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My name is Amitabh Chandra, and I am an economist and an assistant professor of public-policy at the John F. Kennedy School of Government at Harvard University. I am also a research fellow of the National Bureau of Economic Research (NBER) and affiliated with the Dartmouth Institute for Health Policy at Dartmouth College. My testimony does not reflect the opinions of the institutions that I am affiliated with.

In a jaundiced economic environment where a growing federal budget deficit has just consumed another 700 billion dollars, advocating the case for health care reform may seem imprudent. This view pitches healthcare reform, which may have some costly components, against the reality of a deficit that will grow even larger as entitlement programs and automatic stabilizers expand with slowing economic activity. But not all reforms confront this tradeoff equally. A few can actually improve American healthcare while reducing the pressures on the Federal deficit. I will focus on these reforms today. At the same time, today's economic environment offers great scope for the advancement of well-intentioned but simplistic panaceas for reform— it is tempting to collapse the entire reform debate into one about insuring the uninsured, adopting information-technology, rewriting malpractice laws, or proposing that supplemental healthcare spending should constitute stimulus spending. We must recognize that genuine healthcare reform requires doing substantially more. Senator Baucus, I congratulate you on for recognizing these complexities, and providing great vision for comprehensive reform in your Call to Action for Health Reform 2009.

My argument today is that reforms that target cost-growth in healthcare will improve the efficiency of our healthcare system while strengthening the functioning of America's labor markets, and consequently, the well being of millions of workers. Cost-growth in healthcare has reduced the wages of workers, decreased their ability to be consumers, increased non-employment, swollen the ranks of the uninsured, discouraged job-search and voluntary turnover, and crippled the competiveness of American corporations who offer retiree health benefits. Depending on the nature of reforms that confront this problem, they may even catalyze the economy's ability to emerge from a recession.

Cost-growth in healthcare is not a uniquely American phenomenon, but the incentives underlying our Medicare program aggravate this situation by encouraging the adoption of technologically intensive innovations of dubious clinical and therapeutic value. While beneficial in some patients, these new innovations also offer great scope for overuse in others. Regrettably, despite thirty years of academic research on this topic, warnings from the Congressional Budget Office (CBO) and legions of concerned MedPAC Commissioners, the program is also on the eve of bankrupting the United States. But today's strained budgetary environment may give us the stick needed to domesticate the Medicare monster by finally enacting payment reform that promotes accountability and rewards outcomes. Because of spillovers from the practice of medicine in the Medicare to non-Medicare sectors, both public and private dollars will go further if such reforms are adopted. Indeed, cost savings from Medicare reform could be used to pursue other health reform efforts, some of which will certainly cost money. But it is also my view that in the absence of checking the growth of healthcare spending, or accepting limits to what therapies are covered by insurance, other reform efforts will ultimately fail.

I. Rising Health Insurance Premiums and Labor Markets

Let me first explain the effects of cost-growth in healthcare on labor markets. The smooth operation of labor markets requires fewer headlines that capital markets, but they're equally vital—155 million Americans who are in the civilian labor force are affected by what happens in them. According to a national survey conducted by the Kaiser Family Foundation, since 2000 health-insurance premiums for employer provided health insurance have grown three times more than the corresponding increase in wages. Health insurance premiums for workers do not come out of a unlimited reservoir of firm-profits—they come out of wages, and the extent to which that happens depends on workers valuation of the benefits (amongst other things). As the price of health insurance increases, firms lower the wage portion of compensation. The adjustment towards lower wages is not instantaneous, nor is it dollar for dollar, and is therefore often obscured. But as many academic studies have noted, it is clearly at work. Lower wages means lower consumption and less money for gasoline, food, and retail purchases. Recognizing this tradeoff, some healthy workers may be tempted to decline health insurance. Their departure increases premiums for those remaining in the pool. In economics we call their withdrawal the 'adverse selection death spiral.' It decimates health insurance markets.

There is an important caveat to this discussion: while the uncomfortable arithmetic of the wage-fringe tradeoff applies to employees, it cannot apply to retired workers for whom there are no wages to reduce. Increasing costs of retiree health benefits is forcing firms to lose market share to foreign competitors, or respond by slashing these benefits.

There are many reasons, however, to believe that □rms have limited ability to offset increases in the price of health insurance premiums through lower wages. Institutional constraints, such as the minimum wage, union rules, and other provisions of labor and tax law that prohibit different demographic groups from being paid differently, limit a □rms ability to reduce compensation. For such employees, firms cannot reduce wages but they can move them into part-time jobs without health benefits, or simply lay them

off. And this is exactly what has been happening: Dr. Katherine Baicker and I estimate that a 20% increase in health insurance premiums (which is less that third of what premiums have grown nationally) results in an employment loss of approximately 3.5 million workers. A similar number of workers would move from full-time jobs to part time work. Because of the tremendous geographic variation in the how medicine is practiced, employers may avoid locating in the areas of the United States where this is large cost growth cannot be passed on to workers. For workers in these areas, there will be no jobs and no health insurance.

