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SCORING HEALTH CARE REFORM: CBO'S BUDGET OPTIONS

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SCORING HEALTH CARE REFORM: CBO'S BUDGET OPTIONS

WEDNESDAY, FEBRUARY 25, 2009

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:09 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Wyden, Schumer, Stabenow, Cantwell, Nelson, Carper, Grassley, Hatch, Snowe, Crapo, Roberts, Ensign, and Enzi.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Alan Cohen, Senior Budget Analyst; Shawn Bishop, Professional Staff Member; Chris Dawe, Professional Staff Member and Senior Budget Analyst; and Lauren Bishop, Intern. Republican Staff: Kolan Davis, Staff Director and Chief Counsel; Mark Prater, Deputy Chief of Staff and Chief Tax Counsel; and Mark Hayes, Republican Health Policy Director and Chief Health Counsel.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

General George Marshall once said, "When a thing is done, it's done. Look forward to your next objective." In the last few weeks, the Finance Committee has done a lot: we helped to pass the Children's Health Insurance bill, bringing health care to millions of low-income children, and we helped to pass an economic recovery bill, helping to bolster our Nation's economy.

Now it is time to look forward to our next objective. Our next big objective is health care reform. As President Obama said on Monday, "The rising cost of health care is the single most pressing fiscal challenge we face by far." As OMB Director Orszag said on Monday, "The path to fiscal responsibility must run directly through health care." And as President Obama said yesterday, "Health care reform cannot wait, it must not wait, and it will not wait another year."

Comprehensive health reform is no longer simply an option, it is an imperative. We cannot afford to delay health care reform. Delay will make the problems that we face today even worse. If we delay, millions more Americans will lose coverage. If we delay, premiums will grow even farther out of reach. If we delay, Federal health

spending will absorb an even greater share of the Nation's economy.

Delay will also make it harder to fix the problems. The problems that exist today will continue to grow, and it will cost more to fix them. Health care reform means making coverage affordable over the long run, it means improving the quality of the care, and it means expanding health insurance to cover all Americans.

We need fundamental reform in cost, in quality, and coverage. We need to address all three objectives at the same time; they are interconnected. Cost growth is unchecked because the system still pays for volume, not quality. Quality indicators like life span and infant mortality will remain low because too many Americans are left out of the system. Families do not have coverage because health care costs grow faster than wages. Each problem feeds on the other problems. We, therefore, need a comprehensive response.

To prepare for this effort, the Finance Committee held 10 health care hearings. Last June, we held a day-long health summit, and in November I released my white paper on health reform to advance dialogue and present a path forward.

Meanwhile, the Congressional Budget Office has also worked diligently to prepare two major health care reports: one volume contains more than 100 budget options for changing Federal health care spending in the Nation's health insurance system; the other volume analyzes the key issues that Congress should consider in designing major health reform proposals, and it describes the key assumptions that CBO would use in estimating the effects of those proposals.

These reports are intense efforts by CBO to assist Congress up front in developing health reform legislation. In keeping with the CBO's nonpartisan role, they do not offer recommendations for any specific policy option; deciding what path to take is our job, working together with the new President.

We are grateful to CBO for the hard work that went into these volumes, and we thank them in advance for the enormous effort that will go into analyzing the health care reform legislation that will come from this committee this year.

As our friends at CBO know, our consideration of health care reform will not be just business as usual, for this committee or for CBO. CBO's work will make or break this enterprise.

We need CBO to work with us to find a pathway to health reform. CBO has expertise to help design a bill that we can pass, and President Obama can sign into law this year. I call on CBO to help us find a way to make health reform work.

It's a pleasure to welcome CBO's new Director, Doug Elmendorf, to the committee. We hope that this will be the beginning of a beautiful friendship. So let us look forward to our next objective, let us learn more about the cost and savings of health care options, and let us begin in earnest the job of comprehensive health care reform.

When we have a quorum, and I hope that is very soon, we have a little bit of business to conduct. But before we get to that point, I would now turn to Senator Grassley.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Senator Baucus.

It is obvious we desperately need to improve our health care in America. Our health care system is not a system. Our non-system is a series of disconnected pieces with often perverse, dubious incentives. It costs too much. It is not as consistently high in quality as it ought to be. It leaves tens of millions of Americans uninsured. Every day we wait to do something to improve health care, we do a disservice to the people who elect us to sit in these chairs. We have an opportunity right now to make positive change. It is an opportunity we must take.

But we must also take a sober look at the difficulty of our situation. When our Chairman published his health care reform white paper 3 months ago, I noted the fiscal challenges we face moving forward with such reform. A few people treated me kind of like a skunk at a picnic for raising those issues of reality. Well, I hate to do it again, but everyone knows our fiscal situation has gotten worse since November. Back then, I speculated that we might be looking at a $300-billion stimulus package in the year 2009. I missed that one, did I not? The stimulus package ended up costing over $1 trillion, when interest on the debt is factored in. That debt is growing rapidly.

Let us make sure that we put this in the proper perspective. It has been rightly pointed out that the debt held by the public grew during the 8 years of the last administration. Indeed, in the years of 2001 to 2006, the debt grew, albeit by less than 1 percent per year in terms of Gross National Product. I am going to put up a series of charts, and I want everybody to know that I cannot equal the Grand Pasha of charts that Senator Conrad is, but I am going to attempt to illustrate a little bit.

[The charts appear in the appendix on p. 73.]

Senator GRASSLEY. We have a chart here that shows the national debt. By the way, the greatest debt growth occurred in the last 2 years of that administration, when we had a Democrat-controlled Congress. For all of the criticism that we heard of the marginal rise in public debt in the period 2001 to 2006, what occurred during the last Congress exceeds it altogether.

Moreover, with respect to deficits, again, we heard a lot of criticism of the widespread bipartisan tax relief of 2001 through 2006. In fact, as the next chart shows, the deficit went down as tax relief went into effect. The current administration inherited a $1-trillion deficit, and they promptly added another $1 trillion to our national debt with the stimulus bill.

That bill contains a number of entitlement expansions which, if made permanent, would add another $2 trillion to the debt. And our unfunded obligations for Social Security and Medicare are $40 trillion over the next 75 years.

I have heard some say it is our moral responsibility to provide health care coverage for all. We have an equal, if not greater, moral responsibility to do so in a fiscally sustainable manner. I would like to quote Peter Orszag, OMB Director now, as he was quoted in yesterday's *Washington Post:* "Let me be very clear:

health care reform is entitlement reform. The path of fiscal responsibility must run directly through health care."

For some, fiscal responsibility and health care reform do not usually go together, so it is good to hear the new Director of OMB, and directly from the White House, making this connection. Getting overall health care costs under control is an elusive goal, but, even if it is achievable in the long term, it will not replace the need to tackle the difficult job of slowing the growth in entitlement spending in the near term. If we do not, then we will not be living up to the promise made to protect these important programs for future generations. In their current state, these entitlements—and you obviously know that is Medicare and Medicaid—are not financially sustainable.

But we must be very wary of the idea that we have to spend more up front to reap savings down the road. I do not subscribe to the exclusivity of that argument, but it is an argument that we have to question. Too often with the Federal Government, the upfront spending happens but somehow long-term savings do not happen.

There is no question in my mind that, if we are not careful, Congress can make the situation worse. One could easily see how spending more up front could make the financial problems facing Medicare and Medicaid even worse than they already are today.

The President has an opportunity as he walks this razor's edge between a broken health care system and fiscal catastrophe. He has the opportunity to move beyond the unfortunate partisanship that the Children's Health Insurance was. He has the opportunity to set aside the fiscal alchemy that we have seen in prior budgets, and set new standards of honest budgeting in health care.

I think last night when he said that he is in the process of going through every program in the budget to review it, that that is an important first step. But he also has the opportunity to move beyond the sound bites of campaign into the reality of funding health care coverage in these fiscally challenging times. There is an opportunity here. With the budget tomorrow, the President can show us the pathway to move forward with fiscally responsible health care reform.

As I said on the floor at the end of the CHIP debate, I am willing to move past the partisan politics that have dominated these first few weeks of 2009 because the issue is critical to our constituents. I know that a lot of people—most importantly the chairman of the committee—want to move in that direction.

I am willing to help in that effort. But we clearly have our work cut out for us. That is why I am pleased that we are having this hearing today. The Congressional Budget Office plays a very central role in the reform debate. They are the official scorekeeper. We are going to have to pay close attention to what the Congressional Budget Office has to say about health care reform proposals. We will have to examine closely the cost drivers of that system.

Rising costs put health care coverage out of reach for more people. We need to find ways to encourage more efficiency in the system, to reward providers who consistently deliver quality care, and the Congressional Budget Office has done quite a lot to start this

conversation. So, that is why this important meeting builds on that, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you very much, Senator Grassley.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Today we hear from Dr. Doug Elmendorf, the new Director of the Congressional Budget Office. Welcome, Doug. Your entire statement will be in the record. I just encourage you to summarize, orally, your prepared statement.

STATEMENT OF DOUGLAS ELMENDORF, Ph.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. ELMENDORF. Thank you, Chairman Baucus, Senator Grassley, members of the committee. I am honored to appear before you today as the Director of the Congressional Budget Office, and we look forward to helping all of you as we navigate these issues by providing the technical information that you need to make your decisions.

I will be testifying this morning about the challenges and opportunities that Congress faces in pursuing two policy goals: expanding health insurance coverage and making the health care system more efficient.

To assist the Congress in its deliberations, CBO has produced two major reports, as the chairman mentioned. One, titled "Key Issues in Analyzing Major Health Insurance Proposals," examines the principal elements of reform proposals on which we would base our estimates of the effects on Federal costs, insurance coverage, and other outcomes. The other, titled "Budget Options for Health Care," comprises 115 discrete options to alter Federal programs, affect the private insurance market, or both.

Drawing on these reports, my testimony today makes four key points. First, proposals could achieve near-universal health insurance coverage only by combining three key features: mechanisms for pooling risks, subsidies, and mandates or processes for facilitating enrollment.

Second, a substantial share of health care spending contributes little, if anything, to the overall health of the Nation, but reducing spending without also affecting services that do improve health is challenging.

Third, despite this challenge, many analysts would concur with the importance of several approaches, including providing stronger incentives to patients and providers to trim costs and ensure value, and generating and disseminating more information about the effectiveness of care.

Fourth, many steps that analysts would recommend might not yield substantial budget savings or reductions in national health spending within a 10-year window.

Let me discuss each of these points briefly, in turn. First, achieving near-universal health insurance coverage would require three principal features. To start, mechanisms for pooling risks, both to ensure that people who develop health problems can find affordable coverage and to keep people from waiting until they become sick to buy insurance.

Next, subsidies to make health insurance less expensive, particularly with people with low income who are most likely to be uninsured today. However, for reasons of equity and administrative feasibility, it is difficult for subsidy systems to avoid providing new subsidies to people who already have insurance or who would buy insurance anyway.

Lastly, either an enforceable mandate to obtain insurance or an effective process to facilitate enrollment in a health plan. An enforceable mandate would generally have a greater effect on coverage rates, but without meaningful subsidies it can impose a substantial burden on many people. Without changes in policy, CBO estimates that the average number of non-elderly people who are uninsured will rise from perhaps 48 or 49 million this year to about 54 million a decade from now.

Second, as I noted, a substantial share of spending on health care contributes little to our health, but reducing such spending without also affecting services that do improve health is difficult. As you know, spending on health care has grown much faster than the overall economy for decades, with studies attributing the bulk of that excess cost growth to the development of new treatments and technologies. This imposes an increasing burden on the Federal Government for which the principal driver of the unsustainable budget outlook is health costs, not aging.

This also imposes an increasing burden on the private sector, where the growth of health spending has contributed, importantly, to slow growth in wages, because workers must give up other forms of compensation to offset the rising cost of health insurance.

Third, there are a number of approaches for improving efficiency and controlling costs about which many analysts would probably concur. To start, many analysts would agree that payment systems should move away from a fee-for-service design and should instead focus on incentives to control costs and ensure value.

Exactly how to create these incentives is, unfortunately, less clear. A number of alternative approaches could be considered, and are discussed in our volumes, including fixed payments per patient, bonus payments based on performance, or penalties for substandard care, but the precise effects of these alternatives is uncertain. Policymakers may want to test various options, for example, using demonstration programs in Medicare.

Next, many analysts would agree that the current tax exclusion for employment-based health insurance, which excludes most payments for such insurance from both income and payroll taxes, dampens incentives for cost control because it is open-ended. These incentives could be changed by replacing the tax exclusion or restructuring it in ways that would encourage workers to join health plans with higher cost-sharing requirements and tighter management of benefits. Similarly, changes might be made in cost sharing in Medicare to create stronger incentive for patients to work with their provider to control costs.

In addition, many analysts would agree that more information is needed about which treatments work best for which patients, and about what quality of care is provided by different doctors and hospitals. But absent stronger incentives to improve value and efficiency, the effect of information alone will generally be limited.

Fourth, many steps that analysts would recommend might not yield substantial budget savings or reductions in national health spending within a 10-year window. There are a number of reasons for this. In some cases, savings materialize slowly simply because an initiative is phased in. For example, Medicare could reduce payments to hospitals with high rates of avoidable readmissions, but would first have to gather information about readmission rates and notify hospitals.

In other cases, initiatives that generate savings also have costs to implement. For example, expanding the use of disease management can improve health and may be cost-effective, but may still not generate net spending reductions because the number of people receiving services is much larger than the numbers who ultimately avoid expensive treatments.

In other cases, the Federal budget does not capture directly the reductions in national health spending. For example, if the government provided a preventive service for free, national health spending might decline, but Federal costs could go up because many of the payments would go to cover care that would otherwise have been paid for privately.

In still other cases, incentives to reduce costs are lacking. For example, proposals to establish a medical home might improve health care, but have little impact on spending if the primary care physicians who coordinate care are not given incentives to economize on the use of services.

And very importantly, in many other cases only limited evidence is available. Studies generally examine the effects of discrete policy changes, but typically do not address what would happen if many aspects of the very complicated health care system are changed at the same time.

In sum, many analysts would agree about the direction in which policies should go in order to make the health care system more cost-effective. Patients and providers both need stronger incentives to control costs, as well as more information about the quality and value of the care that is provided, but much less of a consensus exists about crucial details regarding how those changes should be made.

Similarly, many analysts would agree that expanding insurance coverage significantly would require a combination of risk pooling, subsidies, and tools to mandate or facilitate enrollment, but would disagree about the emphasis to place on these three pieces.

Let me conclude by echoing Chairman Baucus and Ranking Member Grassley about the urgency of health care reform. In contrast, with the situation in the economy and financial markets, our system of delivering and paying for health care is not fundamentally different this year from last year.

However, the relatively gradual pace of change in health care is rarely seen as an argument for deferring action. Our current health system evolved over years and decades, and while coverage could be substantially expanded in a few years, it could take many years, or even decades, for the thorough-going changes needed to improve the system's efficiency to come fully to fruition. Because of the lead times involved, nearly all analysts think that those changes should begin now.

Thank you. I am happy to take your questions.

The CHAIRMAN. Thank you very much, Dr. Elmendorf.

[The prepared statement of Dr. Elmendorf appears in the appendix.]

[Whereupon, at 10:30 a.m., the committee was recessed, reconvening at 10:39 a.m.]

The CHAIRMAN. Thank you, Dr. Elmendorf.

The question I really have is, can you give us specific examples of incentives from the CBO budget volumes that go beyond simply cutting provider payments and increasing cost sharing? That is, what ideas do you have to basically change provider incentives to increase quality and reduce health spending? Just some examples, especially on health delivery.

Dr. ELMENDORF. I will mention a few of a score that are in the volume. One is to bundle payments for hospital care and post-acute care. Currently, hospitals receive a single payment for a stay. Medicare will pay separately for follow-up care out of the hospital. If those payments were bundled, then it would be an incentive for the providers to economize on the use of post-acute care, provide only the care that really was important. In our estimate, that would save a considerable amount of money.

A second example is to reduce Medicare payments to hospitals with high readmission rates. Of course, in many cases patients end up back in the hospital because of unavoidable medical complications, but in other cases patients end up back in the hospital because of errors, or at least inefficiencies in care in the hospital or in post-acute care. If hospitals were penalized for unusually high readmission rates, that would provide an incentive to be sure that effective processes were being followed in the hospital and after patients leave the hospital.

A third example is to allow physicians to form what we call Bonus-Eligible Organizations. They are sometimes called accountable care organizations. They are groups of providers that coordinate the care and, thus, can hopefully reduce unnecessary tests, reduce medical errors, and, by providing an incentive to these provider organizations in the form of bonuses if—and only if—their care for patients meets high standards and they reduce expenditures, that again provides an incentive for those organizations to economize unnecessary care. So those are three specific examples of ways that would save the government money and ways that would improve the quality of care.

The CHAIRMAN. Now, look at each of the three. I suppose there are some costs involved with each of the three, too, in addition to the potential savings. Can you give us some sense of which among those three has the greatest cost savings?

Dr. ELMENDORF. I am reluctant to rank these policies because there is a good deal of uncertainty about their effects, and because for each of the policies there is really a dial that can be adjusted in how stringent the policy is.

So, as we have calibrated these various policies in our volume, the largest gains come from the bundling of payments. But, if one were to provide larger bonuses or penalties for these Bonus-Eligible Organizations and if one were to impose different-sized penalties for unusually high readmission rates, then one could enhance the

savings under those other options. So for a lot of these options there is both the qualitative choice of what to focus on and a quantitative choice, which is just how big to make the penalties or bonuses.

The CHAIRMAN. What is your degree of confidence on the quality measure? That is, some way to measure the degree to which a bonus and/or a penalty should be imposed based upon quality and how that quality is determined?

Dr. ELMENDORF. I think we are at an early point in measuring the quality of health care. A lot of work is being done to improve methods of measurement to design effective standards. We also need to continue to work on ways to collect that information in an efficient way. That is part of what health information technology can do. So we are at an early point, but I think we are at a sufficient point where—and I think most analysts would judge—policies could move forward that base financial rewards on measures of quality.

The CHAIRMAN. If you look at the white paper I put out, if we are going to work, logically, in areas that we have data and put off to a little later areas where we are still gathering data, can you give me a sense of what that schedule might be?

Dr. ELMENDORF. I think the aspects of health care reform where there is the best evidence involves changes in the payment rates, particularly—I talked about the effect of changing the tax exclusion. We have evidence about the way in which people's out-of-pocket costs of health care affect the quantity of care that they demand and receive.

The CHAIRMAN. I am focused more on delivery.

Dr. ELMENDORF. In terms of the relatively less clear area——

The CHAIRMAN. To track payments to providers or trimming direct payments to providers. I am trying to get away from that. That is a different subject. We may get there, but that is a different subject. I am talking, focusing right now on delivery.

Dr. ELMENDORF. So, within the delivery category, I think the items that are clearer are those that provide financial incentives to existing organizations that they can follow up on in their existing structure. So, for example, penalizing hospitals for excess readmission rates, that can be done by the existing organizational structure. It would take longer and would be less clear to us what the effects would be of encouraging these accountable care organizations, because that would require building these structures that do not yet exist and seeing how they work.

The CHAIRMAN. We have a long ways to go. Thank you very much.

Dr. ELMENDORF. Yes, sir.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. With so many people here and with a vote at 11:30, I may only get one chance. So I would ask for short answers, because I would like to get through three issues.

People often cite the need to focus on prevention, health care costs, implement more health information systems, or comparative effectiveness research to reduce costs. From your work on these proposals, do you agree that more prevention, implementing health

IT systems, and doing comparative effectiveness research will result in significant health care savings?

