recognizes that the reserve is not sufficient to fully fund comprehensive reform, and we are committed to working with Congress to find additional resources to devote to health care reform. By identifying specific health savings for the health care reserve fund, the Administration is making a down payment on two goals: expanding health care coverage to all Americans and restraining growth in health care costs. Progress on these goals will be a continuous effort of the Administration. As additional information from research, demonstration projects, and other sources becomes available, it will be used to develop new and refined means of addressing these challenges.

Approach to Health Care Reform

The President is eager to work with Members of Congress to develop a comprehensive health care reform proposal that will provide high-quality, affordable health coverage to all Americans while addressing long-term drivers of health spending in public and private health programs. Many promising approaches to health reform have been proposed by many different people, and the President looks forward to developing a health reform approach through an open and inclusive process that explores all serious ideas that achieve the common goals of expanding coverage, improving quality, and constraining costs. To get a sense of what elements the Administration believes are key pieces to include in any health reform proposal, I want to summarize the Administration's eight guiding principles for health reform.

1. **Protect Families' Financial Health.** The plan must reduce the growing premiums and other costs American citizens and businesses pay for health care. People must be protected from bankruptcy due to catastrophic illness.
2. **Assure Affordable, Quality Health Coverage for All Americans.** The plan must put the United States on a clear path to cover all Americans. The plan must reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added health benefits.
3. **Provide Portability of Coverage.** People should not be locked into their job just to secure health coverage.
4. **Guarantee Choice of Doctors.** The plan should provide Americans a choice of health plans and physicians. Also, they should have the option of keeping their employer-based health plan.
5. **Invest in Prevention and Wellness.** The plan must invest in public health measures proven to reduce cost drivers in our system—such as obesity, sedentary lifestyles, and smoking—as well as guarantee access to proven preventive treatments.
6. **Improve Patient Safety and Quality Care.** The plan must ensure the implementation of proven patient safety measures and provide incentives for

changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.

7. **End Barriers to Coverage for People with Pre-existing Medical Conditions.** No American should be denied coverage because of preexisting conditions.
8. **Reduce Long-term Growth of Health Costs for Businesses and Government.** The plan must pay for itself by reducing the level of cost growth, improving productivity, and dedicating additional sources of revenue.

The Administration looks forward to working with Members of Congress to develop a detailed health reform proposal through an open and inclusive process.

Strengthening Medicare

Without a change in policy, Federal Medicare spending is expected to more than double between 2009 and 2019 from approximately \$425 billion in 2009 to \$872 billion in 2019. The Hospital Insurance (HI) trust fund is expected to be exhausted within the next ten years.

The Budget would improve the Medicare program for beneficiaries by aligning incentives toward quality, promoting efficiency and accountability, and encouraging shared responsibility. These proposals would also strengthen the program's finances, extend solvency of the HI trust fund by two years, and reduce average annual growth in spending from 7.4 percent to 6.8 percent over the next ten years.

The Budget includes the following proposals:

- Reduce Medicare overpayments to private insurers through competitive payments. Under current law, Medicare pays Medicare Advantage plans 14 percent more on average than what Medicare spends for beneficiaries enrolled in the traditional fee-for-service program. This is because the current system bases payments on administratively determined benchmarks that are set well above the cost of providing fee-for-service Medicare benefits. Let me illustrate how inefficient this is. MedPAC estimates that the Federal government pays \$1.30 for each \$1.00 in Medicare Advantage supplementary benefits, without any compelling evidence of better quality of care. Medicare Advantage overpayments undermine Medicare's financial future and are estimated to increase premium costs this year for beneficiaries in Medicare fee-for-service by approximately \$3 per person per month.

The Administration would replace the current mechanism used to establish payments with a new competitive system in which payments would be based upon an average of plans' bids submitted to Medicare. The Administration's proposal

would better align plan payments with the actual cost of coverage. This would allow the market, not Medicare, to set the reimbursement limits. Our proposal would save taxpayers more than \$175 billion over ten years as well as reduce Part B premiums.

- Reduce drug prices. The Administration will accelerate access to affordable generic biologic drugs through the establishment of a workable regulatory, scientific, and legal pathway for generic versions of biologic drugs. To retain incentives for the research and development of breakthrough products, a period of exclusivity would be guaranteed for the original innovator product, which is generally consistent with the principles in the Hatch-Waxman law for traditional products. Brand biologic manufacturers would also be prohibited from reformulating existing products into new products to restart the exclusivity process, a process known as ever-greening. Furthermore, the Administration would prevent drug companies from blocking generic drugs from consumers by prohibiting anticompetitive agreements and collusion between brand name and generic drug manufacturers intended to keep generic drugs off the market.