Recessions create painful job-losses and income uncertainty. Even worse, Americans lose their health-insurance when they lose their jobs. They respond by being more reluctant to switch jobs. My colleague Brigitte Madrian estimates that the turnover rate for those with employer provided health-insurance is 25 percent lower that for those without. But such switching is key to revitalizing our economy, as workers should leave failing firms and move to more exciting opportunities. The health of the economy is vitally tied to the speed and precision with which this matching process is accomplished. Job-lock, induced by the lack of portability of health-insurance, is making the most energetic labor market in the world increasingly sclerotic. The worst news has yet to come—the historical record on the relationship between unemployment and the business cycle suggests that peak unemployment rates are usually seen over a year after the economy starts to grow. Many if not most of these families will lose access to affordable health insurance.

Employers often respond to these pressures by capping insurance benefits. Doing so is short-sighted: we now have evidence that such caps result in adverse clinical outcomes, worse adherence, and increased hospital and ER costs. Worse, the presence of caps means that patients are not insured against catastrophic costs—exactly what insurance is supposed to protect against. The capping of benefits combined with the fact that many workers are not only losing jobs but also their health insurance implies that Americans are a substantially higher risk for a medical bankruptcy (between 20 and 50 percent of all personal bankruptcies are medically related).

All this cost-growth in health may have been palatable if the increase in costs meant greater quality or higher patient satisfaction. But neither is true. Katherine Baicker and I have shown that the association between spending and quality is actually negative. My colleagues at the Dartmouth Institute have demonstrated that 30 percent of medical spending has been shown to confer no medical or therapeutic benefit. The United States spends over 2.1 trillion dollars a year on healthcare. 30 percent of that is 700 billion dollars. We're spending a financial bailout every year, with the difference that this one rescues no one. The growing price of health insurance is creating two Americas—one with Americans who lack health insurance and are subject to great uncertainty about medical expenses, and another whose members carry expensive health insurance polices which promise great hope. But relative to the price of this insurance, this group second receives little when outcomes and patient satisfaction are actually measured. We can do better for both groups.

II. Incremental Reform

What are we to do about this situation? In the short-run, we should allow workers to retain access to health insurance benefits. Extending COBRA coverage remains a reform lever, but this gives workers who're unemployed access to expensive healthcare.

Reforming the individual health insurance market through regulatory reform offers promise. But it poses several challenges. Reforming the individual market will require us to address variation across states in the extent to which insurance is 'community rated'. Otherwise, insurers will charge sick people more in states without these provisions. Forbidding such behavior and forcing firms to charge sick patients the premium for healthy patients will put insurers out of business; an outcome that helps no one. Arguing that poor-sick and rich-healthy persons should be charged the same premiums reflects a normative preference for redistribution (from the healthy to the sick) and we should not be surprised if voters object to such a system. Defining the extent to which such redistribution or 'social insurance' operates in insurance markets is only vaguely guided by economics—politics and voter opinion ultimately determine such things. Geographic variation in how medicine is practiced will mean that premiums for Hanover, New Hampshire will be substantially higher than those in McAllen, Texas. Simply deregulating insurance markets will do nothing to address these concerns. And, at the end of the day, none of these reforms ensure that premium growth reflects growth in valuable services.

People who have already purchased insurance and then fall sick pose a particular policy problem: insurance is not just about protecting against unexpected high expenses this year, but is also about protecting against the risk of persistently higher future expenses in the case of chronic illness. With this kind of protection, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, which suggests a strong role for regulation in protecting such enrollees. Nor are insurers held responsible when inadequate coverage raises the costs for a future insurer, such as Medicare for those over age sixty-five. These problems highlight the limited availability of true long-run insurance offerings. But these are the reform issues that Congress can turn to even in times of great fiscal pressure.

One reform idea that we hear more of in coming months is that that large-scale expansions in insurance are most necessary in terms of economic crisis. I agree with the spirit of this comment, but want to highlight an important caveat to how it is best accomplished. Reforms that are permanently expansive will weaken the Federal budget situation even more and compromise America's long-term economic prospects by raising capital costs and forcing future generations of Americans to pay higher taxes. While it may be tempting to view some of this spending as part of a stimulus package, my colleague and former U.S. Treasury Secretary, Lawrence Summers, has noted that wise stimulus spending has the hallmark of being able to be shut off in a year or two, and be linked to a concrete deficit reducing action in the future. Permanent expansions in government healthcare spending are unlikely to meet either criterion. A compromise position at this point may be to offer vouchers, or authorize temporary expansions of Federal and State health insurance policies to American families.