Dr. ELMENDORF. I think it is clear that those sorts of changes will result, if implemented correctly, in significant health improvements. The extent to which there are cost savings is more complicated. In terms of preventive care, when analysts look at this, there are a range of sorts of services: some of them are very cost-effective, some of them would be much less cost-effective. So the cost savings depend crucially on exactly how or what circumventive care is encouraged, what sort of comparative effectiveness results are obtained, and how they are used. It is hard to make a blanket statement.

Senator GRASSLEY. All right.

One reform that some have proposed involves creating a new public plan to compete with private insurance in the private marketplace. If one assumes that this public plan would reimburse doctors, hospitals, and other providers at Medicare payment rates, some analysts have predicted what this might do to the availability of private coverage. That analysis has predicted that the below-market reimbursement rates for doctors and hospitals would result in the government plan having artificially lower rates.

If this is the case, do you believe that over time a public plan would crowd out some private coverage? If so, what portion of the market would end up in a government-run plan, and how many people would lose private coverage as a result?

Dr. ELMENDORF. Designing a system in which a public plan could compete on a level playing field with private plans is extremely difficult. We are wrestling now with how we would model proposals to try to do that. The provider payments that you highlighted are certainly an important issue, but there are others: administrative costs, what sort of risk pooling happens, whether the public plan ends up with sicker patients or the private plans end up with the sicker patients.

There are issues about the cost of capital between public and private plans. Private plans need to worry about the risk of the costs exceeding the money they are taking in. One would have to decide how a public plan would deal with that sort of risk, who is left holding the bag, and think about how to calculate the cost of that. So, there is a set of issues.

It is true that, if a public plan ends up paying lower provider payments than private plans pay, that is certainly a leg-up for the public plan. But these other issues are going to be very important deciding whether that—that is not the only way, essentially, and the other issues will be very important in deciding whether that was the net effect or whether other things were working in different directions.

Senator GRASSLEY. All right.

Just, if I could put together a comprehensive health reform proposal this very day and I presented it to you this very day, how long would it take to get a preliminary score?

Dr. ELMENDORF. It depends on the extent to which your plan draws on elements that we have already thought hard about and estimated, or elements that we have not yet thought hard about. So, for all the volume of these volumes, not every issue is covered

here, and we are working as fast as we can to expand the set of options that we have a sufficient grasp of, so that we can turn around estimates quickly. Not everything is covered. We are not there yet, to be honest, so the timetable depends an awful lot on what the plan consists of.

Senator GRASSLEY. All right.

I should have probably been more precise. Let us just suppose my plan included everything that you have had some intellectual look at presented to you. How long would it take to get a preliminary cost?

Dr. ELMENDORF. So, I am not just trying to stall you, but I will say that even then there is this complication that pieces of these books are not additive, so there are a number of provisions that would work against each other or with each other. So the interaction effects, which can be very, very important substantively—we think about health IT and incentives to use information—can be much more powerful together than separately.

So even to the extent of which we have all the pieces, the interactions would be important. So I am loathe to give you a specific timetable, but I can just say we understand—and I started, as you did, talking about the urgency of this—how vitally important it is that we move quickly on the materials we have received from anybody here, and we will do our very best.

Senator GRASSLEY. Thank you.

Dr. ELMENDORF. Thank you, Senator.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I particularly appreciate your answer to Senator Grassley because it was very direct, very logical, and very honest. I mean, everything is always a lump. Senators are always, when are you going to get us the cost of this lump package, and it does not work that way. It is broken down into pieces, some of which you have studied, some of which you have not. I am just glad you said that.

In the Deficit Reduction Act in 2005, we greatly expanded the flexibility of States to spend money on Medicaid. State waivers came in, the rest of it. Let me just posit that to me, the most important part of health care in a person's life is EPSDT, Early Periodic Screening, Diagnosis, and Treatment. I think that is where it all begins. That is where all the patterns are set.

Now, the result is that Governors can now alter EPSDT, and in fact a number of them have, and they have taken it right out of circulation because they can put it somewhere else. That is their right. I was against Medicaid waivers. I still am. So, that is the fact.

So at the time back in 2005, CBO estimated that these changes to Medicaid cost sharing and benefits would save $3.2 billion over 5 years, and $16 billion over 10 years. The practical impact of this "new flexibility," however, has been just what I said, that a lot of States have eliminated EPSDT. I think that is a disaster for health reform substantively, that they have lost their Medicaid coverage in respect to that.

So my question is this: when estimating benefit changes like DRA changes to EPSDT, does CBO take into account the increased costs associated with decreased access to care at that level? Quite

frankly, I do not know how you trail it on through life, but it sure does trail: teeth, mental, dental, all the rest of it. For example, there are a lot of children in West Virginia who have lost access to mental health services because of this so-called flexibility that we allowed in 2005, and of course this lack of access is what shows up in CBO's scoring sheet as savings.

I would like you to comment a little bit on that, because I do not know whether CBO takes into account the increased costs that accrue as a result of the savings now and the increased costs later because of such obvious effects of not paying attention to children when they are young.

Dr. ELMENDORF. So, I am not familiar with that particular cost estimate, Senator, but I can say as a general matter that we very much take account of all of the interconnections in health care in terms of people's health and the financing of health care that we can. For example, we have a very elaborate effort under way now to track all the various channels through which policies that reduce smoking can affect both public spending and private health care spending, and that involves just the issues you have raised about delayed effects over time, working through many channels of mothers, babies, adults and their behavior, different sorts of diseases, different ways that care is paid for.

We are, as an example, working very hard to try to map as many of those tentacles of this problem as we can. So it is certainly our objective to always incorporate in-cost estimates and, in the qualitative discussion that accompanies the estimates, as many of these effects on health just by itself, and then on health spending as we can. As you understand, it is a very complicated business.

Senator ROCKEFELLER. It is.

Dr. ELMENDORF. I am not sure that we always get it right, but we are always trying.

Senator ROCKEFELLER. I know that.

And I just want to add one more thing. It is one thing to talk about smoking, because I would think that everybody sort of has an idea of what that might be. But it is another thing to talk about autism, or deafness, or cleft palates, or little baby teeth that come in diseased, and therefore everything after that is much worse, and it is too late by the time they are 6 or 7 years old and they get bigger teeth. I really do not understand the process by which you follow that through. I do not have enough time for you to answer that fully, but could you take a quick shot at it? It is complicated stuff.

Dr. ELMENDORF. So, I am not familiar, to be honest, with how we model that. But let us get back to you, and we will explain what we do and how we do it, and we will talk with you about ways that we might be able to improve that.

Senator ROCKEFELLER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Roberts?

Senator ROBERTS. You surprised me, Mr. Chairman.

The CHAIRMAN. You are a hard one to surprise. I take that as a compliment.

Senator ROBERTS. Thank you, sir.

Doctor, thank you for being here today, and thank you for all the work that you do. It is an almost impossible task. And your predecessor, Dr. Orszag.

CBO does more than just estimate the cost of our policies. Your office also guides policy. Inasmuch as you try to predict people's reactions to our policy changes, that is almost impossible. I know this is very difficult. None of us has a crystal ball to look into the future. Sometimes we crack that ball for you, and sometimes you end up with a cracked ball, and that does not work very well either.

But I think we all appreciate that trying to predict the effects of policy changes in the complex world of health care is very challenging. I understand that you have scores for 115 different proposals. That is rather amazing, that you have already done that work.

I would like to suggest this fact: the enormous difficulty of predicting the effects, and sometimes the unintended consequences of our policies, is just one of the many good reasons that we should act very deliberately and with great restraint as we wade further into the policies—note I said "wade;" I think we are diving headlong into about a foot-deep pool—that will have such a huge impact on today's, and future, generations.

Now, if the Grand Pasha of charts is Senator Conrad over here, you are the imperial holder of the yardstick in regards to scores. Lord knows how many times I have heard the Finance Committee conference reports, being the chairman of the World Health Care Coalition both in the House and the Senate, worried about a particular program that means the difference between good health care or not, or rationing health care, the unique problems.

I would hear about something that would happen when one of the members would have a burr under their saddle: use your score and then come up with something that we were trying to protect, or change something we were trying to protect or do away with it. And we would say, how on earth did they do that?

Basically, somebody took a Lizzie Borden axe to a program that we thought was absolutely vital, and then we ended up trying to pull teeth—maybe one of the teeth that was referred to by Senator Rockefeller that had become diseased—and that becomes almost impossible. So I am making a longer statement than I should about the law of unintended consequences, and I hope that we can address those issues.

Between the Children's Health Insurance Program—that is SCHIP 1 that was referred to by our Minority Leader, Senator Grassley, and SCHIP 2, or what I called SCHIP "boo"—and the economic stimulus package, this Congress has already spent hundreds of billions of dollars on a range of health care reforms. I doubt that too many members of this committee and their staffs—staff probably has, but I am not too sure about us—have really waded through all of that, and I commend you for your work on it.

Some of these reforms I agree with, but the vast majority were, in my opinion, rushed through this body far too quickly without due diligence and debate that such important policies, and the American people who will be affected by them, certainly deserve.

I was very disappointed by this hasty, and I think detrimental, commencement to the 111th Congress.

Now, that being said, our distinguished chairman backed off of 30 reported statements when he made a statement at Monday's White House summit that the budget reconciliation process should be used as a vehicle to rush through health care reform.

And so, Mr. Chairman, I do look forward to working, or working together again, and to this committee returning to the bipartisan and deliberative body that it has been in the past.

President Obama said last night, that particular portion of the speech that I was very heartened by, where he was committed to working with Republicans, the endangered species of the Congress, and recognized that the government's role is not to supplant private enterprise, but to catalyze it. I thought that was a very important word.

The health care sector already has some very useful models of successful partnerships between the government and the private sector—I am talking about Medicare Part D and the prescription drug program—and I look forward to working with the President and with this committee to apply the lessons that we have learned from these successes for the benefit of all Americans.

I just have one quick question. I think I have 15 seconds, so I apologize for this. As you know, the MMA and its creation of the Part D prescription drug program included the non-interference provision that prohibited the government from negotiating drug prices, a big controversial subject on the committee and in the health care debate.

Are your views consistent with the statements of Dr. Orszag and Dr. Holtz-Eakin, that striking the non-interference clause would have a negligible effect on the Federal budget, given that the CBO has consistently lowered its baseline for total Part D expenditures—I think we ought to underline that about 6 times—since the program was implemented? When comparing the same time periods, is there any basis for believing that government negotiation would work better than the competitive market-based structure of the program to hold down costs?

Dr. ELMENDORF. Senator, CBO's views do not change with the director. We as an organization still believe that granting the Secretary of HHS additional authority to negotiate for lower drug prices would have little, if any, effect on prices for the same reason that my predecessors have explained, which is that the private drug plans are already negotiating drug prices, and they are negotiating using the levers they have available, which are——

Senator ROBERTS. I do not mean to interrupt you, sir, but that is the answer that I was looking for, so I am going to stop you right there.

What would have to happen for any party to negotiate deeper savings than already achieved in the program? Would they not have to restrict the drug coverage? That is the danger of it. I apologize, Mr. Chairman.

Dr. ELMENDORF. The negotiating lever that is used to lower drug prices is the threat of not allowing that drug to be prescribed, or putting limitations on its being prescribed within that drug plan.

Senator ROBERTS. Which is already the challenge we face in rural Montana, sir.

The CHAIRMAN. All right.

Dr. ELMENDORF. Might I just use 15 seconds, Senator——

The CHAIRMAN. Briefly.

Dr. ELMENDORF [continuing]. To agree with your point about unintended consequences? I think in this book of the effects of various policy changes, we put down specific numbers to focus our thinking, other people's thinking. But one should take many of the digits with a certain grain of salt because we do not know. I think you are absolutely right about that, sir.

The CHAIRMAN. Thank you, Senator. I might say, I do not think at any time did I ever say that reconciliation would be used for health care reform. I have not totally ruled it out, but my strong, strong preference is we not have to go down that road. I am doing everything I can to prevent us from going down that road.

Next, the Grand Chart Pasha from North Dakota. [Laughter.]

Senator CONRAD. Thank you, Mr. Chairman. The Grand Pasha. I do not know what that means exactly. We do not use those terms out in North Dakota that often. I guess down in Kansas, there is a little different lingo.

Senator ROBERTS. Oh, we have great piles of it in our feed lots, so we thought——

Senator CONRAD. Remember now, it is my turn. [Laughter.] You know, for years I have counted you as a friend, and still do. And still do.

First of all, Mr. Chairman, I want to thank you for your strong and steady leadership of this committee on this issue, and conducting the business of this year. I mean, you have had an enormous load dumped on your shoulders, and I think all of us can say you have really conducted yourself with distinction.

Let me try to put this in a budget perspective, because I serve on that committee as well. Over the last 8 years, our debt has doubled. We are on course to double the debt again. If we do, we are going to have a debt that is over 100 percent of the Gross Domestic Product of this country. At the White House the other day at the Fiscal Responsibility Summit, speakers there said the current course is completely unsustainable, that over the next 40 years, if we stay on the current course, we will hit a debt-to-GDP of 300 percent.

To put that in perspective, after World War II our debt was about 125 percent of the Gross Domestic Product. If we look at the major industrialized countries of the world, no one is even close to a debt as much as 300 percent of GDP. I think the closest today would be Japan, that is about 189 percent of GDP.

The consequences of a failure to change this cost trajectory, as it has been described to the Budget Committee repeatedly in hearing after hearing last year and this year, would be catastrophic.

Allen Sinai, the distinguished economist, told us in a hearing just weeks ago that if we do not get a hold of our long-term debt situation, our country will look like a banana republic. That point was echoed by other economists of virtually every philosophical point of view.

Health care, as the chairman has indicated, is the 800-pound gorilla. He is quite right, and the President is quite right, to make that a top priority. The projections show that we are spending 16 percent of GDP now on health care, but we are headed on the current trend line, over the next 40 years, to 37 percent of GDP. That would be more than 1 of every 3 dollars in the economy.

Now, so what do we do about it? First of all, it is very hard for me to understand, when we are spending 16 percent of GDP, about twice as much as any other country, why the answer is to put more money into the system. I look at the analysis that was done comparing the Mayo system, the Mayo Clinic, with UCLA. The costs at Mayo were roughly half the costs at UCLA—half—and the health outcomes were better.

Now, can you help me understand how we substantially affect this cost curve? The first question is, do you think it is sustainable to go from 16 percent of GDP on health care to 37 percent, which is what our current trend line would do?

Dr. ELMENDORF. No. Absolutely not.

Senator CONRAD. Senator Wyden has offered us a plan that is about cost-neutral over 5 years. I would just tell you, from my perspective, from a budget perspective, it seems that we would be going in the wrong direction to put more money into this system. Is it possible, in the analysis that you have done, to avoid going to a higher share of GDP in this system over the next 5 years?

Dr. ELMENDORF. It is a big ship. It is not moving that fast, but it is very big, and it is very hard to turn. There is no doubt that the sooner that you start and the more aggressively you shift incentives, the faster the ship will turn. I am loathe, sitting here, offhand, to predict exactly what could happen by certain dates. But the difference that you have highlighted between the Mayo Clinic and UCLA is very large. To be fair, I think UCLA has argued that they have a sicker group of patients than the Mayo Clinic. I am not an expert enough to judge that.

Experts who have studied the geographic variation observe patterns that differ across areas: the Mayo Clinic has fewer specialists than UCLA; people stay in the hospital less time, they get fewer tests. But knowing exactly what tests to stop and what specialists to stop seeing is the challenge.

And I think that the incentives can move the system there, but there will need to be thorough-going changes in incentives that will need to involve substantial amounts of money because it will require a reorientation about the way that we structure health care delivery.

Senator CONRAD. Thank you.

The CHAIRMAN. Senator Enzi, you are next.

Senator ENZI. Thank you, Mr. Chairman. Thank you, Doctor, for your direct answers. Thank you, Mr. Chairman, for the great job you are doing with putting together a task force with the ranking member and the three committees that will be involved in it—Finance Committee, HELP, and Budget—to come up with some health care reform and to do it in a relatively short period of time.

I appreciate the President's emphasis in the economic summit on the need for health care reform, and again last night in his speech. I also appreciate Senator Daschle's book. I am one of the biggest

promoters of that—I help keep it on the best-seller list—because it has one of the best histories, I think, on health care reform and what we have not gotten done before, and some ways to get something done. So, I do encourage everybody to read that.

To get to a question, the key issues in the "Analyzing Major Health Insurance Proposals" report: CBO states, "Nearly 95 percent of individuals who are eligible to enroll in Medicare Part D do so because of late enrollment penalties, penalties that are intended to discourage eligible individuals from waiting to develop a health problem before they enroll."

My question relates to the necessity of health care reform legislation including an individual mandate to purchase insurance coverage. Given the government's experience with Medicare Part D enrollment, is there conclusive evidence that we can get to full coverage, or close to full coverage, without imposing an individual mandate?

Dr. ELMENDORF. In our estimation, achieving what we termed near-universal coverage requires, as I mentioned, a combination of pooling mechanisms, which Medicare has, of subsidies, which Medicare has, and either of mandates or procedures that facilitate enrollment. The procedures can be quite important, so when one turns a certain age one is enrolled in Medicare. One can opt out, but one is, by default, enrolled. That can matter.

In Massachusetts, in an effort to enforce their mandate, they required a third-party—the insurance companies, essentially—to report on who has insurance. As you know from the tax code forms of income where there is information provided from a third party, we get very high compliance rates. In cases where there is not information provided like that, we get lower compliance rates.

So procedures that facilitate the flows of information, the ease of enrolling, the social pressure—there are societal standards. People pay taxes not just because they might get caught, but because they think it is their role as a citizen. So all these other factors can be very important in complementing a mandate or in doing some of the work without a mandate.

Senator ENZI. Thank you.

As an advocate of the Small Business Health Pooling, I always appreciate the comments about pooling, which I do think would stimulate competition considerably and take care of a portion of that problem.

Now, in your testimony, you mentioned that the current tax exclusion dampens incentives for cost control because it is open-ended. You expand by stating, "Those incentives could be changed by replacing the tax exclusion or restructuring it in ways that would encourage workers to join health plans with higher cost-sharing requirements and tighter management of benefits."

Could you expand a little bit on that statement?

Dr. ELMENDORF. Yes. The crucial issue is that, because health insurance has this exclusion, an individual, through their employer, can essentially buy more health insurance, and then ultimately more health care, at a discounted price. To buy a certain amount of automobile, or clothing, or something else, one has to pay tax on the income and then use the remaining money to buy the item.

For health insurance, by doing it without paying tax, you essentially get it at a lower price. That price is lower to the extent that one's tax rate is higher. So the current system provides the largest incentives to people who have the highest tax rates, which are the people who have the highest incomes and are most likely to have insurance anyway.

So restructuring, from different analysts' perspective, can accomplish several things. One is, by making somebody like me, say, who faces a reasonably high tax rate, more sensitive to the cost of extra insurance, something people call "gold-plated insurance"—which really just means insurance that covers more things with my having to pay less out of pocket—making me more sensitive to that, so I am more inclined to want my employer to buy me a more trimmed-down insurance package.

At the same time, a restructuring incentive could provide a bigger incentive to people with lower incomes who might then respond to the greater subsidy by being more likely to take up insurance. So the restructuring can accomplish things in terms of both cost-effectiveness and coverage, depending on how you chose to do it.

Senator ENZI. Thank you, Mr. Chairman. My time has expired.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

I share Senator Conrad's view: we have never gotten out of the gate faster on this cause of health reform, and it is because of you and your white paper. We are very appreciative of that leadership.

Last night, Dr. Elmendorf, the President delivered some very exciting news for the cause of health reform. In effect, he said, after 60 years of debate, he wants health reform enacted this year, that it is time to stop stalling and to actually get it done.

Now, I share Chairman Conrad's view with respect to the financing of health care. At a time when you are spending enough money in this country this year to go out and hire a doctor for every seven families and pay the doctor $235,000, hypothetically, to care for seven families, Chairman Conrad is saying you ought to be careful about spending more before you reform the system.