The Budget would also bring down the drug costs of Medicaid by increasing the Medicaid drug rebate for brand-name drugs from 15.1 percent to 22.1 percent of the Average Manufacturer Price, applying the additional rebate to new drug formulations, and allowing States to collect rebates on drugs provided through Medicaid managed care organizations.

- Improve Medicare and Medicaid payment accuracy. The Government Accountability Office (GAO) has labeled Medicare “high-risk” due to the billions of dollars lost to overpayments and fraud each year. The Administration proposes \$311 million in FY 2010 for program integrity activities for CMS that will initially be targeted to remedy the vulnerabilities in Medicare, including Medicare Advantage and the prescription drug benefit (Part D), as well as Medicaid. CMS will be able to respond more rapidly to emerging program integrity vulnerabilities across these programs through an increased capacity to identify excessive payments and new processes for identifying and correcting problems. With this additional funding, the Administration will be better able to minimize inappropriate payments, close loopholes, and provide better value for program expenditures to beneficiaries and taxpayers.
- Improve care after hospitalizations and reduce hospital readmission rates. Nearly 18 percent of hospitalizations of Medicare beneficiaries result in the readmission of patients who have been discharged from the hospital within the last 30 days. Sometimes such readmissions cannot be prevented, but many are avoidable. Under the policy in the Budget, hospitals would receive bundled payments that cover not just hospitalization, but care from certain post-acute providers for the 30 days after hospitalization, and hospitals with high rates of readmission would be paid less if certain patients are re-admitted to the hospital within that 30-day period. This combination of incentives and penalties should lead to better care

after a hospital stay and result in fewer readmissions—saving roughly \$26 billion over ten years.

- Expand the Hospital Quality Improvement Program. The health care system tends to pay for the quantity of services delivered, not their quality. Experts have recommended that hospitals and doctors be paid based on delivering high quality care, or what is called “pay for performance.” The Budget proposes to link a portion of Medicare payments for acute inpatient hospital services to hospitals’ performance on specific quality measures. This program would improve the quality of care delivered to Medicare beneficiaries and is estimated to save more than \$12 billion over ten years.

No single proposal or approach will address all the factors that contribute to growing health care costs. Rather the Administration will engage in continuous efforts that will lead progressively over time to more efficient and high-quality health care. The President welcomes the opportunity to work with Members of Congress to strengthen the Medicare program. Both Medicare and Medicaid policy changes could complement broader efforts to contain cost growth in the rest of the nation’s health care system. The Administration will consider and evaluate additional options to strengthen Medicare, guided by the following four principles.

Build the Base of Information to Undertake Future Program Modernization. First, we must pursue a vigorous research and demonstration agenda in order to lay the foundation for future improvements in our payment systems. The Budget includes new funding to do just that. New Medicare and Medicaid demonstration and pilot projects will advance the Administration’s objectives for improving the Medicare and Medicaid programs by evaluating payment reforms, options to provide higher quality care at lower costs, and to improve beneficiary education and understanding of benefits offered.

Pursue Options to Address the Underlying Causes of Unnecessary Health Care Spending. While many analysts agree that more information is needed about which treatments work best for a given patient, the effect of information alone generally would be limited. In many cases, the current system does not create incentives for doctors, hospitals, other providers, or patients to avoid costs that do not substantially improve healthcare outcomes. We need stronger payment incentives to adopt evidence-based standards of care and to encourage use of high-value care. Also, most analysts attribute the bulk of cost growth to the development of new treatments and other medical technologies.^[11] Medicare payment systems tend to encourage the adoption of newer, more-costly services even in the absence of clear evidence establishing that those services are better. Therefore, we also need to think about payment policies that reward use of efficient and effective medical technologies.

Encourage Care Coordination, Prevention, and Other Services That Promote High Quality, Efficient Health Care. Health care in the United States is characterized by high spending without commensurately better health outcomes, relative to other industrialized

^[11] CBO. Technological Change and the Growth of Health Care Spending. January 2008.

nations.^[12] Our fragmented health care delivery system, which lacks care coordination and rewards intensive and high-cost care over preventive care, contributes to this result. For instance, more than two-thirds of Medicare spending is for beneficiaries with five or more chronic conditions.^[13] Medicare patients with chronic diseases (e.g., diabetes, congestive heart failure, renal failure) may receive care from multiple physicians and providers at the same time and take a number of different drugs to treat their various conditions. However, patients and families often must manage their own care unassisted across different providers. The lack of clear accountability among multiple providers for managing care, communicating with patients and each other regarding a plan of care, and for a patient's health outcomes leads to medical errors, duplication of services, and unnecessary spending.