Regardless of the chosen option, we should not delude ourselves into thinking that insuring the uninsured assures them access to high-quality healthcare. The focus on the uninsured is predicated on the view that the insured are receiving high-quality care, equating higher spending and higher quality. The frequent failure of the use of best practices and the tremendous geographic variation in the use of costly care of uncertain medical benefit are often obscured in the focus on the uninsured. Insuring the uninsured will give them access to the sort of health care that everyone else receives: a combination of valuable care, overuse of some costly interventions with little proven benefit, and underuse of some vitally important therapies— care that is sometimes coordinated but often fragmented. This is better than no care, but it highlights the problem of collapsing the entire debate about U.S. health care reform down to the issue of uninsurance: health insurance does not guarantee good health care.

III. Structural Reform

A deeper, more challenging reform proposal would be to think about the fundamental causes for cost-growth in healthcare. The aging of the population has very little to do with this trend. We have a malpractice system that encourages physicians to use every imaging and diagnostic test in the healthcare armamentarium. However, my research shows it's wrong to argue that malpractice is the principal driver of increases in healthcare spending. Rather, cost-growth in healthcare stems from the adoption of new medical technologies that while offering great hope to some patients also offer tremendous scope for overuse in others. The biggest monster under the bed is the gluttonous Medicare program whose perverse incentive structure rewards the adoption of these technologies, encourages financial entrepreneurship by providers, motivates improper physician-industry associations and undesirable forms of physician self-referral. It penalizes prevention and jettisons accountability by reducing healthcare to thousands of discrete billing codes.

Because the same providers treat Medicare and non-Medicare patients in an environment of shared practice norms, what happens in Medicare spills over into the care of non-Medicare population. If a new cardiac catheterization laboratory is set up to treat heart-attacks in the elderly, it can surely be used to perform angioplasty for stable coronary disease in a 45 year old? Even though the former intervention has been shown to be life-saving, the latter procedure has been shown to generate zero benefit as an initial management strategy. Zero Benefit. Not small benefit. Zero Benefit. These insights are probably quite familiar to members of this Committee and to the Commissioners of MedPAC, both of whom have been prescient in recognizing the disincentive effects of Medicare. But it is these very spillovers that offer us an opportunity for reform. Introducing value based reimbursement in Medicare will spillover onto non-Medicare patients. Profiling physicians in the Medicare program on quality will information that will be used by insurers who cover the non-Medicare program to negotiate better prices. Information about quality and resource use is a public good, and is consequently underprovided. Government has a unique role in subsidizing the production of such public-goods.

Reforming Medicare will require enormous Congressional courage, as the beneficiaries

of the status quo will launch a bitter fear-campaign against attempts to inject accountability. But, as I stated earlier, it is my view that today's strained budgetary environment may give us the stick needed to domesticate this monster by finally enacting payment reform that promotes accountability and rewards outcomes. For real reform we have to provide these reforms not only for acute care, but also for ambulatory care. At the Dartmouth Institute, Dr. Elliott Fisher, and Dr. Julie Bynum have made great progress in our understanding how to measure, monitor, and benchmark the longitudinal efficiency of physicians in such settings. But we do not claim to know all the answers.

Reform efforts that target cost-growth require more than the adoption of cost-effectiveness analysis (CEA)—they will require us to measure and reward outcomes for services that are not easily brought under traditional approaches to cost effectiveness analysis because they are not provided to treat specific abnormalities. These range from variations in the intensity of management of chronic disease to different approaches in diagnosing patients with new symptoms or concerns. The remarkable variations in per-patient spending observed across academic medical centers with similar outcomes are largely due to differences in use of largely discretionary services such as the frequency of physician office visits or specialist consultation, differences in the relative intensity of imaging services, and how much time similar patients spend in institutional settings. There is evidence that suggests the growth of these services, as opposed to treatments that are administered in an inpatient setting (and amenable to evaluation by CEA), account for the lion's share of cost growth in U.S. healthcare.

IV. Conclusion

I liken the recent financial-crisis and accompanying bailout to a heart-attack—swift, costly, therapy with rescue angioplasty is the only way to restore blood flow and preserve life. But two vital measures of the economy's long-term health—the state of its labor markets and the size of long-term federal budget are ailing. Ignoring these ailments is like a healthcare plan that treats acute events, but ignores prevention and chronic disease management. Ironically, we have great expertise in setting up such plans.

Healthcare reform that addresses cost-growth will enhance the productivity of labor markets, and have effects on the wages, consumption, employment and insurance of millions. It can energize our ability to emerge from recession. If such reform is engineered by reforming the Medicare program, we would also have improved the long-term budget situation. Doing so would help us cope better with the next economic challenge that America will surely face.