Now, in reading your budget books, there is not a single option, as far as I can tell, other than this tax code that produces the savings quickly. I just want to review with you, because it is option 9, 10, and 11. I listened to your discussion about bundling reform. I happen to think that is very important. Those are savings it takes 10 years to realize.

So to start with, on the tax code—and let us just do this in theory—is it not possible to generate additional revenue that would be progressive in nature—and you touched on it in your last answer—and also serve as a disincentive to inefficient spending by reforming the Federal health tax rules?

Dr. ELMENDORF. Yes.

Senator WYDEN. And it would be possible to start generating those savings if, through the leadership of the President, Chairman Baucus, and Chairman Kennedy, you passed it this year. You could start realizing those savings that you have identified as progressive and a bar to inefficiency? You could start realizing those in the first year, again, in theory?

Dr. ELMENDORF. Yes.

Senator WYDEN. Having established that, would it not be possible, in theory, to do that and still honor the pledges that the President made in his campaign? The President said, two distinct characteristics of the future of health care were important to him: one, that everybody ought to be able to keep the coverage they have—I think there is bipartisan support for that—and second, we should not subject individuals, particularly the hard-working middle-class folks, to new taxes. Would it not be possible to also generate that revenue in the first year and keep the President's pledges?

Dr. ELMENDORF. I am not a theorist, so I am going to revert to the numbers. The way that the changes in the tax exclusion that we study in our book generate these savings is by having people pay tax on this form of compensation on which they are not paying tax today. So the money is not coming out of thin air, as it were. It is not coming immediately from the enhancements in efficiency. These options do lead to enhanced efficiency, as we have said.

Senator WYDEN. Right. But——

Dr. ELMENDORF. But one should not look at the number and say, well, that is this many hundreds of billions of dollars of extra efficiency. A lot of that is just, I would pay higher taxes because I have tacked on my——

Senator WYDEN. I understand that. I understand that, and I share your view. What I am talking about, though, is tax reform. My sense is, if you pick up on what Chairman Baucus has talked about in the white paper and a number of us have had an interest in, through tax reform you could give a very generous deduction, $16,000, $17,000, at a time when the typical family of four spends $12,600 on a basic package, and also come up with new revenue in order to finance an expansion of coverage.

That is why I want to be sensitive. You cannot get involved in these approaches that go to drafting a particular bill. But in theory, it seems to me you can honor the President's pledges, both of them, keep the coverage you have, and not clobber middle-class people with new taxes.

My time is about up. I want to give you the last word.

Dr. ELMENDORF. Well, I think that maybe the last thing to say is that changes in the tax treatment of health insurance have important distributional effects, as well as important efficiency effects. When we and the Joint Committee on Taxation analyze proposals that you might put to us about changing the tax code, we will try to report on both of those because I am sure that both will be of concern to you all.

Senator WYDEN. Fair enough.

Thank you, Mr. Chairman.

Dr. ELMENDORF. Thank you, Senator.

The CHAIRMAN. Senator Carper?

Senator CARPER. Thank you, Mr. Chairman. I feel very fortunate to join all of you on this committee today, and this year, given the challenges that we face on health care.

I have a son who is in college who is taking Chinese, and he has taught me a few words. One of the things he tells me is that the symbol in Chinese for danger or caution is also basically the same for opportunity. When we look at the challenges with respect to the

cost of health care, the availability of health care, there are huge, huge challenges. But there is also real opportunity here, and we appreciate, Dr. Elmendorf, your helping us to identify that and to cost it out.

I had the privilege of meeting with Dr. Elmendorf yesterday, with Senator Collins. We talked a bit about postal issues. I was impressed by how knowledgeable you were. You are a very quick study, and I am impressed, again, here today.

On the notion of counter-intuitiveness, I was at a breakfast conversation with somebody this morning, talking about how sometimes health policies that clearly lead to better outcomes cannot be scored in a way that would reflect that, and this person said, with tongue in cheek, if somehow we can inspire premature death, that is one of the sure ways that CBO can score that as a savings. [Laughter.] I do not think any of us wants to do that, but I thought there was a little more than a grain of truth to that.

In all my conversations with health care experts and those who have been immersed in this debate on health reform, they all seem to agree with this statement. I will just read it: "Universal coverage does not, on its own, lead to a healthy America." I just add, if we are looking to truly reign in health care costs, we are going to have to look at much more than just addressing the issue of the uninsured and the under-insured.

With that said, let me just ask, do you agree with that statement that I just read? If so, what policy options has CBO identified that will reign in costs, while also creating a healthier America, with healthier Americans?

Dr. ELMENDORF. I agree very strongly that the most important things we can do for Americans' health may well lie outside the health care system, if one means by that doctors and hospitals. We have, for example, greatly falling rates of smoking in this country, which is good for our health. Roughly, the rate of smoking has fallen in half during my lifetime. But also during my lifetime, the rate of obesity among adults has essentially doubled. That is not about health care per se, that is about behavior.

Senator CARPER. Let me just interrupt you for a second to follow up on that point.

Do you sense that one of the things that has happened in this country in our lifetime, really in the last 10 or 20 years, is that smoking has become almost socially unacceptable in a lot of circles?

Dr. ELMENDORF. Certainly it is harder to smoke in many public places. There have been increases in taxes on smoking. I think there have been a variety of policies.

Senator CARPER. What I am getting at is, I think what we have to do is to sort of train our society or encourage our society to regard over-eating, to the effect that it makes us very large and unhealthy, we have to almost do for obesity what we have done for the use of tobacco, where people harm their health as well. I would just offer that as a notion.

Dr. ELMENDORF. I think the challenge for you, in a sense, is the extent to which public policy can affect these health trends. So smoking, the dangers come from a rather specific set of products that are controlled very heavily. Obesity and other health problems stem from a whole variety of behaviors and products. So, although

I think there is little doubt it would improve health to be less obese, how you move public policy to accomplish that is not so clear.

Moreover, as you mentioned, the effect on spending is not so clear. Saving people from a certain disease enables them to live longer, which is obviously all to the good, but does not mean that they will not get some other disease that will be expensive later. That is the sort of general reason why improvements in health do not always reduce health care spending. Obviously it is much better to live a long time and then get sick, but the cost of that will still come to bear.

Senator CARPER. Like some of my colleagues, I like to work out regularly and exercise. I stopped by the Central YMCA in Wilmington a couple of days ago to work out early in the morning before I came down here, and there is a fellow who lives in the YMCA. There are about 150 people who live in the YMCA. This guy is 86 years old. He followed me into the Y, into the work-out room where I do all my exercises and all, which normally I do not appreciate when people want to just dog me when I am trying to work out. But I was patient with him; it was well-intended. He was complaining about smoking. He said, I live here. I cannot smoke in my room, I cannot smoke in the lobby, I cannot smoke in any part of the building, I cannot smoke in the inner circle downstairs. I cannot even smoke out on the front steps of this building anymore.

Plus, you have increased the cost of tobacco by enormous amounts. I thought and said, well, that is one of the reasons why people are smoking less. I said, my friend, I know you are 86, you smoked all of your life, so I am not going to suggest you stop now, but a lot of people have stopped because of the policies we have adopted and put in place. We have to take similar kinds of, I think, enlightened approaches with respect to obesity and getting people to take better care of themselves.

Last question. In many ways our system is counter-intuitive—I mentioned that before—in both the financing and delivery of health care. We can see this in the payment rates for primary care doctors versus specialists, as well as the current obstacles and disincentives for providers to coordinate care.

CBO highlights several policy options that would promote health care coordination, including the Bonus-Eligible Organizations. This concept seems to align with my belief that focusing more on a holistic approach to health care delivery in our country will enable our doctors to provide a higher quality of care.

Here is my question.

The CHAIRMAN. We are waiting for the question, Senator.

Senator CARPER. All right. How to improve the quality of health care and the budgetary impacts it could have. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator CARPER. I got there.

The CHAIRMAN. All right.

Dr. ELMENDORF. So, I will be very brief. I think the general approach is to provide payments that reward quality of care, or to reward health outcomes rather than rewarding specific treatments that are delivered. There are different mechanisms for doing that.

Some involve focus on primary care physicians as the gateway to the health care system. Many in our book talk about ways to provide incentives to hospitals to focus on the quality of the outcome. Some involve incentives for doctors who are now paid on a fee-for-service basis, and some of these options have been paid more on a capitated basis, just to say per-patient, and then they do not have at least a financial incentive to prescribe all the additional tests they can.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman. Thank you for all of the thoughtful leadership on this.

Doctor, is it not true—I mean, health care is a unique situation because it in some ways is counter-intuitive to other things that we do, because the reality is that, the more people who are in the system, the more people who are covered, the more you can reduce costs, which is different than other kinds of issues that we approach.

The reality that, if someone does not go to a doctor and instead uses an emergency room, the most expensive way to receive their care, that increases the cost of the system. So what we have, we are spending a lot of money in a lot of different ways, but, because we do not cover everyone and because someone cannot get primary care and cannot get what they need on the front end, we actually increase costs. So, it is an interesting system. In fact, just because we cut services, it does not mean someone is not going to get sick, or get cancer, or have an accident, and so on.

So, I wonder if you might just speak to that. Recently in *Health Affairs* there was published an overview of the impact in Missouri of sweeping Medicaid cuts that were made back in 2005, where more than 100,000 people, because of the cuts in coverage, lost their coverage, faced reduced benefits and higher costs, and they ended up, in fact, seeing greater uncompensated care in the hospital, and, in fact, shortfalls in community health centers, which meant they were paying more for community health centers in State grants, and certainly we pay Federal dollars and so on.

So, I wonder if you might comment about the Missouri experience, if you are familiar with it, and the impact of just cutting programs instead of looking more broadly.

Dr. ELMENDORF. I apologize, Senator. I am actually not familiar with the Missouri experience, but I will certainly go and become more familiar now.

I think the general point I would make is that you are certainly right that there are cases of people who, because they lack insurance, on having certain preventive services or tests done, that will lead to greater expense later.

However, I think it would be a mistake to think of that as the bulk of the story. Our estimates are that, on average, uninsured people use about 60 percent as much care as the insured population today, 60 percent. If they were insured, we estimate that they would use between 75 and 95 percent as much care as the insured population receives today. So, on balance, we think they will be getting more care, and that will increase spending on their health care. It will make them healthier. Again, this is a case

where the health effects and spending effects are not always aligned.

Senator STABENOW. Right.

Dr. ELMENDORF. Getting better care will make them healthier. That is why most people talk about trying to expand insurance coverage.

Senator STABENOW. Right.

Dr. ELMENDORF. But overall, we think that more spending will be devoted to their health care than is the case today, and that is a cost that the system will have to absorb in some form.

Senator STABENOW. You had spoken, though, in one of your points, that the challenge was reducing cost, but at the same time increasing the quality of care, essentially, that is being given. Is that not really what you were talking about as well? I mean, it is not just reducing costs, it is increasing quality and outcomes and changing the costs as well. So it is prevention, it is EPSDT, as Senator Rockefeller was talking about, as opposed to someone getting very, very sick and walking in to an emergency room.

Dr. ELMENDORF. Yes. I think that is exactly right. It is ultimately about health. It is not even always about cost savings, per se, as cost effectiveness. The concern people have now is that we are spending a lot of money and that we are not getting all that we could from it. If we could make the system more efficient, then we could get either more care, better health, or less spending, or both in some combination, depending on the exact policies that you put into place.

So, it is the potential to move on all those dimensions. But of course, you do not get them all equally. There is a choice about how much greater efficiency we would take in the form of better health and how much in the form of money to use for other goods and services.

Senator STABENOW. Right. Right. Thank you very much.

Dr. ELMENDORF. Thank you, Senator.

The CHAIRMAN. Thank you, Senator, very much.

Senator Nelson, you are next.

Senator NELSON. Thank you, Mr. Chairman.

I am curious. One analysis in your statement today talked about the value of insurance risk pools. In the plan that is offered by Senator Wyden that I am a co-sponsor of, it organizes large pools of insureds around States or, in the case of small States, several small States could join together in order to get millions of lives over which to spread the health risk, and therefore bring down the insurance premium. Talk some more about that as a viable way of bringing down health care costs.

Dr. ELMENDORF. Insurance markets are one of the topics they give young economists to study because they are so interesting. Unlike other markets, free market insurance markets sometimes collapse altogether because the people most in need of the insurance are the ones most likely to sign up for it. That increases the cost of providing the insurance, then that higher cost drives out some other people who would like it, but do not need it quite so badly.

The group that is left can be even sicker and even more expensive. This happens—it is called a "death spiral"—for an insurance plan. It does not always happen, but it emphasizes the importance

of pooling people together. This is an important reason why large employer-based plans work because it is a large group of people brought together for reasons unrelated to health.

Senator NELSON. Sure. Absolutely.

So, on the basis of what you said, if you combine large insurance pools with mandatory coverage for all the 44 million uninsured in the country, now you have everyone in a pool, unless they elect to stay with their employer-sponsored coverage, and therefore theoretically it ought to bring down the cost of that insurance, should it not?

Dr. ELMENDORF. Yes. I mean, ensuring that people sign up and are in an insurance plan before they get sick, that they are actually insuring in the sense of paying premiums while they are healthy, in the event of getting sick, would reduce the cost to people who are in the plan otherwise. Absolutely.

Senator NELSON. All right.

Now, you answered the mandatory universal coverage question. But I am trying to get at your earlier statement, that basically small groups that get older and older and sicker and sicker, that is not the way to offer affordable insurance coverage.

Dr. ELMENDORF. Right.

Senator NELSON. So the larger and larger that we can get these pools of people to spread the health risk——

Dr. ELMENDORF. Yes.

Senator NELSON [continuing]. So that you are dealing with millions, not just, for example, a large company that might have 100,000 lives that they are insuring. So you can bring down the cost of the insurance premium, can you not, with millions?

Dr. ELMENDORF. Larger pools will have lower costs than small pools. Absolutely.

Senator NELSON. And, ergo, the larger the pool, the smaller the cost?

Dr. ELMENDORF. Yes. Although once a pool gets to a certain size, then the frequency of particular problems in that pool will settle down to be pretty close to the national average. So I cannot do in my head how much that matters, millions rather than hundreds of thousands.

Another thing I would say about larger pools, they have lower administrative costs often as well, depending on just how they are structured. So, there can be a number of advantages.

Senator NELSON. All right.

Now, let us say we bring in the 46 million people who are uninsured, who do not have health insurance, but they get health care and they get it now from the emergency room and so forth. Now, is that going to cause a greater demand for physician services that is going to give us heartburn about having enough physicians?

Dr. ELMENDORF. Our estimates are that insuring the currently uninsured would raise national health spending by something under 5 percent. So it would, by itself, lead to more demand for all sorts of medical services. I think many of the proposals that have been discussed also try to find ways to provide incentives to economize unnecessary services, so that pushes back against that. I do not think that the shortage of providers is really a central issue in considering the expansion of health insurance coverage.

Senator NELSON. All right.

Just one final, quick question. We got some extremist statements that came out by some sectors of the body politic about the stimulus bill in that, in this comparative effectiveness research, that it was going to cause a denial of medical treatments. You have heard the extremist statements. So why do you not debunk that theory, is the question?

Dr. ELMENDORF. Comparative effectiveness research is a way of finding out what works and what does not. An important obstacle to our deciding as a society what treatments people should get and not get is that we in many cases do not know what treatments are more or less effective. The variation in spending across regions of the country is most intense in those areas where the least is known, where in fact there is not clear guidance of what sorts of diagnostic tests are most useful, what sorts of after-hospitalization care is most useful. Learning about that, what works and what does not, does not by itself change the care that is delivered.

It provides the information. The follow-up question, but it is a separate question, is what doctors learn, how the information is disseminated, and how doctors and hospitals respond to that, and what incentives are provided for them to respond to that information. That is really a separate question. I think at this point the comparative effectiveness discussion is about how to learn better what works and what does not.

Senator NELSON. Thanks.

The CHAIRMAN. Thank you, Senator.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman. Thank you for your leadership.

Welcome, Dr. Elmendorf.

Dr. ELMENDORF. Thank you.

Senator SNOWE. In previous testimony you did discuss, and you did hear as well today, about the tax exclusion in employer-based health care. I would like to discuss that because I well recall the former Secretary of Health and Human Services Leavitt mentioned and discussed this whole proposition, and putting a cap of $15,000, which in a State like Maine, which is a high-cost State, obviously would have serious impact. So, it would be inadequate in a high-cost State. Maybe it would be inadequate in a low-cost State and you could invite ways that they could meet up to that cap.

What would you suggest in this regard? Have you considered those variations among States in terms of the cost of delivering health care, and is there a better way to accomplish that under this goal? Because obviously it is about achieving greater equity among all States and the efficient use of taxpayers' dollars, and subsidizing those health care systems. So, if you have a flat tax, so to speak, and a uniform standard across all States that does not really adjust for the variations that exist, it may be beyond their control.

Dr. ELMENDORF. You are absolutely right, Senator, that establishing a national cap on the size of the tax exclusion would have differential effects relative to current insurance costs in different parts of the country. That is a feature, unfortunately, that pervades the tax code. I have friends who live in New York City who

cannot understand why they are being taxed at a higher rate as if they were a "rich person," when after all, in New York City, given the cost of housing and everything else, they do not feel rich at all.

So all these issues, all the places that the tax brackets change, any sort of fixed-dollar amount, will have disproportionate effects across the country. I do not know an effective solution to that, I am afraid.

Senator SNOWE. Yes. So there are not any adjustments that could be made with respect to the dollar amount that is suggested for exclusion from taxation? I mean, pay coverage cost for the poverty level—are there any elements that we ought to be considering in that regard?

Dr. ELMENDORF. If I were teaching an economics class, I would write a formula on the blackboard that could relate that cap to the cost of health care or something else. I do not know if that is at all a practical strategy. There is a further issue, which is that to some extent the costs vary for reasons, as you say, that are not under people's direct control.

But the other reason they vary is because certain parts of the country have practice patterns in medicine that are more lavish than other parts of the country, and the goal of the policy is essentially to lead the places that are spending more than they need to to look to the places that are spending smaller amounts and learn from them and move in that direction.

So, in terms of the effectiveness, one would not want, in a sense, to have this policy—in terms of the effectiveness leading to health care efficiency, you would not want the policy to bind equally various parts of the country. Health care spending is several times in Florida what it is in Minnesota, and that is viewed as, that is the source of the opportunity, essentially, in the savings, is to put more pressure on Florida and places like it that have higher costs.

Senator SNOWE. On comparative practices and the effectiveness, in evaluating comparative practices, I know that CBO gave a scoring of savings of $1.3 billion, as I understand it, over 10 years for the comparative effectiveness study. Is that about right?

Dr. ELMENDORF. I believe so, yes.

Senator SNOWE. It seems like a very low number, given what could be accomplished. I am wondering, is it the study that is at fault, or is there something we should be doing to improve or modify the study that could increase the amount of savings that could be derived from such comparisons?

Dr. ELMENDORF. I think the challenge is that information alone is not enough. It is acting on the information.

Now, to some extent, when doctors and hospitals learn better what works and what does not, they will naturally change their practice patterns, and that will lead to some savings. But to generate larger savings, one would need, in legislation, to provide incentives or penalties for following or not following where that information leads. This particular legislation does not do that. That is the second step I mentioned a moment ago, which is deciding how to use that information.

That means getting the providers to change their practices, but then on top of that, changing the reimbursement rules so that the

Federal Government would recapture those changes. So, it is both parts. It is, they are doing the more cost-effective thing, and it is changing the way Medicare pays them, to recapture those savings for the Federal Government.

Senator SNOWE. So, in other words, we would require them to adopt those practices once they were evaluated to be obviously effective methods of treatment, and also achieve cost savings.

