Financing Health Care Reform

Presented to

Committee on Finance Round Table
United States Senate

By

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Mr. Chairman and Members of the Finance Committee: Thank you for inviting me to participate in your roundtable on financing health care reform. I am currently a senior fellow at Project HOPE and president of the Defense Health Board, a federal advisory board to the Secretary of Defense. After many years as a policy researcher, I spent most of the 1990's primarily focusing on issues relating to Medicare and Medicaid--as Administrator of the Health Care Financing Administration, chair of the Physician Payment Review Commission and chair of the Medicare Payment Advisory Commission. During much of this decade, I have also worked on issues relating to health care for the military and veterans populations as co-chair of the President's Task Force on Ways to Improve Health Care Delivery for Our Nations Veterans, co-chair of the Task Force on the Future of Military Health Care, commissioner on the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission) as well as my current work with the Defense Health Board. The views I am presenting here reflect what I have learned from these various experiences as well as my training as an economist. These views are my own and not necessarily the views of Project HOPE or any of the other organizations I have mentioned.

We are here today to discuss financing issues in healthcare, with particular interest in ways to produce savings in the healthcare system. The questions you have posed indicate a willingness to consider revising the current tax treatment of health care, particularly as it relates to employer-sponsored insurance.

Fundamentals

Although it is sometimes hard to tell, there is wide-spread agreement on many of the fundamentals regarding health care reform.

First, people need health insurance coverage. Although the numbers are subject to both fluctuation and measurement error, current estimates are that approximately 46 million people, some 15% of the population, are without coverage. Being without coverage adversely affects the person without coverage both medically and financially and also has consequences on the community where he or she lives. We need to make affordable insurance available to every American. We can debate whether or not to require that each person have coverage. There are some obvious advantages to such a requirement but it also raises a variety of issues that need to be resolved.

Second, the current growth rate in health care spending is unsustainable. We are currently spending around $2.4 trillion on health care. At more than 16% of the economy, it represents a significantly larger share devoted to health care than any other country. Even more alarming that the absolute level of spending, is the growth rate in spending. Economists have frequently remarked on the so-called "excess spending gap" in health care—growth that has averaged around 2.5 percentage points fast than the rest of the economy, in real terms. This spending gap has been more or less present for several decades. If it continues in the future, it will have profound effects on the Federal budget, crowding out other important programs and functions and/or increasing the

government's share of the economy to unprecedented levels. It is also stressing the budgets of employers and consumers. Throughout the decade, rising health care costs have been associated with rising premiums and small increases in cash wages.

Third, there is also clear evidence that despite high, rapidly growing spending, the U.S. has persistent problems providing clinically-appropriate care to its population. In addition, there are significant problems with patient safety. Research suggests that adults receive only about 55% of the known clinically appropriate care for their medical conditions. Also, as the Institute of Medicine made known a decade ago, as many as 100,000 patients may die each year from medical errors. More recent studies have suggested little progress in this area. It seems quite obvious that the United States is not receiving appropriate value for the large sums of money being spent on health care.

The controversy and conflict starts to arise in how best to respond to these fundamental problems that the country faces. The more detailed and specific the strategies and solutions, the greater is the potential for dispute.

Options

Estimates of the cost of extending coverage to all Americans run as high as $1.5 trillion over the next ten years, some estimates even a little higher. The Administration's "down-payment" in the budget represents less than half of that amount, suggesting the need for a lot more financing, a lot more savings or a combination of both. It also suggests a roll-

out of several years duration may be needed in order to get the spending in balance. The experience in Massachusetts suggests expansion of insurance coverage to almost the entire population can occur very quickly.

There are many ways to provide funding for expanding coverage. The Congressional Budget Office provided 115 options in the first volume of its December publication on Health Care. Other ideas could undoubtedly be generated. However many of them raise relatively small amounts of revenue and may only modestly address issues of encouraging more clinical appropriate or safe care, if they address these issues at all. I am going to focus on only a few areas for change.

The current tax treatment of healthcare

The current tax treatment of health care has long been a focus of concern for economists. According to the CBO, the cost of the current tax treatment in terms of foregone income and payroll taxes was $246 billion for 2007; estimates for FY 2009 put the cost at $315 billion. It thus represents one of the largest tax expenditures in the Federal budget and is regarded by most economists as being both an inefficient and inequitable way to subsidize the purchase of insurance.

The current treatment is inequitable because the exclusion is worth more the higher the person's income and not available to those without employer sponsored insurance. It's inefficient because it distorts the choice between cash wages and other forms of

compensation, frequently doesn't reflect the type of insurance that would be purchased if it was the employee's choice and may encourage the purchase of more extensive insurance than would be purchased under neutral tax treatment between wages and insurance. How, how fast and how much to limit the current tax treatment of employer sponsored insurance and what to put in its place will determine how much revenue can be obtained.

My preferred alternative is to move from the current exclusion to a refundable credit that declines with income but provides some amount of subsidy even at high incomes. Capping the current exclusion, could be viewed as an alternative, or as part of the phase-in to a move away from the exclusion. Capping it at relatively high levels but indexing it to general inflation rather than medical expenditures would generate less pain and perhaps less resistance but also less revenue. It also maintains the current inequity although that could be partially offset depending on the type of subsidy used for those without employer health insurance.

Concern has been raised that many or most employers would stop offering insurance coverage if the current tax treatment were changed. What is likely to happen depends on what else is available, under what terms and whether coverage is required. These requirements can be structured in ways that would make it more or less likely for employers to continue offering insurance. To the extent that employer sponsored insurance remains a way to help attract more skilled employees, employers—especially large employers—are likely to continue offering coverage for at least the near-term.