Most of Medicare's current payment systems reinforce fragmentation by paying each provider separately and by paying for greater volume and intensity of services even when a more efficient mix of services could produce similar or superior health outcomes. Moreover, the current payment structure offers little incentive for physicians, hospitals, and other providers to integrate, coordinate care, improve the quality of care, or to control the cost of care across the spectrum of settings. Their lack of coordination among physicians, hospitals, and other providers is exacerbated by inadequate adoption and use of electronic health records, which further impedes the coordination of medications, tests, and referrals. The Recovery Act takes essential first steps in building the infrastructure for modernizing the health care system, for example by providing Medicare incentive payments for physicians and hospitals that are meaningful users of electronic health records and through investments in research on the most effective medical treatments. However, we need to build upon this infrastructure to create new financial incentives across Medicare payment systems to promote integration, quality, and high-value care for beneficiaries and taxpayers.

There are several approaches to encouraging greater coordination of care, and as I mentioned previously, the Budget's proposals would begin this transformation. For example, the Budget includes proposals to bundle payments for a hospital stay and post-acute care providers and to reduce payments to hospitals in certain cases when patients are readmitted within 30 days. CMS is conducting a demonstration project that tests the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes of care. By moving away from a fragmented fee-for-service system and toward bundled and more integrated payment systems that include a broad array of

^[12] The United States spent 15.3 percent of GDP on health care, more than any other Organization for Economic Cooperation and Development (OECD) country in 2006 and well above the OECD average of 8.9 percent. The United States also has the highest health expenditure per capita spending of any OECD country, at \$6,714 in 2006, compared with the OECD average of \$2,824. The United States had below average life expectancy in 2005 and the highest obesity rate for adults in 2006 among OECD countries for which measures were available. "OECD Health Data 2008: How Does the United States Compare." <http://www.oecd.org/dataoecd/46/2/38980580.pdf>. OECD Data 2008—Frequently Requested Data. http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (downloaded November 30, 2008).

^[13] Partnership for Solutions. "Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update. Johns Hopkins University and Robert Wood Johnson Foundation. Slide 27.

services and providers, we would create financial incentives for physicians and providers to coordinate care, improve the quality of that care, and provide care in the most efficient and clinically-appropriate setting.

We can also encourage greater coordination and quality of care by making specific payments to providers for the care coordination role and linking a portion of payments to performance on quality measures. The Budget includes a proposal that would enable physicians to form voluntary groups that coordinate care for Medicare beneficiaries and to receive performance-based payments for the coordinated care. The Budget also includes, as I previously discussed, a proposal to create hospital quality incentive payments in which a portion of payments is directly tied to hospitals' performance on certain measures. CMS is also conducting demonstration projects that test the effect of quality incentive payments on home health agencies and skilled nursing facilities.

Other approaches include medical homes, disease management organizations, and community networks or teams to coordinate care, improve patient compliance with plans of care, and encourage preventive health care and patient wellness. The Department of Health and Human Services is beginning to test these concepts and examine the research, and will make recommendations that the Administration will consider in developing future options for modernizing Medicare's payment systems.

As part of the ongoing effort to encourage care coordination, appropriate use of preventive services, and high-quality health care, Medicare payment policies need to forge closer ties between payments and individual physician performance and efficiency. The Administration believes that the current physician payment system, while it has served to limit spending to a degree, needs to be reformed to give physicians incentives to improve quality and efficiency. Thus, while the baseline reflects our best estimate of what the Congress has done in recent years, we are not suggesting that should be the future policy. As part of health care reform, the Administration would support comprehensive but fiscally responsible reforms to the payment formula. The Administration believes Medicare and the country need to move toward a system in which doctors face better incentives for high-quality care rather than simply more care.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires a report on value-based purchasing for physicians, which can help inform policy decisions. There are also a number of demonstration projects and policy options that could help Congress and the Administration consider how best to encourage more efficient and high-quality medical practice patterns. CMS is conducting several demonstration projects that offer incentive payments for physicians to provide preventive services and coordinate care to help patients avoid more costly illnesses. The Administration wants to examine a wide variety of options and engage in an open process to improve quality and efficiency in physician services. Lastly, one factor that helps perpetuate inefficiencies in health care is a lack of clarity regarding what it costs and who bears those costs. Beneficiaries' responsibility for costs may vary depending on the type of service, the part of Medicare that covers it, and whether they have supplemental coverage. It may also vary based on

their income level, in the case of Part B premiums. Policies to improve beneficiaries' ability to be partners in improving the value of care also will be explored.

Improve Medicaid and Children's Health Insurance Program (CHIP) Coverage for Low-Income Individuals

The Recovery Act protects health care coverage for millions of Americans during the recession by temporarily increasing Federal funding to help States facing budget shortfalls maintain their current Medicaid and CHIP programs. While the Recovery Act provides more funding to support Medicaid, the Budget proposes to make sure these funds are spent efficiently by focusing on proposals to improve Medicaid financing and program integrity, reducing costs and helping States detect and avoid improper payments.