Dr. ELMENDORF. Yes. I think the word "require" is complicated because these studies do not prove—the efficacy of health care varies very much across individuals in certain situations, so the studies are not going to say, in general, this whole type of medicine is completely worthless, or this whole type is completely useful. They are much more nuanced than that, and that is part of the challenge in creating the incentives for providers to do these things in the cases where they are useful, and not where they are not. I think we have options in this book that try to change the reimbursement rates that can be used to recapture those savings, but I think that is the piece which is not in the legislation, per se, that you have described.

Senator SNOWE. Right. I think we have to determine whether or not those practices are effective enough to achieve cost savings, and then implement a mechanism for doing so. I am just wondering if we should not have the Institute of Medicine or some other independent entity evaluating those practices so it can accelerate the process. I mean, many of the obvious methods and practices that should have been used, for example, have not been used. I mean, there has been a 10-year lag period before they are commonly adopted. That is problematic.

Dr. ELMENDORF. Right.

Senator SNOWE. And if the NIH is going to have a budget beyond $30 billion, it seems to me we ought to be extracting a value from that research. So I am just wondering what we can do to redesign the process or create an independent entity that puts a value on that practice once it is ascertained that it is the most effective treatment and can achieve cost savings.

Dr. ELMENDORF. Most analysts would agree wholeheartedly that more emphasis on that sort of research would be useful. But again, the bigger cost savings for the government will require follow-up steps to put that information into practice.

Senator SNOWE. I think, whatever kind of system we develop in providing universal health care coverage is really going to be predicated on a very sustainable fiscal foundation, otherwise it cannot be sustained for the long term.

Dr. ELMENDORF. Yes.

Senator SNOWE. So, I mean, I think that that is key. Thank you very much for your contribution.

Dr. ELMENDORF. Thank you.

Senator SNOWE. Thank you, Mr. Chairman.

Dr. ELMENDORF. Thank you, Senator.

The CHAIRMAN. Thank you, Senator.

On that last point, Dr. Elmendorf, how do we lock in sustainable policies that do not get too costly and out of hand? I mean, Congress does meet, and we could always ratchet back. But is there some kind of institutional way, some systematic way that comes to

mind to make sure that these reforms actually accomplish their objectives and do not cost us and get out of hand?

Dr. ELMENDORF. I think there are several levers that you have. Part is through the Federal health programs, and Medicare especially. By changing the rules of the game, you will directly affect the care of Medicare patients, but indirectly affect care throughout the health care system because, for example, hospitals that have IT will use that not just for the Medicare patients, but for all of their patients. Hospitals that are reorganized to provide the right kinds of post-acute care for Medicare patients will do that for all of their patients. So, Medicare is an important lever.

A second lever that you have is the tax exclusion, as I said, which, if changed, could set in motion very strong private incentives, could catalyze the activities of the private sector for the insurance purchasers to push on the insurers, and then on the providers, to be more cost-effective.

Beyond that, of course, there is discussion about the role that a national health board of some sort might play. I think the crucial issues there are what powers exactly you and your colleagues would devolve to the board. A number of health analysts would argue that Medicare could function more efficiently if the Congress gave CMS greater authority in running Medicare. Other people would worry that that authority would not be used well and that more fine-grained congressional oversight is helpful. But that is the sort of issue that one would face in a very pronounced way in setting up a health board of some sort: what exactly is the board empowered to do?

The CHAIRMAN. I would like to ask you a little bit about aligning incentives. In order to realign incentives for health care providers, do you believe we need to put providers payments more at risk? That is, do we need to create both a financial up side and also a down side to providers based on the quality of care they deliver, and is this a necessary element of delivery reforms to drive quality, drive efficiency? What do you think?

Dr. ELMENDORF. Yes. I think most health analysts would agree very strongly with that. There is this term "capitation," which you know, which means to pay providers a fixed amount per person. There are risks in going to full capitation. If a provider gets a fixed amount regardless of what he has done for the patient, then the financial incentive is not to do anything. That can be dangerous. On the other hand, a fee-for-service system is essentially the exact opposite of that: whatever services are ordered up, the government pays for.

So, moving somewhere along that continuum from this fee-for-service system that we use now in many ways in our health care system toward a system of greater capitation would be a widely shared objective. What that means, essentially, is that then providers—and we have some options like this in our volumes—then bear some of the risk. But the flip-side of that is, they also receive an incentive for providing only useful care.

These sorts of incentives are best if combined with measures of quality. So, for example, in the option that we study for these Bonus-Eligible Organizations of doctors, we assumed in the proposal that the bonuses would be payable if money was saved and

if certain standards of care were met. That is a way of making sure that providers do not scrimp unduly on the care, while providing them some incentive to take away the things that really are not important.

The CHAIRMAN. What is your sense of how much of the solution is in aligning payments with quality, where there are rewards and where there are costs? I mean, how much is this part of the solution here?

Dr. ELMENDORF. I think the incentives are absolutely essential. I think there are few analysts who would disagree with that. In almost every part of our private behavior, and in many parts of public policy, we weigh benefits and costs in deciding what to do—everything that you or I buy privately, but also in public policy, in the ways we regulate, for example, pollutants. We do not drive dangerous pollutants down to nothing, we drive them down to a point beyond which it seems like it is unreasonably costly to reduce them and would deprive people of other goods that they want and need.

In health care, we have a system where there is very little of that weighing of benefits and costs because of insurance and the way insurance is structured: both publicly and privately, almost anything that providers want to do, they can do. Now, there has obviously been evolution in that over time. A very important factor holding down the growth of health care cost in the 1990s was a move toward greater management of benefits through managed care.

So we are not in an absolute fee-for-service world by any means, but we still have an awful lot of places where anything which is prescribed is reimbursed for, and shifting to a world where both the patients and the providers are trying to think about benefits and costs is central to saving money without just arbitrarily slashing what gets done and what does not get done.

In a sense, if we do not save money intelligently, then we will, through force of the numbers that you have described and that Senator Conrad emphasized, ultimately cut something. The question I think that we face is whether we can develop the information and the incentives now to make those choices wisely or whether we are forced, ultimately, to take the meat axe to the system.

The CHAIRMAN. Right. Right.

So what is the most efficient way to find out the proper quality measures? I mean, we can farm it out. CBO can do it. Private companies can have their own. How do we make more headway on this question? This seems to be central, one of the central features of health care reform.

Dr. ELMENDORF. Yes. Providers are working to develop some of these standards, ways of keeping track of health outcomes and sharing that information. Those that are focused on providing value have moved in some of these ways themselves. There are people in private organizations who are trying to coordinate that activity. So my former Brookings colleague, Mark McClellan, who was the Director of the Centers for Medicare and Medicaid Services, is doing some of that in his work now at Brookings.

I think a Federal role, though, is amply justified. Information has a benefit that spills across people in the system, and often the

government has a useful role to play in funding the generation and dissemination of that kind of information.

The summation, again, is important. It is not just a matter of some group of very smart people in Washington have a list of what works and what does not. The crucial thing is that a doctor sitting at a patient's bedside has that information at hand. So health IT can play an important role in sort of both directions of information flow, both in collecting information on what works and what does not, and also sending it back to doctors and nurses and so on to use in real time.

The CHAIRMAN. Right.

Some suggest we need to move much more toward evidence-based medicine. I mean, drilling down two or three different levels of what works based on the evidence, not on someone's opinion, as much.

Dr. ELMENDORF. Right.

The CHAIRMAN. Your thoughts about that, and how important is that? Do we have the data to get there, and how do we get the data to get there if we do not currently have the data?

Dr. ELMENDORF. That is right. That is absolutely necessary. I think anybody who has spent time with serious health problems and has talked with doctors and nurses understands, for all of the wondrous things that we can do in health care, ultimately how limited their knowledge is about the effect of certain treatments, certain procedures. Learning more is essential. That requires funding.

This is exactly the sort of information where, analysts would argue, the government has an important role to play because it is—people call it public good to have that information available. That is what comparative effectiveness research is about. Then there is, as I said, the dissemination of the information, and there is also the incentive to use it.

So clearly, if a piece of research says that some procedure is of absolutely no value or has a negative consequence on health outcomes, then all providers who know that will stop doing that. But the harder cases are where something is unlikely to have any useful effect and it would be much better, more sensible, to try a different course of treatment than this one.

And, in those sorts of gray areas, it is very important for the providers and the patients to bear some of the risk, as you said, to bear some of the costs of the more expensive, less useful choice. The options that we talk about in our volumes about ways to penalize poor performance and reward good performance, as measured by health outcomes, is the sort of incentive that would ensure that providers would make use of this information when they have it.

The CHAIRMAN. What are the best lessons learned thus far from reputedly good health organizations that are making a lot of headway in these areas? I am thinking of Mayo, maybe Kaiser, Inter-Mountain, maybe Cleveland. What are some of the lessons learned there that could be applied here?

Dr. ELMENDORF. Analysts do not know for sure. There are patterns that are very, I think, indicative. So at Mayo, for example, there are fewer specialists who will see a patient with a given condition than at many other hospitals. There are fewer procedures that are performed. People spend less time in the hospital. Those

look like areas where—particularly some of those areas where there is very little knowledge about what actually works and what does not. Thus, there is no firm standard. Some areas of the country have evolved in ways where they are——

The CHAIRMAN. They must seem to think it is working, if they are going in those directions. They must think it works.

Dr. ELMENDORF. Well, but I think they do not have much information. So one of the fastest-growing areas of Medicare spending is imaging, MRIs and the like. We do not know a lot—I mean, I am not part of that profession. The medical profession does not know a lot about in what cases that is particularly useful or not.

So without that kind of information, then it depends, I think, an awful lot on what the doctor next to you is doing, and different regions of the country have evolved with different practice patterns.

The CHAIRMAN. Talk about that a minute. I mean, it is my understanding that practice patterns vary widely.

Dr. ELMENDORF. Yes.

The CHAIRMAN. What explains that, and what can be done about that? For example—I do not know. I cannot remember the exact date, but Uwe Reinhardt was sitting right there at the table a couple, 3, 4 months ago, talking about the different costs of end of life among three different hospitals in New Jersey. I have forgotten the variation, but it was stunning. He called each of the three hospitals, as I recall, and said, what in the world is going on here? Why do you charge X times more than the other hospital? The answer is, that is just the way we do it. Then you look at the Jack Wennberg geographic disparities studies.

Dr. ELMENDORF. Right.

The CHAIRMAN. So what is going on there, and what lessons do we learn from that?

Dr. ELMENDORF. So you are exactly right about that. The greatest variation across regions tends to be, as I said, in these areas where there is not much knowledge, so the variation is not so much—if you walk into a hospital with a broken leg, it does not matter much what hospital you walk into, they will do a pretty similar thing because it is pretty evident what the right course of action is.

But the areas where it is not so evident are the areas where——

The CHAIRMAN. They may charge a lot differently for this procedure, too. It is not just what they do, it is what they charge.

Dr. ELMENDORF. Well, that is true as well. Yes. So I think that the key to—and again, it is not just "I think." Analysts who have studied this, with a very wide consensus, would tell you that the key is to figure out better what works and what does not. So there is a clear standard, not a sort of arbitrary, maybe this is good, maybe it is not, and to establish that information and then to set up a system that rewards people, providers, and patients for following that information and penalizes them for doing something that does not appear to be justified by the evidence. So, it is the information with the incentives.

The CHAIRMAN. But how do you get from here to there? Because, if I remember a CBO study, there is about a 29-percent cost savings if the whole country were to practice medicine as in the areas of the northern high plains States. Out of a $2.2- or $3-trillion cost

to the country, that is real money. That is about 30 percent of $2.3 trillion. We are getting $750-some billion in savings right there, theoretically.

Dr. ELMENDORF. That is right.

The CHAIRMAN. And the cost is lower in those higher plains States, and the outcome is better, according to CBO.

Dr. ELMENDORF. So, that is right. I mean, you said at the beginning of the hearing that this was the beginning of a beautiful friendship, so you could invite me and others to come live in your State, which does seem to do a pretty good job. That is probably not a public policy solution for the hundreds of millions of us.

The CHAIRMAN. We would agree with that in Montana. [Laughter.]

Dr. ELMENDORF. You do not want us all there anyway, I know. I do come and visit sometimes, but I know you are happy to see me not clutter it up as well.

I think, again, the key to this is to not just keep paying for any service that is provided in other parts of the country.

The CHAIRMAN. I know. But how do you do that? How do you just not keep paying? How do we get there?

Dr. ELMENDORF. Oh. So, I think this is what our options are about. Now, the options do not save $700 billion a year. That figure has been used, exactly. Maybe there is 30 percent, maybe. Nobody is sure of that either. Maybe there is 30 percent of health care spending that does not add much to health. Our options do not weed out that much money, because the truth is, nobody knows how to save all of that.

The CHAIRMAN. Well, if nobody knows, we cannot let perfection be the enemy of the good here.

Dr. ELMENDORF. And I am not suggesting that.

The CHAIRMAN. We have to go with what we have. We have to get moving here.

Dr. ELMENDORF. As I said at the very beginning, most analysts agree very strongly that the time for action is now, particularly because we are not sure exactly which of these specific procedures would work. But the things that we talked about: changing the tax exclusion so that people and their employers have incentives to buy leaner insurance policies, and changing cost-sharing in Medicare so that patients have an incentive to be vigilant about what is being done to them. The examples I started with: more bundling of payments so that there are fewer people who are each collecting for a service and more coordinated decision-making about what should be done. So the bundling, I think, is very important. Encouraging providers to come together in what will be called Bonus-Eligible Organizations, providing real financial incentives for that. That is a step in that direction.

There is no single step that is likely to do this, and certainly none that we are aware of. We are in areas that we do not have experience with, and that is the problem that CBO finds in scoring these changes. We know that there are incremental changes in some existing policies, but these broader changes, we have not tried.

The CHAIRMAN. It is my understanding that some countries overseas and some systems in the U.S. that are cost-effective and de-

liver high-quality care emphasize primary care. Your thoughts on that? I vaguely recall some country that is 75 percent primary care and about 25 percent specialists. I have forgotten what country that is. We are about the opposite in this country. Is there anything to be learned from that?

Dr. ELMENDORF. Oh, yes, I think so. I think many analysts would agree that providing a system in which primary care physicians do not just pass off patients to specialists immediately would be a system that would improve health and save money. We analyze in our book effective medical homes, for example, which is a way of giving the primary care physician a more central role.

That alone does not save money, by our estimates, because the primary care physician, as we have scored that particular option, does not have an incentive of any sort not to keep sending patients out to specialists. So the coordination—in our option, primary care physicians are paid to play more of a coordinating role. That would improve health. It does not, by itself, save money.

The CHAIRMAN. Do they play a more coordinated role in other countries?

Dr. ELMENDORF. Yes. I think in other countries, you are right, that there is—there is a wide variation across countries, of course—less high-tech medicine employed in a number of other countries. As I said before, one of the distinguishing features of the Mayo Clinic and other places that seem to provide high-quality care at low cost is greater emphasis on primary care and less on specialists. That is not always true. Again, not every example lines up perfectly on the line, there is a lot of variation, but that does seem to be a common factor, a greater emphasis on primary care.

The CHAIRMAN. All right.

So what specific policies related to primary care have the greatest likelihood of bending the growth curve in health spending system-wide?

Dr. ELMENDORF. The option that we analyzed for Bonus-Eligible Organizations, or what Mark McClellan would call Accountable Care Organizations, the way those options would tend to work—and there are some examples of this being tried in the private sector—is that the primary care physician plays a more central role and that there is more management of the care beyond that so that people do not automatically get sent to specialists X, Y, and Z. So it is a collection of doctors.

But the problem is, for hospitals, we can establish a single payment for an entire stay because it is one integrated organization. For physicians, it is harder to do that. We are still, in Medicare, stuck in a more purely fee-for-service world because physicians are all independent. So what these Bonus-Eligible Organizations do is, they pull the physicians together—it is a voluntary option, as we model it—in a coordinated way, so it is a set of physicians with different specialties who are working together. It is just what managed care does. This is what effective HMOs do, like Kaiser Permanente.

The CHAIRMAN. And that is what Mayo does.

Dr. ELMENDORF. Right. And the studies have——

The CHAIRMAN. I mean, the doctors and hospital are all part of the same system.

Dr. ELMENDORF. Right.

The CHAIRMAN. And they are salaried.

Dr. ELMENDORF. Yes. Exactly. The studies that have been done, cases where doctors are paid a fixed salary and it is all one organization, have shown in some cases 30 percent less spending on health than organizations where it is sort of lots of independent players all jockeying for their piece of the action. So I think it is undoubtedly providing incentives to pull providers into groups and have those groups manage care that will be good for health through fewer medical errors, less mistaken tests and so on, but also good for spending.

The CHAIRMAN. All right.

Irrespective of the problems of rules 14 and 3, the scoring rules, will you provide analysis of savings in your report on anti-fraud in health reform, even though those savings would not be an official score?

Dr. ELMENDORF. Wherever possible, meaning when our time and knowledge allow, we will try to provide estimates of the effect of administrative changes on benefit payments. As you know from the scoring rule, it is not part of the official score but is information, like coverage rates and everything else, that we will try to provide you whenever we can.

The CHAIRMAN. I dislike the rule, but the rule is what it is. Intuitively it is clear: if you spend a little more money in anti-fraud and in rooting out a lot of this waste—the President mentioned last night the so-called fraud in Medicare. If we spend a little more money trying to find it, you are going to have, on a net basis, very significant savings. So, irrespective of rules 14 and 3, you will still find ways to indicate——

Dr. ELMENDORF. We will try to inform you as best we can. As you know, Senator, the responsibility for that rule lies above my pay grade.

The CHAIRMAN. Well, Congress, I think, enacted it. Does that not come out of some budget conference somewhere? I do not know.

Dr. ELMENDORF. So there is a set of rules—I presume there are ones between 3 and 14, although I could not actually name them for you—that are used to try to provide a little order in what is already a very chaotic budget process, and in some cases they serve that purpose effectively, and in other cases I understand they are very frustrating. But those are rules that are the province of the budget committees.

The CHAIRMAN. But you still are a smart person, and you can still make some sense of what the savings would be.

Dr. ELMENDORF. Thank you, Senator. We do our best.

The CHAIRMAN. We want to keep this beautiful relationship. [Laughter.]

Dr. ELMENDORF. Yes, I certainly do.

The CHAIRMAN. All right.

I have a lot of other questions, but I think I will not ask them now, except to say that people talk a lot about prevention. We have to have more preventive care, especially with respect to chronic care, obesity and smoking, heart disease, and so forth. How do we get at that so it is not just wasted preventive spending, but on that basis is very positive?

Dr. ELMENDORF. There are a couple of issues in getting at that. Part of it is defining public policy levers that actually lead to healthier behavior. As I mentioned to Senator Carper, for smoking, the bad stuff comes in only a few rather specific ways that have been regulated, I think, pretty closely for a long time.

For obesity, one challenge is, if one imposed the tax, say, on sugar-sweetened beverages, well, there are still a lot of snack foods in the world. My daughters could tell you about an awful lot of different things they could eat or drink. So, it is a very difficult, very broad-based set of factors that leads to obesity, and to a number of other conditions. Influencing them all through public policy is in some ways much more challenging, in fact, than tobacco. Even on the tobacco side, that has been a decades-long policy effort to reduce smoking.

So the first problem is trying to find the policy levers to affect health. The second issue is whether those changes in health status show up as changes in Federal spending, and that depends on who is paying and——

The CHAIRMAN. Right. I think we know all that. I am not asking that question. I am asking you to drill down the next couple, three levels. What are they? What are those levers that work?

Dr. ELMENDORF. I do not think analysts are very clear about that.

The CHAIRMAN. Well, what is your best guess?