Reforming Medicare physician reimbursement

Although many of the ways Medicare reimburses for services needs to be changed if it is to be part of a move to a value-based-based system of reimbursement, the way Medicare pays physicians is particularly egregious. Fees have remained essentially flat throughout the decade while the cost of providing services has not. This means that physicians who practice a conservative style of medicine, and have not changed their billing or practice behavior are unlikely to have covered their costs under Medicare. At the same time, total spending under Part B, including spending for Part B drugs, has been increasing at rates of 10-12% per year.

The use of a Sustainable Growth Rate (SGR) that ties the growth in overall Part B spending to the growth of the economy, attempts to achieve this growth rate by relating the fees for some 7000 billing codes to a level that would achieve the desired spending. The pressure on fees occurs whenever the growth in the economy slows and/or increases in the volume and mix of services occurs. Both of these have occurred for much of the decade. The fundamental problem with the SGR is that its objective of controlling total spending is inconsistent with the incentives it produces for individual physicians. Nothing physicians do as individuals or even as large groups will affect overall Part B spending but their fees will be affected by what other physicians do collectively, irrespective of their own behavior.

The use of the SGR would control spending if it were implemented—which has rarely occurred because of concerns about access but even if it were, it would do nothing to improve quality or clinical appropriateness. The removal of the SGR, with no other changes, would probably result in even bigger increases in Part B spending, if behavior in the 1980's is any guide.

Some short term patches could help, such as using multiples SGRs or the use of separate SGRs for multispecialty group practices, and having CMS more aggressively review billing by physicians who are clear outliers in terms of their use of medical procedures and ancillary services. But unless the Congress is prepared to consider SGRs at the practice level, I believe the key to reform is developing a more aggregative payment strategy. In the near term, payments need to be developed that cover all the services that a physician provides to a patient for the treatment of one or more chronic diseases. Also, bundled payments should be developed for high-cost, high volume DRGs, to include at a minimum the payment of all physician services associated with the DRG and perhaps to include the cost of the hospital stay as well.

Developing a new payment strategy and adopting the administrative changes to implement it will take several years. There are no quick fixes to physician payment reform.

Comparative Clinical Effectiveness Research and Value-Based Insurance

The development of more and better information on comparative clinical effectiveness, particularly if its use were encouraged by such concepts as value-based insurance and value based reimbursement, could both improve care quality and potentially slow health care spending. The well known variations on geographic spending in the U.S., particularly now that it appears that the high spending areas have no better health outcomes or responses to patient preferences, offers ample evidence that there are substantial differences of opinion on how best to treat patients with various medical conditions that are not based on good clinical evidence.

The question is how best to generate the information on which medical interventions work best, for whom, and under what circumstances and then how best to make use of the information. Several pieces of legislation were introduced in 2007 and 2008, including S.3408, The Comparative Effectiveness Research Act of 2008, attempting to initiate such efforts. These efforts have now been jump-started with the $1.1 billion for comparative effectiveness research provided in the Stimulus bill. As important as this provision is, it needs to be recognized as the first step in what will need to be a long-term commitment in investing in such efforts. If we are to gain the kind of information that will be needed to produce more effective clinical guidelines, it will take substantial investments over time in order to better understand the data from existing studies as well as generating new information through the use of registries, epidemiological studies and even new prospective trials. These studies will need to occur wherever there are substantial variations in how medical conditions are being treated now as well as investing in similar efforts for new medical procedures.

The Stimulus bill provided important new funding for the initiation of such efforts but did not indicate how future funding will be provided. It also has not answered many difficult questions such as who should be responsible for generating or at least funding new studies, where should the information be stored and how it should be disseminated and otherwise made available to both professionals and the public. Further legislation will be needed to address these issues.

As important as generating new information is, new information alone may not be enough to change physician or patient behavior. Changing incentives for clinicians and their patients, better aligning financial incentives between clinicians and institutional providers and combining information on effectiveness with cost data in setting reimbursements rates will also be important if spending is to change. Value-based insurance concepts which encourage the use of lower co-payments for more clinically appropriate treatments and value-based reimbursement which reimburses the clinicians and institutions more favorably who provide more clinically appropriate care and do so more efficiently, will also help change behavior.

I believe that changing behavior to encourage the use of more clinically appropriate behavior and discouraging what is less clinically appropriate (that is, don't say "no", make it more expensive for the patient and less well reimbursed for the clinician) needs to start with creating credible, objective, transparent information. This means that keeping these functions separate is very important. The groups creating the information

should be separate from the payers as much as that is possible. Otherwise the information is likely to be regarded as "tainted" or at least portrayed as a way of keeping physicians from providing the "best care they can for their patients", even if there is little evidence to suggest that is true.

The use of value-based insurance and value-based reimbursement has more general use than only reinforcing the evidence from comparative clinical effectiveness studies. Varying co-payments to encourage the choice of more efficient physicians and institutions is a strategy that is starting to be used by private payers, reportedly with positive effects. It would be useful for CMS to be granted similar authority for use in Medicare. Current legal deference to individual physician decision-making and the general inability of CMS to make use of information on cost and quality in most of its reimbursement policies would need to be changed.

Concluding Note

Evidence from Massachusetts suggests that expanding coverage can be done quickly. Many of the savings that are under consideration, particularly those that are also aimed at improving quality and clinical appropriateness, may take several years to implement and produce savings. That's a reality that is sometimes hard for people to acknowledge.