- Contain drug spending. Prescription drug costs are high and rising. The Budget would bring down the drug costs of Medicaid by increasing the basic drug rebate for brand-name drugs from 15.1 percent to 22.1 percent of the Average Manufacturer Price, allow States to collect rebates on drugs provided through Medicaid managed care organizations, and apply the additional drug rebate to new formulations of existing drugs. All the savings would be devoted to the health care reserve fund. The Budget also establishes a pathway for affordable generic versions of biologic drugs. To retain incentives for research and development for the innovation of breakthrough products, a period of exclusivity would be guaranteed for the original innovator product, consistent with Hatch-Waxman principles for traditional products.
- Improve payment accuracy. The Budget directs CMS to remedy vulnerabilities in Medicare and Medicaid. CMS will be able to respond more rapidly to emerging program integrity vulnerabilities across these programs through an increased capacity to identify excessive payments and new processes for identifying and correcting problems.

Additional Health Investments

The FY 2010 Budget includes \$76.8 billion in discretionary funding for HHS. We will transmit a more detailed Budget in April, but three key initiatives that I would like to highlight are:

- Food and Drug Administration (FDA). The Budget includes more than \$1 billion to strengthen FDA's efforts to make food safer. It also supports FDA's new efforts to allow Americans to buy safe and effective drugs from other countries and to establish a new regulatory pathway to approve generic biologics.
- National Institutes of Health (NIH) – Cancer. Over \$6 billion is included in NIH to begin a multi-year plan to double cancer research. These resources will be committed strategically, to have the greatest impact on developing innovative diagnostics, treatments, and cures for cancer. This initiative will build upon the

unprecedented \$10 billion provided in the Recovery Act for various types of activities, including cancer and other disease research, in 2009 and 2010.

- Indian Health Service (IHS). The Budget includes over \$4 billion for the Indian Health Service to support and expand the provision of health care services and public health programs for American Indians and Alaska Natives. Investments will focus on improving the health outcomes to address persistent health disparities and foster healthy Indian communities.

Strengthen and Target Family Support Programs

In addition to the Medicare, Medicaid and CHIP initiatives described above, the Budget also invests resources in rigorously evaluated and effective family support programs to improve child health and life outcomes. For example, the Budget builds the framework for creating and scaling up a Nurse-Home Visitation program that could ultimately serve all eligible first-time mothers who seek services. Rigorous research has shown, with rare consistency, that a well-implemented nurse home visitation program can have large and sustained impacts on important outcomes for children and families. This program saves money in the long-term by reducing child abuse and neglect, preterm births, and arrest rates for both parents and adolescents who participated in the program.

Also, the Recovery Act makes historic investments in early childhood programs including Head Start and Early Head Start, and the 2010 Budget sustains those levels.

The Recovery Act includes an additional \$1 billion for Head Start, \$1.1 billion for Early Head Start expansion, and \$2 billion for the Child Care and Development Block Grant (CCDBG). This level will double the number of children served by Early Head Start and expand and improve Head Start. The increase in CCDBG will make child care assistance available to more low-income working families and provide additional funds for States to improve the quality and availability of child care services. The Recovery Act also makes important investments in coordination and quality for these programs.

The Recovery Act also provides a \$5 billion TANF Emergency Contingency Fund, which is targeted to States that are serving an increasing number of needy families. During the recession, it is reasonable to expect that many States will temporarily expand their TANF programs to serve the rising number of poor families. The emergency fund provides an 80 percent Federal match to States with increased expenditures for basic assistance, non-recurrent short-term benefits, and subsidized employment. The emergency fund will enable States to provide time-limited, much-needed help for their citizens during this economic crisis, without undermining the work participation and other requirements of the 1996 welfare reform law.

Conclusion

The President's Budget strikes a new course for America. It presents the fiscal path with honesty, and deficits are projected to fall in half by the end of the President's first term compared to the deficit inherited by the Administration when it came to office in January

2009. Altogether, the policies in the Budget would reduce the deficit by \$2 trillion over the next ten years, begin to address the key contributor to the nation's long-term fiscal short-fall by proposing health savings measures that could help "bend the curve" on long-term health costs, and begin the process of health care reform.

The country faces grave challenges, both in terms of its short-term economic health and its long-term fiscal future, and working our way out of these difficulties will not happen overnight. The policies proposed in this Budget and those enacted last month in the Recovery Act and CHIP reauthorization represent important first steps on the path toward a high-performing health system and economic and fiscal health. I look forward to working with you in the weeks and months ahead to continue the process of addressing the challenges facing our nation.