Dr. ELMENDORF. Decline in costs—relative cost of food over time is viewed by analysts as an important factor in leading to more consumption of food. That suggests that raising the costs of certain kinds of food might reverse that. But the problem is, as I said, it is a very broad set of foods and people need food for many useful purposes, so taxing it is not maybe the most likely political outcome anyway.

I am sorry. Maybe it is my lack. If we get back to CBO and my staff tells me I missed my opportunity, we will send you a more complete answer. But I do not think that the analysts actually know very clearly how to change behavior. There are bully pulpit aspects and so on, but in terms of a direct, forceful way to change some of those behaviors, I do not think analysts have the answer to that question.

The CHAIRMAN. Well, is the solution not more primary care coverage? With universal coverage, everybody is seeing his or her primary care doctor in an early stage, early age, and it is consultations and so on and so forth, and the doctor will work with the patient and the parents a little more about, say, obesity, if that is it, or heart disease? I do not know. It just seems to me that that can be part of it.

Dr. ELMENDORF. I can see my doctor once a year and she gives me heck about getting enough exercise. That has a little effect. So I have to go, so getting people to go to the doctors helps, but I also have to actually get up at 6 every morning and do it, and she is not there to guide that. So some of it is going to see the doctor, and some of it is just people learning what is important.

The other thing, of course, my doctor does is, she gives me a variety of tests on some frequency to try to detect problems early. In some cases, more of that can be very beneficial for health and for

money savings, but not always. The problem with prevention is that one ends up administering tests to a lot of people, a relative number of people who actually would have a certain condition and would, through this test, be saved from some worse, often terrible, outcome.

The CHAIRMAN. But after a while, it seems to me, we are going to get to the point where not every test is given to everybody. At that time we are going to know more about people, we will know it is not worth it in this person for various reasons, and for that person it is high-risk.

Dr. ELMENDORF. Cost effectiveness is important there as well. I mean, studies of specific forms of tests and other preventive care find a very wide range of cost effectiveness, just as for treatments. It does not really look any different. Some things we should do more of because they are very cost-effective, and some things are not very cost-effective. We can see this to some extent when groups of physicians will advise certain sorts of tests for people over certain ages. There is some balancing act.

The CHAIRMAN. My guess is, as we move further along, between the DNA curve and the human genome, that we are going to know a lot more too about what works and does not work.

Dr. ELMENDORF. That is probably right. But I should say, that is one of the factors that people worry about in terms of health spending and in terms of health insurance coverage. So the more than can be deduced from a piece of my DNA, the harder it might be for me to get health insurance if it turns out that I have some potentially expensive condition.

The CHAIRMAN. Well, we will deal with that.

Dr. ELMENDORF. There is that issue.

The CHAIRMAN. We will find ways to deal with that.

Dr. ELMENDORF. Well, but that is a very important matter because in the current insurance market that is not——

The CHAIRMAN. I understand. I understand. We will find a way to deal with that.

Dr. ELMENDORF. And then I think the second issue is that some of these things that we will discover will turn out to be—a part of that will be development of new technologies, new treatments for dealing with problems that are at a very, sort of a molecular level that we do not have today that can be very, very beneficial, but also could be very, very expensive.

The CHAIRMAN. Well, thank you very much, Dr. Elmendorf. I have to tell you, we have a huge problem ahead of us. This is the most difficult public policy undertaking I have experienced in my Senate life here. I have been here 30 years. There is nothing as difficult as this, nothing as important as this. I cannot think of anything that depends so much on CBO as this, especially at a time when it is new territory. We are not in the old situation where, as even Senator Grassley once said, whatever CBO said, you are God. In my judgment, you are not God.

Dr. ELMENDORF. Correct.

The CHAIRMAN. My judgment is, there is a whole new era. You might be Moses, but not God. [Laughter.] But there is a whole new era here.

Dr. ELMENDORF. I need to get you to talk to my kids, Senator. [Laughter.]

The CHAIRMAN. As I said earlier, it is not too much of an overstatement to say CBO can make or break health care reform. I mean that, because we have to go by your numbers, whatever you come up with. And I do believe——

Dr. ELMENDORF. Senator, may I respectfully disagree?

The CHAIRMAN. And I do believe there are several different intellectually honest pathways to get from here to there. It is not just one automatic. So, it means we have to be ever more creative to find intellectually honest pathways to get the savings that we have to have, practically as well as politically, to get health care reform.

Dr. ELMENDORF. Senator, I would like to just respectfully disagree with the "make or break" rule that you have assigned to us. We will do our very best to provide you, and all members of this committee and the rest of the members of Congress, with the technical information that you need, the best estimates that the knowledge in the world can provide about the effects of alternative policies, but as you understand, the hard decisions will be yours.

The CHAIRMAN. No, that is incorrect. The hard decisions will be all of ours, both of us, you and me. You cannot pass the buck. The hard decisions are here, and the hard decisions are yours, and the hard decisions are all of ours in the country in trying to make this work.

The hearing is adjourned.

[Whereupon, at 12:13 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony

Statement of
Douglas W. Elmendorf
Director

Options for Expanding Health Insurance Coverage and Controlling Costs

before the
Committee on Finance
United States Senate

February 25, 2009

Chairman Baucus, Senator Grassley, and Members of the Committee, thank you for inviting me to testify this morning about the opportunities and challenges that the Congress faces in pursuing two major policy goals: (1) expanding health insurance coverage, so that more Americans receive appropriate health care without undue financial burden, and (2) making the health care system more efficient, so that it can continue to improve Americans' health but at a lower cost in both the public and private sectors. Both are complex endeavors in their own right, and interactions and trade-offs between them may arise.

First, with respect to expanding health insurance coverage, my testimony makes the following key points:

- Without changes in policy, a substantial and growing number of people under age 65 will lack health insurance. The Congressional Budget Office (CBO) estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019. That projection is consistent with long-standing trends in coverage and largely reflects the expectation that health care costs and health insurance premiums will continue to rise faster than people's income—making health insurance more difficult to afford.

- Proposals could achieve near-universal health insurance coverage by combining three key features:

  - Mechanisms for pooling risks—both to ensure that people who develop health problems can find affordable coverage and to keep people from waiting until they are sick to sign up for insurance. Options include strengthening the current employment-based system, modifying the market for individually purchased insurance, and establishing a new mechanism such as an insurance exchange.

  - Subsidies to make health insurance less expensive for individuals and families, particularly those with lower income who are most likely to be uninsured today. For reasons of equity and administrative feasibility, however, it is difficult for subsidy systems to avoid "buying out the base"—that is, providing new subsidies to people who already have insurance or would have purchased it anyway.

  - Either an enforceable mandate for individuals to obtain insurance or an effective process to facilitate enrollment in a health plan. An enforceable mandate would generally have a greater effect on coverage rates, but without meaningful subsidies, it could impose a substantial burden on many people—given the cost of health insurance relative to the financial means of most uninsured individuals.

- Certain trade-offs arise in choosing how to design subsidies and mandates. To achieve near-universal coverage through subsidies alone would require that they cover a very large share of the premiums—which is an expensive proposition. But policymakers may also be reluctant to establish the penalties and enforcement mechanisms necessary to make a mandate effective. Other policies that adopted more limited versions of those three features could reduce the number of uninsured people to a lesser extent at a lower budgetary cost.

Second, with respect to controlling costs and improving efficiency—so that we get the best health for the amount we spend as a nation—some key considerations are these:

- Spending on health care has generally grown much faster than the economy as a whole, and that trend has continued for decades. In part, that growth reflects the improving capabilities of medical care—which can confer tremendous benefits by extending and improving lives. Studies attribute the bulk of cost growth to the development of new treatments and other medical technologies, but features of the health care and health insurance systems can influence how rapidly and widely new treatments are adopted.

- The high and rising costs of health care impose an increasing burden on the federal government as well as state governments and the private sector. Under current policies, CBO projects, federal spending on Medicare and Medicaid will increase from about 5 percent of gross domestic product (GDP) in 2009 to more than 6 percent in 2019 and about 12 percent by 2050. Most of that increase will result from growth in per capita costs rather than from the aging of the population. In the private sector, the growth of health care costs has contributed to slow growth in wages because workers must give up other forms of compensation to offset the rising costs of employment-based insurance.

- The available evidence also suggests that a substantial share of spending on health care contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without also affecting services that improve health will be difficult. In many cases, the current system does not create incentives for doctors, hospitals, and other providers of health care—or their patients—to control costs. Significantly reducing the level or slowing the growth of health care spending below current projections would require substantial changes in incentives. Given the central role of medical technology in cost growth, reducing or slowing spending over the long term would probably require decreasing the pace of adopting new treatments and procedures or limiting the breadth of their application.

Third, controlling costs and improving efficiency present many challenges, but there are a number of approaches about which many analysts would probably concur:

- Many analysts would agree that payment systems should move away from a fee-for-service design and should instead provide stronger incentives to control costs, reward value, or both. A number of alternative approaches could be considered—including fixed payments per patient, bonuses based on performance, or penalties for substandard care—but their precise effects are uncertain. Policymakers may thus want to test various options (for example, using demonstration programs in Medicare) to see whether they work as intended or to determine which design features work best. Almost inevitably, though, reducing the amount that is spent on health care will involve some cutbacks or constraints on the number and types of services provided relative to currently projected levels.

- Many analysts would agree that the current tax exclusion for employment-based health insurance—which exempts most payments for such insurance from both income and payroll taxes—dampens incentives for cost control because it is open-ended. Those incentives could be changed by replacing the tax exclusion or restructuring it in ways that would encourage workers to join health plans with higher cost-sharing requirements and tighter management of benefits. (Given stronger incentives, the competition among health plans for enrollees could then determine the optimal mix of payment systems for providers.)

- Many analysts would agree that more information is needed about which treatments work best for which patients and about what quality of care different doctors, hospitals, and other providers deliver. The broad benefits that such information provides suggest a role for the government in funding research on the comparative effectiveness of treatments, in generating measures of quality, and in disseminating the results to doctors and patients. But absent stronger incentives to control costs and improve efficiency, the effect of information alone on spending will generally be limited.

- Many analysts would agree that controlling federal costs over the long term will be very difficult without addressing the underlying forces that are also causing private costs for health care to rise. Private insurers generally have more flexibility than Medicare's administrators to adapt to changing circumstances—a situation that policymakers may want to remedy—but changes made in the Medicare program can also stimulate broader improvements in the health sector.

Fourth, many of the steps that analysts would recommend might not yield substantial budgetary savings or reductions in national spending on health care within a 10-year window—and others might increase federal costs or total spending—for several reasons:

- In some cases, savings may materialize slowly because an initiative is phased in. For example, Medicare could save money by reducing payments to hospitals that have a high rate of avoidable readmissions (for complications following a discharge) but would have to gather information about readmission rates and notify hospitals before such reductions could be implemented. More generally, the process of converting innovative ideas into successful programmatic changes could take several years. Of course, for proposals that would increase the budget deficit, phase-in schedules reduce the amount of the increase that is captured in a 10-year budget window.

- Even if they generate some offsetting savings, initiatives are not costless to implement. For example, expanding the use of disease management services can improve health and may well be cost-effective—that is, the value of the benefits could exceed the costs. But those efforts may still fail to generate net reductions in spending on health care because the number of people receiving the services is generally much larger than the number who would avoid expensive treatments as a result. In other cases, most of the initial costs would be incurred in the first 10 years, but little of the savings would accrue in that period.

- Moreover, the effect on the federal budget of a policy proposal to encourage certain activities often differs from the impact of those activities on total spending for health care. For example, a preventive service could be cost-reducing overall, but if the government began providing that service for free, federal costs would probably increase—largely because many of the payments would cover costs for care that would have been received anyway.

- In some cases, additional steps beyond a proposal are needed for the federal government to capture savings generated by an initiative. For example, requiring that hospitals adopt electronic health records would reduce their costs for treating Medicare patients, but the program's payment rates would have to be reduced in order for the federal government to capture much of those savings.

- Savings from some initiatives may not materialize because incentives to reduce costs are lacking. For example, proposals to establish a "medical home" might have little impact on spending if the primary care physicians who would coordinate care were not given financial incentives to economize on their patients' use of services. Those proposals could increase costs if they simply raised payments to those primary care physicians.

- In some cases, estimating the budgetary effects of a proposal is hampered by limited evidence. Studies generally examine the effects of discrete policy changes but typically do not address what would happen if several changes were made at the same time. Those interaction effects could mean that the savings from combining two or more initiatives will be greater than or less than the sum of their individual effects.

Finally, I offer some observations on the issues that arise when trying to expand coverage and reduce costs at the same time:

- By themselves, steps to substantially expand coverage would probably increase total spending on health care and would generally raise federal costs. Those federal costs would be determined primarily by the number of people receiving subsidies of their premiums and the average amount of the subsidy. Steps that reduced the costs of the health insurance policies would limit the federal costs of providing premium subsidies but could not eliminate those costs.

- An expansion of coverage could be financed in a number of ways. One option is to limit or eliminate the current tax exclusion for employment-based health insurance. The savings from taking such steps would grow steadily because the revenue losses that stem from that exclusion are rising at the same rate as health care costs. The same can generally be said about using reductions in Medicare or Medicaid spending to offset the costs of expanding insurance coverage. Those methods of financing could adversely affect some people's current coverage, however, and other financing options that would either raise revenues or reduce other spending are also available.

On a broad level, many analysts agree about the direction in which policies would have to go in order to make the health care system more cost-effective: Patients and providers both need stronger incentives to control costs as well as more information about the quality and value of the care that is provided. But much less of a consensus exists about crucial details regarding how those changes are made—and similar disagreements arise about how to expand insurance coverage. In part, those disagreements reflect different values or different assessments of the existing evidence, but often they reflect a lack of evidence about the likely impact of making significant changes to the complex system of health insurance and health care.

CBO's Recent Volumes on Health Care

Concerns about the number of people who are uninsured and about the rising costs of health insurance and health care have given rise to proposals that would substantially modify the U.S. health insurance system and that seek to reduce federal or total spending for health care. The complexities of the health insurance and health care systems pose a major challenge for the design of such proposals and inevitably raise

questions about their likely impact. To assist the Congress in its upcoming deliberations, CBO has produced two major reports that address such proposals.

The December 2008 report titled *Key Issues in Analyzing Major Health Insurance Proposals* describes the assumptions that CBO would use in estimating the effects of various elements of such proposals on federal costs, insurance coverage, and other outcomes. It also reviews the evidence upon which those assumptions are based and, if the evidence points to a range of possible effects rather than a precise prediction, the factors that would influence where a proposal falls within the range. The report does not provide a comprehensive analysis of any specific proposal; rather, it identifies and examines many of the critical factors that would affect estimates of a variety of proposals. In particular, it considers the types of issues that would arise in estimating the effects of proposals to:

- Provide tax credits or other types of subsidies to make insurance less expensive to the purchaser;
- Require individuals to purchase health insurance, typically paired with a new system of government subsidies;
- Require firms to offer health insurance to their workers or pay into a fund that subsidizes insurance purchases;
- Replace employment-based coverage with new purchasing arrangements or provide strong incentives for people to shift toward individually purchased coverage; or
- Provide individuals with coverage under, or access to, existing insurance plans such as the Medicare program, either as an additional option or under a "Medicare-for-all" single-payer arrangement.

Wherever possible, the analysis describes in quantitative terms how CBO would estimate the budgetary and other effects of such proposals. In other cases, it describes the components that a proposal would have to specify in order to permit estimation of those effects. The report reflects the current state of CBO's analysis of and judgments about the likely response of individuals, employers, insurers, and providers to changes in the health insurance and health care systems. Certainly, the details of particular policies and the way in which they are combined, as well as new evidence or analysis related to the issues discussed here, could affect CBO's estimates of the effects of large-scale health insurance proposals.

The December 2008 report titled *Budget Options, Volume 1: Health Care,* comprises 115 discrete options to alter federal programs, affect the private health insurance market, or both. It includes many options that would reduce the federal budget deficit and some that would increase it. Although similar to CBO's previous reports on budget options, this volume reflects an extensive and concerted effort to substantially

expand the range of topics and types of proposals considered and includes estimates of many approaches that the agency had not previously analyzed. (Volume 2, containing budget options that are not related to health care, is forthcoming.) The report is organized thematically, rather than by program, and covers the following areas:

- The private health insurance market and the tax treatment of health insurance;
- Changing the availability of health insurance through existing federal programs;
- The quality and efficiency of health care and geographic variation in spending for Medicare;
- Paying for services in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
- Premiums and cost sharing in federal health programs;
- Long-term care;
- Health behavior and health promotion; and
- Closing the gap between Medicare's spending and receipts.

The options that were included stem from a variety of sources, including extensive discussions with Congressional staff; reviews of legislative proposals, the President's budget, and academic literature; and analyses conducted by CBO staff, other government agencies, and private groups. Although the number of health-related policy options is significantly greater than in previous *Budget Options* volumes, it is not an exhaustive list. CBO's estimates are sensitive to the precise specifications of each option and could change in the future for a variety of reasons, including changes in economic conditions or other factors that affect projections of baseline spending or the availability of new evidence about an option's likely effects. It should also be noted that the options' effects may not be additive; that is, there could be important interaction effects among options that make their cumulative impact larger or smaller than the sum of the estimates. Some of the options that are particularly complex may be candidates for demonstration projects or pilot programs, which could help resolve the uncertainty about their effects.[1]

The remainder of my testimony largely summarizes the conclusions reached in the *Key Issues* volume. Those conclusions—and the background information and evidence

1. Estimates of the impact on revenues of proposals to change the federal tax code are prepared by the staff of the Joint Committee on Taxation (JCT) and would be incorporated into any formal CBO estimate of a proposal's effects on the federal budget. For its recent reports on health care, CBO consulted with JCT about the behavioral considerations that are incorporated into both agencies' estimates, and JCT prepared the revenue estimates for several of the options.

on which they are based—are also relevant to much of CBO's analysis for the *Budget Options* volume. Although summarizing all 115 options would not be feasible here, my testimony highlights some of the agency's main findings.

Background on Spending and Coverage

Spending on health care and related activities will account for about 18 percent of GDP in 2009—an expected total of $2.6 trillion—and under current law that share is projected to reach 20 percent by 2017. Annual health expenditures per capita are projected to rise from about $8,300 to about $13,000 over that period. Federal spending accounts for about one-third of those totals, and federal outlays for the Medicare and Medicaid programs are projected to grow from about $720 billion in 2009 to about $1.4 trillion in 2019. Over the longer term, rising costs for health care represent the single greatest challenge to balancing the federal budget. (For additional discussion, see the November 2007 CBO report *The Long-Term Outlook for Health Care Spending*.)

The number of people who are uninsured is also expected to increase because health insurance premiums are likely to continue rising much faster than income, which will make insurance more difficult to afford. As noted above, CBO estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019. The estimate for 2009 does not reflect the recent deterioration in economic conditions, which could result in a larger uninsured population, nor does it take into account recently enacted legislation.

Employment-Based Insurance

For several reasons, most nonelderly individuals obtain their insurance through an employer, and employment-based plans now cover about 160 million people, including spouses and dependents. One fundamental reason such plans are popular is that they are subsidized through the tax code—because nearly all payments for employment-based insurance are excluded from taxable compensation and thus are not subject to income and payroll taxes. Another factor is the economies of scale that larger group purchasers enjoy, which reduce the average amount of administrative costs that are embedded in premiums; partly as a result, large employers are more likely than small employers to offer insurance to their workers. Overall, about three-fourths of workers are offered employment-based insurance and are eligible to enroll in it.

Another commonly cited reason for the popularity of employment-based policies is that employers offering coverage usually pay most of the premium—a step they take partly to encourage broad enrollment in those plans, which helps keep average costs stable. Ultimately, however, the costs of those employers' payments are passed on to employees as a group, mainly in the form of lower wages.

Other Sources of Coverage

Other significant sources of coverage for nonelderly people include the individual insurance market and various public programs. Roughly 10 million people are covered by individually purchased plans, which have some advantages for enrollees; for example, they may be portable from job to job, unlike employment-based insurance. Even so, individually purchased policies generally do not receive favorable tax treatment. In most states, premiums may vary to reflect an applicant's age or health status, and applicants with particularly high expected costs are generally denied coverage.

Another major source of coverage is the federal/state Medicaid program and the related but smaller CHIP. Both programs provide free or low-priced coverage for children in low-income families and (to a more limited degree) their parents; Medicaid also covers poor individuals who are blind or disabled. On average, Medicaid and CHIP are expected to cover about 43 million nonelderly people in 2009 (and there are also many people eligible for those programs who have not enrolled in them).[2] Medicare also covers about 7 million people younger than 65 who are disabled or have severe kidney disease.

About 12 million people have insurance coverage from various other sources, including federal health programs for military personnel. The total number of nonelderly people with health insurance at any given point in 2009 is expected to be about 216 million.

Approaches for Reducing the Number of Uninsured People

Concerns about the large number of people who lack health insurance have generated proposals that seek to increase coverage rates substantially or achieve universal or near-universal coverage. Two basic approaches could be used:

- Subsidizing health insurance premiums, either through the tax system or spending programs, which would make insurance less expensive for people who are eligible, or
- Establishing a mandate for health insurance, either by requiring individuals to obtain coverage or by requiring employers to offer health insurance to their workers.

By themselves, premium subsidies or mandates to obtain health insurance would not achieve universal coverage. Those approaches could be combined and could be implemented along with provisions to facilitate enrollment in ways that could achieve near-universal coverage. (Many of the issues and trade-offs that arise in designing such

2. That figure represents average enrollment (rather than the number of people enrolled at any time during the year) and excludes nonelderly individuals living in institutions (such as nursing homes), people living in U.S. territories, and people receiving only limited benefits under Medicaid (such as family planning services).

initiatives are also illustrated by the more incremental options to expand insurance coverage that are examined in the *Budget Options* volume.)

Subsidizing Premiums

Whether new subsidies are delivered through the tax system or a spending program, several common issues arise. Trade-offs exist between the share of the premiums that is subsidized, the number of people who enroll in insurance as a result of the subsidies, and the total costs of the subsidies. As the subsidy rate increases, more people will be inclined to take advantage of them, but the higher subsidy payments will also benefit those who would have decided to obtain insurance anyway. Beyond a certain point, therefore, the cost per newly insured person can grow sharply because a large share of the additional subsidy payments is going to otherwise insured individuals.

To hold down the costs of subsidies, the government could limit eligibility for subsidy payments to individuals who are currently uninsured. That restriction, however, would create incentives for insured individuals to drop their coverage. Some proposals might try to distinguish between people who become uninsured in response to subsidies and those who would have been uninsured in the absence of a government program (for example, by imposing waiting periods for individuals who were previously enrolled in an employment-based plan), but such proposals could be very difficult to administer. In addition, providing benefits only to the uninsured might be viewed as unfair by people with similar income and family responsibilities who purchased health insurance and would therefore be ineligible for the subsidies.

Another approach to limiting costs would target subsidies toward the lower-income groups, who are most likely to be uninsured otherwise, but such approaches can also have unintended consequences that affect the costs of a proposal. If eligibility was limited to people with income below a certain level, then those with income just above the threshold would have strong incentives to work less or hide income in order to qualify for the subsidies or maintain their eligibility. Phasing out subsidies gradually as income rises would reduce those incentives, but it would increase the amount of subsidy payments that go to individuals and families who would have had insurance in any event.

Restructuring the Existing Tax Subsidies. Tax subsidies could be restructured to expand coverage in several ways. For example, the current tax exclusion for employment-based health insurance could be replaced with a deduction or tax credit to offset the costs of insurance, and tax subsidies could be extended to include policies purchased in the individual insurance market. That step would sever the link between employment and tax subsidies for private health insurance and could give similar people the same subsidy whether or not they were offered an employment-based health plan.

Deductions and credits differ, however, in their effectiveness at reaching the uninsured. An income tax deduction might provide limited benefits to low-income

individuals because, like the existing exclusion, its value is less for those in lower tax brackets. In contrast, tax credits can be designed to provide lower- and moderate-income taxpayers with larger benefits than they would receive from tax deductions or exclusions. An important question regarding tax credits—particularly for lower-income people who pay relatively little in income taxes and are also more likely to be uninsured—is whether the credits would be refundable and therefore fully available to individuals with little or no income tax liability.

For the same budgetary costs, a refundable tax credit might be more effective at increasing insurance coverage, both because it can be designed to provide a larger benefit to low-income people than they receive under current law and because those recipients might be more responsive to a given subsidy than are people with higher income. Still, the effect on coverage rates might be limited if people do not receive refundable tax credits before their premium payments are due.

Providing Subsidies Through Spending Programs. The government could seek to increase coverage rates by spending funds to subsidize insurance premiums. New subsidies could be provided implicitly by expanding eligibility for Medicare, Medicaid, or CHIP or explicitly by creating a new program. To hold costs down, benefits could be targeted on the basis of income, assets, family responsibilities, and insurance status. Targeting benefits, however, would require program administrators to certify eligibility and enforce the program's rules, which would affect coverage and the program's costs.

The Effects of Subsidy Proposals. Proposals to subsidize insurance coverage would affect decisions by both employers and individuals. Employers' decisions to offer insurance to their workers reflect the preferences of their workers, the cost of the insurance that they can provide, and the costs of alternative sources of coverage that workers would have. Smaller firms appear to be more sensitive to changes in the cost of insurance than are larger employers. Subsidies that reduce the cost of insurance offered outside the workplace would cause some firms to drop coverage or reduce their contributions. When deciding whether to enroll in employment-based plans, workers would consider the share of the premium that they pay as well as the price and attractiveness of alternatives. The available evidence indicates that a small share of the population would be reluctant to purchase insurance even if subsidies covered nearly all of the costs.

Related Budget Options. Several of the alternatives included in CBO's *Budget Options* volume highlight the potential effects of changing the tax treatment of health insurance. For example, Option 10 would replace the current exclusion from income taxes for employment-based health insurance with a tax deduction that phases out at higher income levels. That option would increase federal revenues by approximately $550 billion through 2018 (as estimated by the staff of the Joint Committee on Taxation). Because that option would increase the effective price of health insurance for higher-income taxpayers, it would, by CBO's estimation, increase the number of

uninsured people by about 1.5 million in 2014 (in part because some employers would decide to stop offering coverage). Those estimates are sensitive to the parameters of the deduction and particularly to the range of income over which the deduction is phased out.

Other examples illustrate the effects on federal costs and coverage that stem from targeting different populations. Allowing low-income young adults to enroll in Medicaid, as described in Option 23, would cover about 1.1 million people in 2014, at a federal cost of about $22 billion over the 2010–2019 period, according to CBO's estimates. Allowing low-income parents with children eligible for Medicaid to enroll in the program, as described in Option 24, would cost about $38 billion over the same period and would expand coverage to about 1.4 million parents and 700,000 children in 2014.

Another approach is illustrated by Option 7, which would create a voucher program to subsidize the purchase of health insurance for households with income below 250 percent of the federal poverty level. Specifically, individuals would receive up to $1,500, and families would receive up to $3,000. According to CBO's estimates, that approach would reduce the net number of uninsured people by about 2.2 million in 2014. Overall, approximately 4 million people would use the voucher, but about 1.7 million of those people would have had coverage in the individual health insurance market or through an employer. In addition, about 100,000 people would become newly uninsured as a result of small employers' electing not to offer coverage because of the new voucher program. The total cost to the federal government of such a voucher program would be about $65 billion over the next decade.

Mandating Coverage

In an effort to increase the number of people who have health insurance or to achieve universal or near-universal coverage, the government could require individuals to obtain health insurance or employers to offer insurance plans. Employer mandates could include a requirement that employers contribute a certain percentage of the premium, which would encourage their workers to purchase coverage. To the extent that the required contributions exceeded the amounts that employers would have paid under current law, offsetting reductions would ultimately be made in wages and other forms of compensation.

The impact of a mandate on the number of people covered by insurance would depend on its scope, the extent of enforcement, and the incentives to comply, as well as the benefits that enrollees received. Individual mandates, for example, could be applied broadly to the entire population of the United States or to a specific group, such as children; employer mandates might vary by the size of the firm. (Option 3 in the *Budget Options* volume is a specific requirement for large employers to offer coverage or pay a fee. Under the provisions of that option, the number of newly insured individuals would be relatively small, only about 300,000.)

Penalties would generally increase individuals' incentives to comply with mandates, but when deciding whether to obtain insurance, people would also consider the likelihood of being caught if they did not comply. Data from the tax system and from other government programs, where overall rates of compliance range from roughly 60 percent to 90 percent, indicate that mandates alone would not achieve universal coverage, largely because some people would still be unwilling or unable to purchase insurance.

Facilitating Enrollment

Simplifying the process of enrolling in health insurance plans or applying for subsidies could yield higher coverage rates and could also increase compliance with a mandate to obtain coverage. One approach would be to enroll eligible individuals in health insurance plans automatically, giving them the option to refuse that coverage or to switch to a different plan. Automatic enrollment has been found to increase participation rates in retirement plans and government benefit programs. It requires the government, an employer, or some other entity to determine the specific plan into which people will be enrolled, however, and those choices may not always be appropriate for everyone.

Factors Affecting Insurance Premiums

Premiums for employment-based plans are expected to average about $5,000 per year for single coverage and about $13,000 per year for family coverage in 2009. Premiums for policies purchased in the individual insurance market are, on average, much lower—about one-third lower for single coverage and one-half lower for family policies. Those differences largely reflect the fact that policies purchased in the individual market generally cover a smaller share of enrollees' health care costs, which also encourages enrollees to use fewer services. An offsetting factor is that average administrative costs are much higher for individually purchased policies. The remainder of the difference in premiums probably arises because people who purchase individual coverage have lower expected costs for health care to begin with.

The federal costs of providing premium subsidies, and the effects of those subsidies on the number of people who are insured, would depend heavily on the premiums charged. Premiums reflect the average cost that any insurer—public or private—incurs, and those costs are a function of several factors:

- The scope of benefits the coverage includes and its cost-sharing requirements,
- The degree of benefit management that is conducted,
- The administrative costs the insurer incurs, and
- The health status of the individuals who enroll.

Insurers' costs also depend on the mechanisms and rates used to pay providers and on other forces affecting the supply of health care services. Proposals could affect many of those factors directly or indirectly. For example, the government might specify a minimum level of benefits that the coverage must provide in order to qualify for a subsidy or fulfill a mandate; such a requirement could have substantial effects on the proposal's costs or its impact on coverage rates.

Design of Benefits, Cost Sharing, and Related Budget Options

Health insurance plans purchased in the private market tend to vary only modestly in the scope of their benefits—with virtually all plans covering hospital care, physicians' services, and prescription drugs—but they vary more substantially in their cost-sharing requirements. A useful summary statistic for comparing plans with different designs is their "actuarial value," which essentially measures the share of health care spending for a given population that each plan would cover. Actuarial values for employment-based plans typically range between 65 percent and 95 percent, with an average value between 80 percent and 85 percent. Cost-sharing requirements for enrollees tend to be greater for policies purchased in the individual insurance market, where actuarial values generally range from 40 percent to 80 percent, with an average value between 55 percent and 60 percent.

Public programs also vary in the extent of the coverage they provide. Medicaid requires only limited cost sharing (reflecting the low income of its enrollees); cost sharing under CHIP may be higher but is capped as a share of family income. Medicare's cost sharing varies substantially by the type of service provided; for example, home health care is free to enrollees, but most hospital admissions incur a deductible of about $1,000. In addition, the program does not cap the out-of-pocket costs that enrollees can incur. Overall, the actuarial value of Medicare's benefits for the nonelderly population is about 15 percent lower than that of a typical employment-based plan. Those considerations would affect CBO's analysis of proposals to expand enrollment in public programs.

In general, the more comprehensive the coverage provided by a health plan, the higher the premium or cost per enrollee. Indeed, an increase in a health plan's actuarial value would also lead enrollees to use more health care services. Reflecting the available evidence, CBO estimates that a 10 percent decrease in the out-of-pocket costs that enrollees have to pay would generally cause their use of health care to increase by about 1 percent to 2 percent. The agency would apply a similar analysis to proposals that included subsidies to reduce the cost-sharing requirements that lower-income enrollees face.

Several budget options examine the effects of changing cost-sharing requirements in the Medicare program. Option 81 would replace the program's current requirements with a unified deductible, a uniform coinsurance rate, and a limit on out-of-pocket costs. That option would reduce federal spending by about $26 billion over 10 years —mostly because of the increase in cost sharing for some services and the resulting

reduction in their use. Option 83 would combine those changes in the Medicare program with limits on the extent to which enrollees could purchase supplemental insurance policies (known as medigap plans) that typically cover all of Medicare's cost-sharing requirements. That option would reduce federal spending by about $73 billion over 10 years—with the added savings emerging because enrollees would be more prudent in their use of care once their medigap plans did not cover all of their cost-sharing requirements. Options 84, 85, and 86 would reduce federal outlays by imposing cost sharing for certain Medicare services that are now free to enrollees, and Option 89 would increase federal outlays by eliminating the gap in coverage (commonly called the doughnut hole) in the design of Medicare's drug benefit. Options 95 through 98 would reduce federal spending by introducing or increasing cost-sharing requirements for health care benefits provided to veterans, military retirees and their dependents, and dependents of active-duty personnel.

Management of Benefits

Another factor affecting health insurance premiums and thus the costs or effects of legislative proposals is the degree of benefit and cost management that insurers apply. Nearly all Americans with private health insurance are enrolled in some type of "managed care" plan, but the extent to which specific management techniques are used varies widely. Common techniques to constrain costs include negotiating lower fees with a network of providers, requiring that certain services be authorized in advance, monitoring the care of hospitalized patients, and varying cost-sharing requirements to encourage the use of less expensive prescription drugs. Overall, CBO estimates, premiums for plans that made extensive use of such management techniques would be 5 percent to 10 percent lower than for plans using minimal management. Conversely, proposals that restricted plans' use of those tools would result in higher health care spending than proposals that did not impose such restrictions.

Administrative Costs

Some proposals would affect the price of health insurance by changing insurers' administrative costs. Some types of administrative costs (such as those for customer service and claims processing) vary in proportion to the number of enrollees in a health plan, but others (such as those for sales and marketing efforts) are more fixed; that is, those costs are similar whether a policy covers 100 enrollees or 100,000. As a result of those economies of scale, the average share of the policy premium that covers administrative costs varies considerably—from about 7 percent for employment-based plans with 1,000 or more enrollees to nearly 30 percent for policies purchased by very small firms (those with fewer than 25 employees) and by individuals.

Some administrative costs would be incurred under any system of health insurance, but proposals that shifted enrollment away from the small-group and individual markets could avoid at least a portion of the added administrative costs per enrollee that are observed in those markets. In general, however, substantial reductions in administrative costs would probably require the role of insurance agents and brokers

in marketing and selling policies to be sharply curtailed and the services they provide to be rendered unnecessary.

Spending by Previously Uninsured People

The impact that the mix of enrollees has on health insurance premiums is also an important consideration, particularly for proposals that would reduce the number of people who are uninsured. The reason is that the use of health care by the previously uninsured will generally increase when they gain coverage. On average, the uninsured currently use about 60 percent as much care as the insured population, CBO estimates, after adjusting for differences in demographic characteristics and health status between the two groups.

On the basis of the research literature and an analysis of survey data, CBO estimates that enrolling all people who are currently uninsured in a typical employment-based plan would increase their use of services by 25 percent to 60 percent; that is, they would use between 75 percent and 95 percent as many services as a similar group of insured people. The remaining gap in the use of services reflects the expectation that, on average, people who are uninsured have a lower propensity to use health care, a tendency that would persist even after they gained coverage. For more incremental increases in coverage rates, CBO would expect that people who chose to enroll in a new program would be more likely to use medical care than those who decided not to enroll.

In addition, recent estimates indicate that about a third of the care that the uninsured receive is either uncompensated or undercompensated—that is, they either pay nothing for it or pay less than the amount that a provider would receive for treating an insured patient. To the extent that such care became compensated under a proposal to expand coverage, health care spending for the uninsured would increase, regardless of whether their use of care also rose.

Proposals Affecting the Choice of an Insurance Plan

The government could affect the options available to individuals when choosing a health insurance plan—and the incentives they face when making that choice—in a number of ways. In particular, proposals could establish or alter regulations governing insurance markets, seek to reveal more fully the relative costs of different health insurance plans, or have the federal government offer new health insurance options.

The effects of proposals on insurance markets would depend on more than the impact they have on the premiums charged or on the share of the premium that enrollees have to pay; those effects would also reflect the market dynamics that arise as individuals shift among coverage options and as policy premiums adjust to those shifts. In particular, the risk that some plans would experience "adverse selection"—that is, that their enrollees will have above-average or higher-than-expected costs for health care—

has important implications for the operation of insurance markets and for proposals that would regulate those markets or introduce new insurance options.

Insurance Market Regulations and Related Budget Options

Proposals could seek to establish or alter regulations governing the range of premiums that insurers may charge or the terms under which individuals and groups purchase coverage. Purchases in the individual insurance market and most policies for small employers are governed primarily by state regulations. Those regulations differ in the extent to which they limit variation in premiums, require insurers to offer coverage to applicants, permit exclusions for preexisting health conditions, or mandate coverage of certain benefits. Roughly 20 percent of applicants for coverage in the individual market have health problems that raise their expected costs for health care substantially, and in most states they may be charged a higher premium or have their application denied; as a result, premiums are correspondingly lower in those states for the majority of applicants.

Proposals might seek to modify the regulation of health insurance markets in order to make insurance more affordable for people with health problems or to give consumers more choices, but those goals might conflict with each other. For example, limiting the extent to which premiums for people in poor health can exceed those for people in better health (as some states currently do) would reduce premiums for those who have higher expected costs for health care, but it would also raise premiums for healthier individuals and thus could reduce their coverage rates. Other proposals might counteract such limits on variations in premiums—for example, by allowing people to buy insurance in other states. That approach would enable younger and relatively healthy individuals living in states with tight limits to purchase a cheaper policy in another state. Older and less healthy residents who continued to purchase individual coverage in the tightly regulated states, however, would probably face higher premiums as a result.

By themselves, changes in the regulation of the small-group and individual insurance markets would generally have modest effects on the federal budget and on the total number of people who are insured. Those budgetary effects would primarily reflect modest shifts into or out of Medicaid, CHIP, or employment-based coverage as those options became more or less attractive relative to coverage in the individual market. Proposals to require insurers to cover all applicants or to guarantee coverage of preexisting health conditions would benefit people whose health care would not be covered otherwise, but insurers would generally raise premiums to reflect the added costs.

Another approach that has attracted attention recently involves so-called high-risk pools. Most states have established such pools to subsidize insurance for people who have high expected medical costs and have either been denied coverage in the individual insurance market or been quoted a very high premium. Overall participation in high-risk pools is limited—there are currently about 200,000 enrollees nationwide—but proposals could seek to expand the use of those pools by providing new federal

subsidies. The costs of such subsidies would depend primarily on the average health care costs of enrollees, the share of those costs covered by the pool, and the number of people who enrolled as a result.

CBO analyzed several specific options related to the regulation of insurance markets in its *Budget Options* volume. For example, Option 2 would allow insurers licensed in one state to sell policies to individuals living in any other state and to be exempt from the regulations of those other states. Under that option, premiums would tend to rise for people with higher expected costs for health care living in states that tightly regulate insurance markets, and premiums would fall correspondingly for low-cost individuals in those states because some of them would find insurance policies with lower premiums sold in other states with looser regulations. As a result, according to CBO's estimates, by 2014 about 600,000 people with relatively low expected health care spending would gain coverage and about 100,000 people with higher expected costs would drop their coverage. In addition, some firms would stop offering health insurance plans altogether, resulting in an additional loss of coverage for about 100,000 employees and their dependents. Those changes in coverage would generate nearly $8 billion in additional federal revenues over 10 years, as some compensation shifted from untaxed health benefits to taxable wages. Among those who were no longer offered employment-based coverage, a small number would enroll in Medicaid causing roughly a $400 million increase in federal outlays over the 2010–2019 period.

Option 6 would require states to use "community rating" of premiums for small employers who purchase coverage from an insurer—meaning that insurers would have to charge all applicants the same per-enrollee premium for a given policy. Under that option, total enrollment in the small-group health insurance market would fall by about 400,000 (or roughly 1 percent of current enrollment) in 2014, reflecting the net effect of both increased enrollment by people with high expected costs and decreased enrollment by people with low expected costs. The budget deficit would be reduced by about $5 billion over the next decade, largely as a result of higher tax revenues. Option 4 would require all states to establish high-risk pools and provide federal subsidies toward enrollees' premiums. Enrollees would be responsible for paying premiums up to 150 percent of the standard rate for people of similar age. That option would increase the deficit by about $16 billion over the 2010–2019 period; on net, about 175,000 individuals who would have been uninsured otherwise would gain insurance coverage in 2014.

Steps to Reveal Relative Costs

Some proposals would seek to restructure the choices that individuals face—and expose more clearly the relative costs of their health insurance options—either by reducing or eliminating the current tax subsidy for employment-based insurance or by encouraging or requiring the establishment of managed competition systems. Both approaches would provide stronger incentives for enrollees to weigh the expected benefits and costs of policies when making decisions about purchasing insurance. As a

result, many enrollees would choose health insurance policies that were less extensive, more tightly managed, or both, compared with the choices made under current law.

The current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent, on average, if both the income and payroll taxes that are avoided are taken into account. Eliminating that exclusion, or replacing it with a fixed-dollar tax credit or deduction, would effectively require employees to pay a larger share of the added costs of joining a more expensive plan; conversely, employees would capture more of the savings from choosing a cheaper plan. As a result, according to CBO's estimates, people would ultimately select plans with premiums that were between 15 percent and 20 percent lower than the premiums they would pay under current law. Less extensive changes, such as capping the amount that may be excluded at a certain dollar value, would have proportionally smaller effects on average premiums.

The key features of a managed competition system involve a sponsor, such as an employer or government agency, offering a structured choice of health plans and making a fixed-dollar contribution toward the cost of that insurance. Enrollees would thus bear the cost of any difference in premiums across plans. In CBO's estimation, a proposal requiring that approach would yield average premiums for health insurance that were about 5 percent lower than those chosen under current law. Proposals that also adopted other features of managed competition, such as standardization of benefits across plans and adjustments of sponsors' payments to those plans to reflect the health risk of each enrollee, might yield more intense competition among plans and help avoid problems of adverse selection.

Federally Administered Options and Related Budget Options

Under some proposals, the federal government would make available additional options for insurance—for example, by providing access to the private health plans that are offered through the Federal Employees Health Benefits (FEHB) program. The effects of that approach would depend critically on how the premiums for nonfederal enrollees were set. If insurers could charge different premiums to different applicants on the basis of their expected costs for health care, the option would resemble the current small-group and individual markets and thus would have little impact. Alternatively, if new enrollees were all charged the same premium, the FEHB plans would be most attractive to people who expected to have above-average costs for health care. If no subsidies were provided, the total premiums charged to nonfederal enrollees would probably be much higher than those observed in the program today—so the number of new enrollees would probably be limited. Depending on the specific features of such proposals, providing access to FEHB plans might not prove to be financially viable because of adverse selection into those plans.

The government could also design an insurance option based on Medicare that would be made more broadly available, on a voluntary basis, to the nonelderly population. The federal costs per enrollee would depend primarily on the benefits that system pro-

vided; the rates used to pay doctors, hospitals, and other providers of health care; and the extent of any premium subsidies that were offered to enrollees—all of which could differ from Medicare's current design. As for whether such a plan would be more or less costly than a private health insurance plan that provided the same benefits to a representative group of enrollees, the answer would vary geographically. Assuming that Medicare's current rules applied, those costs would be comparable in many urban areas, but in other areas, the cost of the government-run plan would be lower (as is evident in the current program through which Medicare beneficiaries may enroll in a private health plan). At the same time, because Medicare currently provides broad access to doctors and hospitals and employs little benefit management, a Medicare-based option might attract relatively unhealthy enrollees, which could drive up its premiums, federal costs, or both.

Many of the same considerations would arise in designing a single-payer, Medicare-for-all system, but that approach might raise some unique issues as well—and the scale of its impact on federal costs could obviously be much larger if nearly all of the population was covered. Enrollees could be offered a choice of plans under a single-payer system (as happens in Medicare). If, instead, only one design option was offered and all residents were required to enroll in it, then concerns about adverse selection would not arise. That approach could also reduce the administrative costs that doctors and hospitals currently incur when dealing with multiple insurers. The lack of alternatives with which to compare that program, however, could make it more difficult to assess the system's performance. More generally, that approach would raise important questions about the role of the government in managing the delivery of health care.

Under the provisions of Option 27 in the *Budget Options* volume—which would allow individuals and employers to buy into the FEHB program—CBO estimates that about 2.3 million people would enroll in 2014, of whom about 1.3 million would have been uninsured otherwise. The new program would constitute a separate insurance risk pool for nonfederal enrollees, and their premiums would not be the same as those for federal employees. However, premiums would be the same for all nonfederal enrollees within each plan in a particular geographic area and would be structured so that they did not lead to any new outlays by the federal government. The estimate reflects an assessment that the individuals who enrolled in the program would have greater-than-average health risks, which would lead to higher premiums than if the entire eligible population had enrolled in the program. Although considerable uncertainty exists about the financial viability of FEHB plans in such a program, CBO estimated that features such as an annual open-enrollment period, limited exclusions of coverage for preexisting health conditions, and participation by small employers would limit adverse selection and yield a stable pool of enrollees. The buy-in option would increase the deficit by almost $3 billion from 2010 to 2019, reflecting the net effect of reduced revenues (from a shift in employers' compensation to nontaxable health insurance) and reduced outlays from lower enrollment in Medicaid.

Option 18 would establish a Medicare buy-in program for individuals ages 62 to 64. CBO's analysis reflects an assessment that the government could set a premium at a level such that the program was self-financing; that is, the premium would not be subsidized (and a mechanism would be established to ensure that outcome). As with the option to buy into the FEHB program, CBO would expect the buy-in program to attract individuals with higher-than-average health risks. Although the program would be structured so that enrollees paid its full costs through their premiums, federal spending would increase by about $1 billion over 10 years because some people would choose to retire—and thus receive Social Security benefits—earlier than they would have otherwise. In a typical year of the buy-in program, CBO estimates, about 300,000 people would participate, of whom 200,000 would otherwise have purchased individual coverage, 80,000 would have been uninsured, and 20,000 would have remained employed and had employment-based coverage.

Factors Affecting the Supply and Prices of Health Care Services

The ultimate effects of proposals on the use of and spending for health care depend not only on factors that affect the demand for health care services, such as the number of people who are insured and the scope of their coverage, but also on factors that affect the supply and prices of those services. The various methods used for setting prices and paying for services, and the resulting payment rates, affect the supply of health care services by influencing the decisions that doctors, hospitals, and other providers of care make about how many patients to serve and which treatments their patients will receive. Average payment rates for Medicare, Medicaid, and private insurers also differ, which would affect the budgetary impact of proposals that shifted enrollees—and their costs—from one source of coverage to another. Changes in payment rates for public programs or in the amount of uncompensated care provided to the uninsured could also affect private payment rates.

Payment Methods, Incentives for Providers, and Related Budget Options

Most care provided by physicians in the United States is paid for on a fee-for-service basis, meaning that a separate payment is made for each procedure, each office visit, and each ancillary service (such as a laboratory test). Hospitals are generally paid a fixed amount per admission (a bundled payment to cover all of the services that the hospital provides during a stay) or an amount per day. Such payments may encourage doctors and hospitals to limit their own costs when delivering a given service or bundle, but they can also create an incentive to provide more services or more expensive bundles if the additional payments exceed the added costs.

Other arrangements, such as salaries for doctors or periodic capitation payments (fixed amounts per patient), do not provide financial incentives to deliver additional services. Those approaches raise concerns, however, about providers' incentives to stint on care or avoid treating sicker patients. One study randomly assigned enrollees to different health plans and found that those in an integrated plan (which owns the hospitals used by enrollees and pays providers a salary) used 30 percent fewer services

than enrollees in a fee-for-service plan, but whether those results could be replicated more broadly is unclear.

Proposals could seek to change payment methods either indirectly or directly. They could change the payment methods used by private health plans indirectly by encouraging shifts in enrollment toward plans that have lower-cost payment systems. For public programs, such as Medicare and Medicaid, federal policymakers could directly change payment methods. In either case, making those changes could prove to be very difficult.

Chapter 5 of CBO's *Budget Options* volume examines a number of policies that could change the way that providers are paid and thus the incentives they have. Most of those options focus on Medicare, but other options address Medicaid or the larger health care system. Some options would involve relatively modest changes in payment methods, but others would make more dramatic changes to those methods and thus to incentives for providers. Given the significant uncertainty surrounding the effects of some approaches, a series of pilot projects or demonstration programs might provide valuable insights into how to design new payment systems to achieve lower spending while maintaining or improving the quality of care.

Option 30, for example, would bundle Medicare's payments for hospital and post-acute care. Under the specifications of that option, federal spending would be reduced by about $19 billion over the 2010–2019 period, CBO estimates. That approach would constitute a significant change in the way Medicare pays for post-acute care (which includes services provided by skilled nursing facilities and home health agencies). Medicare would no longer make separate payments for post-acute care services following an acute care inpatient hospital stay. Instead, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided both there and in nonhospital settings. Hospitals would have incentives to reduce the cost of post-acute care for Medicare beneficiaries by lessening its volume and intensity or by contracting with lower-cost providers.

Option 38 illustrates how Medicare could move away from fee-for-service payments to physicians in favor of a blend of capitated and per-service payments. That option would require the Centers for Medicare and Medicaid Services (CMS) to assign each beneficiary who participates in fee-for-service Medicare to a primary care physician. Those physicians would receive approximately three-fourths of their Medicare payments on a per-service basis and approximately one-fourth under a capitated arrangement; they would also receive bonuses or face penalties, depending on the total spending for all Medicare services incurred by their panel of beneficiaries. In response to the incentives created by that payment approach, physicians would probably try to reduce spending among their panel of patients in several ways—for example, by limiting referrals to specialists, increasing their prescribing of generic medications, and reducing hospitalizations for discretionary procedures. According to CBO's estimates, this option would increase payments to physicians and decrease

payments to all other Medicare providers, with a net federal savings of about $5 billion between 2010 and 2019.

Payment Rates and Related Budget Options

The financial incentives created by different payment systems—and the spending amounts they yield—also depend on the level at which payment rates, or prices, are set. Those rates depend partly on the methods that are used to set them. Private-sector payment rates are set by negotiation, reflecting the underlying costs of the services and the relative bargaining power of providers and health plans; in turn, bargaining power depends on factors such as the number of competing providers or provider groups within a local market area. Fee-for-service payment rates in Medicare and Medicaid are generally set administratively. That method poses a number of challenges, including how to determine providers' costs—particularly for services that require substantial training or that become cheaper to provide when they are performed more frequently. Additional issues include how to account for the quality of those services and their value to patients, and what impact rate setting might have on the development of new medical technology.

On average, payment rates under Medicare and Medicaid are lower than private payment rates. Specifically, Medicare's payment rates for physicians in 2006 were nearly 20 percent lower than private rates, on average, and its average payment rates for hospitals were as much as 30 percent lower. As for Medicaid, recent studies indicate that its payment rates for physicians and hospitals were about 40 percent and 35 percent lower, respectively, than private rates. Within Medicare, and probably within Medicaid as well, those differentials vary geographically and tend to be larger in rural areas and smaller in urban areas (where competition among providers is generally greater). Given those differences, proposals that shifted enrollment between private and public plans could have a large impact on payments to providers and on spending for health care. Depending on how providers responded to those changes, enrollees' access to care could be affected.

Chapters 7 and 8 of the *Budget Options* volume examine a wide variety of ways in which payment rates for medical services and supplies could be changed under both the Medicare and Medicaid programs. In particular, Option 55 would reduce (by 1 percentage point) the annual update factor under Medicare for inpatient hospital services; by CBO's estimates, that change would yield $93 billion in savings over 10 years. Option 59 includes several alternatives for increasing payment rates for physicians under Medicare, which (under current law) are scheduled to fall by about 21 percent in 2010 and by about 5 percent annually for several years thereafter. The 10-year cost of those alternatives ranges from $318 billion to $556 billion.

Responses to Changes in Demand or Payment Rates

Changes in payment rates could also have an indirect effect on spending by altering the number of services that providers would be willing to supply. Similarly, the budgetary effects of covering previously uninsured individuals would depend not only on

the resulting increase in their demand for care but also on how that increase affected the supply and prices of services. Because the number of U.S.-trained physicians that will be available to work over the next 10 years is largely fixed, supply adjustments in the short run would have to occur in other areas—which could include changes in the number of hours doctors worked or in their productivity, inflows of foreign-trained physicians, or changes in doctors' fees and patients' waiting times.

Whether and to what extent the supply of physicians and other providers would become constrained also depends on the size of the increase in demand for their services and the amount of time available for adjustments to occur. CBO's analysis indicates that providing the uninsured population with coverage that is similar to a typical employment-based plan would increase total demand for physicians' services and hospital care by between 2 percent and 5 percent. If payment rates rose in response to that increase in demand, the impact on spending could be larger. Spending on behalf of previously uninsured people would also increase to the extent that the uncompensated care they had received became compensated.

Uncompensated Care and Cost Shifting

Another issue that arises when analyzing payment rates is whether relatively low rates for public programs or the costs of providing uncompensated or undercompensated care to the uninsured lead to higher payment rates for private insurers—a process known as cost shifting. To the extent that such cost shifting occurs now, proposals that reduced the uninsured population or that switched enrollees from public to private insurance plans could affect private payment rates and thus alter insurance premiums. For that to occur, however, doctors and hospitals would have to lower the fees they charged private health plans in response to a decline in uncompensated care or an increase in their revenues from insured patients.

Overall, the effect of uncompensated care on private-sector payment rates appears to be limited. According to one recent set of estimates, hospitals provided about $35 billion in uncompensated care in 2008, representing roughly 5 percent of their total revenues.[3] Roughly half of those costs may be offset, however, by payments under Medicare and Medicaid to hospitals that treat a disproportionate share of low-income patients. Estimates of uncompensated care provided by doctors are considerably smaller, amounting to a few billion dollars, so the costs of providing such care do not appear to have a substantial effect on private payment rates for physicians.

Whether and to what extent payments to hospitals under Medicare and Medicaid fall below the costs of treating those patients is more difficult to determine. Recent studies indicate, however, that when payment rates change under those programs, hospitals shift only a small share of the savings or costs to private insurers (the same logic would apply for uncompensated care). Instead, lower payment rates from public programs or

3. Jack Hadley and others, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, Web Exclusive (August 25, 2008), pp. W399–W415.

large amounts of uncompensated care may lead hospitals to reduce their costs, possibly by providing care that is less intensive or of lower quality than would have been offered had payments per patient been larger.

Administrative Issues and Effects on Other Programs

The extent to which proposals would affect health insurance coverage or federal budgetary costs, and the timing of those effects, would depend partly on the administrative responsibilities and costs that those proposals entailed and partly on their interactions with other government programs. Other factors would also affect coverage and costs, including the impact of any maintenance-of-effort provisions that might be applied to states or employers and the treatment of various segments of the population, including people who are ineligible for current government health programs and those who—although eligible—are generally difficult to reach and enroll.

Administrative Issues

Proposals could require both federal and state governments to assume new administrative responsibilities and could allocate those responsibilities to new or existing agencies. How well agencies fulfilled new missions—and how long it would take them to do so—would depend on the scope of the new responsibilities and the funding provided. Even with adequate funding, implementing a major initiative might take several years, as illustrated by the experience with the new Medicare drug benefit. One way to ease the implementation of a new federal program would be to build on existing programs; CHIP, for example, was implemented relatively rapidly because it largely built on the existing infrastructure of the state-operated Medicaid program.

Maintenance-of-Effort Requirements

A proposal that created new subsidies for health insurance could lead employers or states to scale back the coverage that they sponsor, particularly if a new federally funded program provided similar or more generous benefits. To prevent such responses or offset their effects on federal spending, proposals could include maintenance-of-effort provisions. Monitoring and enforcing such requirements for private firms would be difficult, however, unless proposals specified effective reporting mechanisms and sufficient penalties for violations.

States' maintenance-of-effort provisions are generally structured in two ways: requiring states to maintain existing programs at historical eligibility or benefit levels (as is done under CHIP), or requiring states to continue spending funds at certain historical or projected levels or to return some of their savings to the federal government (as is done for the Medicare drug benefit). The effectiveness of such requirements would depend on how they were defined, the enforcement mechanisms that were specified, and the incentives for states to comply. The provisions for CHIP and the Medicare drug benefit are examples of effective approaches.

Effects on Other Federal Programs

Proposals could also have unintended effects on eligibility for other federal programs that are not directly related to health care. New subsidies for health insurance might be counted as income or assets when determining eligibility for benefits in means-tested programs (such as the Supplemental Nutrition Assistance Program, formerly known as the Food Stamp program) unless explicitly excluded by law. Proposals that changed the employment-based health insurance system could shift compensation between wages and fringe benefits, thus affecting eligibility for government benefits (including Social Security) or tax credits (such as the earned income tax credit) that are based on cash earnings. Temporary or aggregate adjustments could be made to benefit formulas in order to minimize any adverse effects, but some recipients might still be made worse off.

Treatment of Certain Populations

The treatment of certain populations would present various administrative challenges for proposals to expand coverage. Some individuals, including military personnel and veterans, already receive health benefits from the federal government, and issues might arise regarding the coordination of their current benefits with new federal subsidies. In other cases, federal health programs currently deny benefits to certain populations, such as unauthorized immigrants or prison inmates, and proposals would have to specify whether and how those restrictions would apply to new programs. Other populations, such as the homeless, face challenges enrolling in existing programs, and similar issues might arise in designing new subsidies for health insurance. Those considerations would affect both the costs of proposals and their overall impact on rates of insurance coverage.

Changes in Health Habits and Medical Practices

In addition to any broader changes they make in the health insurance and payment systems, proposals could include specific elements designed to induce individuals to improve their own health or to encourage changes in how diseases are treated. Through a combination of approaches, proposals could try to change the behavior of both patients and providers by:

- Promoting healthy behavior, including measures aimed at reducing rates of obesity and smoking;
- Expanding the use of preventive medical care, which can either impede the development or spread of a disease or detect its presence at an early stage;
- Establishing a "medical home" for each enrollee, typically involving a primary care physician who would coordinate all of his or her care;

- Adopting "disease management" programs that seek to coordinate care for and apply evidence-based treatments to certain diseases, such as diabetes or coronary artery disease;

- Funding research comparing the effectiveness of different treatment options, the results of which could help discourage the use of less clinically effective or less cost-effective treatments;

- Expanding the use of health information technology, such as electronic medical records, which would make it easier to share information about patients' conditions and treatments; and

- Modifying the system for determining and penalizing medical malpractice.

Some of those initiatives could improve individuals' health or enhance the quality of the care that they receive, but it is not clear that they also would reduce overall health care spending or federal costs. In its analysis of such initiatives, CBO considers the available studies that have assessed the particular approaches. In many cases, those studies do not support claims of reductions in health care spending or budgetary savings.

Challenges in Demonstrating Savings

For several reasons, it may be difficult to generate reductions in health care spending from such initiatives. In some cases, the problem is largely one of identifying and targeting the people whose participation would cause health care spending to decline. Broad programs aimed at preventive medical care and disease management could reduce the need for expensive care for a portion of the recipients but could also provide additional services—and incur added costs—for many individuals who would not have needed costly treatments anyway. To generate net reductions in spending, the savings that such interventions generated for people who would have needed expensive care would therefore have to be large enough to offset the costs of serving much larger populations.

A related issue is that many individuals or health plans might already be taking the steps involved (or will in the future) even in the absence of a new requirement or incentive. The effect of any proposal would have to be measured against that trend, and a large share of any subsidies involved might go to people who (or health plans that) would have taken those steps even if there were no requirements or incentives to do so. For example, some doctors and hospitals are already using electronic medical records, and more will adopt that technology in the future under current law, so new subsidy payments would go to many providers who would have purchased such systems anyway, and savings would accrue only for those providers who accelerated their purchases as a result of the subsidy.

In other cases, the effect on health care spending depends crucially on whether doctors and patients have incentives to change the use of health care services. For example, studies may find that a given treatment has fewer clinical benefits or is less cost-effective (meaning that added costs are high relative to the incremental health benefits) for certain types of patients—but those results may not have a substantial effect on the use of that treatment unless the financial incentives facing doctors (through their payments) or patients (through their cost sharing) are aligned with the findings. Similarly, proposals to establish a medical home may have little impact on spending if the primary care physicians who would coordinate care were not given financial incentives to limit their patients' use of other health services.

Other types of initiatives might ultimately yield substantial long-term health benefits but might not generate much savings, at least in the short term. Even if successful, measures to reduce smoking and obesity—two factors linked to the development of chronic and acute health problems—might not have a substantial impact on health care spending for some time. In the long term, spending on diseases caused by poor health habits could decline substantially, but the impact on federal costs would also have to account for people living longer and receiving more in Medicare benefits (for the treatment of other diseases and age-related ailments) as well as other government benefits that are not directly related to health care (including Social Security benefits). Similarly, investments in health information technology might require substantial start-up costs that would be difficult to recapture in the typical 5- and 10-year budgetary time frames used to evaluate legislative proposals.

Demonstrating savings might also be difficult because of data limitations and methodological concerns. For example, studies have found that tort limits, by reducing malpractice awards, cause premiums for malpractice insurance to fall and thus could have a very modest impact on doctors' fees and health care spending. Some observers argue that tort limits would yield larger reductions in that spending because doctors would stop ordering unnecessary tests and taking other steps to reduce the risk of being sued. CBO has not found consistent evidence of such broader effects, but that may reflect the difficulty of disentangling the impact of changes to the medical malpractice system from other factors affecting medical costs.

Related Budget Options

In its *Budget Options* volume, CBO estimated the effect of several approaches aimed at changing health habits or medical practice. For example, Option 106 would impose a new excise tax on sugar-sweetened beverages (equal to 3 cents per 12 ounces of beverage), which would raise about $50 billion in revenues from 2010 to 2019. CBO did not, however, estimate that spending on health care would be reduced under that option. After evaluating the available evidence, CBO could not establish causal links between lower consumption of sugar-sweetened beverages (which would occur under the option) and the use of health care. Studies indicate, for example, that people would offset the reduction in their consumption of such beverages with increases in consumption of other unhealthy foods—so the impact on obesity rates is not clear. In

addition, even though obesity is associated with higher spending on health care, the effect of losing weight on spending for health care is more difficult to determine.

CBO also analyzed the effects of establishing a "medical home" for chronically ill enrollees in the Medicare fee-for-service program (see Option 39). As designed, that option would increase Medicare spending by about $6 billion over 10 years because of the fees provided to practitioners who elected to become medical homes. Alternatively, approaches that would give primary care physicians a financial incentive to limit their patients' use of expensive specialty care—such as the option imposing partial capitation, discussed above—could reduce Medicare spending (depending on the specific features of their design). In the realm of preventive medical care, CBO analyzed the impact of basing Medicare's coverage of such services on evidence about their effectiveness (see Option 110). That option would save nearly $1 billion over 10 years because it would lead the Medicare program to drop coverage for services that are currently covered even though an independent task force has recommended against their use (reflecting evidence that the preventive services are either ineffective or do more harm than good).

Under Option 45, the federal government would fund research that compares the effectiveness of different medical treatments. The results of that research would gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States; the resulting reductions in spending for federal health programs would partly offset the federal costs of conducting that research. Option 8 would impose specific limits on medical malpractice awards; the resulting reduction in premiums for malpractice insurance would yield reductions in the federal budget deficit of nearly $6 billion over 10 years. (CBO did not conclude that the option would have broader effects on the use of health care services.)

Finally, Options 46 through 49 provide various approaches to increase the adoption of health information technology and electronic medical records. Option 46 would create incentives under the Medicare program to adopt that technology; the primary effects on federal outlays would stem from the payment of bonuses for adopting it or the collection of penalties for not doing so. Option 47 would require doctors and hospitals to use electronic health records in order to participate in Medicare. CBO judged that virtually all doctors and hospitals would adopt electronic health records as a result, reducing the federal budget deficit by about $34 billion over 10 years (or by a larger amount if Medicare's payments to doctors and hospitals were also reduced to capture the resulting gains in their productivity).

Effects on Total Health Care Spending, the Scope of the Federal Budget, and the Economy

Proposals that would substantially change the health insurance market could affect total spending on health care, the flow of payments between various sectors of the economy, and the operation of the U.S. economy. CBO will consider those effects in its analyses of major health care proposals.

Effects on Total Spending and the Scope of the Federal Budget

Many health insurance proposals would have an impact on total spending for health care, and some might contain provisions that explicitly limit the level or rate of growth in health care spending; such proposals might impose a global budget or budgetary cap on all or a part of that spending. The effectiveness of such strategies would depend on several factors, including the scope of the global budget, the targets selected for different categories of spending, and the mechanisms used to enforce the caps.

In addition to their overall effects on federal spending and revenues, proposals that made substantial changes to the health insurance system or its financing methods could raise a number of budgetary issues. Such proposals could have substantial effects on the flows of payments among households, employers, and federal and state governments—even if the proposals were budget neutral from a federal perspective. Some proposals might assign the federal government a more active role in the health insurance market; for example, the government could be required to disburse subsidies covering the cost of health insurance, collect health insurance premiums from policyholders, or make payments to insurers. Any of those changes might raise questions regarding who—the government, the insured, or the insurer—would bear financial responsibility for any shortfalls in payments that might occur.

Other proposals might require that individuals or businesses make payments directly to nongovernmental entities. Depending on the specific provisions of such proposals, CBO might judge that payments resulting from federal mandates should be recorded as part of the federal budget even if the funds did not flow through the Treasury. The extent of federal control and compulsion is a critical element in determining budgetary treatment. In general, CBO believes that federally mandated payments—those resulting from the exercise of sovereign power—and the disbursement of those payments should be recorded in the budget as federal transactions.

Effects on the Economy

Proposals that made large-scale changes affecting the provision and financing of health insurance could also have an impact on the broader economy. Because most health insurance is currently provided through employers, proposals could affect labor markets by changing individuals' decisions about whether and how much to work and employers' decisions to hire workers. Such effects could arise in several ways:

- Proposals that decreased the return from an additional hour of work, by imposing new taxes or phasing out subsidies or credits for health insurance as earnings rise, could cause some people to work fewer hours or leave the labor force.

- Proposals that made health insurance less dependent on employment status could induce some people to retire earlier and others to change jobs more often.

- Proposals that treated firms differently on the basis of such characteristics as the number of employees or average wages could affect the allocation of workers among firms.

- Proposals that required employers to provide health insurance could adversely affect the hiring of employees earning at or near the minimum wage, because the total compensation of those workers could exceed their value to the firm.

Some observers have asserted that domestic firms providing health insurance to their workers incur higher costs for compensation than do competitors based in countries where insurance is not employment based and that fundamental changes to the health insurance system could reduce or eliminate that disadvantage. Although U.S. employers may appear to pay most of the costs of their workers' health insurance, economists generally agree that workers ultimately bear those costs. That is, when firms provide health insurance, wages and other forms of compensation are lower (by a corresponding amount) than they otherwise would be. As a result, the costs of providing health insurance to their workers are not a competitive disadvantage for U.S.-based firms.

In addition to their effects on the labor market, proposals could also affect the size of the nation's stock of productive capital, especially through their effects on government budgets. Those effects would depend partly on how the costs of any insurance expansions or other changes were financed. The net effect on the economy of a broad proposal to restructure the health insurance system would, not surprisingly, depend crucially on the details.

United States Senate
Committee on Finance

Sen. Chuck Grassley · Iowa
Ranking Member

Opening Statement of Sen. Chuck Grassley
Finance Committee Hearing, "Scoring Health Care Reform: CBO's Budget Options"
Wednesday, February 25, 2009

Let me begin this morning by restating something I know many people in this room consider obvious: We desperately need to improve health care in America. We have a health care system that is no system at all. Health care in America is a series of disconnected pieces with often perverse or dubious incentives. Health care in America costs too much. Health care in America is not as consistently high in quality as it should be. Health care in America leaves tens of millions of Americans uninsured. Every day we wait to do something to improve health care in America, we do a disservice to the people who elect us to sit in these chairs.

We have an opportunity right now to make positive change. It is an opportunity we should take. But we must also take a sober look at the difficulty of our situation. When Senator Baucus published his health care reform white paper three months ago, I noted the fiscal challenges we face moving forward with health care reform. A few people treated me like the skunk at the party for saying so. Well, I hate to do it again, but everyone knows our fiscal situation has gotten far worse since November. Back in November, I speculated that we might be looking at a 300 billion dollar stimulus package in early 2009. I missed that one, didn't I? The stimulus package ended up costing over 1 trillion dollars when the interest is factored in.

Our national debt is growing rapidly. And let's make sure we put this in the proper perspective. It has been rightly pointed out that the debt held by the public grew during the eight years of that last Administration. Indeed, in the years from 2001 to 2006, the debt grew, albeit by less than one percent per year in terms of GDP. I have a chart here that shows that.

By the way, the greatest debt growth occurred in the last two years of that Administration, when we had a Democratic-controlled Congress. For all the criticism we heard of the marginal rise in public debt in the period of 2001-2006, what occurred during the last Congress exceeds it altogether. Moreover, with respects to deficits, again we heard a lot of criticism of the widespread bipartisan tax relief after 2001 and through 2006.

In fact, as the next chart shows, the deficit went down as tax relief went into full effect. The current Administration inherited a one trillion dollar deficit, and they promptly added another one trillion dollars to our national debt with their so-called economic stimulus bill.

The stimulus bill contains a number of entitlement expansions, which if made permanent, would add another two trillion dollars to the debt. And our unfunded obligation for Social Security and Medicare is more than 40 trillion dollars over the next 75 years.

I have heard some folks say it is our moral responsibility to provide health care coverage for all. We have an equal if not greater moral responsibility to do so in a fiscally sustainable manner. Let me quote Peter Orszag, OMB Director, in yesterday's Washington Post. He said: "Let me be very clear: Health care reform is entitlement reform. The path of fiscal responsibility must run directly through health care."

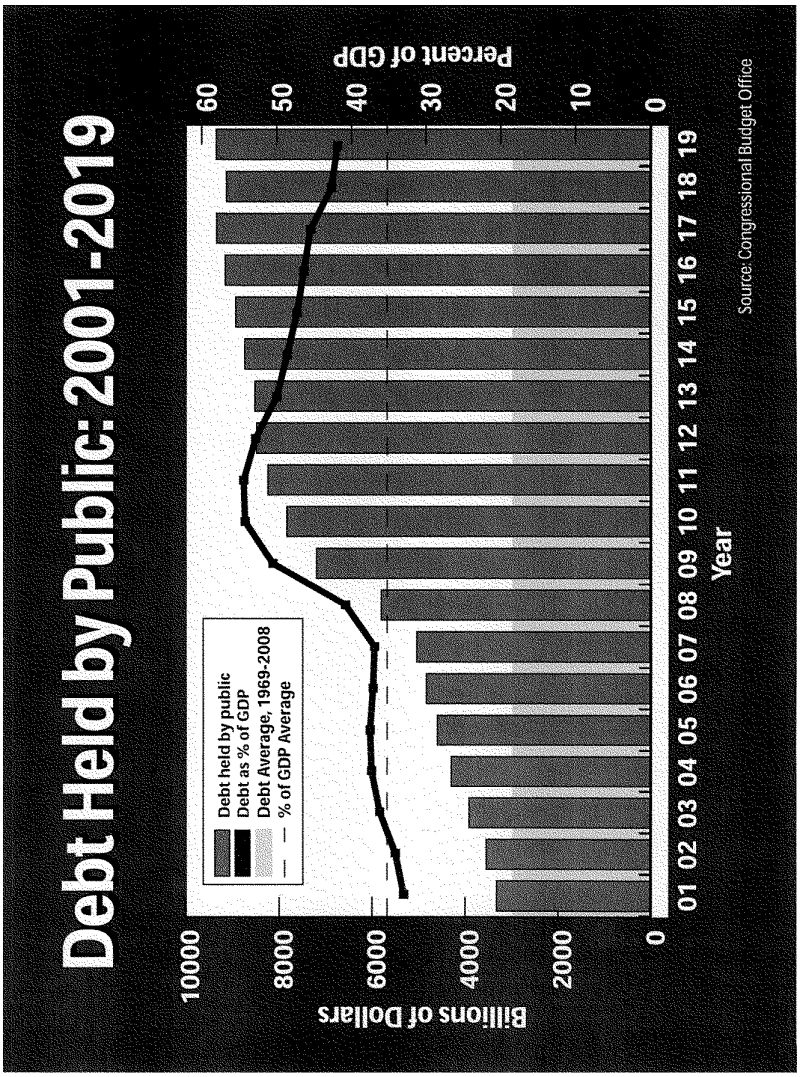
For some, fiscal responsibility and health care reform don't usually go together. So it's good to hear the new Director of the Office of Management and Budget at the White House making this connection. Getting overall health care costs under control is an elusive goal. Even if it is achievable in the long-term, it will not replace the need to tackle the difficult job of slowing the growth in entitlement spending in the near-term.

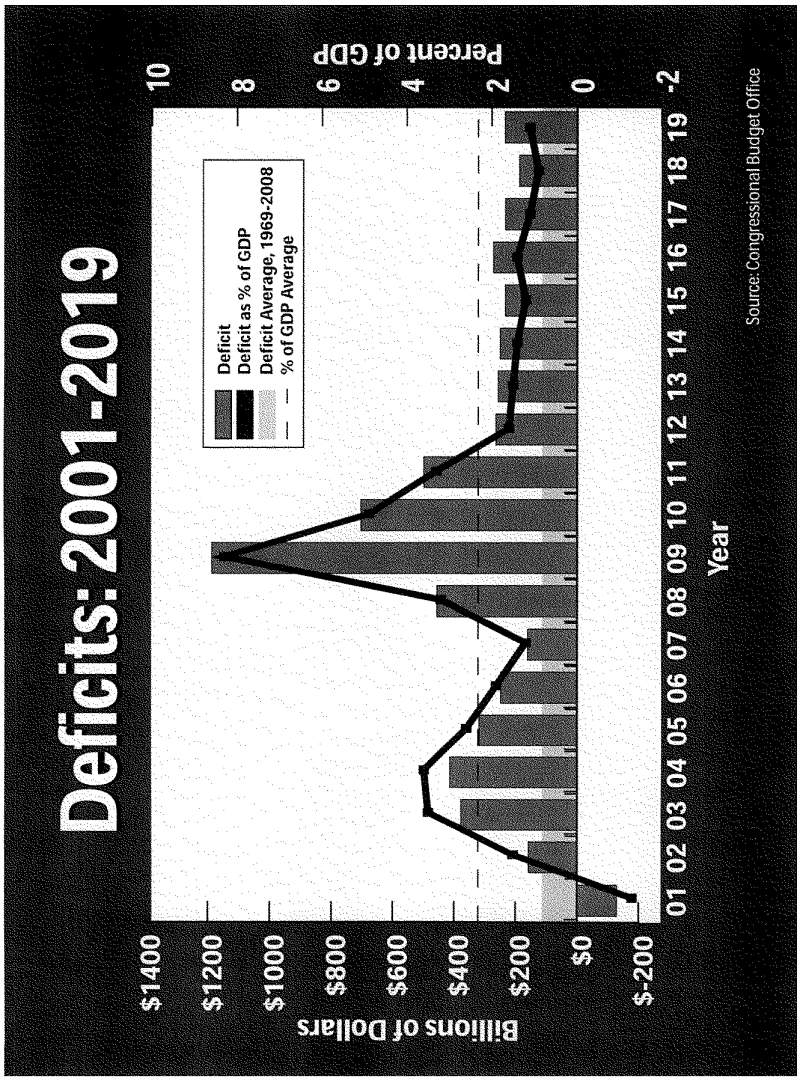
If we don't, then we won't be living up to the promise made to protect these important programs for future generations. In their current state, these entitlements – and here I'm talking about Medicare and Medicaid – are not financially sustainable.

But, we must be very wary of the idea that we have to spend more up front to reap savings down the road. Too often with the federal government, the up-front spending happens, but the long-term savings don't. There's no question in my mind that if we're not careful, Congress could make the situation worse. One could easily see how spending more up front could make the financial problem facing Medicare and Medicaid even worse than it already is today.

The President has an opportunity as he walks this razor's edge between a broken health care system and fiscal catastrophe. He has the opportunity to move beyond the unfortunate partisanship of the final Children's Health Insurance bill and the stimulus. He has the opportunity to set aside the fiscal alchemy we have seen in prior budgets and set a new standard for honest budgeting in health care. He has the opportunity to move beyond the sound bites of campaigns and into the reality of funding health care coverage in fiscally challenging times. There is an opportunity here. With the budget tomorrow, the President can show us a pathway to move forward with fiscally responsible health care reform.

As I said on the floor at the end of the CHIP debate, I am willing to move past the partisan politics that have dominated these first few weeks of 2009, because the issue is critical to our constituents. I'm willing to find ways to work together. But we clearly have our work cut out for us. That's why I'm pleased that we are having this hearing today. The Congressional Budget Office plays a central role in the health care reform debate. They are the official scorekeeper on fiscal issues for Congress. We are going to have to pay close attention to what the Congressional Budget Office has to say about health care reform proposals. We will have to examine closely the cost drivers in our system and what to do about them. Rising costs put health coverage out of reach for more and more people. We need to find ways to encourage more efficiency in the system. And we need to reward providers who consistently delivery higher quality care. The Congressional Budget Office has done quite a lot to start this conversation, and I look forward to the testimony today.


Debt Held by Public: 2001-2019
Billions of Dollars
Percent of GDP
Year
Debt held by public
Debt as % of GDP
Debt Average, 1969-2008
% of GDP Average
0
2000
4000
6000
8000
10000
0
10
20
30
40
50
60
01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19
Source: Congressional Budget Office


Deficits: 2001-2019
Billions of Dollars
$1400
$1200
$1000
$800
$600
$400
$200
$0
$-200
Percent of GDP
10
8
6
4
2
0
-2
01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19
Year
Deficit
Deficit as % of GDP
Deficit Average, 1969-2008
% of GDP Average
Source: Congressional Budget Office